

NSF (National Standard Format) USER MANUAL

NSF OVERVIEW

This manual contains record layouts of the NSF, which is used to bill CMS-1500, Medical, and Dental claims.

The instructions for transmitting a file are as follows:

- Logon to www.emomed.com.
- Select "Send files" link.
- Populate the window with the file name.
- Submit the information.

A window appears either confirming successful receipt or notifying of non-receipt of the file.

If the receipt was successful, check for appropriate responses in the "Receive Provider files" area of the www.emomed.com website. Claim confirmation and Functional Acknowledgement (997) files are generated daily and remain on-line for more than 30 days.

If the receipt was not successful and the biller is unable to determine the reason for the non-receipt, contact the Infocrossing Healthcare Services (IHS) Help Desk at (573) 635-3559.

If no claim confirmation file is available after 2 complete business days, contact the IHS Help Desk at (573) 635-3559.

PROCESSING OVERVIEW

For Health Care Services/Dental Services using the National Standard Format (NSF)

Claims for one or more providers may be submitted on a file. These claims can be different types (health care services or dental services). Electronic claim submissions should be made as frequently as possible to avoid unnecessary delays in reimbursement.

The first record on each file must be a Record Type 'AA0'. This record contains file origination information concerning the creation of specific information for all providers billing on the file. The information submitted on this record is posted to the MO HealthNet Electronic Media Claims (EMC) reference file, assuring an accurate contact address is always on file for future Service Bureau information.

FILE SPECIFICATIONS FOR HEALTH CARE/DENTAL (NSF)

The file name must be CLAIMS.ALI on diskettes or emomed.com, it may be any name you choose.

Record Type 'AA0' Processor Data must be the first record on each file.

Record Type 'ZA0' File Control must be the last record on each file.

For files with multiple providers, Record Type 'BA0' Provider Data and Record Type 'YA0' Provider Batch Control are required for each different provider.

All records are 320 bytes long plus a 2 byte end of record marker

All data in the records must be text format using IBM ASCII characters.

The end of record marker is a two byte field containing the value HEX OD OA (Carriage Return/Line Feed).

There are no field separators.

The end of file marker is a 1 byte HEX 1A.

This section of the manual contains National Standard Format (NSF) as accepted by CMS. It contains information in order for you to send MO HealthNet CMS-1500 and Dental claims to Infocrossing Healthcare Services. **If you are beginning development for MO HealthNet, we strongly recommend you develop the NSF layout.**

MEDICAL/CMS-1500/DENTAL OVERVIEW

What follows explains what fields/records are required for MO HealthNet claims. The Electronic Media Claims NSF layout as published by CMS, version 003.00, giving you actual field lengths and positions.

CMS-1500 claims have a minimum of 5 records per claim. One CA0 record, one DA0 record, one EA0 record, 1 - 12 FA0 records, and one XA0 record. Dental claims have a minimum of 6 records per claim, one CA0 record, one DA0 record, one EA0 record, 1 - 13 FA0 records, 1 - 13 FD0 records and one XA0 record.

Required Records

AA0 File Header Record "Submitter Data"

BA0 Batch Header Record "Provider Data 1"

CA0 Claim Header Record "Patient Data"

DA0 Insurance Information "Payor Data 1"

EA0 Claim Record

FA0 Service Line Detail "Root Segment"

FD0 Service Line Detail "Dental Segment" (Dental Claims Only)

XA0 Claim Trailer Record "Record Summary"

YA0 Batch Trailer Record

ZA0 File Trailer Record

Record Layout Charts (for CMS-1500 and Dental)

Description of Headings

Field No.----- Field Number

Field Name----- Field Name

Table Value----- Data element identifier for the Data Definition Table.

Default----- A "YES" implies that the field is required for **all** claims.

A "NO" implies that the field is not always required or not required for all MO HealthNet claims or the field is optional.

"Not Used" implies that the field is NOT applicable to MO HealthNet billing and will not be used if submitted.

CLAIM SUBMISSION RESTRICTIONS

Services or cases which require substantiating documentation or clarifying information cannot be billed via electronic format and must be billed on paper claims. These may include:

*Sterilization consents

Abortions

*Hysterectomies

Medicare crossover claims—these claims should be submitted to Medicare via the customary procedure.

Emergency procedures performed which would otherwise require prior authorization.

Services for which special consideration is appropriate, e.g., complicated surgery requiring an operative report.

Services exceeding MO HealthNet benefits, thereby requiring the provider's statement of medical necessity.

Any procedures where the CPT-4 procedure coding system does not accurately identify the services being rendered.

Other insurance resources present but no payment from other sources indicated. In such cases, justification for nonpayment is required.

Services requiring denture certification, home health certification, or hearing aid certification.

*Second surgical opinion procedures

Eyeglass lenses

Complex consultations

Visits relating to a "grower" baby

*Oxygen and respiratory equipment justification

*Medical referral of restricted participants.

Any other claims which require special handling or attachments.

*** May not be submitted in batch files, but may be submitted individually as attachments on emomed.com.**

RECORD NAME: FILE HEADER RECORD TYPE AA0 "SUBMITTER DATA"

Required by MO HealthNet - Must be first record for NSF

Must be followed by BA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "AA0"	C-24	AA0
02	SUB ID		Not Used

03	RESERVED (AA0-03.0)		Not Used
04	SUBMISSION TYPE		Not Used
05	SUBMISSION NO		Not Used
06	SUB NAME	C-47	YES
07	SUB ADDR1	C-47	YES
08	SUB ADDR2	C-47	YES
09	SUB CITY	C-47	YES
10	SUB STATE	C-47	YES
11	SUB ZIP	C-47	YES
12	SUB REGION	C-47	NO
13	SUB CONTACT	C-47	NO
14	SUB PHONE	C-47	YES
15	CREATION DATE		Not Used
16	SUBMISSION TIME		Not Used
17	RECEIVER ID		Not Used
18	RECEIVER TYPE CODE		Not Used
19	VERSION CODE-NATIONAL		00300
20	VERSION CODE-LOCAL		Not Used
21	TEST/PROD IND		Not Used
22	PASSWORD		Not Used
23	RETRANSMISSION STATUS		Not Used
24	ORIGINAL SUB ID		Not Used
25	VENDOR APP CAT		Not Used
26	VENDOR SOFTWARE VER		Not Used
27	VENDOR SOFTWARE UPDTE		Not Used
28	COB FILE IND		Not Used
29	PROCESS FROM DATE		Not Used
30	PROCESS THRU DATE		Not Used
31	ACKNOWLEDGMENT REQUEST		Not Used
32	DATE OF RECEIPT		Not Used

17.0	RECEIVER ID	16	X	227	242
18.0	RECEIVER TYPE CODE	1	X	243	243
19.0	VERSION CODE-NATIONAL	5	N	244	248
20.0	VERSION CODE-LOCAL	5	N	249	253
21.0	TEST/PROD IND	4	X	254	257
22.0	PASSWORD	8	X	258	265
23.0	RETRANSMISSION STATUS	1	X	266	266
24.0	ORIGINAL SUB ID	16	X	267	282
25.0	VENDOR APP CAT	1	X	283	283
26.0	VENDOR SOFTWARE VER	5	X	284	288
27.0	VENDOR SOFTWARE UPDTE	2	X	289	290
28.0	COB FILE IND	1	X	291	291
29.0	PROCESS FROM DATE	8	X	292	299
30.0	PROCESS THRU DATE	8	X	300	307
31.0	ACKNOWLEDGMENT REQUEST	1	X	308	308
32.0	DATE OF RECEIPT	8	X	309	316
33.0	FILLER-NATIONAL	4	X	317	320

RECORD/FIELD: AA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "AA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "Submitter Data Record".

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered.

Must be "AA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-02.0

DATA ELEMENT: Submitter Identifier (SUB ID)

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<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(16)	LEFT	SPACES	04	19

DEFINITION: Identifies the submitter as defined by the receiver.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be identical to the SUBMITTER ID entered in the File Trailer Record (ZA0-02.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: May be a federally assigned Employer Identification Number (EIN). EIN is also referred to as a Tax Identification Number (TIN) depending on the receiver's requirements.

RECORD/FIELD: AA0-03.0

DATA ELEMENT: Reserved (AA0-03.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(09)	LEFT	SPACES	20	28

DEFINITION: Unused reserved record space.

CODE VALUES: Not used by MO HealthNet.

VALIDATION:N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-04.0

DATA ELEMENT: Submission Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(06)	LEFT	SPACES	29	34

DEFINITION: Identifies the input medium or method used to transmit the data to the receiver.

CODE VALUES: Not used by MO HealthNet.

<u>CODE VALUES:</u>	<u>ASYN</u>	<u>BISYN</u>	<u>SYN</u>	<u>RJE</u>	<u>FAX</u>	<u>TAPE</u>
	ASY	BSY	NDM	RJE	FAX	TP
	ASY003	BSY024		RJE024		TPCRTG
	ASY012	BSY048		RJE048		TP0800

ASY024	BSY096	RJE096	TP1600
ASY048	BSY192	RJE192	TP6250
ASY096			

<u>DISKETTE</u>	<u>SCANNER</u>	<u>CPU</u>
DSK8SSDSK5SSDSK3SS	SCN	CPU
DSK8SDDSK5SDDSK3SD	SCNOCR	
DSK8DDDSK5DDDSK3DD	SCNICR	
DSK5HDDSK3HD		

VALIDATION: At a minimum, must be a valid code from the above lists.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-05.0

DATA ELEMENT: Submission Number (SUBMISSION NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(06)	LEFT	SPACES	35	40

DEFINITION: The inventory file number of the tape reel or transmission assigned by the submitter's system.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

The Submission Number must be unique for every new file submitted.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-06.0

DATA ELEMENT: Submitter Name (SUB NAME)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(33)	LEFT	SPACES	41	73

DEFINITION: The name of the submitter to which the receiver should direct inquiries regarding this file.

CODE VALUES: See the C-47 table for valid field values.

VALIDATION: Must be entered if required by receiver.

See GENERAL INSTRUCTIONS for "Name 2" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-07.0, AA0-08.0, AA0-09.0, AA0-10.0, AA0-11.0

DATA ELEMENT:	Submitter Street Address 1	(SUB ADDR1)
	Submitter Street Address 2	(SUB ADDR2)
	Submitter City	(SUB CITY)
	Submitter State	(SUB STATE)
	Submitter Zip Code	(SUB ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(30)	LEFT	SPACES	74	103
08.0	X(30)	LEFT	SPACES	104	133
09.0	X(20)	LEFT	SPACES	134	153
10.0	X(02)	LEFT	SPACES	154	155
11.0	X(09)	LEFT	SPACES	156	164

DEFINITION: The mailing address of the submitter of the claim file.

CODE VALUES: See the C-47 table for valid field values.

VALIDATION: Must be entered if required by receiver.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-12.0

DATA ELEMENT: Submitter Region (SUB REGION)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(05)	LEFT	SPACES	165	169

DEFINITION: A receiver defined field that identifies the region submitting the claim. To be used for future regional processing.

CODE VALUES: See the C-47 table for valid field values.

VALIDATION: Must be entered if required by receiver.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-13.0

DATA ELEMENT: Submitter Contact (SUB CONTACT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(33)	LEFT	SPACES	170	202

DEFINITION: Identifies an individual responsible for issues that may arise concerning this submission.

CODE VALUES: See the C-47 table for valid field values.

VALIDATION: Must be entered if required by receiver.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-14.0

DATA ELEMENT: Submitter Telephone Number(SUB PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(10)	LEFT	SPACES	203	212

DEFINITION: The telephone number of the SUBMITTER CONTACT (AA0-13.0).

CODE VALUES: See the C-47 table for valid field values.

VALIDATION: Must be entered if required by receiver.

See GENERAL INSTRUCTIONS for "Telephone" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-15.0

DATA ELEMENT: Creation Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(08)	LEFT	SPACES	213	220

DEFINITION: Identifies the date the submitter created the file.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

Must not be later than the date the file is received.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-16.0

DATA ELEMENT: Submission Time

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(06)	LEFT	SPACES	221	226

DEFINITION: Identifies the time of day that the submitter created the file.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Format: HHMMSS (military time).

HH = hour

MM = minutes

SS = seconds

Must be entered if required by receiver.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-17.0

DATA ELEMENT: Receiver Identification (RECEIVER ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X (16)	LEFT	SPACES	227	242

DEFINITION: A value assigned by the receiver/payor to identify the organization designated to ultimately receive this file to prevent misrouting of claim data.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor / receiver.

Must be identical to the RECEIVER IDENTIFICATION value in the File Trailer Record (ZA0-04.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-18.0

DATA ELEMENT: Receiver Type Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(01)	LEFT	SPACES	243	243

DEFINITION:A code indicating the type of organization designated to receive this file.

CODE VALUES: Not used by MO HealthNet.

- CODE VALUES:
- A - Self Pay
 - B—Workers Compensation
 - C—Medicare
 - D—MO HealthNet
 - E—Other Federal Program
 - F—Insurance Company
 - G—Blue Shield
 - H—CHAMPUS
 - I—Other
 - J—Blue Cross
 - Z—Multiple Payor Organizations

VALIDATION: Must be entered if required by receiver. If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-19.0

DATA ELEMENT: Version Code-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	9(03)V99	RIGHT	ZEROS	244	248

DEFINITION:A code indicating the specification version being used. This is restricted to National use.

CODE VALUES: 00300

VALIDATION: Format: 999V99

Must be entered.

Must be "00301".

FORM LOCATION: N/A

REMARKS: The first three (3) digits BEFORE the implied decimal will indicate changes in record format or any new or deleted records. It is the VERSION of specifications.

The last two (2) digits AFTER the implied decimal will indicate changes in editing. It is the UPDATE NUMBER of the specifications.

RECORD/FIELD: AA0-20.0

DATA ELEMENT: Version Code-Local

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	9(03)V99	RIGHT	ZEROS	249	253

DEFINITION:A code indicating the specification version being used. This is restricted to Local use.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver. Format: 999V99

FORM LOCATION: N/A

REMARKS: Do not use for Medicare. Medicare does not allow local version of the NSF.

RECORD/FIELD: AA0-21.0

DATA ELEMENT: Test/Production Indicator (TEST/PROD IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(04)	LEFT	SPACES	254	257

DEFINITION:A code indicating whether the file is to be used for test or production purposes.

CODE VALUES: Not used by MO HealthNet.

TEST = file should be run through a test system.

PROD = file should be run through a production system.

VALIDATION: Must be entered if required by receiver. If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-22.0

DATA ELEMENT: Password

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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22.0 X(08) LEFT SPACES 258 265

DEFINITION: A user-specific code designed to gain access to the receiver's network/application.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-23.0

DATA ELEMENT: Retransmission Status

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(01)	LEFT	SPACES	266	266

DEFINITION: A code indicating the type of transmission for this file.

CODE VALUES: Not used by MO HealthNet.

CODE VALUES: 0 - Normal Transmission
 8 - Non-Chargeable Retransmission
 9 - Chargeable Retransmission

VALIDATION: Must be entered if required by receiver. If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-24.0

DATA ELEMENT: Original Sub ID

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(16)	LEFT	SPACES	267	282

DEFINITION: Identifies the original submitter of claims in this file.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: Limited to payor who requires identification of the original submitter when transferring claims.

RECORD/FIELD: AA0-25.0

DATA ELEMENT: Vendor Application Category (VENDOR APP CAT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(01)	LEFT	SPACES	283	283

DEFINITION: The category that applies to the vendor who created this file.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by the payor.

FORM LOCATION: N/A

REMARKS: The application category can be used to identify the category the vendor's software (that created this file) applies to. For example, Medicare Part B, Medicare Durable Medical Equipment Regional Carrier, MO HEALTHNET, private and commercial side, etc.

Consult the Matrix/Usage document supplied by the payor/receiver for submission instructions.

RECORD/FIELD: AA0-26.0

DATA ELEMENT: Vendor Software Version (VENDOR SOFTWARE VER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(05)	LEFT	SPACES	284	288

DEFINITION: The version of the software package that was used to create this file.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by the payor.

FORM LOCATION: N/A

REMARKS: Reporting the version of the software can assist in troubleshooting discrepancies between what the biller sent and what the software vendor believes should be send when updates are made.

Consult the Matrix/Usage document supplied by the payor/receiver for submission instructions.

RECORD/FIELD: AA0-27.0

DATA ELEMENT: Vendor Software Update (VENDOR SOFTWARE UPDTE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(02)	LEFT	SPACES	289	290

DEFINITION: The update number of this version of software used to create this file.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by the payor.

FORM LOCATION: N/A

REMARKS: This fields relates to any special "fixes" or updates to the version reported in field AA0-26.0.

Consult the Matrix/Usage document supplied by the payor/receiver for submission instructions.

RECORD/FIELD: AA0-28.0

DATA ELEMENT: Coordination of Benefits File Indicator (COB FILE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(01)	LEFT	SPACES	29	291

DEFINITION: Identifies the NSF file submitted as an NSF

Coordination of Benefits file, exchanged between payors.

CODE VALUES: Not used by MO HealthNet.

CODE VALUES: Y = This file is a NSF COB file

blank = this file is a NSF file

VALIDATION: Y must be entered if this file is to be exchanged between payors for COB purposes.

FORM LOCATION: N/A

REMARKS: Required for COB exchange.

RECORD/FIELD: AA0-29.0

DATA ELEMENT: PROCESS FROM DATE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(08)	LEFT	SPACES	292	299

DEFINITION: The beginning date of the date range that this file covers.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: This is primarily for COB exchange. Required for COB exchange.

RECORD/FIELD: AA0-30.0

DATA ELEMENT: PROCESS THRU DATE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(08)	LEFT	SPACES	300	307

DEFINITION: The end date of the date range that this file covers.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: This is primarily for COB exchange. Required for COB exchange

RECORD/FIELD: AA0-31.0

DATA ELEMENT: Acknowledgment Requested (ACKNOWLEDGMENT REQUEST)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(01)	LEFT	SPACES	308	308

DEFINITION: Indicates if sender of the transmission wants to receive a functional acknowledgment.

CODE VALUES: Not used by MO HealthNet.

CODE VALUES: Y = Functional acknowledgment requested

N = No functional acknowledgment requested

VALIDATION: Must be a valid code.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: AA0-32.0

DATA ELEMENT: DATE OF RECEIPT

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(08)	LEFT	SPACES	309	316

DEFINITION: The date this file was received from the submitter.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: This is to be entered by the receiver of the file.

RECORD/FIELD: AA0-33.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
33.0	X(04)	LEFT	SPACES	317	320

DEFINITION: Unused record space reserved for National use.

CODE VALUES: N/A

VALIDATION:N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: BATCH HEADER RECORD TYPE BA0 "PROVIDER DATA 1"

Required by MO HealthNet

Must be followed by BA1 or CA0

Must follow either AA0 or YA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "BA0"	C-24	BA0
02	EMC PROV ID		Not Used
03	BATCH TYPE	C-61	YES
04	BATCH NO		Not Used
05	BATCH ID		Not Used
06	PROV TAX ID		Not Used
07	RESERVED (BA0-07.0)		Not Used
08	PROV TAX ID TYPE		Not Used
09	PROV MEDICARE NO		Not Used
10	PROV UPIN-USIN ID		Not Used
11	RESERVED (BA0-11.0)		Not Used
12	PROV MEDICAID ID	C-8	YES
13	PROV CHAMPUS NO		Not Used

14	PROV BLUE SHIELD NO		Not Used
15	PROV COMMERCIAL NO		Not Used
16	PROV NO 1		Not Used
17	PROV NO 2		Not Used
18	ORGANIZATION NAME	C-33	YES
19	PROV LAST NAME		Not Used
20	PROV FIRST NAME		Not Used
21	PROV MI		Not Used
22	PROV SPECIALTY		Not Used
23	SPECIALTY LICENSE NO		Not Used
24	STATE LICENSE NO		Not Used
25	DENTIST LICENSE NO		Not Used
26	ANESTHESIA LICENSE NO		Not Used
27	PROV PARTICIPATE IND		Not Used
28	FILLER-NATIONAL		YES

RECORD TYPE: BA0

LEVEL: BATCH

PURPOSE: To identify and provide information regarding the provider of services indicated in this batch.

REQUIREMENTS: This record is required. A "BA0" record is required for every submission.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	AA0 or YA0	BA1 or CA0

NOTES: Only one BA0 record is allowed for each batch.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "BA0"	3	X	01	03
02.0	EMC PROV ID	15	X	04	18
03.0	BATCH TYPE	3	X	19	21
04.0	BATCH NO	4	N	22	25

05.0	BATCH ID	6	X	26	31
06.0	PROV TAX ID	9	X	32	40
07.0	RESERVED (BA0-07.0)	6	X	41	46
08.0	PROV TAX ID TYPE	1	X	47	47
09.0	NATIONAL PROV ID	15	X	48	62
10.0	PROV UPIN-USIN ID	6	X	63	68
11.0	RESERVED (BA0-11.0)	6	X	69	74
12.0	PROV MEDICAID NO	15	X	75	89
13.0	PROV CHAMPUS NO	15	X	90	104
14.0	PROV BLUE SHIELD NO	15	X	105	119
15.0	PROV COMMERCIAL NO	15	X	120	134
16.0	PROV NO 1	15	X	135	149
17.0	PROV NO 2	15	X	150	164
18.0	ORGANIZATION NAME	33	X	165	197
19.0	PROV LAST NAME	20	X	198	217
20.0	PROV FIRST NAME	12	X	218	229
21.0	PROV MI	1	X	230	230
22.0	PROV SPECIALTY	3	X	231	233
23.0	SPECIALTY LICENSE NO	15	X	234	248
24.0	STATE LICENSE NO	15	X	249	263
25.0	DENTIST LICENSE NO	15	X	264	278
26.0	ANESTHESIA LICENSE NO	15	X	279	293
27.0	PROV PARTICIPATE IND	1	X	294	294
28.0	FILLER-NATIONAL	26	X	295	320

RECORD/FIELD: BA0-01.0

DATA ELEMENT: Record Type (RECORD ID 'BA0')

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This field is used to identify the "PROVIDER DATA 1" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered.

Must be BA0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA0-02.0

DATA ELEMENT: EMC Provider Identifier (EMC PROV ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(15)	LEFT	SPACES	04	18

DEFINITION: The unique number assigned to the provider for EMC identification purposes by the payor/receiver.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered. Must be identical to the "EMC Provider Identifier" in the corresponding record

YA0 - 02.0.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-03.0

DATA ELEMENT: Batch Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(03)	LEFT	SPACES	19	21

DEFINITION: This field indicates the type of claims that are included within this batch.

CODE VALUES: See the C-61 table for valid field values.

VALIDATION: Must be entered if required by the receiver. If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA0-04.0

DATA ELEMENT: Batch Number (BATCH NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(04)	RIGHT	ZEROS	22	25

DEFINITION: This is a sequential number assigned by the submitter, to each batch of claims.

CODE VALUES: Not used by MO HealthNet.

Must be equal to 0001 through 9999.

VALIDATION: Must be entered.

Must be numeric.

First occurrence must be 0001.

Whenever the "EMC Provider Identifier", BA0 - 02.0, or "Type of Batch", BA0 - 03.0, changes from those previously entered, the "Batch Number" must be reset to 01.

If the previous "EMC Provider Identifier", BA0 - 02.0 and "Type of Batch", BA0 - 03.0 are identical with those currently being processed, the "Batch Number" must be one greater than the previous "Batch Number".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA0-05.0

DATA ELEMENT: Batch Identification (BATCH ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(06)	LEFT	SPACES	26	31

DEFINITION: The identifier assigned by the submitter/provider to identify a batch within his own system.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Optional at the submitter/provider discretion.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: Used to facilitate the communication between the receiver and submitter/provider, concerning problem batches, as well as the reporting of claims with errors and accepted claims.

RECORD/FIELD: BA0-06.0

DATA ELEMENT: Provider Tax ID (PROV TAX ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(09)	LEFT	SPACES	32	40

DEFINITION: The federally assigned Tax identification number (T.I.N.) of the billing provider. This can be either the Employer Identification Number (E.I.N.) or the Social Security Number (S.S.N.) of the provider.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by carrier/receiver. The "Provider Tax ID" entered in BA0 - 06.0 must be identical to the "Provider Tax ID" entered in YA0 - 06.0.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 25

REMARKS: N/A

RECORD/FIELD: BA0-07.0

DATA ELEMENT: Reserved Field (BA0 07.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(06)	N/A	SPACES	41	46

DEFINITION: Unused reserved record space.

Reserved for Tax ID expansion.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA0-08.0

DATA ELEMENT: Provider Tax ID Type (PROV TAX ID TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(01)	N/A	SPACE	47	47

DEFINITION: A code which identifies the type of Provider Tax ID entered in BA0 - 06.0.

CODE VALUES: Not used by MO HealthNet.

E = Employer Identification Number S = Social Security Number X = Corporate name, but Social Security Number

VALIDATION: Must be entered if required by payor. If entered, must be a valid code from the above list.

If this field is equal to "E" or "X", then the "Provider Organization Name" (BA0 - 18.0) must not be blank unless an individual provider (solo practioner) has a Tax ID/EIN "E" in which case, BA0-19.0 must not

be blank. If this field is equal to "S" then the "Provider Last Name" (BA0 - 19.0) and "Provider First Name" (BA0 - 20.0) must not be blank.

FORM LOCATION: CMS-1500 Block 25

REMARKS: N/A

RECORD/FIELD: BA0-08.0

DATA ELEMENT: National Provider Identifier (NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(15)	LEFT	SPACES	48	62

DEFINITION: The National Provider Identifier assigned to the provider.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If entered:

This field must contain the National Provider Identifier (NPI) for Medicare claims once the NPI is implemented.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: If the NPI is not entered or entered incorrectly, all Medicare claims contained within the batch may be rejected.

REQUIREMENTS: The NPI must be entered if the batch contains any claims that are to be processed by a Medicare payor.

RECORD/FIELD: BA0-10.0

DATA ELEMENT: Provider "UPIN" - "USIN" ID (PROV UPIN-USIN ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(06)	LEFT	SPACES	63	68

DEFINITION: The number assigned to the provider by the National Registry for Medicare Identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Not applicable at this time.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-11.0

DATA ELEMENT: Reserved Field (BA0 11.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(06)	LEFT	SPACES	69	74

DEFINITION: Unused reserved record space.

Reserved for UPIN expansion.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA0-12.0

DATA ELEMENT: Provider MO HealthNet Number (PROV MO HEALTHNET NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(15)	LEFT	SPACES	75	89

DEFINITION: The number assigned to the Provider by a MO HealthNet

State Agency for identification purposes.

CODE VALUES: See the C-8 table for valid field values.

VALIDATION: If entered:

This field must contain the MO HealthNet Provider Number as it appears on the Payor's Provider File.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: If the MO HealthNet Provider Number is not entered or entered incorrectly all MO HealthNet claims contained within the batch may be rejected.

REQUIREMENTS: The MO HealthNet Provider Number must be entered if the batch contains any claims that are to be processed by a MO HealthNet payor.

RECORD/FIELD: BA0-13.0

DATA ELEMENT: Provider Champus Number (PROV CHAMPUS NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(15)	LEFT	SPACES	90	104

DEFINITION: The number assigned to the Provider by the Champus payor for identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If entered:

This field must contain the Champus Provider Number as it appears on the Payor's Provider File.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: If the Champus Provider Number is not entered or entered incorrectly all Champus claims contained within the batch may be rejected.

REQUIREMENTS: The Champus Provider Number must be entered if the batch contains any claims that are to be processed by a Champus payor.

RECORD/FIELD: BA0-14.0

DATA ELEMENT: Provider Blue Shield Number (PROV BLUE SHIELD NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(15)	LEFT	SPACES	105	119

DEFINITION: The number assigned to the Provider by the Blue Shield payor for identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If entered:

This field must contain the Blue Shield number as it appears on the Payor's Provider File.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: If the Blue Shield Provider Number is not entered or entered incorrectly all Blue Shield claims

contained within a batch may be rejected.

REQUIREMENTS: The Blue Shield Provider Number must be entered if the batch contains any claims that are to be processed by a Blue Shield payor.

RECORD/FIELD: BA0-15.0

DATA ELEMENT: Provider Commercial Number (PROV COMMERCIAL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(15)	LEFT	SPACES	120	134

DEFINITION: The number assigned to the Provider by the Commercial payor for identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If entered:

This field must contain the Commercial Payor's Provider number as it appears on the Payor's Provider File.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 25 & 33

REMARKS: If the Commercial Payor's Provider Number is not entered or entered incorrectly all commercial

claims contained within a batch may be rejected.

REQUIREMENTS: The Commercial Carrier's Provider Number must be entered if the batch contains any claims that are to be processed by a commercial payor.

RECORD/FIELD: BA0-16.0

DATA ELEMENT: Provider Other Number 1 (PROV NO 1)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(15)	LEFT	SPACES	135	149

DEFINITION: The number assigned to the provider by the receiver for other identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered as required by receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: Example: Specific number assigned for Workmen's Compensation, Health Maintenance Organization

(HMO) or Additional Commercial Number.

RECORD/FIELD: BA0-17.0

DATA ELEMENT: Provider Other Number 2 (PROV NO 2)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(15)	LEFT	SPACES	150	164

DEFINITION: The number assigned to the provider by the receiver for other identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered as required by the receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: Example: Specific number assigned for Workmen's Compensation, Health Maintenance Organization

(HMO) or Additional Commercial Number.

RECORD/FIELD: BA0-18.0

DATA ELEMENT: Provider Organization Name (ORGANIZATION NAME)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(33)	LEFT	SPACES	165	197

DEFINITION: The name of the group or organization submitting this batch of claims for payment.

CODE VALUES: See the C-33 table for valid field values.

VALIDATION: Must be entered if required by payor.

If entered:

This field should contain the Organization's (Group's) name as it appears on the Payor's File. See GENERAL INSTRUCTIONS for "Name 2" entry. If BA0 - 08.0 equals "E" or "X" this field must not be blank.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-19.0 BA0-20.0 BA0-21.0

DATA ELEMENT: Provider Last Name (PROV LAST NAME)

Provider First Name (PROV FIRST NAME)

Provider Middle Initial (PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(20)	LEFT	SPACES	198	217
20.0	X(12)	LEFT	SPACES	218	229
21.0	X(01)	LEFT	N/A	230	230

DEFINITION: The Last Name, First Name, and Middle initial of the individual provider submitting this batch of claims for payment.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

If entered:

This field should contain the Individual Provider's last name, first name, and middle initial as it appears on the Payor's File.

See GENERAL INSTRUCTIONS for "Name 1" entry.

If Record Type BA0 - 08.0 equals "S" these fields must not be blank.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-22.0

DATA ELEMENT: Provider Specialty (PROV SPECIALTY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(03)	LEFT	SPACES	231	233

DEFINITION: A code indicating the primary specialty of the provider, as defined by the receiver.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA0-23.0

DATA ELEMENT: Specialty License Number (SPECIALTY LICENSE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(15)	LEFT	SPACES	234	248

DEFINITION: The Specialty License Number of the provider rendering services, as assigned by the licensing board of that specialty.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-24.0

DATA ELEMENT: State License Number (STATE LICENSE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(15)	LEFT	SPACES	249	263

DEFINITION: The state license number of the provider.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-25.0

DATA ELEMENT: Dentist License Number (DENTIST LICENSE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(15)	LEFT	SPACES	264	278

DEFINITION: The state license number of the dentist.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver. See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-26.0

DATA ELEMENT: Anesthesia License Number (ANESTHESIA LICENSE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(15)	LEFT	SPACES	279	293

DEFINITION: The state license number of the anesthesiologist.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by receiver.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA0-27.0

DATA ELEMENT: Provider Participation Indicator (PROV PARTICIPATE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(01)	LEFT	SPACES	294	294

DEFINITION: Indicates if the provider participates in the Medicare program.

CODE VALUES: Not used by MO HealthNet.

Y = Participating

N = Non-Participating

VALIDATION: If entered, must be a valid code from code list.

FORM LOCATION: N/A

REMARKS: This is required if this file is a COB NSF file.

RECORD/FIELD: BA0-28.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(26)	N/A	SPACES	295	320

DEFINITION: Unused reserved record space for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: BATCH HEADER RECORD TYPE BA1 "PROVIDER DATA 2"

Not Required by MO HealthNet

Must follow BA0

Must be followed by CA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "BA1"	C-24	BA1
02	EMC PROV ID		Not Used
03	BATCH TYPE		Not Used
04	BATCH NO		Not Used
05	BATCH ID		Not Used
06	PROV TYPE ORG		Not Used
07	PROV SVC ADDR1		Not Used

08	PROV SVC ADDR2		Not Used
09	PROV SVC CITY		Not Used
10	PROV SVC STATE		Not Used
11	PROV SVC ZIP		Not Used
12	PROV SVC PHONE		Not Used
13	PROV PAY TO ADDR1		Not Used
14	PROV PAY TO ADDR2		Not Used
15	PROV PAY TO CITY		Not Used
16	PROV PAY TO STATE		Not Used
17	PROV PAY TO ZIP		Not Used
18	PROV PAY TO PHONE		Not Used
19	FILLER-NATIONAL		YES

RECORD TYPE: BA1

LEVEL: BATCH

PURPOSE: Additional record to identify and provide information regarding the provider of services indicated in this batch.

REQUIREMENTS: This record must be entered if required by the payor.

ORDER: Preceding Record Type Following Record Type
 BA0 CA0

NOTES: Only one BA1 record is allowed for each batch.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "BA1"	3	X	01	03
02.0	EMC PROV ID	15	X	04	18
03.0	BATCH TYPE	3	X	19	21
04.0	BATCH NO	4	N	22	25
05.0	BATCH ID	6	X	26	31

06.0	PROV TYPE ORG	3	X	32	34
07.0	PROV SVC ADDR1	30	X	35	64
08.0	PROV SVC ADDR2	30	X	65	94
09.0	PROV SVC CITY	20	X	95	114
10.0	PROV SVC STATE	2	X	115	116
11.0	PROV SVC ZIP 9	9	X	117	125
12.0	PROV SVC PHONE	10	X	126	135
13.0	PROV PAY TO ADDR1	30	X	136	165
14.0	PROV PAY TO ADDR2	30	X	166	195
15.0	PROV PAY TO CITY	20	X	196	215
16.0	PROV PAY TO STATE	2	X	216	217
17.0	PROV PAY TO ZIP	9	X	218	226
18.0	PROV PAY TO PHONE	10	X	227	236
19.0	FILLER-NATIONAL	84	X	237	320

RECORD/FIELD: BA1-01.0

DATA ELEMENT: Record Type (RECORD ID 'BA1')

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This field is used to identify the "PROVIDER DATA 2" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered.

Must be BA1.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA1-02.0

DATA ELEMENT: EMC Provider Identifier (EMC PROV ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(15)	LEFT	SPACES	04	18

DEFINITION: The unique number assigned to the provider for EMC identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be identical to the "EMC Provider

Identifier" in the corresponding record YA0 - 02.0

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA1-03.0

DATA ELEMENT: Batch Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(03)	LEFT	SPACES	19	21

DEFINITION: This field indicates the type of claims that are included within this batch.

CODE VALUES: Not used by MO HealthNet.

100 - All Others

200 - Dental

VALIDATION: Must be entered if required by the receiver. If entered, must be a valid code from the above list.

The "Batch Type" entered in BA1 - 03.0 must equal the "Batch Type" entered in YA0 - 03.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA1-04.0

DATA ELEMENT: Batch Number (BATCH NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	9(04)	RIGHT	ZEROS	22	25

DEFINITION: This is a sequential number assigned by the submitter, to each batch of claims.

CODE VALUES: Not used by MO HealthNet.

Must be equal to 0001 through 9999.

Must be numeric.

The "Batch Number" entered in BA1.04 must be identical to the "Batch Number" entered in BA0.04.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA1-05.0

DATA ELEMENT: Batch Identification (BATCH ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(06)	LEFT	SPACES	26	31

DEFINITION: The identifier assigned by the submitter/provider to identify a batch within his own system.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Optional at the submitter/provider discretion.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: Used to facilitate the communication between the receiver and submitter/provider, concerning

problem batches, as well as the reporting of claims with errors and accepted claims.

RECORD/FIELD: BA1-06.0

DATA ELEMENT: Provider Type Organization(PROV TYPE ORG)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(03)	LEFT	SPACES	32	34

DEFINITION: The organizational structure of the billing provider of service.

CODE VALUES: Not used by MO HealthNet.

001 = Solo Practice

002 = Partnership

003 = PA (Professional Association)

004 = Clinic

005 = Single entity facility/hospital (all hospital provided under a single provider number or corporate entity).

006 = Distinct part facility/hospital (a unit of a hospital or corporate entity billing under a separate provider number) billing for professional service.

007 = Individual (corporation filing under an individual provider or tax number (SSN) (common with suppliers)).

008 = Corporation.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: BA1-07.0 BA1-08.0 BA1-09.0 BA1-10.0 BA1-11.0

DATA ELEMENT: Provider's Service Address 1 (PROV SVC ADDR1)
Provider's Service Address 2 (PROV SVC ADDR2)
Provider's Service City (PROV SVC CITY)
Provider's Service State (PROV SVC STATE)
Provider's Service Zip (PROV SVC ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(30)	LEFT	SPACES	35	64
08.0	X(30)	LEFT	SPACES	65	94
09.0	X(20)	LEFT	SPACES	95	114
10.0	X(02)	LEFT	SPACES	115	116
11.0	X(09)	LEFT	SPACES	117	125

DEFINITION: The current street address, city, state, and zip code of the Provider, designates where services were rendered.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA1-12.0

DATA ELEMENT: Provider's Service Telephone Number (PROV SVC PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(10)	LEFT	SPACES	126	135

DEFINITION: The telephone number, including area code at which the provider can be contacted (where services were rendered).

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Telephone" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA1-13.0 BA1-14.0 BA1-15.0 BA1-16.0 BA1-17.0

DATA ELEMENT: Provider's Pay - To Address 1 (PROV PAY TO ADDR1)
Provider's Pay - To Address 2 (PROV PAY TO ADDR2)
Provider's Pay - To City (PROV PAY TO CITY)
Provider's Pay - To State (PROV PAY TO STATE)
Provider's Pay - To Zip (PROV PAY TO ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(30)	LEFT	SPACES	136	165
14.0	X(30)	LEFT	SPACES	166	195
15.0	X(20)	LEFT	SPACES	196	215
16.0	X(02)	LEFT	SPACES	216	217
17.0	X(09)	LEFT	SPACES	218	226

DEFINITION: The current street mailing address, city, state, and zip code of the Provider, designates where

payment is to be sent.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA1-18.0

DATA ELEMENT: Provider's Pay - To Telephone Number (PROV PAY TO PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(10)	LEFT	SPACES	227	236

DEFINITION: The telephone number including area code at which the provider can be contacted, designates where payment is to be sent.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Telephone" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: N/A

RECORD/FIELD: BA1-19.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(84)	LEFT	SPACES	237	320

DEFINITION: Unused reserved record space for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CLAIM HEADER RECORD TYPE CA0 "PATIENT DATA"

Required by MO HealthNet

Must follow BA0 or BA1 or XA0

Must be followed by CB0 or DA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "CA0"	C-24	CA0
02	RESERVED (CA0-02.0)		
03	PAT CONTROL NO	C-31	NO
04	PAT LAST NAME	C-2	YES
05	PAT FIRST NAME	C-2	YES

06	PAT MI		Not Used
07	PAT GENERATION		Not Used
08	PAT DATE OF BIRTH		Not Used
09	PAT SEX		Not Used
10	PAT TYPE OF RESIDENCE		Not Used
11	PAT ADDR1		Not Used
12	PAT ADDR2		Not Used
13	PAT CITY		Not Used
14	PAT STATE		Not Used
15	PAT ZIP		Not Used
16	PAT PHONE		Not Used
17	PAT MARITAL STATUS		Not Used
18	PAT STUDENT STATUS		Not Used
19	PAT EMPLOYMENT STATUS		Not Used
20	PAT DEATH IND		Not Used
21	PAT DATE OF DEATH		Not Used
22	OTHER INSURANCE IND	C-3	YES
23	CLAIM EDITING IND		Not Used
24	TYPE OF CLAIM IND		Not Used
25	LEGAL REP IND		Not Used
26	ORIGIN CODE		Not Used
27	PAYOR CLM CONTROL NO		Not Used
28	PROVIDER NUMBER		Not Used
29	CLAIM ID NO		Not Used
30	FILLER-NATIONAL		YES

RECORD TYPE: CA0

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the patient who received the services indicated in this claim.

REQUIREMENTS: A CA0 record is required for every claim.

ORDER: Preceding Record Type Following Record Type
 BA0, BA1 or XA0 CA1, CB0 or DA0

NOTES: Only one CA0 record is allowed for each claim.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "CA0"	3	X	01	03
02.0	RESERVED (CA0-02.0)	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	PAT LAST NAME	20	X	23	42
05.0	PAT FIRST NAME	12	X	43	54
06.0	PAT MI	1	X	55	55
07.0	PAT GENERATION	3	X	56	58
08.0	PAT DATE OF BIRTH	8	X	59	66
09.0	PAT SEX	1	X	67	67
10.0	PAT TYPE OF RESIDENCE	1	X	68	68
11.0	PAT ADDR1	30	X	69	98
12.0	PAT ADDR2	30	X	99	128
13.0	PAT CITY	20	X	129	148
14.0	PAT STATE	2	X	149	150
15.0	PAT ZIP	9	X	151	159
16.0	PAT PHONE	10	X	160	169
17.0	PAT MARITAL STATUS	1	X	170	170
18.0	PAT STUDENT STATUS	1	X	171	171
19.0	PAT EMPLOYMENT STATUS	1	X	172	172
20.0	PAT DEATH IND	1	X	173	173
21.0	PAT DATE OF DEATH	8	X	174	181
22.0	OTHER INSURANCE IND	1	X	182	182
23.0	CLAIM EDITING IND	1	X	183	183

24.0	TYPE OF CLAIM IND	2	X	184	185
25.0	LEGAL REP IND	1	X	186	186
26.0	ORIGIN CODE	9	X	187	195
27.0	PAYOR CLM CONTROL NO	17	X	196	212
28.0	PROVIDER NUMBER	15	X	213	227
29.0	CLAIM ID NO	6	X	228	233
30.0	FILLER-NATIONAL	87	X	234	320

RECORD/FIELD: CA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "CA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Patient Data" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered.

Must be "CA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CA0-02.0

DATA ELEMENT: RESERVED (CA0-02.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: Reserved record space.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: See the C-31 table for valid field values.

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents. Consult the Matrix/Usage document supplied by the Payor/Receiver for additional information.

RECORD/FIELD: CA0-04.0, CA0-05.0, CA0-06.0

DATA ELEMENT:	Patient Last Name	(PAT LAST NAME)
	Patient First Name	(PAT FIRST NAME)
	Patient Middle Initial	(PAT MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(20)	LEFT	SPACES	23	42
05.0	X(12)	LEFT	SPACES	43	54
06.0	X(01)	N/A	SPACES	55	55

DEFINITION: The name of the individual to whom the services were provided.

CODE VALUES: See the C-2 table for valid field values.

VALIDATION: See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: CMS-1500 Block 2

REMARKS: N/A

RECORD/FIELD: CA0-07.0

DATA ELEMENT: Patient Generation (PAT GENERATION)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(03)	LEFT	SPACES	56	58

DEFINITION: The generation of the patient, such as I, II, III, Jr, Sr.

CODE VALUES: Not used by MO HealthNet.

I, II, III, IV, JR, SR

VALIDATION: Must be entered if required by payor. Must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 2

REMARKS: N/A

RECORD/FIELD: CA0-08.0

DATA ELEMENT: Patient Date of Birth (PAT DATE OF BIRTH)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(08)	LEFT	SPACES	59	66

DEFINITION: The date the patient was born.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

Must be less than or equal to the From Date of Service (FA0-05.0).

FORM LOCATION: CMS-1500 Block 3

REMARKS: N/A

RECORD/FIELD: CA0-09.0

DATA ELEMENT: Patient Sex Code (PAT SEX)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(01)	N/A	SPACE	67	67

DEFINITION: Code indicating the sex of the patient.

CODE VALUES: Not used by MO HealthNet.

M=MALE

F=FEMALE

VALIDATION: Must be entered.

Must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 3

REMARKS: N/A

RECORD/FIELD: CA0-10.0

DATA ELEMENT: Patient Type of Residence (PAT TYPE OF RESIDENCE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(01)	N/A	SPACE	68	68

DEFINITION: A code which indicates patient place of residence.

CODE VALUES: Not used by MO HealthNet.

S = Skilled Nursing Home

R = Residential Treatment Facility

P = Private Home

N=Nursing Home

VALIDATION: Must be entered if required by payor. If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CA0-11.0, CA0-12.0, CA0-13.0, CA0-14.0 CA0-15.0

DATA ELEMENT:	Patient Address 1	(PAT ADDR1)
	Patient Address 2	(PAT ADDR2)
	Patient City	(PAT CITY)
	Patient State	(PAT STATE)
	Patient Zip Code	(PAT ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(30)	LEFT	SPACES	69	98
12.0	X(30)	LEFT	SPACES	99	128
13.0	X(20)	LEFT	SPACES	129	148
14.0	X(02)	LEFT	SPACES	149	150
15.0	X(09)	LEFT	SPACES	151	159

DEFINITION: The mailing address of the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Address" entry.

Must be entered if required by payor.

FORM LOCATION: CMS-1500 Block 5

REMARKS: N/A

RECORD/FIELD: CA0-16.0

DATA ELEMENT: Patient Telephone Number (PAT PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(10)	LEFT	SPACES	160	169

DEFINITION: The telephone number. including area code, at which the patient may be contacted.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Telephone" entry.

FORM LOCATION: CMS-1500 Block 5

REMARKS: N/A

RECORD/FIELD: CA0-17.0

DATA ELEMENT: Patient Marital Status (PAT MARITAL STATUS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(01)	N/A	SPACE	170	170

DEFINITION: A code which indicates the marital status of the patient.

CODE VALUES: Not used by MO HealthNet.

S = Single

M = Married

D = Divorced

W=Widowed

X=Legally Separated

U=Unknown

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 8

REMARKS: N/A

RECORD/FIELD: CA0-18.0

DATA ELEMENT: Patient Student Status (PAT STUDENT STATUS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(01)	N/A	SPACE	171	171

DEFINITION: A code which indicates the student status of the patient if 19 years of age or older, not handicapped and not the insured.

CODE VALUES: Not used by MO HealthNet.

F = Full-time student

P = Part-time student

N = Not a student

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 8

REMARKS: N/A

RECORD/FIELD: CA0-19.0

DATA ELEMENT: Patient Employment Status (PAT EMPLOYMENT STATUS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(01)	N/A	SPACE	172	172

DEFINITION: A code indicating employment status of the patient.

CODE VALUES: Not used by MO HealthNet.

1 = Employed full-time

2 = Employed part-time

3 = Not employed

4 = Self-employed

5 = Retired

6 = On active military duty

7 = Reserved for national assignment

8 = Reserved for national assignment

9 = Unknown

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 8

REMARKS: N/A

RECORD/FIELD: CA0-20.0

DATA ELEMENT: Patient Death Indicator (PAT DEATH IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
200	X(01)	N/A	SPACE	173	173

DEFINITION: A code which indicates the provider is billing services for a patient who is deceased.

CODE VALUES: Not used by MO HealthNet.

D = patient is deceased

N = patient is not deceased

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

If 'D', complete Date of Death (CA0-21.0).

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CA0-21.0

DATA ELEMENT: Patient Date of Death (PAT DATE OF DEATH)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(08)	LEFT	SPACES	174	181

DEFINITION: Date patient was deceased.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

Should be present if Death Indicator (CA0-20.0) equals 'D'.

Date of service (FA0-05.0 and 06.0) must be equal to or less than date of death.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CA0-22.0

DATA ELEMENT: Other Insurance Indicator (OTHER INSURANCE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(01)	N/A	SPACE	182	182

DEFINITION: A code which indicates the patient has other insurance which may or may not be reflected on this claim.

CODE VALUES: See the C-3 table for valid field values.

VALIDATION: Must be entered if required by payor/receiver.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 11d

REMARKS: 1. Patient has declared that he/she has other insurance which may pay a portion of this claim and provided the necessary insurance information. (Not all insurance companies require the other insurance fields to be completed.)

2. Patient has declared that he/she has other insurance which may pay a portion of this claim but did not furnish the insurance information for this claim.

3. The provider has asked the patient if he/she has other insurance, and the patient has stated that they do not.

RECORD/FIELD: CA0-23.0

DATA ELEMENT: Claim Editing Indicator (CLAIM EDITING IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(01)	N/A	SPACES	183	183

DEFINITION: A code assigned by the receiver to determine the adjudication program.

CODE VALUES: Not used by MO HealthNet.

A = Self Pay

B = Worker's Compensation

C = Medicare

D = MO HealthNet

E = Other Federal Program

F = Commercial Insurance Company

G = Blue Cross and Blue Shield

H = CHAMPUS

I = HMO

J = Federal Employees Program (FEP)

K = Central Certification

L = Self Administered Group

M = Medicare Claim Review

N = Medicare ADS Response

O = Indian Health Services

P = Blue Cross

Z = Other

VALIDATION: Must be entered if required by the receiver. If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 1 and 11

REMARKS: If Receiver Type Code, AA0-18.0, equals "Z", some payors may require this field.

RECORD/FIELD: CA0-24.0

DATA ELEMENT: Type of Claim Indicator (TYPE OF CLAIM)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(02)	LEFT	SPACES	184	185

DEFINITION: A code which indicates the type of claim.

CODE VALUES: Not used by MO HealthNet.

A = Ambulance

B = Anesthesia

C = Chiropractic

D = Dental

E = Durable Medical Equipment

F = Medical

G = Occupational Therapy

H = Oxygen

J = Parenteral/Enteral

K = Podiatry

L = Physical Therapy

M = Speech/Language Therapy

N = Surgery

O = Other

P = EPSDT

Z = Multiple Types of Service

VALIDATION: Must be entered if required by payor. If entered, must be valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CA0-25.0

DATA ELEMENT: Legal Representative Indicator (LEGAL REP IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(01)	N/A	SPACE	186	186

DEFINITION: A code which indicates that someone other than the patient is to receive the explanation of benefits and/or the payment. (Person who is legally responsible for the patient.)

CODE VALUES: Not used by MO HealthNet.

Y = Yes, there is a responsible party.

N = No, there is not a responsible party.

VALIDATION: Must be entered if required by payor. If entered, must a valid code from the above list.

If 'Y', then the name and address of the responsible party (CB0-04.0 through 11.0) must be entered.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CA0-26.0

DATA ELEMENT: Origin Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(09)	LEFT	SPACES	187	195

DEFINITION: A code to denote the geographic area where the service(s) being submitted on this claim was/were performed.

CODE VALUES: Not used by MO HealthNet.

United Postal Service ZIP Code.

VALIDATION: Must be entered if required by the Payor/Receiver.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: N/A

REMARKS: This code allows a Payor/Receiver to properly route claims to various claim adjudication entities.

RECORD/FIELD: CA0-27.0

DATA ELEMENT: Payor Claim Control Number

(PAYOR CLM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(17)	LEFT	SPACES	196	212

DEFINITION: A number assigned by the Payor/Receiver to identify the claim.

CODE VALUES: Not used by MO HealthNet.

Blanks / Spaces are only valid values.

VALIDATION: Must be blank / space filled.

FORM LOCATION: N/A

REMARKS: For Payor/Receiver usage only.

For assignment of an Internal / Document /Claim Control Number (ICN/DCN/CCN) that the Payor/Receiver will pass to an adjudication system.

RECORD/FIELD: CA0-28.0

DATA ELEMENT: Provider Number (PROVIDER NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(15)	LEFT	SPACES	213	227

DEFINITION: The number assigned to the provider by the payor/receiver for identification purposes.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by Payor/Receiver.

If entered:

This field must contain the Provider Number as it appears on the Payor's/Receiver's file.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 33

REMARKS: The Payor/Receiver may elect to allow the Provider Number to be submitted in this Claim Level record instead of at the Batch Level in the "BA0" record.

Consult the Matrix/Usage document supplied by the Payor/Receiver for additional information and submission instructions.

RECORD/FIELD: CA0-29.0

DATA ELEMENT: Claim Identification Number (CLAIM ID NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(06)	LEFT	SPACES	228	233

DEFINITION: Unique number of identification assigned to the claim by the sender.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by the Payor/Receiver.

FORM LOCATION: N/A

REMARKS: This number is not a portion of the MEDICAL RECORD NUMBER (EA1-11.0) or the PATIENT ACCOUNT NUMBER (CA0-03.0).

This number is expected to be assigned by the sender's software system. One practice may be to assign a sequential number. Consult the Matrix/Usage Guide supplied by the Payor/Receiver for additional information.

RECORD/FIELD: CA0-30.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(87)	LEFT	SPACES	234	320

DEFINITION: Reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CLAIM HEADER RECORD TYPE CB0 "LEGAL REPRESENTATIVE DATA"

Not Required by MO HealthNet

Must follow CA0

Must be followed by DA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "CB0"	C-24	CB0
02	RESERVED (CB0-02.0)		Not Used
03	PAT CONTROL NO		Not Used

04	RESP PERSON LAST NAME		Not Used
05	RESP PERSON FIRST NAME		Not Used
06	RESP PERSON MI		Not Used
07	RESP PERSON ADDR1		Not Used
08	ESP PERSON ADDR2		Not Used
09	RESP PERSON CITY		Not Used
10	RESP PERSON STATE		Not Used
11	RESP PERSON ZIP		Not Used
12	RESP PERSON PHONE		Not Used
13	FILLER-NATIONAL		YES

RECORD TYPE: CB0

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the legal representative who is to receive the payment and/or explanation of benefits on behalf of the patient.

REQUIREMENTS: This record is required only if the payor will recognize a legal representative for the patient.

ORDER: Preceding Record Type Following Record Type
 CA0 or CA1 DA0

NOTES: Only one CB0 record is allowed for each claim.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "CB0"	3	X	01	03
02.0	RESERVED (CB0-02.0)	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	RESP PERSON LAST NAME	20	X	23	42
05.0	RESP PERSON FIRST NAME	12	X	43	54
06.0	RESP PERSON MI	1	X	55	55
07.0	RESP PERSON ADDR1	30	X	56	85
08.0	RESP PERSON ADDR2	30	X	86	115

09.0	RESP PERSON CITY	20	X	116	135
10.0	RESP PERSON STATE	2	X	136	137
11.0	RESP PERSON ZIP	9	X	138	146
12.0	RESP PERSON PHONE	10	X	147	156
13.0	FILLER – NATIONAL	164	X	157	320

RECORD/FIELD: CB0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "CB0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Legal Representative Data" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered if required by payor.

Must be "CB0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CB0-02.0

DATA ELEMENT: Reserved (CB0-02.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: Reserved record space.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CB0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number. Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: CB0-04.0 CB0-05.0, CB0-06.0

DATA ELEMENT: Responsible Person Last Name (RESP PERSON LAST NAME)

Responsible Person First Name (RESP PERSON FIRST NAME)

Responsible Person Middle Initial (RESP PERSON MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(20)	LEFT	SPACES	23	42
05.0	X(12)	LEFT	SPACES	43	54
06.0	X(01)	N/A	SPACES	55	55

DEFINITION: The name of the responsible person who is to receive the explanation of benefits and/or the payment on behalf of the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Name 1" entry.

Must be entered if required by payor.

Must be entered if Legal Representative Indicator

(CA0-25.0) equals 'Y'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CB0-07.0 CB0-08.0, CB0-09.0, CB0-10.0, CB0-11.0

DATA ELEMENT:	Responsible Person Address 1	(RESP PERSON ADDR1)
	Responsible Person Address 2	(RESP PERSON ADDR2)
	Responsible Person City	(RESP PERSON CITY)
	Responsible Person State	(RESP PERSON STATE)

Responsible Person Zip Code

(RESP PERSON ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(30)	LEFT	SPACES	56	85
08.0	X(30)	LEFT	SPACES	86	115
09.0	X(20)	LEFT	SPACES	116	135
10.0	X(02)	LEFT	SPACES	136	137
11.0	X(09)	LEFT	SPACES	138	146

DEFINITION: The mailing address of the responsible person.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Address" entry.

Must be entered if required by payor.

Must be entered if Legal Representative Indicator

(CA0-25) equals 'Y'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CB0-12.0

DATA ELEMENT: Responsible Party Telephone Number (RESP PERSON PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(10)	LEFT	SPACES	147	156

DEFINITION: The telephone number of the responsible party who is to receive the explanation of benefits and/or the payment on behalf of the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Telephone" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: CB0-13.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(164)	LEFT	SPACES	157	320

DEFINITION: Reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: INSURANCE INFORMATION RECORD TYPE DA0 "PAYOR DATA 1"

Required for MO HealthNet processing

Must follow CA0 or CB0

Must be followed by DA1, DA2 or EA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "DA0"	C-24	DA0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	CLAIM FILING IND		Not Used
05	SOURCE OF PAY	C-27	NO
06	INSURANCE TYPE CODE		Not Used
07	PAYOR ORGANIZATION ID		Not Used
08	PAYOR CLAIM OFFICE NO		Not Used
09	PAYOR NAME	C-53	YES
10	GROUP NO		Not Used
11	GROUP NAME		Not Used
12	PPO/HMO IND		Not Used
13	PPO ID		Not Used
14	PRIOR AUTH NO		Not Used
15	ASSIGN OF BENEFITS		Not Used
16	PAT SIGNATURE SOURCE		Not Used
17	PAT REL TO INSURED		Not Used

18	INSURED ID NO	C-1	YES
19	INSURED LAST NAME		Not Used
20	INSURED FIRST NAME		Not Used
21	INSURED MI		Not Used
22	INSURED GENERATION		Not Used
23	INSURED SEX		Not Used
24	INSURED DATE OF BIRTH		Not Used
25	INSURED EMPL STATUS		Not Used
26	SUPPLEMENTAL INS IND		Not Used
27	INSURANCE LOCATION ID		Not Used
28	MEDICAID ID NO		Not Used
29	SUPPLEMENTAL PATIENT ID		Not Used
30	ASSIGN 4081 IND		Not Used
31	COB ROUTING IND		Not Used
32	FILLER-NATIONAL		YES

RECORD TYPE: DA0

LEVEL: CLAIM

PURPOSE: To identify the Payor(s) involved with and/or having liability for the resolution of this claim.

REQUIREMENTS: At least one DA0 record is required on every claim.

All known payors are to be identified by using this record.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	CA0, CB0, DA0,DA0, DA1, DA2, DA3	DA1, DA2, or DA3or EA0

NOTES: When requesting payment from a secondary payor it is extremely important that the EOB/remittance information be provided from the primary payor(s). This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy EOB.

Multiple DA0 records should be sequenced according to national and state coordination of benefits rules. The primary payor should always be first regardless of whether or not payment is being requested in this transmission.

The order of the records should always be:

PRIMARY followed by SECONDARY insurance (if applicable), and then TERTIARY insurance (if applicable). The CLAIM FILING INDICATOR (DA0-04.0) should be used to direct the claim to the appropriate payor(s).

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "DA0"	3	X	01	03
02.0	SEQUENCE NO2	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	CLAIM FILING IND	1	X	23	23
05.0	SOURCE OF PAY	1	X	24	24
06.0	INSURANCE TYPE CODE	2	X	25	26
07.0	PAYOR ORGANIZATION ID	5	X	27	31
08.0	PAYOR CLAIM OFFICE NO	4	X	32	35
07-08	Redefined as NATIONAL PAYER ID	9	X		
09.0	PAYOR NAME	33	X	36	68
10.0	GROUP NO	20	X	69	88
11.0	GROUP NAME	33	X	89	121
12.0	PPO/HMO IND	1	X	122	122
13.0	PPO ID	15	X	123	137
14.0	PRIOR AUTH NO	15	X	138	152
15.0	ASSIGN OF BENEFITS	1	X	153	153
16.0	PAT SIGNATURE SOURCE	1	X	154	154
17.0	PAT REL TO INSURED	2	N	155	156
18.0	INSURED ID NO	25	X	157	181
19.0	INSURED LAST NAME	20	X	182	201
20.0	INSURED FIRST NAME	12	X	202	213
21.0	INSURED MI	1	X	214	214
22.0	INSURED GENERATION	3	X	215	217
23.0	INSURED SEX	1	X	218	218
24.0	INSURED DATE OF BIRTH	8	X	219	226
25.0	INSURED EMPL STATUS	1	X	227	227
26.0	SUPPLEMENTAL INS IND	1	X	228	228

27.0	INSURANCE LOCATION ID	7	X	229	235
28.0	MEDICAID ID NO	25	X	236	260
29.0	SUPPLEMENTAL PATIENT ID	25	X	236	260
30.0	ASSIGN 4081 IND	1	X	286	286
31.0	COB ROUTING IND	1	X	287	287
32.0	FILLER-NATIONAL	33	X	288	320

RECORD/FIELD: DA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "DA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "INSURANCE INFORMATION"- "PAYOR DATA 1" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: A claim must have at least one "DA0" record and may have up to three.

Must be "DA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 03 used to sequence the "DA0" records and to associate "DA0" records with "DA1" and "DA2" records.

CODE VALUES: See the C-21 table for valid field values.

VALIDATION: Must be entered. Must be a valid code from the above list.

A claim must have at least one "DA0" record and may have up to three. All "Dan" records must be grouped as "DA0", "DA1", "DA2" by sequence number.

The first (or only) record must be identified by a sequence number of '01'.

FORM LOCATION: N/A

REMARKS: Multiple DA0 records should be sequenced according to national and state coordination of benefits rules. The primary payor should always be first regardless of whether or not payment is being requested in this transmission.

The order of the records should always be PRIMARY followed by SECONDARY insurance (if applicable) and then TERTIARY insurance (if applicable). The CLAIM FILING INDICATOR (DA0-04.0) should be used to direct the claim to the appropriate payor(s).

RECORD/FIELD: DA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique identifier assigned by the provider to identify the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

RECORD/FIELD: DA0-04.0

DATA ELEMENT: Claim Filing Indicator(CLAIM FILING IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	LEFT	SPACES	23	23

DEFINITION: A code indicating whether or not this record is being provided in order to obtain payment from the indicated payor or for informational purposes only.

CODE VALUES: Not used by MO HealthNet.

P = Payment is being requested of this payor. "P" also indicates that a payment request is being made to only one payor.

M = Payment is being requested of this payor. "M" also indicates that payment requests are being made to more than one payor at the same time.

I = Payment is not being requested of this payor. Information is to be used for informational purposes only. (To indicate information on a secondary payor.) VALIDATION: Must be entered.

Must be a valid code from the above list.

A claim must have one and only one "DA0" record with a "P" or at least two "DA0" records with "M's" (may have up to 3 records with "M's").

A claim may have up to two "DA0" records with "I's" as long as the total number of records (P's, M's and I's) do not exceed 3.

The claim may not have a mixture of "DA0" records with both "P's" and "M's".

FORM LOCATION: CMS-1500 Blocks 9, 11

REMARKS: The "M" code is not, repeat not, to be used to indicate crossover/piggyback situations such as Medicare/MO HealthNet, Medicare/Medigap, Medicare/Blue Shield, Medicare/commercial, Blue Shield/Champus etc. The "M" code is used to direct the claim to multiple payor's at the "same" time, not one after another.

Crossover/piggyback situations are indicated by creating another "DA0" record secondary to the primary insurance.

Example Medicare/MO HealthNet:

The first (primary) "DA0" record would have a

CLAIM FILING IND (DA0-04.0) of "P" and a SOURCE OF PAY (DA0-05.0) of "C". The second (secondary) "DA0" record would have a CLAIM FILING IND (DA0-04.0) of "I" and a SOURCE OF PAY (DA0-05.0) of "D". Depending upon the agreement the Medicare Carrier has with that particular MO HealthNet intermediary the claim would be forwarded to the MO HealthNet intermediary upon resolution of the claim by Medicare.

Example Medicare/Medigap:

The procedures are identical for Medigap processing except that the secondary payor is identified by not only the SOURCE OF PAY - NATIONAL (DA0-05.0) of "F" (commercial), "G" (Blue Shield) or "Z" (other), but by the INSURANCE TYPE CODE (DA0-06.0) of "MG" (Medigap).

RECORD/FIELD: DA0-05.0

DATA ELEMENT: Source of Payment (SOURCE OF PAY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(01)	LEFT	SPACES	24	24

DEFINITION: A national code identifying the payment source for this claim for the indicated payor.

CODE VALUES: See the C-27 table for valid field values.

VALIDATION: Must be entered.

Must be a valid code from the above list.

FORM LOCATION: CMS-1500 Blocks 9, 11

REMARKS: When Medicare is identified as the primary source of payment (DA0-02.0 = 1, DA0-04.0 = P, and DA0-05.0 = C) development for other insurance has been undertaken and it has been determined that Medicare is the primary payer.

RECORD/FIELD: DA0-06.0

DATA ELEMENT: Insurance Type Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(02)	LEFT	SPACES	25	26

DEFINITION: Identifies the type of insurance (policy).

CODE VALUES: Not used by MO HealthNet.

MG = MEDIGAP POLICY - code requesting that the Medicare carrier forward this EOB to this payor. Only allowed for SEQUENCE NO's (DA0-02.0) of "02" or "03". Only one allowed on a claim. Must follow a "DA0" with a SOURCE OF PAY (DA0-05.0) of "C" (Medicare).

SP = SUPPLEMENTAL POLICY

IP = INDIVIDUAL POLICY

PP = PERSONAL PAYMENT (CASH - NO INSURANCE)

GP = GROUP POLICY

LT = LITIGATION

AP = AUTO INSURANCE POLICY

LD = LONG TERM POLICY

OT = OTHER

The following code must only be used if the SOURCE OF PAY (DA0-05.0) is "C" (Medicare): MP = MEDICARE PRIMARY (MEDICARE SECONDARY REASON CODES)

12 = WORKING AGED BENEFICIARY/SPOUSE WITH EMPLOYER GROUP HEALTH PLAN

13 = ESRD BENEFICIARY IN THE 12 MONTH COORDINATION PERIOD WITH AN EMPLOYER'S GROUP HEALTH PLAN

14 = NO FAULT INSURANCE INCLUDING AUTO/OTHER

15 = WORKER'S COMPENSATION

16 = PHS OR OTHER FEDERAL AGENCY

41 = BLACK LUNG

42 = VA

43 = DISABLED BENEFICIARY UNDER AGE 65 WITH LGHP

47 = ANY LIABILITY INSURANCE

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Blocks 9, 11

REMARKS: N/A

RECORD/FIELD: DA0-07.0 DA0-08.0

DATA ELEMENT: Payor Organization Identification (PAYOR ORGANIZATION ID) Payor Claim Office Number (PAYOR CLAIM OFFICE NO) Redefined as National Payer Identifier (PAYERID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(05)	LEFT	SPACES	27	31
08.0	X(04)	LEFT	SPACES	32	35

DEFINITION: The identification number for the payor.

The National PAYERID (DA0-07.0 and DA0-08.0) is to be entered for Medicare when implemented.

The PAYOR ORGANIZATION ID (DA0-07.0) will identify the insurance company or government agency which has been identified as having some liability for payment on this claim.

The PAYOR CLAIM OFFICE NO (DA0-08.0) will identify the specific payor location responsible for processing this claim.

CODE VALUES: Not used by MO HealthNet.

BLUE CROSS AND BLUE SHIELD - use either the NAIC (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS) assigned identifier or the BCBS plan number (00xxx) for the organization id.

Use the "alpha prefix" from the subscriber's identification card as the claim office number.

COMMERCIAL INSURERS - use the NAIC assigned number (xxxxx) for the organization in and use the claim office location off the insured's identification card for the claim office number.

MO HEALTHNET - use the MO HealthNet Division assigned number for the organization id and "NONE" for the claim office number or "AIDxx" (xx = state code) for the organization id and "0001", "0002" etc. for the claim office number. (Multiple codes will be necessary in states with more than one MO HealthNet carrier.)

CHAMPUS - use the NAIC assigned number (xxxxx) for the organization id and the region / project code for the claim office number.

Code Region/Project

SER SOUTHEAST REGION

MAR MID-ATLANTIC REGION

WTR WESTERN REGION

NTR NORTHERN REGION

SCR SOUTH CENTRAL REGION

CRI CALIFORNIA PROJECT

CMN CATCHMENT AREA MANAGEMENT PROJECT

(NAVY - CHARLESTON, SC)

CMF CATCHMENT AREA MANAGEMENT PROJECT

(AIRFORCE - _____, TX)

OTHERS - use the NAIC assigned number (xxxxx) or the value of "OTHER" for the organization id.

PERSONAL PAY - use "SELF " for the organization id.

VALIDATION: Must be entered if required by Payor.

If entered, must be a valid code from the above list.

If "OTHER" is allowed by the Payor, the PAYOR NAME (DA0-09.0) MUST be completed.

FORM LOCATION: CMS-1500 Blocks 9, 11

REMARKS: N/A

RECORD/FIELD: DA0-09.0

DATA ELEMENT: Payor Name

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(33)	LEFT	SPACES	36	68

DEFINITION: The name of the payor organization.

CODE VALUES: See the C-53 table for valid field values.

VALIDATION: Must be entered if required by the receiver of the claim data file.

See GENERAL INSTRUCTIONS for "Name 2" (company name) entry.

Always required if "OTHER" is submitted as the PAYOR ORGANIZATION IDENTIFICATION (DA0-07.0).

FORM LOCATION: CMS-1500 Blocks 9, 11

REMARKS: N/A

RECORD/FIELD: DA0-10.0

DATA ELEMENT: Group Number (GROUP NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(20)	LEFT	SPACES	69	88

DEFINITION: The identification number assigned by the payor to the group or plan through which insurance is provided.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

Must be completed when the primary source of payment (DA0-05.0) equals B, E, F, G, H, I, J, or Z and Medicare secondary payment is being requested.

If entered, must only contain 0-9, A-Z, forward slash (/), period (.), comma (,), hyphen (-), number sign (#), ampersand (&) and blank (). No other characters are allowed.

Must NOT equal the PAYOR ID (DA0-07.0).

Must NOT equal the INSURED'S IDENTIFICATION NUMBER (DA0-18.0).

Must NOT contain all zeroes (0's) or a combination of all zeroes (0's) and spaces ().

Must NOT contain all nines (9's) or a combination of all nines (0's) and spaces (). EXCEPT for certain commercial claims which allow "999999" (six nines followed by spaces).

Must NOT contain any of the following laterals:

"UNKNOWN", "123456789", "INDIVIDUAL", "NONE", "SELF", "N/A" OR "NOT APPLICABLE".

Must NOT equal the GROUP NAME (DA0-11.0).

FORM LOCATION: CMS-1500 Blocks 9a, 11

REMARKS: Some payors require this information for all claims others may only require it, if necessary, for COB processing.

If available, it should be provided for all payors since it's presence may expedite the processing of the claim.

This information is required for processing Medicare secondary claims.

RECORD/FIELD: DA0-11.0

DATA ELEMENT: Group Name

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(33)	LEFT	SPACES	89	121

DEFINITION: The name of the group or plan through which insurance is being provided.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

Must be completed when the primary source of payment (DA0-05.0) equals B, E, F, G, H, I, J, or Z and Medicare secondary payment is being requested.

See GENERAL INSTRUCTIONS for "Name 2" (company name) entry.

Must NOT equal the PAYOR ID (DA0-07.0).

Must NOT equal the INSURED'S IDENTIFICATION NUMBER (DA0-18.0).

Must NOT contain all zeroes (0's) or a combination of all zeroes (0's) and spaces ().

Must NOT contain all nines (9's) or a combination of all nines (0's) and spaces () EXCEPT for certain commercial claims which allow "999999" (six nines followed by spaces).

Must NOT contain any of the following literals: "UNKNOWN", "123456789", "INDIVIDUAL", "NONE", "SELF", "N/A" OR "NOT APPLICABLE".

Must NOT equal the GROUP NUMBER (DA0-10.0).

FORM LOCATION: CMS-1500 Blocks 9d, 11

REMARKS: Some payors require this information for all claims others may only require it, if necessary, for COB processing.

If available, it should be provided for all payors since it's presence may expedite the processing of the claim.

This information is required for processing Medicare secondary claims.

RECORD/FIELD: DA0-12.0

DATA ELEMENT: Preferred Provider Organization Indicator/Health Maintenance Organization Indicator (PPO/HMO IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(01)	LEFT	SPACES	122	122

DEFINITION: An indicator that the provider is submitting this claim to or has submitted this claim to the indicated payor under a Special Processing Agreement.

CODE VALUES: Not used by MO HealthNet.

Y = Claim is to be processed under a PPO/HMO agreement.

I = Claim is to be processed under a CHAMPUS "Internal" Partnership agreement.

E = Claim is to be processed under a CHAMPUS "External" Partnership agreement.

N = Claim is not a PPO or HMO claim.

C = Claim is to be processed under a CHAMPUS "CAM Charleston" Partnership agreement.

G = Claim is to be processed as a CHAMPUS Army CAM Demonstration.

H = Claim is to be processed as a CHAMPUS Navy CAM Demonstration.

J = Claim is to be processed as a CHAMPUS Air Force CAM Demonstration.

O = Claim is to be processed under a CHAMPUS MCSP PPO agreement.

P = Claim is to be processed under a CHAMPUS MCSP Prime agreement.

T = Claim is to be processed under a CHAMPUS TRICARE MCSP Extra agreement.

U = Claim is to be processed under a CHAMPUS TRICARE MCSP HMO agreement.

X = Claim is to be processed as a CHAMPUS Cooperative Care Claim.

VALIDATION: Must be a valid code from the above list if required by the payor.

Must NOT be "Y" or "N" if the SOURCE OF PAY (DA0-05.0) contains an "H" (CHAMPUS).

Must NOT be "I", "E", "C", "G", "H", "J", "O", "P", "T", "U" or "X" unless the SOURCE OF PAY (DA0-05.0) is an "H".

Must be "I", "E", "C", "G", "H", "J", "O", "P", "T", "U", or "X" if the SOURCE OF PAY (DA0-05.0) is an "H" (CHAMPUS) and the PPO/HMO ID (DA0-13.0) is not blank.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA0-13.0

DATA ELEMENT: Preferred Provider Organization Identification (PPO ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(15)	LEFT	SPACES	123	137

DEFINITION: The identification number assigned to the preferred provider organization by the payor.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by the payor.

Must follow the GENERAL INSTRUCTIONS for "Identification Numbers".

Must be entered if the PPO/HMO IND (DA0-12.0) was I, E, C, G, H, J, O, P, T, U, or X. Must contain the military treatment facility ID when filing CHAMPUS partnership claims.

FORM LOCATION: N/A

REMARKS: Some payors will require that the data be entered if the PPO/HMO IND (DA0-12.0) is NOT "N" or SPACE.

RECORD/FIELD: DA0-14.0

DATA ELEMENT: Prior Authorization Number(PRIOR AUTH NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(15)	LEFT	SPACES	138	152

DEFINITION: A number, code or other indicator that the services provided on this claim have been authorized by the payor.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by the payor and prior approval has been obtained from the payor or his agent.

FORM LOCATION: CMS-1500 Block 23

REMARKS: N/A

RECORD/FIELD: DA0-15.0

DATA ELEMENT: Assignment of Benefits Indicator (ASSIGN OF BENEFITS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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15.0 X(01) LEFT SPACES 153 153

DEFINITION: An indicator showing whether or not the provider has obtained a signed form authorizing the payor to pay the provider.

CODE VALUES: Not used by MO HealthNet.

Y = Yes, benefits have been assigned to the provider and a signed form is on file in the provider's office.

N = No, benefits have not been assigned, insured did not authorize payment to provider.

O = Pay Other Organization/Legal (for NSF COB)

VALIDATION: Must be entered if required by the payor.

If entered, must be a valid code from the above.

FORM LOCATION: CMS-1500 Block 13

REMARKS: Please note that this is not the same as the provider accepting assignment; this is the insured's authorization. Some payors (commercial) may make payment to the provider based upon this indicator. Others such as Medicare and Blue Shield may use the PROVIDER ACCEPT ASSIGNMENT INDICATOR (EA0-34.0).

Medicare requires that this indicator be "Y" prior to crossing claims to MEDIGAP payors.

An indicator of "Y" does not preclude the need for a signed RELEASE OF INFORMATION form (EA0-13.0).

RECORD/FIELD: DA0-16.0

DATA ELEMENT: Patient Signature Source (PAT SIGNATURE SOURCE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(01)	LEFT	SPACES	154	154

DEFINITION: An indicator on how the patient/subscriber authorization signatures, to permit releasing medical information, were obtained and how they are being retained by the provider.

CODE VALUES: Not used by MO HealthNet.

C = Signed CMS-1500 claim form on file.

S = Signed signature authorization form for Block 12 on file.

M = Signed signature authorization form for Block 13 on file.

B = Signed signature authorization form or forms for both Block 12 and Block 13 are on file.

P = Signature generated by provider because the patient was not physically present for services.

VALIDATION: Must be entered if required by the payor.

If entered must be a valid code from the above list.

FORM LOCATION: CMS-1500 Blocks 12

REMARKS: N/A

RECORD/FIELD: DA0-17.0

DATA ELEMENT: Patient Relationship To Insured (PAT REL TO INSURED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	9(02)	RIGHT	ZEROS	155	156

DEFINITION: A code indicating the relationship of the patient to the insured.

CODE VALUES: Not used by MO HealthNet.

01 = Patient is Insured.

02 = Spouse

03 = Natural Child/Insured has Financial Responsibility (includes legally adopted child)

04 = Natural Child/insured does not have Financial Responsibility (includes legally adopted child)

05 = Step Child

06 = Foster Child

07 = Ward of the Court

08 = Employee

09 = Unknown - Patient's relationship to the insured is other than that indicated

10 = Handicapped Dependent

11 = Organ Donor

12 = Cadaver Donor

13 = Grandchild

14 = Niece/Nephew

VALIDATION: Must be numeric.

Must be a code from the above list.

FORM LOCATION: CMS-1500 Block 6

REMARKS: If code 09 is used an explanation should be entered in the remarks area (Record Type XA0 Field 22.0).

RECORD/FIELD: DA0-18.0

DATA ELEMENT: Insured Identification Number (INSURED ID NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(25)	LEFT	SPACES	157	181

DEFINITION: Insured's unique identification number, assigned by the Third Party Payor.

CODE VALUES: See the C-1 table for valid field values.

VALIDATION: See GENERAL INSTRUCTIONS for identification number entry. Must not contain all zeros or all nines (9's). May not contain any of the following literals:

"unknown", "individual", "self",

"1234567890" or "none"

FORM LOCATION: CMS-1500 Blocks 1a, 9a

REMARKS: Subscriber ID

Sponsor ID

HIC ID

SSN ID

Participant ID

Employee ID (Group self administered)

RECORD/FIELD: DA0-19.0 DA0-20.0 DA0-21.0

DATA ELEMENT:	Insured Last Name	(INSURED LAST NAME)
	Insured First Name	(INSURED FIRST NAME)
	Insured Middle Initial	(INSURED MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(20)	LEFT	SPACES	182	201
20.0	X(12)	LEFT	SPACES	202	213
21.0	X(01)	LEFT	SPACES	214	214

DEFINITION: The last, first, middle name of the insured individual.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for Name 1 (individual names) entry.

FORM LOCATION: CMS-1500 Blocks 4, 9

REMARKS: N/A

RECORD/FIELD: DA0-22.0

DATA ELEMENT: Insured Generation

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(03)	LEFT	SPACES	215	217

DEFINITION: The generation of the patient, such as I,II, III, Jr, or Sr.

CODE VALUES: Not used by MO HealthNet.

I, II, III, IV, JR, SR

VALIDATION: If entered, must be one of the above codes.

FORM LOCATION: CMS-1500 Blocks 4, 9

REMARKS: N/A

RECORD/FIELD: DA0-23.0

DATA ELEMENT: Insured Sex

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(01)	LEFT	SPACES	218	218

DEFINITION: A code designating the insured's sex.

CODE VALUES: Not used by MO HealthNet.

M - Male

F - Female

U - Unknown

VALIDATION: Must be entered if required by payor (receiver).

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Blocks 11a, 9b

REMARKS: N/A

RECORD/FIELD: DA0-24.0

DATA ELEMENT: Insured Date of Birth

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(08)	LEFT	SPACES	219	226

DEFINITION: The date of birth of the insured.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor (receiver).

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for Date entry.

FORM LOCATION: CMS-1500 Blocks 9b, 11a

REMARKS: N/A

RECORD/FIELD: DA0-25.0

DATA ELEMENT: Insured Employment Status Code (INSURED EMPL STATUS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(01)	LEFT	SPACES	227	227

DEFINITION: Code to indicate employment status of the insured individual.

CODE VALUES: Not used by MO HealthNet.

1 = Employed full-time

2 = Employed part-time

3 = Not employed

4 = Self-employed

5 = Retired

6 = On active military duty

7 = Reserved for national assignment

8 = Reserved for local assignment

9 = Unknown

VALIDATION: Must be entered if required by payor (receiver).

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Blocks 11d, 9c

REMARKS: N/A

RECORD/FIELD: DA0-26.0

DATA ELEMENT: Supplemental Insurance Indicator (SUPPLEMENTAL INS IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(01)	LEFT	SPACES	228	228

DEFINITION: Indicates whether patient is carrying other insurance, is eligible for MO HealthNet or is eligible for Medicare.

CODE VALUES: Not used by MO HealthNet.

I = Patient is Eligible for Medicare

M = MO HealthNet

P = Primary Payer in MSP Situations

S = Supplemental/Medigap

W = MO HealthNet and MSP

X = MO HealthNet and Medigap

Y = MO HealthNet, MSP and Medigap

Z = MSP and Medigap

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA0-27.0

DATA ELEMENT: Insurance Location Identifier (INSURANCE LOCATION ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(7)	LEFT	SPACES	229	235

DEFINITION: A code to identify the location, Title XIX coverage, county of coverage, branch number, HMO Satellite, plan contract number, etc.

CODE VALUES: Not used by MO HealthNet.

As developed by the payor or receiver.

VALIDATION: Must be entered if required by payor or receiver.

If entered, must be a valid code from the list maintained by the payor/receiver.

FORM LOCATION: N/A

REMARKS: Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: DA0-28.0

DATA ELEMENT: MO HealthNet Identification Number (MO HEALTHNET ID NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(25)	LEFT	SPACES	236	260

DEFINITION: Insured's unique MO HealthNet identification number.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for identification number entry. Must not contain all zeros or all nines (9's). May not contain any of the following literals:

"unknown", "individual", "self", "1234567890" or "none"

FORM LOCATION: CMS-1500, Block 10d

REMARKS: If Medicare patient is entitled to MO HealthNet (DA0-26.0 = "M") this field must be entered.

RECORD/FIELD: DA0-29.0

DATA ELEMENT: Supplemental Patient Identification Number (SUPPLEMENTAL PAT ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(25)	LEFT	SPACES	261	285

DEFINITION: Supplemental ID on file with sender of the COB claim.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: If available, this is required for COB exchange.

RECORD/FIELD: DA0-30.0

DATA ELEMENT: Assignment for 4081 Claim

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(01)	LEFT	SPACES	286	286

DEFINITION: Beneficiary assignment for mandatory Medicare (Section 4081) Claim.

CODE VALUES: Not used by MO HealthNet.

1 = 4081

2 = Regular Crossover

VALIDATION: If entered must be valid code from code list.

FORM LOCATION: N/A

REMARKS: This is required for COB exchange.

RECORD/FIELD: DA0-31.0

DATA ELEMENT: Coordination of Benefits Routing Indicator (COB ROUTING IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(01)	LEFT	SPACES	287	287

DEFINITION: Identifies the type of coordination of benefits exchange.

CODE VALUES: Not used by MO HealthNet.

1 = Regeneration

2 = Manual crossover transaction

3 = HMO

4 = Travelers (Railroad Beneficiaries)

VALIDATION: If entered must be valid code from code list.

FORM LOCATION: N/A

REMARKS: This is required for NSF COB exchange.

RECORD/FIELD: DA0-32.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(33)	LEFT	SPACES	288	320

DEFINITION: Unused record space reserved for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: INSURANCE INFORMATION RECORD TYPE DA1 "PAYOR DATA 2"

Not Required by MO HealthNet

Must follow DA0

Must be followed by DA2 or EA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "DA1"	C-24	DA1
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	PAYOR ADDR1		Not Used
05	PAYOR ADDR2		Not Used
06	PAYOR CITY		Not Used

07	PAYOR STATE		Not Used
08	PAYOR ZIP		Not Used
09	DISALLOWED COST CONT		Not Used
10	DISALLOWED OTHER		Not Used
11	ALLOWED AMOUNT		Not Used
12	DEDUCTIBLE AMOUNT		Not Used
13	COINSURANCE AMOUNT		Not Used
14	PAYOR AMOUNT PAID		Not Used
15	ZERO PAY IND		Not Used
16	ADJUDICATION IND 1		Not Used
17	ADJUDICATION IND 2		Not Used
18	ADJUDICATION IND 3		Not Used
19	CHAMPUS SPNSR BRANCH		Not Used
20	CHAMPUS SPNSR GRADE		Not Used
21	CHAMPUS SPNSR STATUS		Not Used
22	INS CARD EFFECT DATE		Not Used
23	INS CARD TERM DATE		Not Used
24	BALANCE DUE		Not Used
25	EOMB DATE1		Not Used
26	EOMB DATE2		Not Used
27	EOMB DATE3		Not Used
28	EOMB DATE4		Not Used
29	CLAIM RECEIPT DATE		Not Used
30	AMT PAID TO BENE		Not Used
31	BENE CHECK/EFT TRACE NO		Not Used
32	BENE CHECK DATE		Not Used
33	AMT PAID TO PROV		Not Used
34	PROV CHECK/EFT TRACE NO		Not Used
35	PROV CHECK DATE		Not Used
36	INTEREST PAID		Not Used

37	APPROVED AMT		Not Used
38	FILLER-NATIONAL		YES

RECORD TYPE: DA1

LEVEL:CLAIM

PURPOSE: To supply additional information for identifying the payor and/or to provide prior adjudication status information from primary payors.

REQUIREMENTS: When filing 'secondary' claims a "DA1" record is required for every payor who has received and/or processed the claim prior to this submission.

ORDER: Preceding Record Type Following Record Type
 DA0 DA0, DA2 or EA0

NOTES: When requesting payment from a secondary payor it is extremely important that the EOB/remittance information be provided from the primary payor(s). This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy EOB.

FIELD NO	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "DA1"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	PAYOR ADDR1	30	X	23	52
05.0	PAYOR ADDR2	30	X	53	82
06.0	PAYOR CITY	20	X	83	102
07.0	PAYOR STATE	2	X	103	104
08.0	PAYOR ZIP	9	X	105	113
09.0	DISALLOWED COST CONT	7	N	114	120
10.0	DISALLOWED OTHER	7	N	121	127
11.0	ALLOWED AMOUNT	7	N	128	134
12.0	DEDUCTABLE AMOUNT	7	N	135	141
13.0	COINSURANCE AMOUNT	7	N	142	148
14.0	PAYOR AMOUNT PAID	7	N	149	155
15.0	ZERO PAY IND	1	X	156	156

16.0	ADJUDICATION IND 1	2	X	157	158
17.0	ADJUDICATION IND 2	2	X	159	160
18.0	ADJUDICATION IND 3	2	X	161	162
19.0	CHAMPUS SPNSR BRANCH	1	X	163	163
20.0	CHAMPUS SPNSR GRADE	2	X	164	165
21.0	CHAMPUS SPNSR STATUS	1	X	166	166
22.0	INS CARD EFFECT DATE	8	X	167	174
23.0	INS CARD TERM DATE	8	X	175	182
24.0	BALANCE DUE	7	N	183	189
25.0	EOMB DATE1	8	X	190	197
26.0	EOMB DATE2	8	X	198	205
27.0	EOMB DATE3	8	X	206	213
28.0	EOMB DATE4	8	X	214	221
29.0	CLAIM RECEIPT DATE	8	X	222	229
30.0	AMT PAID TO BENE	9	N	230	238
31.0	BENE CHECK/EFT TRACE NO	15	X	239	253
32.0	BENE CHECK DATE	8	X	254	261
33.0	AMT PAID TO PROV	9	N	262	270
34.0	PROV CHECK/EFT TRACE NO	15	X	271	285
35.0	PROV CHECK DATE	8	X	286	293
36.0	INTEREST PAID	9	N	294	302
37.0	APPROVED AMT	9	N	303	311
38.0	CONTRACT AGREEMENT IND	1	X	312	312
39.0	FILLER-NATIONAL	8	X	313	320

RECORD/FIELD: DA1-01.0

DATA ELEMENT: Record Identifier (RECORD ID "DA1")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "INSURANCE INFORMATION" - "PAYOR DATA 2" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: A claim may have up to three "DA1" records. Each must have a corresponding "DA0" record.

Must be "DA1".

FORM LOCATION: N/A

REMARKS: Multiple "DA1" records must have corresponding "DA0" records. The records are 'matched' by SEQUENCE NO (DA0-02.0 and DA1-02.0).

RECORD/FIELD: DA1-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 03 used to sequence the "DA1" records and to associate "DA1" records with "DA0" and "DA2" records.

CODE VALUES: See the C-21 table for valid field values.

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (DA0-02.0) submitted in the preceding "DA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page DA0.04.

RECORD/FIELD: DA1-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique identifier assigned by the provider to identify the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD/FIELD: DA1-04.0 DA1-05.0 DA1-06.0 DA1-07.0 DA1-08.0

DATA ELEMENT: Payor Address Line 1 (PAYOR ADDR1)
 Payor Address Line 2 (PAYOR ADDR2)
 Payor City (PAYOR CITY)
 Payor State (PAYOR STATE)
 Payor Zip Code (PAYOR ZIP CODE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(30)	LEFT	SPACES	23	52
05.0	X(30)	LEFT	SPACES	53	82
06.0	X(20)	LEFT	SPACES	83	102
07.0	X(02)	LEFT	SPACES	103	104
08.0	X(09)	LEFT	SPACES	105	113

DEFINITION: Payor's claim mailing address for this particular payor ID and claim office.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

If entered, see GENERAL INSTRUCTIONS for "address" entry.

FORM LOCATION: CMS-1500 Blocks 9, 11

REMARKS: N/A

RECORD/FIELD: DA1-09.0

DATA ELEMENT: Disallowed Cost Containment Amount (DISALLOWED COST CONT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	9(5)V99	RIGHT	ZEROS	114	120

DEFINITION: The amount disallowed by the payor due to the failure of either the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested for this claim.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor.

REMARKS: Under some state (federal?) COB statues and regulations, secondary payors do not have any liability for amounts disallowed by the primary payor because of the failure of the provider or insured to fulfill a cost containment provision under the primary contract.

RECORD/FIELD: DA1-10.0

DATA ELEMENT: Disallowed Other Amount(DISALLOWED OTHER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	9(5)V99	RIGHT	ZEROS	121	127

DEFINITION: The amount disallowed by the payor for reasons OTHER than the failure of the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested for this claim.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor.

REMARKS: N/A

RECORD/FIELD: DA1-11.0

DATA ELEMENT: Allowed Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	9(5)V99	RIGHT	ZEROS	128	134

DEFINITION: The maximum amount determined by the payor as being "allowable" under the provisions of the contract prior to the determination of actual payment.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor.

REMARKS: This field may be used to report the total amount allowed on the claim for Medicare Secondary Payor submission purposes.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: DA1-12.0

DATA ELEMENT: Deductible Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	9(5)V99	RIGHT	ZEROS	135	141

DEFINITION: The amount deducted, by the payor, from the allowed amount in order to meet the contract "deductible" provisions.

The amount applied toward the deductible by this payor.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor.

REMARKS: This field may be used to report the total amount of deductible on the claim for Medicare Secondary Payor submission purposes.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: DA1-13.0

DATA ELEMENT: Coinsurance Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	9(5)V99	RIGHT	ZEROS	142	148

DEFINITION: The amount deducted, by the payor, from the allowed amount in order to meet the "coinsurance" provisions of the contract.

The amount applied toward the coinsurance by this payor.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor.

REMARKS: This field may be used to report the total amount of coinsurance on the claim for Medicare Secondary Payor submission purposes.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: DA1-14.0

DATA ELEMENT: Payor Amount Paid

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	9(5)V99	RIGHT	ZEROS	149	155

DEFINITION: The amount paid by the payor on this claim.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

Must be a positive, unsigned numeric value.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor.

REMARKS: This field may be used to report the total amount paid on the claim for Medicare Secondary Payor submission purposes.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: DA1-15.0

DATA ELEMENT: Zero Payment Indicator (ZERO PAY IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	LEFT	SPACES	156	156

DEFINITION: An indicator showing:

- 1) that the claim has been filed to the payor,
- 2) that the payor has processed the claim and so informed the provider, and
- 3) that the PAYOR PAID AMOUNT (DA0-4.0) is the entire amount paid by the payor on this claim.

A payment of ZERO may be the result of the payor determining that they have no liability for the claim or that the entire liability was applied to deductibles and coinsurance.

CODE VALUES: Not used by MO HealthNet.

Z = Zero payment.

N = Payment amount is greater than zero.

SPACE = Claim has not been filed or payment notification has not been received from this payor.

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

If entered, must be a valid code from the above list.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor(s).

REMARKS: The purpose of this indicator is to allow payors to process secondary claims with zero payments by the primary payor without having to obtain an EOB from the payor or insured.

The provider is certifying that he has filed the claim to the indicated payor, the payor has processed the claim to completion, informed the provider of the results of that processing and that the amount shown in PAYOR PAID AMOUNT (DA1-14.0) is the actual amount that the payor paid on the claim.

RECORD/FIELD: DA1-16.0 DA1-17.0 DA1-18.0

DATA ELEMENT: Adjudication Indicator 1 (ADJUDICATION IND 1)

Adjudication Indicator 2 (ADJUDICATION IND 2)

Adjudication Indicator 3 (ADJUDICATION IND 3)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(02)	LEFT	SPACES	157	158
17.0	X(02)	LEFT	SPACES	159	160
18.0	X(02)	LEFT	SPACES	161	162

DEFINITION: Codes indicating the reason(s) why the payor denied or reduced benefits on this claim.

Use all of the codes that apply, up to the maximum of three (3).

CODE VALUES: Not used by MO HealthNet.

01 = Benefits exhausted

02 = Non-covered benefits

03 = Insured coverage lapsed or did not exist

04 = Cost containment disallowed

05 = Entire amount applied to deductible

06 = Charges exceeded allowance

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

If entered, must be a valid code from the above list.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor(s).

REMARKS: N/A

RECORD/FIELD: DA1-19.0

DATA ELEMENT: CHAMPUS Sponsor Branch (CHAMPUS SPNSR BRANCH)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(01)	LEFT	SPACES	163	163

DEFINITION: CHAMPUS sponsor's military branch of service obtained from the military identification card

CODE VALUES: Not used by MO HealthNet.

1 = Army

2 = Air Force

3 = Marines

4 = Navy

5 = Coast Guard

6 = Public Health Service

7 = NOAA (National Oceanic & Atmospheric Adm.)

VALIDATION: If entered, must be a valid code from the above list.

Required if source of payment = H (Champus) and claim filing indicator is `P'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA1-20.0

DATA ELEMENT: CHAMPUS Sponsor Grade (CHAMPUS SPNSR GRADE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(02)	LEFT	SPACES	614	165

DEFINITION: CHAMPUS sponsor's military grade obtained from the military identification card.

CODE VALUES: Not used by MO HealthNet.

See EXHIBIT 2 for valid values.

VALIDATION: If entered, must be a valid code from Exhibit 2. Required if source of payment = H (Champus) and claim filing indicator is `P'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA1-21.0

DATA ELEMENT: CHAMPUS Sponsor Status

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>
21.0	X(01)	LEFT	SPACES	166

DEFINITION: CHAMPUS sponsor's military status obtained from the military identification card.

CODE VALUES: Not used by MO HealthNet.

1 = Active Military

2 = Retired Military

3 = Deceased

VALIDATION: If entered, must be a valid code from the above list.

Required if source of payment = H (Champus) and claim filing indicator is `P'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA1-22.0

DATA ELEMENT: Insurance Card Effective Date (INS CARD EFFECT DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(08)	LEFT	SPACES	167	174

DEFINITION: The effective date is obtained from the insurance identification card.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for Date Entry.

Required if source of payment = H (CHAMPUS) and claim filing indicator is `P'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA1-23.0

DATA ELEMENT: Insurance Card Termination Date (INS CARD TERM DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(08)	LEFT	SPACES	175	182

DEFINITION: The effective date is obtained from the insurance identification card.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for Date Entry.

Required if source of payment = H (Champus) and claim filing indicator is `P'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA1-24.0

DATA ELEMENT: Balance Due

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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24.0 9(5)V99 RIGHT ZEROS 183 189

DEFINITION: Amount of total charges remaining if partial payment is made by the patient. If no balance remains, show zeros.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

FORM LOCATION: CMS-1500 Block 30

REMARKS: N/A

RECORD/FIELD: DA1-25.0 DA1-26.0 DA1-27.0 DA1-28.0

DATA ELEMENT: EOMB DATE1
 EOMB DATE2
 EOMB DATE3
 EOMB DATE4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(08)	LEFT	SPACES	190	197
26.0	X(08)	LEFT	SPACES	198	205
27.0	X(08)	LEFT	SPACES	206	213
28.0	X(08)	LEFT	SPACES	214	221

DEFINITION: Date 1 = Date finalized in the system.
 Date 2 = Date EOMB mailed.
 Date 3 = Date of check/EFT transaction
 Date 4 = "Other" Date

CODE VALUES: Not used by MO HealthNet.

Date 1 = Date finalized in the system.

Date 2 = Date EOMB mailed.

Date 3 = Date of check/EFT transaction

Date 4 = "Other" Date

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required for COB exchange.

RECORD/FIELD: DA1-29.0

DATA ELEMENT: CLAIM RECEIPT DATE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(08)	LEFT	SPACES	222	229

DEFINITION: The Date the claim was received by the Payor.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange.

RECORD/FIELD: DA1-30.0

DATA ELEMENT: BENE PAID AMT

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	s9(7)v99	RIGHT	ZEROS	230	238

DEFINITION: Total amount paid to the beneficiary.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

RECORD/FIELD: DA1-31.0

DATA ELEMENT: BENE CHECK/EFT TRACE NO

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(15)	LEFT	SPACES	239	253

DEFINITION: The check number/EFT trace number.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

RECORD/FIELD: DA1-32.0

DATA ELEMENT: BENE CHECK/EFT DATE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	x(08)	LEFT	SPACES	254	261

DEFINITION: The date the Medicare check/EFT was issued to the beneficiary.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

RECORD/FIELD: DA1-33.0

DATA ELEMENT: PROV PAID AMT

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
33.0	S9(7)v99	RIGHT	ZEROS	262	270

DEFINITION: Total amount paid to the provider.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

RECORD/FIELD: DA1-34.0

DATA ELEMENT: PROV CHECK/EFT TRACE NO

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
34.0	X(15)	LEFT	SPACES	271	285

DEFINITION: The check number/EFT trace number.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

RECORD/FIELD: DA1-35.0

DATA ELEMENT: PROV CHECK DATE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
35.0	x(08)	LEFT	SPACES	286	293

DEFINITION: The date the Medicare check\EFT was issued to the provider.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

RECORD/FIELD: DA1-36.0

DATA ELEMENT: INTEREST PAID

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
36.0	S9(7)v99	RIGHT	ZEROS	294	302

DEFINITION: The amount paid by the Payor for the interest due for the delay in processing of the claim by Payor.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

RECORD/FIELD: DA1-37.0

DATA ELEMENT: APPROVED AMT

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
37.0	S9(7)v99	RIGHT	ZEROS	303	311

DEFINITION: The amount approved for all services lines.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange.

RECORD/FIELD: DA1-38.0

DATA ELEMENT: Contractual Agreement Indicator (CONTRACT AGREEMENT IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
<u>NSF (National Standard Format) User Manual</u>					

38.0 X(01) LEFT SPACES 312 312

DEFINITION: Primary Payer has a contractual agreement with the provider that limits what the provider may charge for a service.

CODE VALUES: Y = Yes, contractual agreement exists N = No , contractual agreement does not exist

VALIDATION: If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: For Champus, If yes, the allowed amount (DA1-11.0) is required for double coverage claims.

RECORD/FIELD: DA1-39.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
39.0	X(08)	LEFT	SPACES	313	320

DEFINITION: Unused record space reserved for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: INSURANCE INFORMATION RECORD TYPE DA2 "PAYOR DATA 3"

Not Required by MO HealthNet

Must follow DA0 or DA1

Must be followed by EA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "DA2"	C-24	DA2
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	INSURED ADDR1		Not Used
05	INSURED ADDR2		Not Used
06	INSURED CITY		Not Used

07	INSURED STATE		Not Used
08	INSURED ZIP		Not Used
09	INSURED PHONE		Not Used
10	INSURED RETIRE DATE		Not Used
11	INSURED SPOUSE RETIRE		Not Used
12	INSURED EMPLR NAME		Not Used
13	INSURED EMPLR ADDR1		Not Used
14	INSURED EMPLR ADDR2		Not Used
15	INSURED EMPLR CITY		Not Used
16	INSURED EMPLR STATE		Not Used
17	INSURED EMPLR ZIP		Not Used
18	EMPLOYEE ID NO		Not Used
19	FILLER-NATIONAL		YES

RECORD TYPE: DA2

LEVEL: CLAIM

PURPOSE: To identify the Insured(s) involved with and/or having liability for the resolution of this claim.

REQUIREMENTS: This record must be entered if required by payor.

ORDER:	Preceding Record Type	Following Record Type
	DA0 or DA1	DA0 or EA0

NOTES: When requesting payment from a secondary payor it is extremely important that the EOB/remittance information be provided from the primary payor(s).

This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy EOB.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "DA2"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	INSURED ADDR1	30	X	23	52

05.0	INSURED ADDR2	30	X	53	82
06.0	INSURED CITY	20	X	83	102
07.0	INSURED STATE	2	X	103	104
08.0	INSURED ZIP	9	X	105	113
09.0	INSURED PHONE	10	X	114	123
10.0	INSURED RETIRE DATE	8	X	124	131
11.0	INSURED SPOUSE RETIRE	8	X	132	139
12.0	INSURED EMPLR NAME	33	X	140	172
13.0	INSURED EMPLR ADDR1	30	X	173	202
14.0	INSURED EMPLR ADDR2	30	X	203	232
15.0	INSURED EMPLR CITY	20	X	233	252
16.0	INSURED EMPLR STATE	2	X	253	254
17.0	INSURED EMPLR ZIP	9	X	255	263
18.0	EMPLOYEE ID NO	12	X	264	275
19.0	FILLER-NATIONAL	45	X	276	320

RECORD/FIELD: DA2-01.0

DATA ELEMENT: Record Identifier (RECORD ID "DA2")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "INSURANCE INFORMATION" - "PAYOR DATA 3" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered.

Must be "DA2".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA2-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 03 used to sequence the "DA2" records, and to associate "DA2" records with "DA0" and "DA1" records.

CODE VALUES: See the C-21 table for valid field values.

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (DA0-02.0) submitted in the preceding "DA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page DA0.04.

RECORD/FIELD: DA2-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

RECORD/FIELD: DA2-04.0 DA2-05.0 DA2-06.0 DA2-07.0 DA2-08.0

DATA ELEMENT:	Insured Address Line 1	(INSURED ADDR1)
	Insured Address Line 2	(INSURED ADDR2)
	Insured City	(INSURED CITY)
	Insured State	(INSURED STATE)
	Insured Zip	(INSURED ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(30)	LEFT	SPACES	23	52
05.0	X(30)	LEFT	SPACES	53	82

06.0	X(20)	LEFT	SPACES	83	102
07.0	X(02)	LEFT	SPACES	103	104
08.0	X(09)	LEFT	SPACES	105	113

DEFINITION: The current mailing address of the insured individual.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for Address Entry.

FORM LOCATION: CMS-1500 Block 7

REMARKS: N/A

RECORD/FIELD: DA2-09.0

DATA ELEMENT: Insured Telephone Number (INSURED PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(10)	LEFT	SPACES	114	123

DEFINITION: Telephone number, including area code, at which the insured individual can be contacted.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for Telephone Entry.

FORM LOCATION: CMS-1500 Block 7

REMARKS: N/A

RECORD/FIELD: DA2-10.0

DATA ELEMENT: Insured Retirement Date (INSURED RETIRE DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(08)	LEFT	SPACES	124	131

DEFINITION: The retirement date of the insured.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for Date Entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA2-11.0

DATA ELEMENT: Insured Spouse Retirement Date (INSURED SPOUSE RETIRE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(08)	LEFT	SPACES	132	139

DEFINITION: The retirement date of the Insured's spouse.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor (receiver).

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for Date Entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA2-12.0

DATA ELEMENT: Insured Employer Name(INSURED EMPLR NAME)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(33)	LEFT	SPACES	140	172

DEFINITION: The name of the insured individual's employer.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Name" ENTRY.

FORM LOCATION: CMS-1500 Blocks 11b, 9c

REMARKS: N/A

RECORD/FIELD: DA2-13.0 DA2-14.0 DA2-15.0 DA2-16.0 DA2-17.0

DATA ELEMENT:	Insured Employer Address Line 1	(INSURED EMPLR ADDR1)
	Insured Employer Address Line 2	(INSURED EMPLR ADDR2)
	Insured Employer City	(INSURED EMPLR CITY)
	Insured Employer State	(INSURED EMPLR STATE)
	Insured Employer Zip	(INSURED EMPLR ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(30)	LEFT	SPACES	173	202
14.0	X(30)	LEFT	SPACES	203	232
15.0	X(20)	LEFT	SPACES	233	252
16.0	X(02)	LEFT	SPACES	253	254
17.0	X(09)	LEFT	SPACES	255	263

DEFINITION: The current mailing address of the insured individual's employer.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for Address Entry.

Must be entered if required by payor (receiver).

FORM LOCATION: CMS-1500 Blocks 9c, 11b

REMARKS: N/A

RECORD/FIELD: DA2-18.0

DATA ELEMENT: Employer Identification Number (EMPLOYER ID NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(12)	LEFT	SPACES	264	275

DEFINITION: The identification number assigned by the employer to the employee.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Identification number" entry.

Must be entered if required by payor (receiver).

FORM LOCATION: CMS-1500 Blocks 9a, 11

REMARKS: N/A

RECORD/FIELD: DA2-19.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(45)	LEFT	SPACES	276	320

DEFINITION: Unused record space. Reserved for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

**RECORD NAME: INSURANCE INFORMATION RECORD TYPE DA3 "PAYOR
DATA 4"**

FIELD NO	FIELD NAME	TABLE VALUE	DEFAULT
01	RECORD ID "DA3"	C-24	DA3
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	CLAIM REASON CODE1		Not Used
05	DOLLAR AMOUNT1		Not Used
06	CLAIM REASON CODE2		Not Used
07	DOLLAR AMOUNT2		Not Used
08	CLAIM REASON CODE3		Not Used
09	DOLLAR AMOUNT3		Not Used
10	CLAIM REASON CODE4		Not Used
11	DOLLAR AMOUNT4		Not Used
12	CLAIM REASON CODE5		Not Used
13	DOLLAR AMOUNT5		Not Used
14	CLAIM REASON CODE6		Not Used
15	DOLLAR AMOUNT6		Not Used
16	CLAIM REASON CODE7		Not Used
17	DOLLAR AMOUNT7		Not Used
18	CLAIM MESSAGE CODE1		Not Used
19	CLAIM MESSAGE CODE2		Not Used
20	CLAIM MESSAGE CODE3		Not Used
21	CLAIM MESSAGE CODE4		Not Used
22	CLAIM MESSAGE CODE5		Not Used
23	CLAIM DETAIL LINE COUNT		Not Used
24	CLAIM ADJUST IND		Not Used

25	PROV ADJUST AMT		Not Used
26	BENE ADJUST AMT		Not Used
27	ORIG APPROVE AMT		Not Used
28	ORIG PAID AMT		Not Used
29	ORIG PAYOR CLM CONTROL NO		Not Used
30	FILLER-NATIONAL		Not Used

RECORD TYPE: DA3

LEVEL:CLAIM

PURPOSE: To supply prior adjudication status information from primary payors.

REQUIREMENTS: This record must be entered if this is a Coordination of Benefits file and claim level adjustments have been applied and/or claim level messages were reported.

ORDER: Preceding Record Type Following Record Type
 DA1 DA0 or EA0

NOTES: When requesting payment from a secondary payor it is extremely important that the EOB/remittance information be provided from the primary payor(s). This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy EOB.

FIELD NO	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "DA3"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	CLAIM REASON CODE1	6	X	23	28
05.0	DOLLAR AMOUNT1	7	N	29	35
06.0	CLAIM REASON CODE2	6	X	36	41
07.0	DOLLAR AMOUNT2	7	N	42	48
08.0	CLAIM REASON CODE3	6	X	49	54
09.0	DOLLAR AMOUNT3	7	N	55	61
10.0	CLAIM REASON CODE4	6	X	62	67
11.0	DOLLAR AMOUNT4	7	N	68	74

12.0	CLAIM REASON CODE5	6	X	75	80
13.0	DOLLAR AMOUNT5	7	N	81	87
14.0	CLAIM REASON CODE6	6	X	88	93
15.0	DOLLAR AMOUNT6	7	N	94	100
16.0	CLAIM REASON CODE7	6	X	101	106
17.0	DOLLAR AMOUNT7	7	N	107	113
18.0	CLAIM MESSAGE CODE1	5	X	114	118
19.0	CLAIM MESSAGE CODE2	5	X	119	123
20.0	CLAIM MESSAGE CODE3	5	X	124	128
21.0	CLAIM MESSAGE CODE4	5	X	129	133
22.0	CLAIM MESSAGE CODE5	5	X	134	138
23.0	CLAIM DETAIL LINE COUNT	2	X	139	140
24.0	CLAIM ADJUST IND	1	X	141	141
25.0	PROV ADJUST AMT	7	N	142	148
26.0	BENE ADJUST AMT	7	N	149	155
27.0	ORIG APPROVE AMT	7	N	156	162
28.0	ORIG PAID AMT	7	N	163	169
29.0	ORIG PAYOR CLM CONTROL NO	17	X	170	186
30.0	FILLER-NATIONAL	134	X	187	320

RECORD/FIELD: DA3-01.0

DATA ELEMENT: Record Identifier (RECORD ID "DA3")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "INSURANCE INFORMATION" - "PAYOR DATA 4" record.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered.

Must be "DA3".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: DA3-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 03 used to sequence the "DA3" records, and to associate "DA3" records with "DA0", "DA1" AND "DA2" records.

CODE VALUES: See the C-21 table for valid field values.

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (DA0-02.0) submitted in the preceding "DA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page DA0.04.

RECORD/FIELD: DA3-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

RECORD/FIELD: DA3-04.0 DA3-05.0

DATA ELEMENT: Claim Reason Code 1 Dollar Amount 1

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(06)	LEFT	SPACES	23	28
05.0	S9(5)V99	RIGHT	ZEROS	29	35

DEFINITION: Claim adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: DA3-06 DA3-07.0

DATA ELEMENT: Claim Reason Code 2 Dollar Amount 2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(06)	LEFT	SPACES	36	41
07.0	S9(5)V99	RIGHT	ZEROS	42	48

DEFINITION: Claim adjustment reason code and amount of adjustment. The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

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Washington Publishing Company World Wide Web Site www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association
 Inter-Plan Teleprocessing Services Dept.
 676 North St. Clair Street
 Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: DA3-08.0 DA3-09.0

DATA ELEMENT: Claim Reason Code 3 Dollar Amount 3

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(06)	LEFT	SPACES	49	54
09.0	S9(5)V99	RIGHT	ZEROS	55	61

DEFINITION: Claim adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

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Paper Copy:

Blue Cross and Blue Shield Association
 Inter-Plan Teleprocessing Services Dept.
 676 North St. Clair Street
 Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI SC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: DA3-10.0 DA3-11.0

DATA ELEMENT: Claim Reason Code 4 Dollar Amount 4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
<u>NSF (National Standard Format) User Manual</u>					104

10.0	X(06)	LEFT	SPACES	62	67
11.0	S9(5)V99	RIGHT	ZEROS	68	74

DEFINITION: Claim adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: DA3-12.0 DA3-13.0

DATA ELEMENT: Claim Reason Code 5 Dollar Amount 5

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(06)	LEFT	SPACES	75	80
13.0	S9(5)V99	RIGHT	ZEROS	81	87

DEFINITION: Claim adjustment reason code and amount of adjustment. The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: DA3-14.0 DA3-15.0

DATA ELEMENT: Claim Reason Code 6 Dollar Amount 6

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(06)	LEFT	SPACES	88	93
15.0	S9(5)V99	RIGHT	ZEROS	94	99

DEFINITION: Claim adjustment reason code and amount of adjustment. The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: DA3-16.0 DA3-17.0

DATA ELEMENT: Claim Reason Code 7 Dollar Amount 7

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(06)	LEFT	SPACES	100	105
17.0	S9(5)V99	RIGHT	ZEROS	106	113

DEFINITION: Claim adjustment reason code and amount of adjustment. The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: DA3-18.0 DA3-19.0 DA3-20.0 DA3-21.0 DA3-22.0

- DATA ELEMENT: Claim Message Code 1
 Claim Message Code 2
 Claim Message Code 3
 Claim Message Code 4
 Claim Message Code 5

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(05)	LEFT	SPACES	114	118
19.0	X(05)	LEFT	SPACES	119	123
20.0	X(05)	LEFT	SPACES	124	128
21.0	X(05)	LEFT	SPACES	129	133
22.0	X(05)	LEFT	SPACES	134	138

DEFINITION: Claim level information message codes to convey appeal or other claim-specific information that does not involve a financial adjustment.

CODE VALUES: Not used by MO HealthNet.

For Medicare, use the current Medicare Inpatient (MIA) or Medicare Outpatient (MOA) message codes.

VALIDATION: If entered, Medicare requires a valid MIA/MOA code.

REMARKS: MIA/MOA codes are maintained by CMS.

RECORD/FIELD: DA3-23.0

DATA ELEMENT: Claim Detail Line Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(02)	LEFT	SPACES	139	140

DEFINITION: Number of total detail lines from the original claim.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

REMARKS: Required for COB exchange.

RECORD/FIELD: DA3-24.0

DATA ELEMENT: Claim Adjustment Indicator

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(01)	LEFT	SPACES	141	141

DEFINITION: Indicates if this is an adjustment to a prior claim.

CODE VALUES: Not used by MO HealthNet.

Y = Adjustment to Prior Claim blank = Not an adjustment to a prior claim.

VALIDATION: If entered, must be a valid code from code list.

VALIDATION: If entered, must be a valid code from code list.

REMARKS: Required for COB exchange if this is an adjustment to a prior claim.

RECORD/FIELD: DA3-25.0

DATA ELEMENT: Provider Adjustment Amount (PROV ADJUST AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	S9(5)V99	RIGHT	ZEROS	142	148

DEFINITION: The Medicare provider adjustment amount.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

REMARKS: Required for COB exchange if this is an adjustment to the provider amount.

RECORD/FIELD: DA3-26.0

DATA ELEMENT: Beneficiary Adjustment Amount (BENE ADJUST AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	S9(5)V99	RIGHT	ZEROS	149	155

DEFINITION: The Medicare beneficiary adjustment amount.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

REMARKS: Required for COB exchange if this is an adjustment to the beneficiary amount.

RECORD/FIELD: DA3-27.0

DATA ELEMENT: Original Approved Amount (ORIG APPROVE AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	S9(5)V99	RIGHT	ZEROS	156	162

DEFINITION: The last processed claim approved amount for the claim that is being adjusted.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

REMARKS: Required for COB exchange if this is an adjustment.

RECORD/FIELD: DA3-28.0

DATA ELEMENT: Original Paid Amount (ORIG PAID AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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28.0 S9(5)V99 RIGHT ZEROS 163 169

DEFINITION: The last processed claim payment amount for the claim that is being adjusted. This can be the original claim payment or the amount of most recent adjustment.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

REMARKS: Required for COB exchange, if this is an adjustment.

RECORD/FIELD: DA3-29.0

DATA ELEMENT: Original Payor Claim Control Number

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(17)	LEFT	SPACES	170	186

DEFINITION: The original claim control number or the most recent adjustment control number assigned by the payor to identify the claim to which adjustment is being made.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

REMARKS: Required for COB exchange if this is an adjustment.

RECORD/FIELD: DA3-30.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(134)	LEFT	SPACES	187	320

DEFINITION: Unused record space. Reserved for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CLAIM RECORD TYPE EA0 "CLAIM DATA"

Required for MO HealthNet processing

Must follow DA0, DA1 or DA2

Must be followed by EA1, EA2 or FA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "EA0"	C-24	EA0
02	RESERVED (EA0-02.0)		Not Used
03	PAT CONTROL NO		Not Used
04	EMPL RELATED IND		Not Used
05	ACCIDENT IND		NO
06	SYMPTOM IND	C-62	NO
07	ACCIDENT/SYMPTOM DATE	C-63	NO
08	EXT CAUSE OF ACCIDENT		Not Used
09	RESPONSIBILITY IND		Not Used
10	ACCIDENT STATE		Not Used
11	ACCIDENT HOUR		Not Used
12	ABUSE IND		Not Used
13	RELEASE OF INFO IND		Not Used
14	RELEASE OF INFO DATE		Not Used
15	SAME/SIMILAR SYMP IND		Not Used
16	SAME/SIMILAR SYMP DT		Not Used
17	DISABILITY TYPE		Not Used
18	DISABILITY-FROM DATE		Not Used
19	DISABILITY-TO DATE		Not Used
20	REFER PROV ID NO	C-15	NO
21	REFER PROV UPIN		Not Used
22	REFER PROV TAX TYPE		Not Used
23	REFER PROV TAX ID		Not Used
24	REFER PROV LAST		Not Used
25	REFER PROV FIRST		Not Used
26	REFER PROV MI		Not Used
27	REFER PROV STATE		Not Used
28	ADMISSION DATE-1	C-16	NO

29	DISCHARGE DATE-1	C-16	NO
30	LAB IND	C-44	NO
31	LAB CHARGES		Not Used
32	DIAGNOSIS CODE-1	C-17	YES
33	DIAGNOSIS CODE-2	C-17	NO
34	DIAGNOSIS CODE-3	C-17	NO
35	DIAGNOSIS CODE-4	C-17	NO
36	PROV ASSIGN IND		Not Used
37	PROV SIGNATURE IND		Not Used
38	PROV SIGNATURE DATE		Not Used
39	FACILITY/LAB NAME	C-64	NO
40	DOCUMENTATION IND		Not Used
41	TYPE OF DOCUMENTATION		Not Used
42	FUNCTIONAL STATUS CODE		Not Used
43	SPECIAL PROGRAM IND		Not Used
44	CHAMPUS NON AVAIL IND		Not Used
45	SUPV PROV IND		Not Used
46	RESUBMISSION CODE		Not Used
47	RESUB REFERENCE NO	C-41	NO
48	DATE LAST SEEN		Not Used
49	DATE DOCUMENT SENT		Not Used
50	HOMEBOUND IND		Not Used
51	BLOOD UNITS PAID		Not Used
52	BLOOD UNITS REMAINING		Not Used
53	FILLER-NATIONAL		YES

RECORD TYPE: EA0

LEVEL:CLAIM

PURPOSE: To identify claim level information.

REQUIREMENTS: One EA0 is required on every claim.

ORDER: Preceding Record Type Following Record Type
 DA0, DA1 or DA2 EA1, EA2, or FA0

NOTES: Only one EA0 record is allowed on each claim.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "EA0"	3	X	01	03
02.0	RESERVED(EA0-02.0)	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	0EMPL RELATED IND	1	X	23	23
05.0	ACCIDENT IND	1	X	24	24
06.0	SYMPTOM IND	1	X	25	25
07.0	ACCIDENT/SYMPTON DATE	8	X	26	33
08.0	EXT CAUSE OF ACCIDENT	5	X	34	38
09.0	RESPONSIBILITY IND	1	X	39	39
10.0	ACCIDENT STATE	2	X	40	41
11.0	ACCIDENT HOUR	2	X	42	43
12.0	ABUSE IND	1	X	44	44
13.0	RELEASE OF INFO IND	1	X	45	45
14.0	RELEASE OF INFO DATE	8	X	46	53
15.0	SAME/SIMILAR SYMP IND	1	X	54	54
16.0	SAME/SIMILAR SYMP DT	8	X	55	54
17.0	DISABILITY TYPE	1	X	63	63
18.0	DISABILITY-FROM DATE	8	X	64	71
19.0	DISABILITY-TO DATE	8	X	72	79
20.0	REFER PROV NPI	15	X	80	94
21.0	REFER PROV UPIN	15	X	95	109
22.0	REFER PROV TAX TYPE	1	X	110	110
23.0	REFER PROV TAX ID	9	X	111	119
24.0	REFER PROV LAST	20	X	120	139

25.0	REFER PROV FIRST	12	X	140	151
26.0	REFER PROV MI	1	X	152	152
27.0	REFER PROV STATE	2	X	153	154
28.0	ADMISSION DATE	18	X	155	162
29.0	DISCHARGE DATE	18	X	163	170
30.0	LAB IND	1	X	171	171
31.0	LAB CHARGES	7	N	172	178
32.0	DIAGNOSIS CODE-1	5	X	179	183
33.0	DIAGNOSIS CODE-2	5	X	184	188
34.0	DIAGNOSIS CODE-3	5	X	189	193
35.0	DIAGNOSIS CODE-4	5	X	194	198
36.0	PROV ASSIGN IND	1	X	199	199
37.0	PROV SIGNATURE IND	1	X	200	200
38.0	PROV SIGNATURE DATE	8	X	201	208
39.0	FACILITY/LAB NAME	33	X	209	241
40.0	DOCUMENTATION IND	1	X	242	242
41.0	TYPE OF DOCUMENTATION	1	X	243	243
42.0	FUNCTNL STATUS CODE	2	X	244	245
43.0	SPECIAL PROGRAM IND	2	X	246	247
44.0	CHAMPUS NONAVAIL IND	1	X	248	248
45.0	SUPV PROV IND	1	X	249	249
46.0	SUB/RESUBMISSION CODE	2	X	250	251
47.0	RESUB REFERENCE NO	15	X	252	266
48.0	DATE LAST SEEN	8	X	267	274
49.0	DATE DOCUMENT SENT	8	X	275	282
50.0	HOMEBOUND IND	1	X	283	283
51.0	BLOOD UNITS PAID	3	X	284	286
52.0	BLOOD UNITS REMAINING	3	X	287	289
53.0	CPO PROV NUMBER	6	X	290	295
54.0	IDE NUMBER	15	X	296	310

55.0	FILLER-NATIONAL	10	X	311	320
------	-----------------	----	---	-----	-----

RECORD/FIELD: EA0-01.0

DATA ELEMENT: Record Identification(RECORD ID "EA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Claim Detail Record - EA0.

CODE VALUES: See the C-24 table for valid field values.

VALIDATION: Must be entered.

Must be "EA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-02.0

DATA ELEMENT: Reserved (EA0-02.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: Unused reserved record space.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-03.0 "CLAIM DATA"

DATA ELEMENT: Patient Control Number(PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION:A unique number assigned by the provider to identify the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number"

(CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: EA0-04.0 "CLAIM DATA"

DATA ELEMENT: Employment Related Indicator(EMPL RELATED IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	LEFT	SPACE	23	23

DEFINITION:A code to indicate whether the patient alleges that his/her medical condition is due to the environment or events resulting from employment.

CODE VALUES: Not used by MO HealthNet.

Y = Yes (Employment related)

N = No (Not employment related)

U = Unknown

VALIDATION: Must be entered.

Must be a valid code from above list.

FORM LOCATION: CMS-1500 Block 10a

REMARKS: N/A

RECORD/FIELD: EA0-05.0

DATA ELEMENT: Accident Indicator(ACCIDENT IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(01)	LEFT	SPACE	24	24

DEFINITION:A code to indicate whether the patient's condition was the result of an accident.

CODE VALUES: See the C-18 table for valid field values.

VALIDATION: Must be entered.

Must be a valid code from above list.

If "A" or "O" is entered, EA0-07.0 thru EA0-11.0 must be completed according to payor requirements.

FORM LOCATION: CMS-1500 Blocks 10b, 10c

REMARKS: N/A

RECORD/FIELD: EA0-06.0

DATA ELEMENT: Symptom Indicator(SYMPTOM IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(01)	RIGHT	ZERO	25	25

DEFINITION: An indicator as to whether the "Accident/Symptom Date" (EA0-07.0) represents the date that symptoms were first experienced or the date of last menstrual period (LMP).

CODE VALUES: See the C-62 table for valid field values.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

If code "2" is entered, "Patient Sex" (CA0-09.0) must = "F" (Female).

FORM LOCATION: CMS-1500 Block 14

REMARKS: N/A

RECORD/FIELD: EA0-07.0

DATA ELEMENT: Accident/Symptom Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(08)	LEFT	SPACES	26	33

DEFINITION: The date of the accident or the date that patient first experienced symptoms of illness or the date of the last menstrual period (LMP).

CODE VALUES: See the C-63 table for valid field values.

VALIDATION: If "Symptom Indicator" (EA0-06.0) equals "1" or "2", this field must be completed according to payor requirements.

If "Accident Indicator" (EA0-05.0) equals "A" or "O", this field must be completed according to payor requirements.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 14

REMARKS: N/A

RECORD/FIELD: EA0-08.0

DATA ELEMENT: External Cause of Accident (EXT CAUSE OF ACCIDENT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(05)	LEFT	SPACES	34	38

DEFINITION:A code from the Supplemental Classification of External Causes of Injury and Poisoning section of the ICD-9-CM manual.

CODE VALUES: Not used by MO HealthNet.

ICD-9-CM Diagnosis Codes from E8000 thru E9999

VALIDATION: If "Accident Indicator" (EA0-05.0) equals "O", this field must be completed according to payor requirements.

If entered:

1. Must be the most specific/precise 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.
2. Do not submit a decimal point. The decimal point is implied because each ICD-9-CM code is unique.
3. The first character may only be an 'E'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-09.0

DATA ELEMENT: Responsibility Indicator(RESPONSIBILITY IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(01)	LEFT	SPACE	39	39

DEFINITION: A code to indicate whether or not the accident or illness was caused by another party.

Y = Yes, accident or illness was caused by another party.

N = No, accident or illness was not caused by another party.

VALIDATION: If "Accident Indicator" (EA0-05.0) equals "A" or "O", this field must be completed according to payor requirements.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-10.0

DATA ELEMENT: Accident State

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(02)	LEFT	SPACES	40	41

DEFINITION: State Postal Code identifying the state in which the automobile accident occurred.

CODE VALUES: Not used by MO HealthNet.

See EXHIBIT 1.

VALIDATION: If "Accident Indicator" (EA0-05.0) equals "A", this field must be completed according to payor requirements.

If entered, must be a valid code from EXHIBIT 1.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: CMS-1500 Block 10b

REMARKS: N/A

RECORD/FIELD: EA0-11.0

DATA ELEMENT: Accident Hour

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(02)	LEFT	SPACES	42	43

DEFINITION: The hour when the accident occurred that necessitated the rendering of a service submitted on this claim.

CODE VALUES: Not used by MO HealthNet.

<u>Code</u>	<u>Time AM</u>	<u>Code</u>	<u>Time PM</u>
00	12:00 - 12:59 Midnight	12	12:00 - 12:59 Noon
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59
99	Unknown		

VALIDATION: If "Accident Indicator" (EA0-05.0) equals "A" or "O", this field must be completed according to payor requirements.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-12.0

DATA ELEMENT: Abuse Indicator(ABUSE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(01)	LEFT	SPACE	44	44

DEFINITION:A code to indicate whether the patient's condition, in the provider's opinion, may be the result of abuse.

CODE VALUES: Not used by MO HealthNet.

Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-13.0

DATA ELEMENT: Release of Information Indicator (RELEASE OF INFO IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(01)	LEFT	SPACE	45	45

DEFINITION: A code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations in order to adjudicate the claim.

CODE VALUES: Not used by MO HealthNet.

Y = Yes The provider has on file a signed statement permitting the release of medical/billing information for purposes of claiming insurance benefits.

M = Modified or Restricted Release The provider has limited or restricted authority to release some medical/billing information release for purposes of claiming insurance benefits.

N = No Release The provider does not have permission to release any medical/billing information.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: CMS-1500 Block 12

REMARKS: N/A

RECORD/FIELD: EA0-14.0

DATA ELEMENT: Release of Information Date (RELEASE OF INFO DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(08)	LEFT	SPACES	46	53

DEFINITION: Date that the Release of Information statement was signed by the patient.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If "Release of Information Indicator" (EA0-13.0) equals "Y" or "M", this field must be completed according to payor requirements.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 12

REMARKS: N/A

RECORD/FIELD: EA0-15.0

DATA ELEMENT: Same or Similar Symptom Indicator SAME/SIMILAR SYMP IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	LEFT	SPACE	54	54

DEFINITION: An indicator as to whether the Patient reported that they have previously experienced symptoms similar or identical to those for which services submitted on this claim were rendered.

CODE VALUES: Not used by MO HealthNet.

Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: CMS-1500 Block 15

REMARKS: N/A

RECORD/FIELD: EA0-16.0

DATA ELEMENT: Same or Similar Symptom Date (SAME/SIMILAR SYMP DT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(08)	LEFT	SPACES	55	62

DEFINITION: The previous date that the patient experienced symptoms similar or identical to those for which services submitted on this claim were rendered.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If "Same or Similar Symptom Indicator" (EA0-15.0) equals "Y", this field must be completed according to payor requirements.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 15

REMARKS: N/A

RECORD/FIELD: EA0-17.0

DATA ELEMENT: Disability Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(01)	LEFT	SPACE	63	63

DEFINITION: An indicator to describe type of disability.

CODE VALUES: Not used by MO HealthNet.

1 = Short Term Disability

2 = Long Term Disability

3 = Permanent/Total Disability

4 = No Disability

VALIDATION: Must be entered if required by payor.

If entered, must be valid code from above list.

FORM LOCATION: CMS-1500 Block 16

REMARKS: N/A

RECORD/FIELD: EA0-18.0 EA0-19.0

DATA ELEMENT: Disability-From Date Disability-To Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(08)	LEFT	SPACES	64	71

19.0 X(08) LEFT SPACES 72 79

DEFINITION: The beginning and ending date the patient, in the provider's opinion, was or will be unable to perform the duties normally associated with his/her work.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If "Disability Type" (EA0-17.0) equals "1" or "2", this field must be completed according to payor requirements.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 16

REMARKS: N/A

RECORD/FIELD: EA0-20.0

DATA ELEMENT: Referring Provider National Provider Identifier (REFER PROV NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(15)	LEFT	SPACES	80	94

DEFINITION: The National Provider Identifier assigned to the Referring provider.

CODE VALUES: See the C-15 table for valid field values.

VALIDATION: Must be entered if required by payor.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 17a

REMARKS: N/A

RECORD/FIELD: EA0-21.0

DATA ELEMENT: REFER PROV UPIN

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(15)	LEFT	SPACES	95	109

DEFINITION: The Referring Provider's UPIN.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-22.0

DATA ELEMENT: REFER PROV TAX TYPE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(01)	LEFT	SPACES	10	110

DEFINITION:A code which identifies the referring provider's Tax ID entered in EA0-23.0.

CODE VALUES: Not used by MO HealthNet.

T = TIN Number

S = SS Number

VALIDATION: If entered, must be a valid code from code list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-23.0

DATA ELEMENT: REFER PROV TAX ID

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(09)	LEFT	SPACES	111	119

DEFINITION: The federally assigned Tax identification number (TIN) or the social security number (SSN) of the referring provider.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: See GENERAL INSTRUCTIONS for "identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-24.0 EA0-25.0 EA0-26.0

DATA ELEMENT: Referring Provider Last Name(REFER PROV LAST) Referring Provider First Name(REFER PROV FIRST) Referring Provider Middle Initial (REFER PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(20)	LEFT	SPACES	120	139
25.0	X(12)	LEFT	SPACES	140	151
26.0	X(01)	LEFT	SPACES	152	152

DEFINITION: Name of Provider who referred the patient to the provider of service on this claim.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: CMS-1500 Block 17

REMARKS: N/A

RECORD/FIELD: EA0-27.0

DATA ELEMENT: Referring Provider State(REFER PROV STATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(02)	LEFT	SPACES	153	154

DEFINITION: State Postal Code of the Referring Provider.

CODE VALUES: Not used by MO HealthNet.

See EXHIBIT 1.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from EXHIBIT 1.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: CMS-1500 Block 17

REMARKS: N/A

RECORD/FIELD: EA0-28.0 EA0-29.0

DATA ELEMENT: Admission Date-1 Discharge Date-1

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(08)	LEFT	SPACES	155	162
29.0	X(08)	LEFT	SPACES	163	170

DEFINITION: If services submitted in this claim were performed while the patient was confined in a health care facility, enter the beginning date and if applicable, the ending date of confinement.

CODE VALUES: See the C-16 table for valid field values.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 18

REMARKS: Use "Admission-2" (EA1-14.0) and "Discharge-2" (EA1-15.0) fields if multiple admissions occurred during the service period of this claim.

RECORD/FIELD: EA0-30.0

DATA ELEMENT: Laboratory Indicator(LAB IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(01)	LEFT	SPACE	171	171

DEFINITION:A code to indicate whether or not the Laboratory work was performed outside the provider's office.

CODE VALUES: See the C-44 table for valid field values.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

If "Y" is submitted, "Laboratory Charges" (EA0-29.0), "Facility/Laboratory Name" (EA0-39.0) and fields EA1-04.0 thru EA1-10.0 must be completed according to payor requirements.

FORM LOCATION: CMS-1500 Block 20

REMARKS: N/A

RECORD/FIELD: EA0-31.0

DATA ELEMENT: Laboratory Charges (LAB CHARGES)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	9(5)V99	RIGHT	ZEROS	172	178

DEFINITION: Charges billed to the provider by the Independent Laboratory.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: If "Laboratory Indicator" (EA0-30.0) equals "Y", this field must be completed according to payor requirements.

If entered, must be a positive unsigned numeric value.

FORM LOCATION: CMS-1500 Block 20

REMARKS: N/A

RECORD/FIELD: EA0-32.0 EA0-33.0 EA0-34.0 EA0-35.0

DATA ELEMENT: Diagnosis Code-1 Diagnosis Code-2 Diagnosis Code-3 Diagnosis Code-4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(05)	LEFT	SPACES	179	183
33.0	X(05)	LEFT	SPACES	184	188

34.0	X(05)	LEFT	SPACES	189	193
35.0	X(05)	LEFT	SPACES	194	198

DEFINITION: An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition resulting in a line item service.

CODE VALUES: See the C-17 table for valid field values.

VALIDATION: Must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.

Do not submit a decimal point. The decimal point is implied because each ICD-9-CM code is unique.

The submission of "V", "E" and/or "M" Diagnosis Codes may or may not be accepted by a payor.

FORM LOCATION: CMS-1500 Block 21

REMARKS: The Diagnosis Code should correspond with the age and sex of the patient.

RECORD/FIELD: EA0-36.0

DATA ELEMENT: Provider Assignment Indicator(PROV ASSIGN IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
36.0	X(01)	LEFT	SPACE	199	199

DEFINITION:A code indicating whether the provider accepts assignment.

CODE VALUES: Not used by MO HealthNet.

A = Assigned

N = Not Assigned

B = Assignment accepted on Clinical Lab services only.

P = Patient Refuses to Assign Benefits

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: CMS-1500 Block 27

REMARKS: N/A

RECORD/FIELD: EA0-37.0

DATA ELEMENT: Provider Signature Indicator (PROV SIGNATURE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
37.0	X(01)	LEFT	SPACE	200	200

DEFINITION: The signature of the provider of service(s) reported on this claim which acknowledges the performance of the service(s) and authorizes payment is on file in the provider's office.

CODE VALUES: Not used by MO HealthNet.

Y = Signature of provider is on file.

N = Signature of provider is not on file.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: CMS-1500 Block 31

REMARKS: N/A

RECORD/FIELD: EA0-38.0

DATA ELEMENT: Provider Signature Date(PROV SIGNATURE DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
38.0	X(08)	LEFT	SPACES	201	208

DEFINITION: Date of the provider's signature.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 31

REMARKS: N/A

RECORD/FIELD: EA0-39.0

DATA ELEMENT: Facility/Laboratory Name (FACILITY/LAB NAME)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
39.0	X(33)	LEFT	SPACES	209	241

DEFINITION: The name of the Hospital, Nursing Facility, Laboratory or other facility where services being submitted on this claim were rendered.

CODE VALUES: See the C-64 table for valid field values.

VALIDATION: If "Laboratory Indicator" (EA0-30.0) equals "Y", this field must be completed according to payor requirements.

See GENERAL INSTRUCTIONS for "Name 2" entry.

FORM LOCATION: CMS-1500 Block 32

REMARKS: For Medicare, this field must be completed, if available, if the place of service is other than the patient's home or physician's office.

RECORD/FIELD: EA0-40.0

DATA ELEMENT: Documentation Indicator(DOCUMENTATION IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
40.0	X(01)	LEFT	SPACE	242	242

DEFINITION: An indicator describing if there is documentation pertaining to this claim.

CODE VALUES: Not used by MO HealthNet.

1 = In mail

2 = FAX

3 = On file at Provider's site

4 = On file at Payor's site

5 = Cert Record in this claim

6 = Narrative Record included in this claim

9 = No documentation

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-41.0

DATA ELEMENT: Type of Documentation

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
41.0	X(01)	LEFT	SPACE	243	243

DEFINITION:A code to indicate the Type of Documentation being/or submitted by the provider.

CODE VALUES: Not used by MO HealthNet.

A = DME Prescription

B = Explanation of Benefits (MSP or COB)

C = Diagnostic Report

D = Operative Note

E = PEN Certification

F = Ambulance Certification
 G = Physical Therapy Certification
 H = Chiropractic Justification
 I = Prosthetics/Orthotic Certification
 J = Oxygen Prescription
 Y = Multiple Documentation Items
 Z = Other

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-42.0

DATA ELEMENT: Functional Status Code (FUNCTNL STATUS CODE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
42.0	X(02)	LEFT	SPACES	244	245

DEFINITION:A code based upon the Karnofsky Scale to describe the patient's level of disability.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Do not default to "00" (zero zero).

RECORD/FIELD: EA0-43.0

DATA ELEMENT: Special Program Indicator(SPECIAL PROGRAM IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
43.0	X(02)	LEFT	SPACES	246	247

DEFINITION:A code indicating the Special Program/Project under which the services rendered to the patient were performed.

CODE VALUES: Not used by MO HealthNet.

03 = Special Federal Funding

05 = Disability

06 = PPV/Medicare 100% Payment

07 = Induced Abortion - Danger to Women's Life

08 = Induced Abortion - Victim of Rape/Incest

09 = Second Opinion/Surgery

30 = Medicare Demonstration Project for Lung Volume Reduction Surgery Study

70 thru 99 = Reserved for Local Use

A= CHAMPUS Program For The Handicapped; Patient is Sponsor

B= CHAMPUS Program For The Handicapped; Patient is Spouse

D= CHAMPUS Program For The Handicapped; Patient is Widow Of Sponsor

W= CHAMPUS Program For The Handicapped; Patient is a Child; however, the individual's assigned PFTH Suffix is unknown.

C1 thru C9= CHAMPUS Program For The Handicapped; Patient is a Child (up to nine PFTH Suffix(s) are available for assignment when more than one child from the same family is enrolled in the program).

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-44.0

DATA ELEMENT: CHAMPUS Non-availability Indicator (CHAMPUS NONAVAIL IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
44.0	X(01)	LEFT	SPACE	248	248

DEFINITION:A code to indicate whether or not the provider has a signed CHAMPUS statement of non-availability on file (statement indicates the service was not available at a Military Treatment Facility).

CODE VALUES: Not used by MO HealthNet.

Y = Yes, statement on file

N = No, statement not on file or statement not necessary.

VALIDATION: If "Source of Payment - National" (DA0-05.0) equals "H", this field must be completed according to payor requirements.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-45.0

DATA ELEMENT: Supervising Provider Indicator(SUPV PROV IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
45.0	X(01)	LEFT	SPACE	249	249

DEFINITION:A code to indicate whether any service billed on this claim was supervised by a provider other than the rendering provider.

CODE VALUES: Not used by MO HealthNet.

Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-46.0

DATA ELEMENT: Submission/Resubmission Code (SUB/RESUBMISSION CODE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
46.0	X(02)	LEFT	SPACES	250	251

DEFINITION:A code to indicate the reason for the claim submission.

CODE VALUES: Not used by MO HealthNet.

00 = Original claim

01 = Void/Cancel prior claim (Disregard claim previously submitted - should be an exact duplicate of previous claim).

02 = Resubmission (This claim is a Replacement of a previously submitted claim).

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: CMS-1500 Block 22

REMARKS: Not all payers support submission of Electronic adjustments. Obtain authorization From your payer prior to submitting adjustments.

RECORD/FIELD: EA0-47.0

DATA ELEMENT: Resubmission Reference Number (RESUB REFERENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
47.0	X(15)	LEFT	SPACES	252	266

DEFINITION: Reference Number assigned by payor to the original claim.

CODE VALUES: See the C-41 table for valid field values.

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 22

REMARKS: N/A

RECORD/FIELD: EA0-48.0

DATA ELEMENT: Date Last Seen

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
48.0	X(08)	LEFT	SPACES	267	274

DEFINITION: The date the patient was last seen by the referring/ordering physician for a claim billed by an independent physical therapist or podiatrist.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 19

REMARKS: N/A

RECORD/FIELD: EA0-49.0

DATA ELEMENT: Date Documentation Sent (DATE DOCUMENT SENT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
49.0	X(08)	LEFT	SPACES	275	282

DEFINITION: The date that the documentation noted the in "Documentation Indicator" (EA0-38.0) was sent to payor of this claim.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: Applicable only if the "Documentation Indicator" (EA0-38.0) equals "1", "2", "4" or "6" and the payor requires the information.

RECORD/FIELD: EA0-50.0

DATA ELEMENT: Homebound Indicator (HOMEBOUND IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
50.0	X(1)	LEFT	SPACES	283	283

DEFINITION: To indicate whether an independent lab rendered services to a homebound patient.

CODE VALUES: Not used by MO HealthNet.

Y = Patient is homebound

N = Patient is not homebound

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500, Block 19

REMARKS: N/A

RECORD/FIELD: EA0-51.0

DATA ELEMENT: BLOOD UNITS PAID

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
51.0	X(03)	LEFT	SPACES	284	286

DEFINITION: Number of blood units paid.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: For COB, this is required if blood units were paid.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-52.0

DATA ELEMENT: BLOOD UNITS REMAINING

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
52.0	X(03)	LEFT	SPACES	287	289

DEFINITION: Number of blood units remaining.

CODE VALUES: Not used by MO HealthNet.

VALIDATION: For Coordination of Benefits (COB), this is required if blood units were paid.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA0-53.0

DATA ELEMENT: Care Plan Oversight Provider Number (CPO PRV NUMBER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
53.0	X(06)	LEFT	SPACES	290	295

DEFINITION: This is the Medicare provider number of the Home Health Agency or hospice providing Medicare covered services to the beneficiary for the period during which CPO services were furnished and for which the physician signed the plan of care.

CODE VALUES: N/A

VALIDATION: Must be entered if required by the payor.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500, item 19

REMARKS: For Medicare, physicians billing CPO must enter the HHA or hospice provider number that is treating the beneficiary.

RECORD/FIELD: EA0-54.0

DATA ELEMENT: Investigational Device Exemption Number (IDE NUMBER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
54.0	X(15)	LEFT	SPACES	296	310

DEFINITION: Investigational device exemption number for FDA-Approved clinical trials.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: CMS-1500, Item 23

REMARKS: For Medicare, enter the IDE number when an investigational device is used in a FDA-approved clinical trial.

RECORD/FIELD: EA0-55.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
55.0	X(10)	LEFT	SPACES	311	320

DEFINITION: Unused reserved filler for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CLAIM RECORD TYPE EA1

Not Required by MO HealthNet

Must follow EA0

Must be followed by EA2 or FA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "EA1"	C-24	EA1
02	RESERVED (EA1-02.0)		Not Used
03	PAT CONTROL NO		Not Used
04	FACILITY/LAB ID NO		Not Used
05	RESERVED (EA1-05.0)		Not Used
06	FACILITY/LAB ADDR1		Not Used
07	FACILITY/LAB ADDR2		Not Used
08	FACILITY/LAB CITY		Not Used
09	FACILITY/LAB STATE		Not Used
10	FACILITY/LAB ZIP CODE		Not Used
11	MEDICAL RECORD NO		Not Used
12	RETURN TO WORK DATE		Not Used
13	CONSULT/SURGERY DATE		Not Used
14	ADMISSION DATE-2		Not Used
15	DISCHARGE DATE-2		Not Used
16	SUPV PROV ID NO		Not Used
17	RESERVED (EA1-17.0)		Not Used
18	SUPV PROV LAST		Not Used
19	SUPV PROV FIRST		Not Used
20	SUPV PROV MI		Not Used

21	SUPV PROV STATE		Not Used
22	EMT/PARAMEDIC LAST		Not Used
23	EMT/PARAMEDIC FIRST		Not Used
24	EMT/PARAMEDIC MI		Not Used
25	DATE CARE ASSUMED		Not Used
26	DIAGNOSIS CODE - 5		Not Used
27	DIAGNOSIS CODE - 6		Not Used
28	DIAGNOSIS CODE - 7		Not Used
29	DIAGNOSIS CODE - 8		Not Used
30	FILLER-NATIONAL		YES

RECORD TYPE: EA1

LEVEL:CLAIM

PURPOSE: To identify additional claim level information.

REQUIREMENTS:A maximum one EA1 record may be submitted, if required by payor.

ORDER: Preceding Record Type Following Record Type
 EA0 EA2 or FA0

NOTES: Only one EA1 record is allowed per claim.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "EA1"	3	X	01	03
02.0	RESERVED (EA1-02.0)	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	FACILITY/LAB NPI	15	X	23	37
05.0	RESERVED (EA1-05.0)	15	X	38	52
06.0	FACILITY/LAB ADDR1	30	X	53	82
07.0	FACILITY/LAB ADDR2	30	X	83	112
08.0	FACILITY/LAB CITY	20	X	113	132
09.0	FACILITY/LAB STATE	20	X	113	132

10.0	FACILITY/LAB ZIP CODE	9	X	135	143
11.0	MEDICAL RECORD NO	17	X	144	160
12.0	RETURN TO WORK DATE	8	X	161	168
13.0	CONSULT/SURGERY DATE	8	X	169	176
14.0	ADMISSION DATE-2	8	X	177	184
15.0	DISCHARGE DATE-2	8	X	185	192
16.0	SUPV PROV NPI	15	X	193	207
17.0	RESERVED (EA1-17.0)	15	X	208	222
18.0	SUPV PROV LAST	20	X	223	242
19.0	SUPV PROV FIRST	12	X	243	254
20.0	SUPV PROV MI	1	X	255	255
21.0	SUPV PROV STATE	2	X	256	257
22.0	EMT/PARAMEDIC LAST	20	X	258	277
23.0	EMT/PARAMEDIC FIRST	12	X	278	289
24.0	EMT/PARAMEDIC MI	1	X	290	290
25.0	DATE CARE ASSUMED	8	X	291	298
26.0	DIAGNOSIS CODE-5	5	X	299	303
27.0	DIAGNOSIS CODE-6	5	X	304	308
28.0	DIAGNOSIS CODE-7	5	X	309	313
29.0	DIAGNOSIS CODE-8	5	X	314	318
30.0	FILLER-NATIONAL	2	X	319	320

RECORD/FIELD: EA1-01.0

DATA ELEMENT: Record Identification(RECORD ID "EA1")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Claim Detail Record - EA1.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "EA1".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-02.0

DATA ELEMENT: Reserved (EA1-02.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-03.0

DATA ELEMENT: Patient Control Number(PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION:A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: EA1-04.0

DATA ELEMENT: Facility/Laboratory National Provider Identifier(FACILITY/LAB NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(15)	LEFT	SPACES	23	37

DEFINITION: The National Provider Identifier assigned to the Facility or Laboratory.

CODE VALUES: N/A

VALIDATION: If "Laboratory Indicator" (EA0-28.0) equals "Y", this field must be completed according to payor requirements.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 32

REMARKS: N/A

RECORD/FIELD: EA1-05.0

DATA ELEMENT: Reserved (EA1-05.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(15)	LEFT	SPACES	38	52

DEFINITION: Unused reserved space for the future assignment of a "USIN" Number.

CODE VALUES: "USIN" as assigned.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-06.0 EA1-07.0 EA1-08.0 EA1-09.0 EA1-10.0

DATA ELEMENT:	Facility/Laboratory Street Address-1	(FACILITY/LAB ADDR1)
	Facility/Laboratory Street Address-2	(FACILITY/LAB ADDR2)
	Facility/Laboratory City	(FACILITY/LAB CITY)
	Facility/Laboratory State	(FACILITY/LAB STATE)
	Facility/Laboratory Zip Code	(FACILITY/LAB ZIP CODE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(30)	LEFT	SPACES	53	82
07.0	X(30)	LEFT	SPACES	83	112
08.0	X(20)	LEFT	SPACES	113	132
09.0	X(02)	LEFT	SPACES	133	134
10.0	X(09)	LEFT	SPACES	135	143

DEFINITION: The mailing address of the Facility or Laboratory where the services being submitted on this claim were rendered.

CODE VALUES: N/A

VALIDATION: If "Laboratory Indicator" (EA0-28.0) equals "Y", these fields must be completed according to payor requirements.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: CMS-1500 Block 32

REMARKS: N/A

RECORD/FIELD: EA1-11.0

DATA ELEMENT: Medical Record Number (MEDICAL RECORD NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(17)	LEFT	SPACES	144	160

DEFINITION: A number assigned by the provider to identify the patient's medical records.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-12.0

DATA ELEMENT: Return to Work Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(08)	LEFT	SPACES	161	168

DEFINITION: The date the patient, in the provider's opinion, will be able to resume the performance of the duties normally associated with his/her work.

CODE VALUES: N/A

VALIDATION: If "Disability Type" (EA0-17.0) equals "1" or "2", this field must be completed according to payor requirements.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: CMS-1500 Block 16

REMARKS: N/A

RECORD/FIELD: EA1-13.0

DATA ELEMENT: Consult/Surgery Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(08)	LEFT	SPACES	169	176

DEFINITION: Date of Consult/Surgery for a condition for which this claim is being submitted.

CODE VALUES: N/A

VALIDATION: Must be entered if required by the payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-14.0 EA1-15.0

DATA ELEMENT: Admission Date-2 Discharge Date-2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(08)	LEFT	SPACES	177	184
15.0	X(08)	LEFT	SPACES	185	192

DEFINITION: If services submitted in this claim were performed while the patient was confined in a health care facility, enter the Admission Date and, if applicable, the Discharge Date of the second confinement.

Use the "Admission-2" and "Discharge-2" fields if multiple admissions to a health care facility occurred during the service period of this claim.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-16.0

DATA ELEMENT: Supervising Provider National Provider Identifier (SUPV PROV NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(15)	LEFT	SPACES	193	207

DEFINITION: The National Provider Identifier assigned to the supervising provider.

CODE VALUES: N/A

VALIDATION: If "Supervising Provider Indicator" (EA0-43.0) equals "Y", this field must be completed according to payor requirements.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-17.0

DATA ELEMENT: Reserved (EA1-17.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(15)	LEFT	SPACES	208	222

DEFINITION: Unused reserved space for the future assignment of a "UPIN" Number.

CODE VALUES: "UPIN" as assigned.

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-18.0 EA1-19.0 EA1-20.0

DATA ELEMENT:	Supervising Provider Last Name	SUPV PROV LAST)
	Supervising Provider First Name	(SUPV PROV FIRST)
	Supervising Provider Middle Initial	(SUPV PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(20)	LEFT	SPACES	223	242
19.0	X(12)	LEFT	SPACES	243	254
20.0	X(01)	LEFT	SPACES	255	255

DEFINITION: Name of Provider who supervised the rendering of a service on this claim.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If "Supervising Provider Indicator" (EA0-43.0) equals "Y", these fields must be completed according to payor requirements.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-21.0

DATA ELEMENT: Supervising Provider State (SUPV PROV STATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(02)	LEFT	SPACES	256	257

DEFINITION: State Postal Code of the Supervising Provider.

CODE VALUES: See EXHIBIT 1.

VALIDATION: If "Supervising Provider Indicator" (EA0-43.0) equals "Y", this field must be completed according to payor requirements.

If entered, must be a valid code from EXHIBIT 1.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-22.0 EA1-23.0 EA1-24.0

DATA ELEMENT:	Emergency Technician/Paramedic Last Name	(EMT/PARAMEDIC LAST)
	Emergency Technician/Paramedic First Name	(EMT/PARAMEDIC FIRST)
	Emergency Technician/Paramedic Middle Initial	(EMT/PARAMEDIC MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(20)	LEFT	SPACES	258	277
23.0	X(12)	LEFT	SPACES	278	289
24.0	X(01)	LEFT	SPACES	290	290

DEFINITION: Name of the emergency technician/paramedic on the ambulance run sheet.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: EA1-25.0

DATA ELEMENT: Date Care Was Assumed (DATE CARE ASSUMED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(08)	LEFT	SPACES	291	298

DEFINITION: The date the care of the patient was assumed by another physician.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS, for "Date" entry.

FORM LOCATION: CMS-1500, Item 19

REMARKS: N/A

RECORD/FIELD: EA1-26 EA1-27 EA1-28 EA1-29

DATA ELEMENT: Diagnosis Code-5
 Diagnosis Code-6
 Diagnosis Code-7
 Diagnosis Code-8

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(05)	LEFT	SPACES	299	303
27.0	X(05)	LEFT	SPACES	304	308
28.0	X(05)	LEFT	SPACES	309	313
29.0	X(05)	LEFT	SPACES	314	318

DEFINITION: An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition resulting in a line item service.

CODE VALUES: ICD-9-CM Diagnosis Codes.

VALIDATION: Must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.

Do not submit a decimal point. The decimal point is implied because each ICD-9-CM code is unique.

The submission of "V", "E" and/or "M" Diagnosis

Codes may or may not be accepted by a payor.

FORM LOCATION: N/A

REMARKS: The Diagnosis Code should correspond with the age and sex of the patient.

RECORD/FIELD: EA1-30.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(02)	LEFT	SPACES	319	320

DEFINITION: Unused reserved filler for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

**RECORD NAME: CLAIM RECORD TYPE EA2 "EARLY PERIODIC SCREENING
DIAGNOSTIC TESTING (EPSDT)"**

Not Required by MO HealthNet

Must follow EA0 or EA1

Must be followed by FA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "EA2"	C-24	EA2
02	RESERVED (EA2-02.0)		Not Used
03	PAT CONTROL NO		Not Used
04	SCREENING TYPE		Not Used
05	MED HIST OBTAIN PERF		Not Used
06	MED HIST OBTAIN FIND		Not Used
07	PHYSICAL EXAM PERF		Not Used
08	PHYSICAL EXAM FIND		Not Used
09	VISION ASSESS PERF		Not Used
10	VISION ASSESS FIND		Not Used
11	HEARING ASSESS PERF		Not Used
12	HEARING ASSESS FIND		Not Used

13	DENTAL ASSESS PERF		Not Used
14	DENTAL ASSESS FIND		Not Used
15	DEVELOP ASSESS PERF		Not Used
16	DEVELOP ASSESS FIND		Not Used
17	NUT ASSESS PERF		Not Used
18	NUT ASSESS FIND		Not Used
19	CARD ASSESS PERF		Not Used
20	CARD ASSESS FIND		Not Used
21	GEN/UR ASSESS PERF		Not Used
22	GEN/UR ASSESS FIND		Not Used
23	DIABETES ASSESS PERF		Not Used
24	DIABETES ASSESS FIND		Not Used
25	OTH. SYS. ASSESS PERF		Not Used
26	OTH. SYS. ASSESS FIND		Not Used
27	OTH. SYS. ASSESS DESC		Not Used
28	HBG/HCT LAB TEST PERF		Not Used
29	HBG/HCT LAB TEST FIND		Not Used
30	URINALY LAB TST PERF		Not Used
31	URINALY LAB TST FIND		Not Used
32	SICKLE CELL LAB PERF		Not Used
33	SICKLE CELL LAB FIND		Not Used
34	BLOOD LEAD LAB PERF		Not Used
35	BLOOD LEAD LAB FIND		Not Used
36	TINE TEST PERF		Not Used
37	TINE TEST FIND		Not Used
38	OTHER TEST 1 PERF		Not Used
39	OTHER TEST 1 FIND		Not Used
40	OTHER TEST 1 DESC		Not Used
41	OTHER TEST 2 PERF		Not Used
42	OTHER TEST 2 FIND		Not Used

43	OTHER TEST 2 DESC		Not Used
44	TREATMENT ITEM NO 1		Not Used
45	TREATMENT ITEM NO 2		Not Used
46	TREATMENT ITEM NO 3		Not Used
47	TREATMENT ITEM NO 4		Not Used
48	TREATMENT ITEM NO 5		Not Used
49	TREATMENT ITEM NO 6		Not Used
50	TREATMENT ITEM NO 7		Not Used
51	TREATMENT ITEM NO 8		Not Used
52	TREATMENT ITEM NO 9		Not Used
53	TREATMENT ITEM NO 10		Not Used
54	TREATMENT ITEM NO 11		Not Used
55	TREATMENT ITEM NO 12		Not Used
56	TREATMENT ITEM NO 13		Not Used
57	TREATMENT ITEM NO 14		Not Used
58	TREATMENT ITEM NO 15		Not Used
59	TREATMENT ITEM NO 16		Not Used
60	TREATMENT STAT NO1 IN		Not Used
61	TREATMENT STAT NO2 IN		Not Used
62	TREATMENT STAT NO3 IN		Not Used
63	TREATMENT STAT NO4 IN		Not Used
64	TREATMENT STAT NO1 DE		Not Used
65	TREATMENT STAT NO2 DE		Not Used
66	TREATMENT STAT NO3 DE		Not Used
67	TREATMENT STAT NO4 DE		Not Used
68	TREATMENT STAT NO1 NR		Not Used
69	TREATMENT STAT NO2 NR		Not Used
70	TREATMENT STAT NO3 NR		Not Used
71	TREATMENT STAT NO4 NR		Not Used
72	REFERRAL ITEM NO 1		Not Used

73	REFERRAL ITEM NO 2		Not Used
74	REFERRAL ITEM NO 3		Not Used
75	REFERRAL ITEM NO 4		Not Used
76	REFERRAL ITEM NO 5		Not Used
77	REFERRAL ITEM NO 6		Not Used
78	REFERRAL ITEM NO 7		Not Used
79	REFERRAL ITEM NO 8		Not Used
80	IMMUN POLIO GIVEN		Not Used
81	IMMUN POLIO NOT		Not Used
82	IMMUN DPT/TD GIVEN		Not Used
83	IMMUN DPT/TD NOT		Not Used
84	IMMUN MEAS GIVEN		Not Used
85	IMMUN MEAS NOT		Not Used
86	IMMUN MUMPS GIVEN		Not Used
87	IMMUN MUMPS NOT		Not Used
88	IMMUN RUBELLA GIVEN		Not Used
89	IMMUN RUBELLA NOT		Not Used
90	IMMUN HIB GIVEN		Not Used
91	IMMUN HIB NOT		Not Used
92	IMMUN OTHER GIVEN		Not Used
93	IMMUN OTHER DESC		Not Used
94	FILLER-NATIONAL		YES

RECORD TYPE:EA2

LEVEL:CLAIM

PURPOSE: To provide information from the Primary Care Physician, Health Maintenance Organization, or other qualified MO HealthNet enrolled provider regarding status and results of MO HealthNet Early Periodic Screening Diagnostic Testing. The fields contained in this record are those on the Colorado-103 form which are not covered in other National Standard Format records.

REQUIREMENTS: If required by the payor, an "EA2" record must be submitted after the initial or follow-up medical screening examinations are performed.

ORDER: Preceding Record Type Following Record Type

NOTES: When used, this record must follow the EA0 or EA1 records related to this claim.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "EA2"	3	X	01	03
02.0	RESERVED (EA2-02.0)	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	SCREENING TYPE	1	X	23	23
05.0	MED HIST OBTAIN PERF	1	X	24	24
06.0	MED HIST OBTAIN FIND	1	X	25	25
07.0	PHYSICAL EXAM PERF	1	X	26	26
08.0	PHYSICAL EXAM FIND	1	X	27	27
09.0	VISION ASSESS PERF	1	X	28	28
10.0	VISION ASSESS FIND	1	X	29	29
11.0	HEARING ASSESS PERF	1	X	30	30
12.0	HEARING ASSESS FIND	1	X	31	31
13.0	DENTAL ASSESS PERF	1	X	32	32
14.0	DENTAL ASSESS FIND	1	X	33	33
15.0	DEVELOP ASSESS PERF	1	X	34	34
16.0	DEVELOP ASSESS FIND	1	X	35	35
17.0	NUT ASSESS PERF	1	X	36	36
18.0	NUT ASSESS FIND	1	X	37	37
19.0	CARD ASSESS PERF	1	X	38	38
20.0	CARD ASSESS FIND	1	X	39	39
21.0	GEN/UR ASSESS PERF	1	X	40	40
22.0	GEN/UR ASSESS FIND	1	X	41	41
23.0	DIABETES ASSESS PERF	1	X	42	42
24.0	DIABETES ASSESS FIND	1	X	43	43
25.0	OTH. SYS. ASSESS PERF	1	X	44	44

26.0	OTH. SYS. ASSESS FIND	1	X	45	45
27.0	OTH. SYS. ASSESS DESC	20	X	46	65
28.0	HBG/HCT LAB TEST PERF	1	X	66	66
29.0	HBG/HCT LAB TEST FIND	1	X	67	67
30.0	URINALY LAB TST PERF	1	X	68	68
31.0	URINALY LAB TST FIND	1	X	69	69
32.0	SICKLE CELL LAB PERF	1	X	70	70
33.0	SICKLE CELL LAB FIND	1	X	71	71
34.0	BLOOD LEAD LAB PERF	1	X	72	72
35.0	BLOOD LEAD LAB FIND	1	X	73	73
36.0	TINE TEST PERF	1	X	74	74
37.0	TINE TEST FIND	1	X	75	75
38.0	OTHER TEST 1 PERF	1	X	76	76
39.0	OTHER TEST 1 FIND	1	X	77	77
40.0	OTHER TEST 1 DESC	20	X	78	97
41.0	OTHER TEST 2 PERF	1	X	98	98
42.0	OTHER TEST 2 FIND	1	X	99	99
43.0	OTHER TEST 2 DESC	20	X	100	119
44.0	TREATMENT ITEM NO 1	2	X	120	121
45.0	TREATMENT ITEM NO 2	2	X	122	123
46.0	TREATMENT ITEM NO 3	2	X	124	125
47.0	TREATMENT ITEM NO 4	2	X	126	127
48.0	TREATMENT ITEM NO 5	2	X	128	129
49.0	TREATMENT ITEM NO 6	2	X	130	131
50.0	TREATMENT ITEM NO 7	2	X	132	133
51.0	TREATMENT ITEM NO 8	2	X	134	135
52.0	TREATMENT ITEM NO 9	2	X	136	137
53.0	TREATMENT ITEM NO 10	2	X	138	139
54.0	TREATMENT ITEM NO 11	2	X	140	141
55.0	TREATMENT ITEM NO 12	2	X	142	143

56.0	TREATMENT ITEM NO 13	2	X	144	145
57.0	TREATMENT ITEM NO 14	2	X	146	147
58.0	TREATMENT ITEM NO 15	2	X	148	149
59.0	TREATMENT ITEM NO 16	2	X	150	151
60.0	TREATMENT STAT NO1 IN	2	X	152	153
61.0	TREATMENT STAT NO2 IN	2	X	154	155
62.0	TREATMENT STAT NO3 IN	2	X	156	157
63.0	TREATMENT STAT NO4 IN	2	X	158	159
64.0	TREATMENT STAT NO1 DE	2	X	160	161
65.0	TREATMENT STAT NO2 DE	2	X	162	163
66.0	TREATMENT STAT NO3 DE	2	X	164	165
67.0	TREATMENT STAT NO4 DE	2	X	166	167
68.0	TREATMENT STAT NO1 NR	2	X	168	169
69.0	TREATMENT STAT NO2 NR	2	X	170	171
70.0	TREATMENT STAT NO3 NR	2	X	172	173
71.0	TREATMENT STAT NO4 NR	2	X	174	175
72.0	REFERRAL ITEM NO	12	X	176	177
73.0	REFERRAL ITEM NO	22	X	178	179
74.0	REFERRAL ITEM NO	32	X	180	181
75.0	REFERRAL ITEM NO	42	X	182	183
76.0	REFERRAL ITEM NO	52	X	184	185
77.0	REFERRAL ITEM NO	62	X	186	187
78.0	REFERRAL ITEM NO	72	X	188	189
79.0	REFERRAL ITEM NO	82	X	190	191
80.0	IMMUN POLIO GIVEN	1	X	192	192
81.0	IMMUN POLIO NOT	1	X	193	193
82.0	IMMUN DPT/TD GIVEN	1	X	194	194
83.0	IMMUN DPT/TD NOT	1	X	195	195
84.0	IMMUN MEAS GIVEN	1	X	196	196
85.0	IMMUN MEAS NOT	1	X	197	197

86.0	IMMUN MUMPS GIVEN	1	X	198	198
87.0	IMMUN MUMPS NOT	1	X	199	199
88.0	IMMUN RUBELLA GIVEN	1	X	200	200
89.0	IMMUN RUBELLA NOT	1	X	201	201
90.0	IMMUN HIB GIVEN	1	X	202	202
91.0	IMMUN HIB NOT	1	X	203	203
92.0	IMMUN OTHER GIVEN	1	X	204	204
93.0	IMMUN OTHER DESC	20	X	205	224
94.0	FILLER-NATIONAL	96	X	225	320

RECORD/FIELD:EA2-01.0

DATA ELEMENT: Record Identifier (RECORD ID "EA2")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "EPSDT Screening" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "EA2".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD:EA2-02.0

DATA ELEMENT: Reserved(RESERVED EA2-02.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: Unused reserved record space

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD:EA2-03.0

DATA ELEMENT: Patient Control Number(PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD:EA2-04.0

DATA ELEMENT: Type of Screening(SCREENING TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	N/A	SPACE	23	23

DEFINITION: The type of screening being billed.

CODE VALUES: I = Initial Screening
P = Periodic Screening
F = Follow-up Screening

VALIDATION: Must be entered if required by payor.

Must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD:EA2-05.0 EA2-06.0

DATA ELEMENT:	Medical History Obtained – Performed	(MED HIST OBTAIN PERF)
	Medical History Obtained – Findings	(MED HIST OBTAIN FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(01)	LEFT	SPACES	24	24
06.0	X(01)	LEFT	SPACES	25	25

DEFINITION: Verification that the medical history for the patient was obtained, not obtained or not required and that findings from the medical history were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was obtained
 N = No, it was not obtained
 R = It was not required
 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION:PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-05.0.

FORM LOCATION: 4A - Item 01

REMARKS: Enter the appropriate response to indicate if the medical history was obtained or not obtained. Indicate findings in EA2-06.0 as indicated by contents of EA2-05.0.

RECORD/FIELD:EA2-07.0 EA2-08.0

DATA ELEMENT: Physical Examination Performed? (PHYSICAL EXAM PERF)
 Physical Examination Findings (PHYSICAL EXAM FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(01)	LEFT	SPACES	26	26
08.0	X(01)	LEFT	SPACES	27	27

DEFINITION: Verification that either a physical examination was performed, not performed, or was not required at this time and that findings from the physical examination were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required

FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION: PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-07.0.

FORM LOCATION: 4A - Item 02

REMARKS: Enter the appropriate response to indicate if a physical examination was performed or not performed. Enter findings in EA2-08.0 as indicated by contents of EA2-07.0.

RECORD/FIELD:EA2-09.0 EA2-10.0

DATA ELEMENT: Vision Assessment Performed? (VISION ASSESS PERF)
 Vision Assessment Findings (VISION ASSESS FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(01)	LEFT	SPACES	28	28
10.0	X(01)	LEFT	SPACES	29	29

DEFINITION: Verification that either a vision assessment was performed, not performed, or was not required at this time and that findings from the vision assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required
 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION: PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-09.0.

FORM LOCATION: 4A - Item 03

REMARKS: Enter the appropriate response to indicate if a vision assessment was performed or not performed. Enter findings in EA2-10.0 as indicated by contents of EA2-09.0.

RECORD/FIELD:EA2-11.0 EA2-12.0

DATA ELEMENT: Hearing Assessment Performed? (HEARING ASSESS PERF)
 Hearing Assessment Findings (HEARING ASSESS FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(01)	LEFT	SPACES	30	30
12.0	X(01)	LEFT	SPACES	31	31

DEFINITION: Verification that either a hearing assessment was performed, not performed, or was not required at this time and that findings from the hearing assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required
 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION: PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-11.0.

FORM LOCATION: 4A - Item 04

REMARKS: Enter the appropriate response to indicate if a hearing assessment was performed or not performed. Enter findings in EA2-12.0 as indicated by contents of EA2-11.0.

RECORD/FIELD:EA2-13.0 EA2-14.0

DATA ELEMENT: Dental Assessment Performed? (DENTAL ASSESS PERF)
 Dental Assessment Findings (DENTAL ASSESS FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(01)	LEFT	SPACES	32	32
14.0	X(01)	LEFT	SPACES	33	33

DEFINITION: Verification that either a dental assessment was performed, not performed, or was not required at this time and that findings from the dental assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
N = No, it was not performed
R = It was not required
FINDINGS: N= Normal findings
A= Abnormal findings
Blank = Not applicable

VALIDATION: PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-13.0.

FORM LOCATION: 4A - Item 05

REMARKS: Enter the appropriate response to indicate if a dental examination was performed or not performed. Enter findings in EA2-14.0 as indicated by contents of EA2-13.0.

RECORD/FIELD:EA2-15.0 EA2-16.0

DATA ELEMENT: Developmental (Phys. Growth/Emotional Dev./Learning)
Assessment Performed (DEVELOP ASSESS PERF)
Developmental (Phys. Growth/Emotional Dev./Learning)
Assessment Findings (DEVELOP ASSESS FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	LEFT	SPACES	34	34
16.0	X(01)	LEFT	SPACES	35	35

DEFINITION: Verification that either a developmental assessment was performed, not performed, or was not required at this time and that findings from the developmental assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
N = No, it was not performed
R = It was not required
FINDINGS: N= Normal findings
A= Abnormal findings

Blank = Not applicable

VALIDATION: PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-15.0.

FORM LOCATION: 4A - Item 06

REMARKS: Enter the appropriate response to indicate if a developmental examination was performed or not performed. Enter findings in EA2-16.0 as indicated by contents of EA2-15.0.

RECORD/FIELD:EA2-17.0 EA2-18.0

DATA ELEMENT: Nutritional Assessment Performed (NUT ASSESS PERF)
Nutritional Assessment Findings (NUT ASSESS FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(01)	LEFT	SPACES	36	36
18.0	X(01)	LEFT	SPACES	37	37

DEFINITION: Verification that either a nutritional assessment was performed, not performed, or was not required at this time and that findings from the nutritional assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
N = No, it was not performed
R = It was not required
FINDINGS: N= Normal findings
A= Abnormal findings
Blank = Not applicable

VALIDATION: PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-18.0.

FORM LOCATION: 4A - Item 07

REMARKS: Enter the appropriate response to indicate if a nutritional examination was performed or not performed. Enter findings in EA2-18.0 as indicated by contents of EA2-17.0.

RECORD/FIELD:EA2-19.0 EA2-20.0

DATA ELEMENT: Cardiovascular/Circulatory/Pulmonary/Respiratory (CARD ASSESS PERF)
 Assessment Performed

 Cardiovascular/Circulatory/Pulmonary/Respiratory (CARD ASSESS FIND)
 Assessment Findings

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(01)	LEFT	SPACES	38	38
20.0	X(01)	LEFT	SPACES	39	39

DEFINITION: Verification that either a cardiovascular assessment was performed, not performed, or was not required at this time and that findings from the cardiovascular assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required

 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION:PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-19.0.

FORM LOCATION: 4A - Item 08

REMARKS: Enter the appropriate response to indicate if a cardiovascular assessment was performed or not performed. Enter findings in EA2-20.0 as indicated by contents of EA2-19.0.

RECORD/FIELD:EA2-21.0 EA2-22.0

DATA ELEMENT: Genital/Urinary Tract Assessment (GEN/UR ASSESS PERF)
 Performed

 Genital/Urinary Tract Assessment Findings (GEN/UR ASSESS FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(01)	LEFT	SPACES	40	40
22.0	X(01)	LEFT	SPACES	41	41

DEFINITION: Verification that either a genital/urinary tract assessment was performed, not performed, or was not required at this time and that findings from the genital/urinary tract assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required
 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION: PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-21.0.

FORM LOCATION: 4A - Item 09

REMARKS: Enter the appropriate response to indicate if a genital/urinary tract assessment was performed or not performed. Enter findings in EA2-22.0 as indicated by contents of EA2-21.0.

RECORD/FIELD:EA2-23.0 EA2-24.0

DATA ELEMENT:	Diabetes Assessment Performed	(DIABETES ASSESS PERF)
	Diabetes Assessment Findings	(DIABETES ASSESS FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(01)	LEFT	SPACES	42	42
24.0	X(01)	LEFT	SPACES	43	43

DEFINITION: Verification that either a diabetes assessment was performed, not performed, or was not required at this time and that findings from the diabetes assessment were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required
 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION:PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-23.0.

FORM LOCATION: 4A - Item 10

REMARKS: Enter the appropriate response to indicate if a diabetes examination was performed or not performed. Enter findings in EA2-24.0 as indicated by contents of EA2-23.0.

RECORD/FIELD:EA2-25.0 EA2-26.0 EA2-27.0

DATA ELEMENT:	Other Systems Assessment Performed	(OTH SYS ASSESS PERF)
	Other Systems Assessment Findings	(OTH SYS ASSESS FIND)
	Other Systems Assessment Description	(OTH SYS ASSESS DESC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(01)	LEFT	SPACES	44	44
26.0	X(01)	LEFT	SPACES	45	45
27.0	X(20)	LEFT	SPACES	46	65

DEFINITION: Verification that an assessment not designated in previous fields was performed at this time and that findings from the assessment were either normal or abnormal. Up to 20 characters of description may be entered.

CODE VALUES:	PERFORMED:	Y = Yes, it was performed
		N = No, it was not performed
	FINDINGS:	N= Normal findings
		A= Abnormal findings
		Blank = Not applicable

VALIDATION:PERFORMED:

Enter if needed.

FINDINGS:

Must be entered if response was entered in EA2-25.0.

DESCRIPTION:

Must be entered if response was entered in EA2-25.0

FORM LOCATION: 4A - Item 11

REMARKS: N/A

RECORD/FIELD:EA2-28.0 EA2-29.0

DATA ELEMENT: HGB/HCT Lab Test Performed (HGB/HCT LAB TEST PERF)
HGB/HCT Lab Test Findings (HGB/HCT LAB TEST FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(01)	LEFT	SPACES	66	66
29.0	X(01)	LEFT	SPACES	67	67

DEFINITION: Verification that either an HGB/HCT lab test was performed, not performed, or was not required at this time and that findings from the lab test were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
N = No, it was not performed
R = It was not required
FINDINGS: N= Normal findings
A= Abnormal findings
Blank = Not applicable

VALIDATION:PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-28.0.

FORM LOCATION: 4A - Item 12

REMARKS: Enter the appropriate response to indicate if an HGB/HCT lab test was performed or not performed. Indicate findings in EA2-29.0 as indicated by contents of EA2-28.0.

RECORD/FIELD:EA2-30.0 EA2-31.0

DATA ELEMENT: Urinalysis Lab Test Performed (URINALY LAB TEST PERF)
Urinalysis Lab Test Findings (URINALY LAB TEST FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(01)	LEFT	SPACES	68	68
31.0	X(01)	LEFT	SPACES	69	69

DEFINITION: Verification that either a Urinalysis lab test was performed, not performed, or was not required at this time and that findings from the lab test were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required
 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION:PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-30.0.

FORM LOCATION: 4A - Item 13

REMARKS: Enter the appropriate response to indicate if a Urinalysis lab test was performed or not performed. Indicate findings in EA2-31.0 as indicated by contents of EA2-30.0.

RECORD/FIELD:EA2-32.0 EA2-33.0

DATA ELEMENT: Sickle Cell Lab Test Performed (SICKLE CELL LAB PERF)
 Sickle Cell Lab Test Findings (SICKLE CELL LAB FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(01)	LEFT	SPACES	70	70
33.0	X(01)	LEFT	SPACES	71	71

DEFINITION: Verification that either a Sickle Cell lab test was performed, not performed, or was not required at this time and that findings from the lab test were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required
 FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

Tine Test Findings

(TINE TEST FIND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
36.0	X(01)	LEFT	SPACES	74	74
37.0	X(01)	LEFT	SPACES	75	75

DEFINITION: Verification that either a Tine lab test was performed, not performed, or was not required at this time and that findings from the lab test were either normal or abnormal.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed
 R = It was not required

FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION:PERFORMED:

Must be entered.

FINDINGS:

Must be entered if response other than "not required" was entered in EA2-36.0.

FORM LOCATION: 4A - Item 16

REMARKS: Enter the appropriate response to indicate if a Tine lab test was performed or not performed Indicate findings in EA2-37.0 as indicated by contents of EA2-36.0.

RECORD/FIELD:EA2-38.0 EA2-39.0 EA2-40.0

DATA ELEMENT: Other Test 1 Performed (OTHER TEST 1 PERF)
 Other Test 1 Findings (OTHER TEST 1 FIND)
 Other Test 1 Description (OTHER TEST 1 DESC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
38.0	X(01)	LEFT	SPACES	76	76
39.0	X(01)	LEFT	SPACES	77	77
40.0	X(20)	LEFT	SPACES	78	97

DEFINITION: Verification that a lab test not designated in previous fields was performed at this time and that findings from the lab test were either normal or abnormal. Up to 20 characters of description may be entered.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed

FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION:PERFORMED:

Enter if needed.

FINDINGS:

Must be entered if response was entered in EA2-38.0.

DESCRIPTION:

Must be entered if response was entered in EA2-38.0.

FORM LOCATION: 4A - Item 17

RECORD/FIELD:EA2-41.0 EA2-42.0 EA2-43

DATA ELEMENT:	Other Test 2 Performed	(OTHER TEST 2 PERF)
	Other Test 2 Findings	(OTHER TEST 2 FIND)
	Other Test 2 Description	(OTHER TEST 2 DESC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
41.0	X(01)	LEFT	SPACES	98	98
42.0	X(01)	LEFT	SPACES	99	99
43.0	X(20)	LEFT	SPACES	100	119

DEFINITION: Verification that a lab test not designated in previous fields was performed at this time and that findings from the lab test were either normal or abnormal. Up to 20 characters of description may be entered.

CODE VALUES: PERFORMED: Y = Yes, it was performed
 N = No, it was not performed

FINDINGS: N= Normal findings
 A= Abnormal findings
 Blank = Not applicable

VALIDATION:PERFORMED:

Enter if needed.

FINDINGS:

Must be entered if response was entered in
EA2-41.0.

DESCRIPTION:

Must be entered if response was entered in EA2-41.0.

FORM LOCATION: 4A - Item 18

REMARKS: N/A

RECORD/FIELD:EA2-44.0 THRU EA2-59

DATA ELEMENT: Treatment Item Number 1 Thru 16 (TREATMENT ITEM NO 1 THRU 16)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
44.0	X(02)	LEFT	SPACES	120	121
45.0	X(02)	LEFT	SPACES	122	123
46.0	X(02)	LEFT	SPACES	124	125
47.0	X(02)	LEFT	SPACES	126	127
48.0	X(02)	LEFT	SPACES	128	129
49.0	X(02)	LEFT	SPACES	130	131
50.0	X(02)	LEFT	SPACES	132	133
51.0	X(02)	LEFT	SPACES	134	135
52.0	X(02)	LEFT	SPACES	136	137
53.0	X(02)	LEFT	SPACES	138	139
54.0	X(02)	LEFT	SPACES	140	141
55.0	X(02)	LEFT	SPACES	142	143
56.0	X(02)	LEFT	SPACES	144	145
57.0	X(02)	LEFT	SPACES	146	147
58.0	X(02)	LEFT	SPACES	148	149
59.0	X(02)	LEFT	SPACES	150	151

DEFINITION: Identification of screening items which may require treatment.

- CODE VALUES:
- 01 - MEDICAL HISTORY OBTAINED
 - 02 - PHYSICAL EXAMINATION PERFORMED
 - 03 - VISION
 - 04 - HEARING
 - 05 - DENTAL
 - 06 - DEVELOPMENTAL
 - 07 - NUTRITIONAL
 - 08 - CARDIOVASCULAR/ CIRCULATORY/ PULMONARY / RESP.
 - 09 - GENITAL/URINARY TRACT
 - 10 - DIABETES
 - 11 - OTHER SYSTEMS ASSESSMENT
 - 12 - HBC/HCT LAB TEST
 - 13 - URINALYSIS LAB TEST
 - 14 - SICKLE CELL LAB TEST
 - 15 - BLOOD LEAD LAB TEST
 - 16 - TINE TEST
 - 17 - OTHER 1 SPECIFY
 - 18 - OTHER 2 SPECIFY

VALIDATION: N/A

FORM LOCATION: 5A

REMARKS: Enter up to sixteen numbers from EA2-05.0 thru EA2-41.0 (screening) that resulted in abnormal findings requiring or potentially requiring treatment, or reflecting treatment initiated on the same date as the screening.

RECORD/FIELD:EA2-60.0 THRU EA2-63.0

DATA ELEMENT: Treatment Status Number 1 thru 4IN (TREATMENT STAT NO1 THRU 4 IN)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
60.0	X(02)	LEFT	SPACES	153	153
61.0	X(02)	LEFT	SPACES	154	155
62.0	X(02)	LEFT	SPACES	156	157
63.0	X(02)	LEFT	SPACES	158	159

DEFINITION: Identification of status of screening items which were initiated with this screening.

CODE VALUES: 01 - 18 (Per list on page EA2.27)

VALIDATION: N/A

FORM LOCATION: 6

REMARKS: Enter up to four item numbers from the screening items identified in the treatment items fields (EA2-44.0 thru EA2-59.0 which were initiated with this screening).

RECORD/FIELD:EA2-64.0 THRU EA2-67.0

DATA ELEMENT: Treatment Status Number 1 thru 4DE (TREATMENT STAT NO1 THRU 4 DE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
64.0	X(02)	LEFT	SPACES	160	161
65.0	X(02)	LEFT	SPACES	162	163
66.0	X(02)	LEFT	SPACES	164	165
67.0	X(02)	LEFT	SPACES	166	167

DEFINITION: Identification of status of screening items which were declined with this screening.

CODE VALUES: 01 - 18 (Per list on page EA2.27)

VALIDATION: N/A

FORM LOCATION: 6

REMARKS: Enter up to four item numbers from the screening items identified in the treatment items fields (EA2-44.0 thru EA2-59.0 which were declined with this screening).

RECORD/FIELD:EA2-68.0 THRU EA2-71.0

DATA ELEMENT: Treatment Status Number 1 thru 4NR (TREATMENT STAT NO1 THRU 4 NR)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
68.0	X(02)	LEFT	SPACES	168	169
69.0	X(02)	LEFT	SPACES	170	171
70.0	X(02)	LEFT	SPACES	172	173
71.0	X(02)	LEFT	SPACES	174	175

DEFINITION: Identification of status of screening items which were not required with this screening.

CODE VALUES: 01 - 18 (Per list on page EA2.27)

VALIDATION: N/A

FORM LOCATION: 6

REMARKS: Enter up to four item numbers from the screening items identified in the treatment items fields (EA2-44.0 thru EA2-59.0 which were not required with this screening.

RECORD/FIELD:EA2-72.0 THRU EA2-79.0

DATA ELEMENT: REFERRAL ITEM NO 1THRU 8

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
72.0	X(02)	LEFT	SPACES	176	177
73.0	X(02)	LEFT	SPACES	178	179
74.0	X(02)	LEFT	SPACES	180	181
75.0	X(02)	LEFT	SPACES	182	183
76.0	X(02)	LEFT	SPACES	184	185
77.0	X(02)	LEFT	SPACES	186	187
78.0	X(02)	LEFT	SPACES	188	189
79.0	X(02)	LEFT	SPACES	190	191

DEFINITION: Identification of screening items which are being referred to another doctor

CODE VALUES: 01 - 18 (Per list on page EA2.27)

VALIDATION: N/A

FORM LOCATION: 5B

REMARKS: Enter the treatment line item numbers (1-18) which are being referred to another provider for diagnosis and/or treatment.

RECORD/FIELD:EA2-80.0 EA2-81.0

DATA ELEMENT: Immunization Polio Given Today (IMMUN POLIO GIVEN)
 Immunization Polio Not Given Today (IMMUN POLIO NOT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
80.0	X(01)	LEFT	SPACES	192	192
81.0	X(01)	LEFT	SPACES	193	193

DEFINITION: Verification that the patient's immunization treatment for this condition has been given today, not given today, and why.

CODE VALUES: GIVEN: C= Current - now up to date
 N= Not up to date or more doses to be given
 NOT GIVEN: C= Already up to date, immunization is current

R= Refused by participant or contraindications present

O= Omitted for other reasons

VALIDATION: Either EA2-80.0 or EA2-81.0 must be entered - both cannot be left blank.

FORM LOCATION: 4B - Item 01

REMARKS: Enter the appropriate response to indicate if this immunization has been given at the time of this screening.

RECORD/FIELD:EA2-82.0 EA2-83.0

DATA ELEMENT: Immunization DPT/TD Given Today (IMMUN DPT/TD GIVEN)
 Immunization DPT/TD Not Given Today (IMMUN DPT/TD NOT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
82.0	X(01)	LEFT	SPACES	194	194
83.0	X(01)	LEFT	SPACES	195	195

DEFINITION: Verification that the patient's immunization treatment for this condition has been given today, not given today, and why.

CODE VALUES: GIVEN: C= Current - now up to date
 N= Not up to date or more doses to be given

 NOT GIVEN: C= Already up to date, immunization is current
 R= Refused by participant or contraindications present
 O= Omitted for other reasons

VALIDATION: Either EA2-82.0 or EA2-83.0 must be entered - both cannot be left blank.

FORM LOCATION: 4B - Item 02

REMARKS: Enter the appropriate response to indicate if this immunization has been given at the time of this screening.

RECORD/FIELD:EA2-84.0 EA2-85.

DATA ELEMENT: Immunization Measles (Rubeola) Given Today (IMMUN MEASLES GIVEN)
 Immunization Measles (Rubeola) Not Given Today (IMMUN MEASLES NOT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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84.0	X(01)	LEFT	SPACES	196	196
85.0	X(01)	LEFT	SPACES	197	197

DEFINITION: Verification that the patient's immunization treatment for this condition has been given today, not given today, and why.

CODE VALUES: GIVEN: C= Current - now up to date
 N= Not up to date or more doses to be given
 NOT GIVEN: C= Already up to date, immunization is current
 R= Refused by participant or contraindications present
 O= Omitted for other reasons

VALIDATION: Either EA2-84.0 or EA2-85.0 must be entered - both cannot be left blank.

FORM LOCATION: 4B - Item 03

REMARKS: Enter the appropriate response to indicate if this immunization has been given at the time of this screening.

RECORD/FIELD:EA2-86.0 EA2-87.0

DATA ELEMENT: Immunization Mumps Given Today (IMMUN MUMPS GIVEN)
 Immunization Mumps Not Given Today (IMMUN MUMPS NOT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
86.0	X(01)	LEFT	SPACES	198	198
87.0	X(01)	LEFT	SPACES	199	199

DEFINITION: Verification that the patient's immunization treatment for this condition has been given today, not given today, and why.

CODE VALUES: GIVEN: C= Current - now up to date
 N= Not up to date or more doses to be given
 NOT GIVEN: C= Already up to date, immunization is current
 R= Refused by participant or contraindications present
 O= Omitted for other reasons

VALIDATION: Either EA2-86.0 or EA2-87.0 must be entered - both cannot be left blank.

FORM LOCATION: 4B - Item 04

REMARKS: Enter the appropriate response to indicate if this immunization has been given at the time of this screening.

RECORD/FIELD:EA2-88.0 EA2-89.0

DATA ELEMENT: Immunization Rubella Given Today (IMMUN RUBELLA GIVEN)
 Immunization Rubella Not Given Today (IMMUN RUBELLA NOT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
88.0	X(01)	LEFT	SPACES	200	200
89.0	X(01)	LEFT	SPACES	201	201

DEFINITION: Verification that the patient's immunization treatment for this condition has been given today, not given today, and why.

CODE VALUES: GIVEN: C= Current - now up to date
 N= Not up to date or more doses to be given
 NOT GIVEN: C= Already up to date, immunization is current
 R= Refused by participant or contraindications present
 O= Omitted for other reasons

VALIDATION: Either EA2-88.0 or EA2-89.0 must be entered - both cannot be left blank.

FORM LOCATION: 4B - Item 05

REMARKS: Enter the appropriate response to indicate if this immunization has been given at the time of this screening.

RECORD/FIELD:EA2-90.0 EA2-91.0

DATA ELEMENT: Immunization HIB Given Today (IMMUN HIB GIVEN)
 Immunization HIB Not Given Today (IMMUN HIB NOT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
90.0	X(01)	LEFT	SPACES	202	202
91.0	X(01)	LEFT	SPACES	203	203

DEFINITION: Verification that the patient's immunization treatment for this condition has been given today, not given today, and why.

CODE VALUES: GIVEN: C= Current - now up to date
 N= Not up to date or more doses to be given

NOT GIVEN: C= Already up to date, immunization is current
 R= Refused by participant or contraindications present
 O= Omitted for other reasons

VALIDATION: Either EA2-90.0 or EA2-91.0 must be entered - both cannot be left blank.

FORM LOCATION: 4B - Item 06

REMARKS: Enter the appropriate response to indicate if this immunization has been given at the time of this screening.

RECORD/FIELD:EA2-92.0 EA2-93.0

DATA ELEMENT: Immunization Other Given Today (IMMUN OTHER GIVEN)
 Immunization Other Description (IMMUN OTHER DESC.)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
92.0	X(01)	LEFT	SPACES	204	204
93.0	X(20)	LEFT	SPACES	205	224

DEFINITION: Verification that the patient's immunization treatment for a condition other than one listed in the previous immunization fields has been given today and if it is up to date or not up to date.

CODE VALUES: GIVEN: C= Current - now up to date
 N= Not up to date or more doses to be given

VALIDATION: Optional, if needed.

FORM LOCATION: 4B - Item 07

REMARKS: Enter the appropriate response to indicate if this immunization has been given at the time of this screening. If a response is entered in EA2-92.0, EA2-93.0 must be entered.

RECORD/FIELD:EA2-94.0

DATA ELEMENT: Filler - National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
94.0	X(96)	LEFT	SPACES	225	320

DEFINITION: Unused reserved filler for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: SERVICE LINE DETAIL RECORD TYPE FA0 "ROOT SEGMENT"

Required for MO HealthNet processing

Must follow EA0, EA1 or EA2

Must be followed by FB0

Field No.	Field Name	Table Value	Default
01	RECORD ID "FA0"	C-24	FA0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	LINE ITEM CONTROL NO	C-65	NO
05	SVC FROM DATE	C-16	YES
06	SVC TO DATE	C-16	YES
07	PLACE OF SVC	C-14	YES
08	TYPE OF SVC CODE	C-11	YES
09	HCPCS PROCEDURE CODE	C-30	YES
10	HCPCS MODIFIER 1	C-35	NO
11	HCPCS MODIFIER 2	C-35	NO
12	HCPCS MODIFIER 3		Not Used
13	LINE CHARGES	C-10	YES
14	DIAG CODE POINTER1	C-66	YES
15	DIAG CODE POINTER2		Not Used
16	DIAG CODE POINTER3		Not Used
17	DIAG CODE POINTER4		Not Used
18	UNITS OF SVC	C-28	YES
19	ANESTHESIA/OXYGEN MIN		Not Used
20	EMERGENCY IND		Not Used
21	COB IND		Not Used
22	HPSA IND		Not Used

23	RENDERING PROV ID	C-19	NO
24	REFERRING PROV ID		Not Used
25	REFERRING PROV STATE		Not Used
26	PUR SVC IND		Not Used
27	DISALLOWED COST CONT		Not Used
28	DISALLOWED OTHER		Not Used
29	REVIEW BY CODE IND		Not Used
30	MULTI PROCEDURE IND		Not Used
31	MAMMOGRAPHY CERT NO		Not Used
32	CLASS FINDINGS		Not Used
33	PODIATRY SVC COND		Not Used
34	CLIA ID NO		Not Used
35	PRIMARY PAID AMOUNT		Not Used
36	HCPCS MODIFIER 4		Not Used
37	PROVIDER SPECIALTY		Not Used
38	PODIATRY THERAPY IND		Not Used
39	PODIATRY THERAPY TYPE		Not Used
40	HOSPICE EMPLOYED PROV IND		Not Used
41	HGB/HCT DATE		Not Used
42	HGB RESULT		Not Used
43	HCT RESULT		Not Used
44	PATIENT WEIGHT		Not Used
45	EPO DOSAGE		Not Used
46	SERUM CREATINE DATE		Not Used
47	CREATINE RESULT		Not Used
48	OBLIGATED ACCEPT AMT		Not Used
49	DRUG DISCOUNT AMT		Not Used
50	TYPE OF UNITS IND		Not Used
51	APPROVED AMT		Not Used
52	PAID AMT		Not Used

53	BENE LIABILITY AMT		Not Used
54	BALANCE BILL LIMIT CHG		Not Used
55	LIMIT CHARGE PRCNT		Not Used
56	PERFORM PROV PHONE		Not Used
57	PERFORM PROV TAX TYPE		Not Used
58	PERFORM PROV TAX ID		Not Used
59	PERFORM PROV ASSIGN IND		Not Used
60	PRETRANSPLANT INDICATOR		Not Used
61	ICD-10-PCS		Not Used
62	UNIVERSAL PRODUCT CODE		Not Used
63	DIAG CODE POINTER5		Not Used
64	DIAG CODE POINTER6		Not Used
65	DIAG CODE POINTER7		Not Used
66	DIAG CODE POINTER8		Not Used
67	FILLER-NATIONAL		YES

RECORD TYPE: FA0

LEVEL: CLAIM - ROOT SEGMENT

PURPOSE: To provide information related to the medical/dental services rendered to the patient by the provider.

REQUIREMENTS: This record is required on all claims.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	EA0, EA1, EA2, FA0,	FB0, FB1, FB2, FB3, FD0, FE0
	FB0, FB1, FB2, FB3,	FD0 CERT Records, HA0 or XA0
	FE0, CERT Records, or HA0	

NOTES: 1. There must be at least 1 record type FA0 entered for a claim.

2. There may be up to 99 FXX records entered for a claim. (All "F" records).

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "FA0"	3	X	01	03

02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	SVC FROM DATE	8	X	40	47
06.0	SVC TO DATE	8	X	48	55
07.0	PLACE OF SVC	2	X	56	57
08.0	TYPE OF SVC CODE	2	X	58	59
09.0	HCPCS PROCEDURE CODE	5	X	60	64
10.0	HCPCS MODIFIER 1	2	X	65	66
11.0	HCPCS MODIFIER 2	2	X	67	68
12.0	HCPCS MODIFIER 3	2	X	69	70
13.0	LINE CHARGES	7	N	71	77
14.0	DIAG CODE POINTER1	1	X	78	78
15.0	DIAG CODE POINTER2	1	X	79	79
16.0	DIAG CODE POINTER3	1	X	80	80
17.0	DIAG CODE POINTER4	1	X	81	81
18.0	UNITS OF SVC	4	N	82	85
19.0	ANESTHESIA/OXYGEN MIN	4	N	86	89
20.0	EMERGENCY IND	1	X	90	90
21.0	COB IND	1	X	91	91
22.0	HPSA IND	1	X	92	92
23.0	RENDERING PROV NPI	15	X	93	107
24.0	REFERRING PROV NPI	15	X	108	122
25.0	REFERRING PROV STATE	2	X	123	124
26.0	PUR SVC IND	1	X	125	125
27.0	DISALLOWED COST CONT	7	N	126	132
28.0	DISALLOWED OTHER	7	N	133	139
29.0	REVIEW BY CODE IND	1	X	140	140
30.0	MULTI PROCEDURE IND	1	X	141	141
31.0	MAMMOGRAPHY CERT NO	10	X	142	151

32.0	CLASS FINDINGS	9	X	152	160
33.0	PODIATRY SVC COND	3	X	161	163
34.0	CLIA ID NO	15	X	164	178
35.0	PRIMARY PAID AMOUNT	7	N	179	185
36.0	HCPCS MODIFIER 4	2	X	186	187
37.0	PROVIDER SPECIALTY	3	X	188	190
38.0	PODIATRY THERAPY IND	1	X	191	191
39.0	PODIATRY THERAPY TYPE	1	X	192	192
40.0	HOSPICE EMPLOYED PROV IND	1	X	192	192
41.0	HGB/HCT DATE	8	X	194	201
42.0	HGB RESULT	3	N	202	204
43.0	HCT RESULT	2	N	205	206
44.0	PATIENT WEIGHT	3	N	207	209
45.0	EPO DOSAGE	3	N	210	212
46.0	SERUM CREATINE DATE	8	X	213	220
47.0	CREATINE RESULT	3	N	221	223
48.0	OBLIGATED ACCEPT AMT	7	N	224	230
49.0	DRUG DISCOUNT AMT	7	N	231	237
50.0	TYPE OF UNITS IND	1	X	238	238
51.0	APPROVED AMT	7	N	239	245
52.0	PAID AMT	7	N	246	252
53.0	BENE LIABILITY AMT	7	N	253	259
54.0	BALANCE BILL LIMIT CHG	7	N	260	266
55.0	LIMIT CHARGE PRCNT	7	N	267	273
56.0	PERFORM PROV PHONE	10	X	274	283
57.0	PERFORM PROV TAX TYPE	1	X	284	284
58.0	PERFORM PROV TAX ID	9	X	285	293
59.0	PERFORM PROV ASSIGN IND	1	X	294	294
60.0	PRETRANSPLANT INDICATOR	1	X	295	295
61.0	ICD-10-PCS	7	X	296	302

62.0	UNIVERSAL PRODUCT CODE	14	X	303	316
63.0	DIAG CODE POINTER5	1	X	317	317
64.0	DIAG CODE POINTER6	1	X	318	318
65.0	DIAG CODE POINTER7	1	X	319	319
66.0	DIAG CODE POINTER8	1	X	320	320

RECORD/FIELD: FA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Service Line Detail Record - FA0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be 'FA0'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

All Fxx records must be grouped as FA0, FB0, FB1, FB2 followed by any applicable CERT record(s) and/or Narrative record(s) (or for Dental claims, FA0, FD0) by Sequence Number.

FORM LOCATION: N/A

REMARKS: Consult the Matrix/User Guide document supplied by the payor/receiver to determine the maximum number (sequences) of "FA0" records allowed.

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Date" entry.

Service To Date must be equal or greater than the Service From Date.

FORM LOCATION: CMS-1500 Block 24a

REMARKS: N/A

RECORD/FIELD: FA0-07.0

DATA ELEMENT: Place of Service(PLACE OF SVC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(02)	LEFT	SPACES	56	57

DEFINITION: The code that identifies where the service was performed.

CODE VALUES:

- 00-09 Unassigned
- 11 Office
- 12 Home
- 10, 13-19 Unassigned
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room - Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 20, 27-29 Unassigned
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 30, 35-39 Unassigned
- 41 Ambulance - Land
- 42 Ambulance - Air or Water
- 40, 43-49 Unassigned
- 51 Inpatient Psychiatric Facility

- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 50 Federally Qualified Health Center
- 57-59 Unassigned
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 60, 63, 64 Unassigned
- 66-69 Unassigned
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 70, 73-79 Unassigned
- 81 Independent Laboratory
- 80, 82-89 Unassigned
- 99 Other Unlisted Facility
- 90-98 Unassigned

VALIDATION: Must be entered

Must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 24b

REMARKS: N/A

RECORD/FIELD: FA0-08.0

DATA ELEMENT: Type of Service Code (TYPE OF SVC CODE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(02)	LEFT	SPACES	58	59

DEFINITION: A code that classifies the service.

See the C-11 table for valid field values.

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code form above list.

FORM LOCATION: CMS-1500 Block 24c

REMARKS: N/A

RECORD/FIELD: FA0-09.0

DATA ELEMENT: HCPCS Procedure Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(05)	LEFT	SPACES	60	64

DEFINITION: This is the HCPCS/CPT-4 code that describes the service.

CODE VALUES: HCPCS/CPT-4 code set.

VALIDATION: Must be entered if required by payor.

Must be entered if National Drug Code (FB0-15.0) is blank.

If entered, must be a valid HCPCS/CPT-4 procedure code.

FORM LOCATION: CMS-1500 Block 24d

REMARKS: N/A

RECORD/FIELD: FA0-10.0 FA0-11.0 FA0-12.0

DATA ELEMENT: HCPCS Modifier 1
HCPCS Modifier 2
HCPCS Modifier 3

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(02)	LEFT	SPACES	65	66
11.0	X(02)	LEFT	SPACES	67	68
12.0	X(02)	LEFT	SPACES	69	70

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper adjudication of the service.

FORM LOCATION: CMS-1500 Block 24D

REMARKS: N/A

RECORD/FIELD: FA0-13.0

DATA ELEMENT: Line Charges

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	9(05)V99	RIGHT	ZEROS	71	77

DEFINITION: The charges related to this service.

CODE VALUES: N/A

VALIDATION: Must be positive unsigned numeric value.

FORM LOCATION: CMS-1500 Block 24f

REMARKS: N/A

RECORD/FIELD: FA0-14.0 FA0-15.0 FA0-16.0 FA0-17.0

DATA ELEMENT:	Diagnosis Code Pointer 1	(DIAG CODE POINTER1)
	Diagnosis Code Pointer 2	(DIAG CODE POINTER2)
	Diagnosis Code Pointer 3	(DIAG CODE POINTER3)
	Diagnosis Code Pointer 4	(DIAG CODE POINTER4)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(01)	LEFT	SPACE	78	78
15.0	X(01)	LEFT	SPACE	79	79
16.0	X(01)	LEFT	SPACE	80	80
17.0	X(01)	LEFT	SPACE	81	81

DEFINITION: A pointer to the claim diagnosis code in the order of importance to this service.

- CODE VALUES:
- 1 - indicates the 1st header diagnosis
 - 2 - indicates the 2nd header diagnosis
 - 3 - indicates the 3rd header diagnosis
 - 4 - indicates the 4th header diagnosis

VALIDATION: Pointer 1 must be a valid code from the list above. Values used must point to non-blank header diagnosis field.

FORM LOCATION: CMS-1500 Block 24e

REMARKS: Example:

Header diagnosis entered; 11111 22222 33333 44444

Diagnosis pointer 1 -- 3

Diagnosis pointer 2 -- 4

Diagnosis pointer 3 -- 1

In this example the diagnosis pointers indicate that header diagnosis 3 is the primary code with header diagnosis 4 being the secondary code and header diagnosis 1 as the tertiary code. The 4th diagnosis pointer was not entered because it was not related to this service.

RECORD/FIELD: FA0-18.0

DATA ELEMENT: Units of Service(UNITS OF SVC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	9(03)V9	RIGHT	ZEROS	82	85

DEFINITION: The number of services rendered in days or units.

CODE VALUES: N/A

VALIDATION: Must be Positive unsigned numeric value.

FORM LOCATION: CMS-1500 Block 24g

REMARKS: In order to capture fractional services, use the fourth position with an assumed decimal position.

RECORD/FIELD: FA0-19.0

DATA ELEMENT: Anesthesia/Oxygen Minutes (ANESTHESIA/OXYGEN MIN)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	9(04)	RIGHT	ZEROS	86	89

DEFINITION: The actual number of minutes patient was anesthetized or number of minutes of oxygen.

CODE VALUES: N/A

VALIDATION: When required by Payor, must be positive unsigned numeric value.

FORM LOCATION: CMS-1500 Block 24G

REMARKS: N/A

RECORD/FIELD: FA0-20.0

DATA ELEMENT: Emergency Indicator (EMERGENCY IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(01)	LEFT	SPACE	90	90

DEFINITION: An indicator of whether or not emergency care was rendered in response to the sudden and unexpected onset of a medical condition; a severe injury, or an acute exacerbation of a chronic condition which was threatening to life, limb or sight, and which required immediate medical or surgical treatment.

CODE VALUES: Y - Yes, emergency related (sudden onset of a of a medical condition)
N - No, emergency not related

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code from the above list.

FORM LOCATION: CMS-1500 Block 24i

REMARKS: N/A

RECORD/FIELD: FA0-21.0

DATA ELEMENT: COB Indicator (COB IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(01)	LEFT	SPACE	91	91

DEFINITION: Codes indicating the liability of the primary carrier.

CODE VALUES: A thru Z = RESERVED FOR NATIONAL ASSIGNMENT
0 thru 9 = RESERVED FOR LOCAL ASSIGNMENT

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code from the above list.

FORM LOCATION: CMS-1500 Block 24j

REMARKS: N/A

RECORD/FIELD: FA0-22.0

DATA ELEMENT: HPSA Indicator (HPSA IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(01)	LEFT	SPACE	92	92

DEFINITION: A code that identifies a Health Professional Shortage Area (HPSA).

CODE VALUES: 1, 2, 3, 4

VALIDATION: Must be entered if required by Payor. If entered, must be valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-23.0

DATA ELEMENT: Rendering Provider National Provider Identifier (RENDERING PROV NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(15)	LEFT	SPACES	93	107

DEFINITION: The National Provider Identifier assigned to the rendering provider.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

See GENERAL INSTRUCTIONS for "Identification Numbers" entry.

FORM LOCATION: CMS-1500 Block 24K

REMARKS: N/A

RECORD/FIELD: FA0-24.0

DATA ELEMENT: Referring Provider National Provider Identifier (REFERRING PROV NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(15)	LEFT	SPACES	108	122

DEFINITION: The National Provider Identifier assigned To the referring provider (who referred the services).

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

See GENERAL INSTRUCTIONS for "Identification Numbers" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-25.0

DATA ELEMENT: Referring Provider State (REFERRING PROV STATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(02)	LEFT	SPACES	123	124

DEFINITION: The referring provider's state code.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-26.0

DATA ELEMENT: Purchase Service Indicator (PUR SVC IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(01)	LEFT	SPACE	125	125

DEFINITION: The Purchase Service Indicator.

CODE VALUES: Y = Service was purchased from another entity.

N = Service was not purchased.

VALIDATION: Must be entered if required by Payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-27.0

DATA ELEMENT: Disallowed Cost Containment (DISALLOWED COST CONT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	9(05)V99	RIGHT	ZEROS	126	132

DEFINITION: The portion of line charges disallowed by the payor due to the failure of either the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested for this claim.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

When entered, must be positive unsigned numeric value.

Must not be greater than Line Charges (FA0-13.0).

FORM LOCATION: EOB/REMITTANCE

REMARKS: N/A

RECORD/FIELD: FA0-28.0

DATA ELEMENT: Disallowed Other

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	9(05)V99	RIGHT	ZEROS	133	139

DEFINITION: The portion of line charges disallowed by the payor for reasons OTHER than the failure of the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested for this claim.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

When entered, must be positive unsigned numeric value.

Must not be greater than Line Charges (FA0-13.0).

FORM LOCATION: EOB/REMITTANCE

REMARKS: N/A

RECORD/FIELD: FA0-29.0

DATA ELEMENT: Review By Code Indicator (REVIEW BY CODE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(01)	LEFT	SPACE	140	140

DEFINITION: Indicator describing extenuating circumstances or justifications which might assist in any review of the medical necessity for this service.

CODE VALUES:

- A = Case turned over to a consultant
- B = Pre-Admission testing
- C = XRAY/Lab procedure related to a covered surgery
- D = Provider / supplier determined the service is not covered, but the patient is requesting a formal review by the payor.
- E = Beneficiary was notified that the item might not be considered medically necessary and has agreed in writing to pay for the item. A signed waiver is on file with the provider.
- F = Beneficiary was notified that the item might not be considered medically necessary and has not agreed to pay for the item. No signed waiver is on file with the provider.
- G = Testing for hearing aid. Provider Wants to obtain an intentional because other payors are Involved.

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code from the above list.

FORM LOCATION: CMS-1500, Item 19

REMARKS: N/A

RECORD/FIELD: FA0-30.0

DATA ELEMENT: Multiple Procedure Indicator (MULTI PROCEDURE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(01)	LEFT	SPACE	141	141

DEFINITION: An indicator to assist in the proper adjudication and payment determination in cases involving multiple surgical procedures during the same surgical session.

CODE VALUES: P = Primary
S = Secondary = non multiple procedure

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-31.0

DATA ELEMENT: Mammography Certification Number (MAMMOGRAPHY CERT NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(10)	LEFT	SPACES	142	151

DEFINITION: CMS assigned Certification Number of the certified mammography screening center.

CODE VALUES: N/A

VALIDATION: Must be entered is required by payor.

FORM LOCATION: CMS-1500 Block 32

REMARKS: N/A

RECORD/FIELD: FA0-32.0

DATA ELEMENT: Class Findings

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(09)	LEFT	SPACES	152	160

DEFINITION: Code for class findings for routine foot care.

One Class A, or 2 Class B, or 1 Class B and 2 Class C findings.

CODE VALUES:	CLASS "A" FINDINGS	A10 - Non-traumatic amputation of the foot or integral skeletal portion thereof.
	CLASS "B" FINDINGS	B10 - Absent posterior tibial pulse. B20 - Absent dorsalis pedis. pulse. B31 - Advanced changes (three of the following conditions must exist to be considered advanced): - hair growth (decrease or absence). - nail changes (thickening). - pigmentary changes (discoloration). - skin texture (thin shiny). - skin color (rubor or redness).
	CLASS "C" FINDINGS	C10 - Claudication. C20 - Temperature changes (e.g. cold feet). C30 - Paresthesia (abnormal spontaneous sensations in the feet). C40 - Burning. C50 - Edema.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 21

REMARKS: N/A

RECORD/FIELD: FA0-33.0

DATA ELEMENT: Podiatry Service Condition (PODIATRY SVC COND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
33.0	X(03)	LEFT	SPACES	161	163

DEFINITION: Condition justifying necessity of foot care.

CODE VALUES: See the chart on pages FA0.32 and FA0.33.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500 Block 21

REMARKS: N/A

The following chart lists specific values for field FA0-33.0.

<u>CODE</u>	<u>NARRATIVE</u>
E01	Amputation: leg, foot or part of foot.
E02	ASO (arteriosclerosis obliterans) of the feet.
E03	Arteriosclerosis of the lower extremities.
E04	ASO of the feet, or just ASO.
E05	Buerger's disease: lower extremities.
E06	Generalized arteriosclerosis.
E07	Lumbosacral syringomyelia.
E08	Occlusive peripheral arteriosclerosis: feet
Peripheral neuropathies involving the feet associated with:	
E09	Carcinoma
E10	Hereditary disorders (amyloid neuropathy, angiokeratoma corporis deffusum (fabry's disease), hereditary sensory radicular neuropathy).
E11	Leprosy.
E12	Neurosyphilis.
E13	Traumatic injury.
E20	Chronic phlebitis.
E21	Chronic thrombophlebitis.
E22	Diabetes (non-specified).
E23	Diabetes mellitus.
Peripheral neuropathies involving the feet associated with:	
E24	Diabetes (non-specified).
E25	Diabetes mellitus.
E26	Drugs.
E27	Malnutrition and vitamin deficiency (alcoholism, malabsorption-celiac disease, sprue, malnutrition, pernicious anemia).
E28	Multiple sclerosis.
E29	Uremia (chronic renal disease).
E30	Toxins.

E31	Peripheral vasculas disease: arteries foot or toes.
E32	PVD of the foot or toes.
E40	Acute thromphoplebitis.
E41	Acute plebitis.

The following chart lists specific values for field FA0-33.0.

<u>CODE</u>	<u>NARRATIVE</u>
Systemic conditions for routine foot care required specific primary disease diagnosed required anatomical site for reported services:	
H01	Arterial insufficiency.
H02	Blockage of leg vessels.
H03	Chronic vascular disease.
H04	Circulatory deficiency.
H05	Circulatory impairment.
H06	Circulatory insufficiency.
H07	Clot in leg.
H08	Impaired arterial circulation.
H09	Peripheral arterial insufficiency.
H10	Peripheral neuritis.
H11	Peripheral occlusive disease.
H12	Peripheral vascular disease non-specified. Condition Statement:
A01	The Condition is of such severity that it markedly limits the patient's ability to ambulate and the treatment would allow improvement.
B01	The patient is non-ambulatory and if the condition is left untreated it will likely result in serious medical complications.

RECORD/FIELD: FA0-34.0

DATA ELEMENT: Clinical Laboratory Improvement Amendments of 1988 Identification Number (CLIA ID NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
34.0	X(15)	LEFT	SPACES	164	178

DEFINITION: To submit the CLIA Certificate of Waiver or the CLIA Certificate of Registration Identification Number assigned to the laboratory testing site that rendered this service.

CODE VALUES: As assigned by the Health Standards and Quality Bureau at Health Care Financing Administration's Central Office.

VALIDATION: Must be entered if required by the payor.

If entered, must be a valid CLIA Number as issued by CMS.

FORM LOCATION: CMS-1500, item 23

REMARKS: Consult the Matrix/Users Guide supplied by the Payor/Receiver for additional details regarding submission instructions.

RECORD/FIELD: FA0-35.0

DATA ELEMENT: Primary Paid Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
35.0	9(5)V99	RIGHT	ZEROS	179	185

DEFINITION: The actual amount paid by the payor under the provisions of the contract.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

If entered, must be positive unsigned numeric value.

FORM LOCATION: EOB/REMITTANCE

REMARKS: This field may be used to report the amount paid by detail line item for Medicare Secondary Payor claims.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: FA0-36.0

DATA ELEMENT: HCPCS Modifier 4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
36.0	X(2)	LEFT	SPACES	186	187

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required for proper adjudication of the services.

FORM LOCATION: CMS-1500 Block 24D

REMARKS: N/A

RECORD/FIELD: FA0-37.0

DATA ELEMENT: Provider Specialty

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
37.0	X(3)	LEFT	SPACES	188	190

DEFINITION: A code indicating the primary specialty of the provider, as defined by the receiver.

CODE VALUES: N/A

VALIDATION: Must be entered if required by receiver.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-38.0

DATA ELEMENT: Podiatry Therapy Indicator (PODIATRY THERAPY IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
38.0	X(01)	LEFT	SPACES	191	191

DEFINITION: An indicator of whether or not the podiatry patient is receiving anti-fungal therapy.

CODE VALUES: Y - Yes, patient is receiving anti-fungal therapy.

N - No, patient is not receiving anti-fungal therapy.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-39.0

DATA ELEMENT: Podiatry Therapy Type (PODIATRY THERAPY TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
39.0	X(01)	LEFT	SPACES	192	192

DEFINITION: The type of anti-fungal therapy the podiatry patient is receiving.

CODE VALUES: O - Oral

T - Topical

VALIDATION: If entered, must be a valid code from the above list.

Must be entered if PODIATRY THERAPY IND (FA0.38) has a value of "Y".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-40.0

DATA ELEMENT: Hospice Employed Provider Indicator (HOSPICE EMPLOYED PROV IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
40.0	X(01)	LEFT	SPACES	193	193

DEFINITION: An indicator of whether or not the treatment in the Hospice was rendered by a Hospice employed physician.

CODE VALUES: Y - Yes, Physician is employed by the Hospice

N - No, Physician is not employed by the Hospice

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: CMS-1500, Item 19

REMARKS: N/A

RECORD/FIELD: FA0-41.0

DATA ELEMENT: Hgb/HCT DATE (HGB/HCT DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
41.0	X(08)	LEFT	SPACES	194	201

DEFINITION: Date of the most recent hemoglobin/hematocrit.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: Medicare requires this date for the initial Epoetin therapy claim. It is not required for subsequent claims.

RECORD/FIELD: FA0-42.0

DATA ELEMENT: Hemoglobin Result (HGB RESULT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
42.0	9(03)	RIGHT	ZEROES	202	204

DEFINITION: Result, in grams, of the hemoglobin test.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Medicare requires this data for the initial Epoetin claim. It is not required for subsequent claims.

RECORD/FIELD: FA0-43.0

DATA ELEMENT: Hematocrit Result (HCT RESULT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
43.0	9(02)	RIGHT	ZEROES	205	206

DEFINITION: Result (percentage) of the hematocrit test.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Medicare requires this data for the initial Epoetin claim. It is not required for subsequent claims.

RECORD/FIELD: FA0-44.0

DATA ELEMENT: Patient Weight (PATIENT WEIGHT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
44.0	9(03)	RIGHT	ZEROES	207	209

DEFINITION: Patient's current weight in kilograms.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Medicare requires this data for the initial Epoetin claim. It is not required for subsequent claims.

RECORD/FIELD: FA0-45.0

DATA ELEMENT: Epoetin Dosage (EPO DOSAGE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
45.0	9(03)	RIGHT	ZEROES	210	212

DEFINITION: Epoetin starting dosage in units per kilograms.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Medicare requires this data for the initial Epoetin claim. It is not required for subsequent claims.

RECORD/FIELD: FA0-46.0

DATA ELEMENT: Serum Creatine Date (SERUM CREATINE DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
46.0	X(08)	LEFT	SPACES	213	220

DEFINITION: Date of the most recent serum creatine.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: Medicare requires this date for the initial Epoetin claim. It is not required for subsequent claims.

RECORD/FIELD: FA0-47.0

DATA ELEMENT: Creatine Result (CREATINE RESULT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
47.0	9(03)	RIGHT	ZEROES	221	223

DEFINITION: Results of the creatine to the nearest tenths.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Medicare requires this data for the initial Epoetin claim. It is not required for subsequent claims.

RECORD/FIELD: FA0-48.0

DATA ELEMENT: Obligated to Accept Amount (OBLIGATED ACCEPT AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
48.0	9(05)V99	RIGHT	ZEROES	224	230

DEFINITION: The amount the provider agreed to accept as payment in full under the provisions of the contract.

CODE VALUES: N/A

VALIDATION: Must be entered if applicable and the payor requires the information for the filing of secondary claims EMC.

FORM LOCATION: EOB (Explanation of Benefits) or remittance of primary payor.

REMARKS: This field may be used for Medicare Secondary Payor submission purposes.

RECORD/FIELD: FA0-49.0

DATA ELEMENT: Drug Discount Amount (DRUG DISCOUNT AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
49.0	S9(5)V99	RIGHT	ZEROES	231	237

DEFINITION: Discount drug amount (HCPCS "J" codes) that the provider received.

CODE VALUES: N/A

VALIDATION: Must be entered if required by the payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-50.0

DATA ELEMENT: Type of Units Indicator (TYPE OF UNITS IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
50.0	X(01)	LEFT	SPACES	238	238

DEFINITION: Describes the value in FA0-18.0 (Units of Service).

CODE VALUES:

- 1 = Transportation miles
- 2 = Anesthesia Time
- 3 = Number of Services
- 4 = Oxygen volume units
- 5 = Blood units

VALIDATION: If entered, must be a valid code from code list.

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange.

RECORD/FIELD: FA0-51.0

DATA ELEMENT: Approved Amount (APPROVE AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
51.0	S9(5)V99	RIGHT	ZEROES	239	245

DEFINITION: The approved amount for this line item.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange.

RECORD/FIELD: FA0-52.0

DATA ELEMENT: Paid Amount (PAID AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
52.0	S9(5)V99	RIGHT	ZEROES	246	252

DEFINITION: The amount paid for this line item.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange, if payment was made.

RECORD/FIELD: FA0-53.0

DATA ELEMENT: Beneficiary Liability Amount (BENE LIABILITY AMT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
53.0	S9(5)V99	RIGHT	ZEROES	253	259

DEFINITION: The amount determined to be the patient's liability.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange if patient is liable for amount.

RECORD/FIELD: FA0-54.0

DATA ELEMENT: Balance Bill Limiting Charge (BALANCE BILL LIMIT CHG)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
54.0	S9(5)V99	RIGHT	ZEROES	260	266

DEFINITION: The limiting charge amount.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange when the limiting charge is exceeded.

RECORD/FIELD: FA0-55.0

DATA ELEMENT: Limiting Charge Percent (LIMIT CHARGE PRCNT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
55.0	9(5)V99	RIGHT	ZEROES	267	273

DEFINITION: The percent used for limiting charge.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange when the limiting charge is exceeded.

RECORD/FIELD: FA0-56.0

DATA ELEMENT: Performing Provider Phone (PERFORM PROV PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
56.0	X(10)	LEFT	SPACES	274	283

DEFINITION: The phone number of the performing provider for this service line.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Required, if submitted on a claim, for Coordination of Benefits exchange.

RECORD/FIELD: FA0-57.0

DATA ELEMENT: Performing Provider Tax Type (PERFORM PROV TAX TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
57.0	X(01)	LEFT	SPACES	284	284

DEFINITION: A code which identifies the performing provider's Tax ID entered in FA0-58.0

CODE VALUES: T = TIN Number

S = SS Number

VALIDATION: If entered, must be a valid code from code list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-58.0

DATA ELEMENT: Performing Provider Tax ID (PERFORM PROV TAX ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
58.0	X(09)	LEFT	SPACES	285	293

DEFINITION: The federally assigned Tax identification number (TIN) or the social security number (SSN) of the performing provider.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Identification Number" entry.

REMARKS: N/A

RECORD/FIELD: FA0-59.0

DATA ELEMENT: Performing Provider Assignment Indicator (PERFORM PROV ASSIGN IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
59.0	X(01)	LEFT	SPACES	294	294

DEFINITION: A code indicating whether the performing provider accepts assignment.

CODE VALUES: A = Assigned

N = Not Assigned

B = Assignment accepted on Clinical Lab services only

P = Patient refuses to assign benefits

VALIDATION: See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-60.0

DATA ELEMENT: Pre-Transplant Indicator

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
60.0	X(01)	LEFT	SPACES	295	295

DEFINITION: Indicates whether the patient is a potential lung/heart Transplant participant.

CODE VALUES: Y = Yes, potential transplant patient

N = No, not a potential transplant patient

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above List.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-61.0

DATA ELEMENT: ICD-10-PCS

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
61.0	X(07)	LEFT	SPACES	296	302

DEFINITION: This is the ICD-10-PCS codes that describes The services.

CODE VALUES: ICD-10-PCS code set.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid ICD-10-PCS

Procedure code.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-62.0

DATA ELEMENT: Universal Product Code Number (UNIVERSAL PRODUCT CODE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
62.0	X(14)	LEFT	SPACES	303	316

DEFINITION: Universal Product Code Number.

CODE VALUES: UPC Code List.

VALIDATION: Must be entered, if required by payor.

If entered, must be a valid UPC code.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FA0-63.0 FA0-64.0 FA0-65.0 FA0-66.0

DATA ELEMENT:	Diagnosis Code Pointer 5	(DIAG CODE POINTER5)
	Diagnosis Code Pointer 6	(DIAG CODE POINTER6)
	Diagnosis Code Pointer 7	(DIAG CODE POINTER7)
	Diagnosis Code Pointer 8	(DIAG CODE POINTER8)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
63.0	X(01)	LEFT	SPACE	317	317
64.0	X(01)	LEFT	SPACE	318	318
65.0	X(01)	LEFT	SPACE	319	319
66.0	X(01)	LEFT	SPACE	320	320

DEFINITION: A pointer to the claim diagnosis code in the order of importance to this service.

CODE VALUES:

- 5 - indicates the 5th header diagnosis
- 6 - indicates the 6th header diagnosis
- 7 - indicates the 7th header diagnosis
- 8 - indicates the 8th header diagnosis

VALIDATION: Values used must point to non-blank header diagnosis field.

FORM LOCATION: N/A

REMARKS: Example:

Header diagnosis entered; 11111 22222 33333 44444

Diagnosis pointer 5 -- 2

Diagnosis pointer 6 -- 4

Diagnosis pointer 7 -- 1

In this example the diagnosis pointers indicate that header diagnosis 2 is the fifth code with header diagnosis 4 being the sixth code and header diagnosis 1 as the seventh code. The 8th diagnosis pointer was not entered because it was not related to this service.

**RECORD NAME: SERVICE LINE DETAIL
SEGMENT"**

RECORD TYPE FB0 "MEDICAL

Not required for MO HealthNet processing

Must follow FA0

Must be followed by FA0, FB1, FB2, FB3, FD0, GA0, GC0, GD0, GD1, GE0, GP0,
GU0, GX0, GX1, GX2, HA0 or XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "FB0"	C-24	FB0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	LINE ITEM CONTROL NO		Not Used
05	PUR SVC CHARGE		Not Used
06	ALLOWED AMOUNT		Not Used
07	DEDUCTIBLE AMOUNT		Not Used
08	COINSURANCE AMOUNT		Not Used
09	ORDERING PROV ID		Not Used
10	ORDERING PROV STATE		Not Used
11	PUR SVC PROV ID		Not Used
12	PUR SVC STATE		Not Used
13	PEN GRAMS OF PROTEIN		Not Used
14	PEN CALORIES		Not Used
15	NATIONAL DRUG CODE		Not Used
16	NATIONAL DRUG UNITS		Not Used
17	PRESCRIPTION NO		Not Used

				FROM	THRU
01.0	RECORD ID "FB0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	PUR SVC CHARGE	7	N	40	46
06.0	ALLOWED AMOUNT	7	N	47	53
07.0	DEDUCTIBLE AMOUNT	7	N	54	60
08.0	COINSURANCE AMOUNT	7	N	61	67
09.0	ORDERING PROV NPI	15	X	68	82
10.0	ORDERING PROV STATE	2	X	83	84
11.0	PUR SVC PROV NPI	15	X	85	99
12.0	PUR SVC STATE	2	X	100	101
13.0	PEN GRAMS OF PROTEIN	4	N	102	105
14.0	PEN CALORIES	4	N	106	109
15.0	NATIONAL DRUG CODE	11	X	110	120
16.0	NATIONAL DRUG UNITS	7	N	121	127
17.0	PRESCRIPTION NO	15	X	128	142
18.0	PRESCRIPTION DATE	8	X	143	150
19.0	PRESCRIPT NO OF MOS	2	N	151	152
20.0	SPEC PRICING IND	1	X	153	153
21.0	COPAY STATUS IND	1	X	154	154
22.0	EPSDT IND	1	X	155	155
23.0	EPSDT IND	1	X	155	155
24.0	DME CHARGE IND	1	X	157	157
25.0	HPSA FACILITY ID	15	X	158	172
26.0	HPSA FACILITY ZIP	9	X	173	181
27.0	PUR SVC NAME	33	X	182	214
28.0	PUR SVC ADDR1	30	X	215	244
29.0	PUR SVC ADDR2	30	X	245	274

30.0	PUR SVC CITY	20	X	275	294
31.0	PUR SVC ZIP	9	X	295	303
32.0	PUR SVC PHONE	10	X	304	313
33.0	DRUG DAYS SUPPLY	3	N	314	316
34.0	PAYMENT TYPE IND	1	X	317	317
35.0	FILLER-NATIONAL	3	X	318	320

RECORD/FIELD: FB0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FB0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Service Line Detail Record - FB0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be 'FB0'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: FB0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: FB0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	LEFT	SPACES	23	39

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payor allowed.

If entered, value must match the "Line Item Control Number" (FA0-04.0) submitted in the preceding FA0 record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-05.0

DATA ELEMENT: Purchase Service Charge (PUR SVC CHARGE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	9(05)V99	RIGHT	ZEROS	40	46

DEFINITION: The net cost for the purchased service.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-06.0

DATA ELEMENT: Allowed Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	9(05)V99	RIGHT	ZEROS	47	53

DEFINITION: The maximum amount determined by the payor as being "allowable" under the provisions of the contract prior to the determination of actual payment.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

If entered, must be positive unsigned numeric value.

FORM LOCATION: EOB/REMITTANCE

REMARKS: This field may be used to report the amount allowed by detail line item for Medicare Secondary Payor claims.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: FB0-07.0

DATA ELEMENT: Deductible Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	9(05)V99	RIGHT	ZEROS	54	60

DEFINITION: This is the amount applied to deductible by this payor. The amount deducted, by the payor, from the allowed amount in order to meet the contract "deductible" provisions.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor. If entered, must be positive unsigned numeric value.

FORM LOCATION: EOB/REMITTANCE

REMARKS: This field may be used to report the amount of deductible by detail line item for Medicare Secondary Payor claims.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: FB0-08.0

DATA ELEMENT: Coinsurance Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	9(05)V99	RIGHT	ZEROS	61	67

DEFINITION: The amount deducted, by the payor, from the allowed amount in order to meet the "coinsurance" provisions of the contract. The amount applied toward the coinsurance by this payor.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

If entered, must be positive unsigned numeric value.

FORM LOCATION: EOB/REMITTANCE

REMARKS: This field may be used to report the amount of coinsurance by detail line item for Medicare Secondary Payor claims.

Consult the Matrix/User Guide document supplied by the payor/receiver to determine usage of this data element.

RECORD/FIELD: FB0-09.0

DATA ELEMENT: Ordering Provider National Provider Identifier (ORDERING PROV NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(15)	LEFT	SPACES	68	82

DEFINITION: The National Provider Identifier assigned to the physician who ordered the service.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Numbers" entry.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-10.0

DATA ELEMENT: Ordering Provider State (ORDERING PROV STATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(02)	LEFT	SPACES	83	84

DEFINITION: The ordering provider's state code.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-11.0

DATA ELEMENT: Purchase Service Provider National Provider Identifier (PUR SVC PROV NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(15)	LEFT	SPACES	85	99

DEFINITION: The National Provider Identifier (NPI) assigned to the Provider where the service was purchased.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Numbers" entry.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-12.0

DATA ELEMENT: Purchase Service State (PUR SVC STATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(02)	LEFT	SPACES	100	101

DEFINITION: The state code of the state in which the service was purchased.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-13.0

DATA ELEMENT: Pen Grams of Protein

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	9(04)	RIGHT	ZEROS	102	105

DEFINITION: The grams of Amino Acids prescribed per day.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

If entered, must be positive unsigned numeric value.

FORM LOCATION: N/A

REMARKS: Used on Parenteral claims.

RECORD/FIELD: FB0-14.0

DATA ELEMENT: Pen Calories

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	9(04)	RIGHT	ZEROS	106	109

DEFINITION: The number of calories prescribed per day.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

If entered, must be positive unsigned numeric value.

FORM LOCATION: N/A

REMARKS: Used on Enteral claims.

RECORD/FIELD: FB0-15.0

DATA ELEMENT: National Drug Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(11)	LEFT	SPACES	110	120

DEFINITION: The national drug identification number assigned by the Federal Drug Administration (FDA).

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

FORM LOCATION: CMS-1500 Block 24D

REMARKS: N/A

RECORD/FIELD: FB0-16.0

DATA ELEMENT: National Drug Units

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
<u>NSF (National Standard Format) User Manual</u>					215

16.0 9(07) RIGHT ZEROS 121 127

DEFINITION: The dispensing quantity, based upon the unit of measure as defined by the NDC No. (FB0-15.0).

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

If entered, must be positive unsigned numeric value.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-17.0

DATA ELEMENT: Prescription Number (PRESCRIPTION NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(15)	LEFT	SPACES	128	142

DEFINITION: The unique identification number assigned by the pharmacy or supplier.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-18.0

DATA ELEMENT: Prescription Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(08)	LEFT	SPACES	143	150

DEFINITION: The date the prescription was issued by the referring physician.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-19.0

DATA ELEMENT: Prescription, Number of Months (PRESCRIPTION NO OF MONTHS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	9(02)	RIGHT	ZEROS	151	152

DEFINITION: The number of months the prescription will be in effect.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-20.0

DATA ELEMENT: Special Pricing Indicator (SPEC PRICING IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(01)	LEFT	SPACE	153	153

DEFINITION: N/A

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-21.0

DATA ELEMENT: Copay Status Indicator(COPAY STATUS IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(01)	LEFT	SPACE	154	154

DEFINITION: An indication of whether or not co-payment requirements were met on a line by line basis.

CODE VALUES: 0 = Copay exempt.
1 = Participant did not pay when asked.
2 = Participant did pay when asked.
3 = Participant was not asked.

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code from the above list.

FORM LOCATION: N/A

REMARKS: Generally this is not required by payor, however some payors (usually MEDICAID) have opted to require this information in some states, but only for some procedures.

RECORD/FIELD: FB0-22.0

DATA ELEMENT: EPSDT Indicator(EPSDT IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(01)	LEFT	SPACE	155	155

DEFINITION: An indicator of whether or not "Early and Periodic Screen for Diagnosis and Treatment of children" services are involved with this detail line.

CODE VALUES: Y - yes, EPSDT involvement
N - no, EPSDT not involved

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code from the above list.

FORM LOCATION: CMS-1500 Block 24h

REMARKS: N/A

RECORD/FIELD: FB0-23.0

DATA ELEMENT: Family Planning Indicator (FAMILY PLANNING IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(01)	LEFT	SPACE	156	156

DEFINITION: An indicator of whether or not Family Planning Services are involved with this detail line.

CODE VALUES: Y - Yes, family planning involved
N - No, family planning not involved

VALIDATION: Must be entered if required by Payor.

If entered, must be valid code from the above list.

FORM LOCATION: CMS-1500 Block 24h

REMARKS: N/A

RECORD/FIELD: FB0-24.0

DATA ELEMENT: DME Charge Indicator (DME CHARGE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(01)	LEFT	SPACE	157	157

DEFINITION: Indicates whether it is the first time a charge for Durable Medical Equipment is being submitted.

CODE VALUES: 0 - Not a DME rental, repeat purchase or PEN claim.
1 - First charge for DME rental, or DME repeat purchase.
2 - Subsequent Charge for DME rental, Purchase, or PEN.
3 - Re-certified PEN claim or a PEN claim containing new caloric values as prescribed by the referring physician.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-25.0

DATA ELEMENT: HPSA Facility Identification (HPSA FACILITY ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(15)	LEFT	SPACES	158	172

DEFINITION: The identifier assigned by the Payor to the HPSA facility.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 32

REMARKS: N/A

RECORD/FIELD: FB0-26.0

DATA ELEMENT: HPSA Facility Zip Code (HPSA FACILITY ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(09)	LEFT	SPACES	173	181

DEFINITION: The zip code of the HPSA facility location.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: CMS-1500 Block 32

REMARKS: N/A

RECORD/FIELD: FB0-27.0

DATA ELEMENT: Purchase Service Name (PUR SVC NAME)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(33)	LEFT	SPACES	182	214

DEFINITION: The name of the entity from which service was purchased.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Name 2" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-28.0 FB0-29.0 FB0-30.0 FB0-31.0

DATA ELEMENT:	Purchase Service Address 1	(PUR SVC ADDR1)
	Purchase Service Address 2	(PUR SVC ADDR2)
	Purchase Service City	(PUR SVC CITY)
	Purchase Service Zip	(PUR SVC ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(30)	LEFT	SPACES	215	244
29.0	X(30)	LEFT	SPACES	245	274
30.0	X(20)	LEFT	SPACES	275	294
31.0	X(09)	LEFT	SPACES	295	303

DEFINITION: The address of the entity from which service was purchased.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Address" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-32.0

DATA ELEMENT: Purchase Service Phone (PUR SVC PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(10)	LEFT	SPACES	304	313

DEFINITION: The phone number of the entity from which service was purchased.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Telephone" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-33.0

DATA ELEMENT: Drug Days Supply (DRUG DAYS SUPPLY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
33.0	9(03)	RIGHT	ZEROS	314	316

DEFINITION: Represents from 1 to 100 days supply currently dispensed with this prescription service.

CODE VALUES: 01 Through 100

VALIDATION: Must be entered if required by payor.

Must be an unsigned numeric if National Drug Code (FB0-15.0) is other than spaces and Type of Service (FA0-08.0) is "99" (Other).

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB0-34.0

DATA ELEMENT: PAYMENT TYPE INDICATOR

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
34.0	X(01)	LEFT	SPACES	317	317

DEFINITION: Indicates at what percentage of the approved amount Medicare paid.

CODE VALUES: O = Regular detail = 80%

R = Radiology/Lab = 100%

T - Physical Therapy

P - Psychiatry - 50%*

B = Blood = 80%

VALIDATION: If entered, but be a valid code form code list.

FORM LOCATION: N/A

REMARKS: Used for Coordination of Benefits exchange.

*Once the Medicare Part B deductible is met, coinsurance for most Medigap policies is 50%. MO HealthNet is only responsible for 20%.

RECORD/FIELD: FB0-35.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
35.0	X(03)	LEFT	SPACES	318	320

DEFINITION: Unused national reserved filler.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

**RECORD NAME: SERVICE LINE DETAIL
SEGMENT"**

RECORD TYPE FB1 "MEDICAL

Not Required by MO HealthNet

Must follow FB0

Must be followed by FB2 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "FB1"	C-24	FB1
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	LINE ITEM CONTROL NO		Not Used
05	PLACE OF SVC NAME		Not Used
06	ORDERING PROV LAST		Not Used

07	ORDERING PROV FIRST		Not Used
08	ORDERING PROV MI		Not Used
09	ORDERING PROV UPIN		Not Used
10	REFERRING PROV LAST		Not Used
11	REFERRING PROV FIRST		Not Used
12	REFERRING PROV MI		Not Used
13	REFERRING PROV UPIN		Not Used
14	RENDERING PROV LAST		Not Used
15	RENDERING PROV FIRST		Not Used
16	RENDERING PROV MI		Not Used
17	RENDERING PROV UPIN		Not Used
18	SUPV PROV LAST		Not Used
19	SUPV PROV FIRST		Not Used
20	SUPV PROV MI		Not Used
21	SUPV PROV ID		Not Used
22	SUPV PROV UPIN		Not Used
23	FILLER-NATIONAL		YES

RECORD TYPE: FB1

LEVEL: CLAIM - MEDICAL SEGMENT

PURPOSE: To provide information related to the medical services rendered to the patient by the provider.

REQUIREMENTS: If required by payor, this record must be submitted.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	FA0 or FB0	FA0, FB2, FB3, FD0, FE0 CERT Records, HA0 or XA0

NOTES: There may be up to 99 FXX records entered for a claim. (All "F" records).

MEDICAL SEGMENT

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU

01.0	RECORD ID "FB1"	3	X	01	03
02.0	RECORD ID "FB1"	3	X	01	03
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	PLACE OF SVC NAME	33	X	40	72
06.0	ORDERING PROV LAST	20	X	73	92
07.0	ORDERING PROV FIRST	12	X	93	104
08.0	ORDERING PROV MI	1	X	105	105
09.0	ORDERING PROV UPIN	15	X	106	120
10.0	REFERRING PROV LAST	20	X	121	140
11.0	REFERRING PROV FIRST	12	X	141	152
12.0	REFERRING PROV MI	1	X	153	153
13.0	REFERRING PROV UPIN	15	X	154	168
14.0	RENDERING PROV LAST	20	X	169	188
15.0	RENDERING PROV FIRST	12	X	189	200
16.0	RENDERING PROV MI	1	X	201	201
17.0	RENDERING PROV UPIN	15	X	202	216
18.0	SUPV PROV LAST	20	X	217	236
19.0	SUPV PROV FIRST	12	X	237	248
20.0	SUPV PROV MI	1	X	249	249
21.0	SUPV PROV NPI	15	X	250	264
22.0	SUPV PROV UPIN	15	X	265	279
23.0	FILLER-NATIONAL	41	X	280	320

RECORD/FIELD: FB1-01.0

DATA ELEMENT: Record Identifier (RECORD ID 'FB1')

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Service Line Detail Record - FB1.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be 'FB1'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: FB1-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: FB1-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	LEFT	SPACES	23	39

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payor allowed.

If entered, value must match the "Line Item

Control Number" (FA0-04.0) submitted in the preceding FA0 record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-05.0

DATA ELEMENT: Place of Service Name(PLACE OF SVC NAME)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(33)	LEFT	SPACES	40	72

DEFINITION: Enter the name of the place of service.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Name 2" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-06.0 FB1-07.0 FB1-08.0

DATA ELEMENT:	Ordering Provider Last	(ORDERING PROV LAST)
	Ordering Provider First	(ORDERING PROV FIRST)
	Ordering Prov Middle Initial	(ORDERING PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(20)	LEFT	SPACES	73	92
07.0	X(12)	LEFT	SPACES	93	104
08.0	X(01)	LEFT	SPACES	105	105

DEFINITION: The ordering provider's name.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-09.0

DATA ELEMENT: Ordering Provider UPIN (ORDERING PROV UPIN)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(15)	LEFT	SPACES	106	120

DEFINITION: The ordering provider's UPIN (unique physician identification number).

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-10.0 FB1-11.0 FB1-12.0

DATA ELEMENT:	Referring Provider Last	(REFERRING PROV LAST)
	Referring Provider First	(REFERRING PROV FIRST)
	Referring Provider Middle Initial	(REFERRING PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(20)	LEFT	SPACES	121	40
11.0	X(12)	LEFT	SPACES	141	152
12.0	X(01)	LEFT	SPACE	153	153

DEFINITION: The referring physician name.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: CMS-1500, Block 17

REMARKS: N/A

RECORD/FIELD: FB1-13.0

DATA ELEMENT: Referring Provider UPIN (REFERRING PROV UPIN)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(15)	LEFT	SPACES	154	168

DEFINITION: The referring provider's UPIN (unique physician identification number).

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500, Block 17a

REMARKS: N/A

RECORD/FIELD: FB1-14.0 FB1-15.0 FB1-16.0

DATA ELEMENT:	Rendering Provider Last	(RENDERING PROV LAST)
	Rendering Provider First	(RENDERING PROV FIRST)
	Rendering Provider Middle Initial	(RENDERING PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(20)	LEFT	SPACES	169	188
15.0	X(12)	LEFT	SPACES	189	200
16.0	X(01)	LEFT	SPACE	201	201

DEFINITION: The rendering provider's name.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-17.0

DATA ELEMENT: Rendering Provider UPIN (RENDERING PROV UPIN)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(15)	LEFT	SPACES	202	216

DEFINITION: The rendering physician's UPIN (unique physician identification number).

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-18.0 FB1-19.0 FB1-20.0

DATA ELEMENT: Supervising Provider Last (SUPV PROV LAST)
 Supervising Provider First (SUPV PROV FIRST)
 Supervising Prov Middle Initial (SUPV PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(20)	LEFT	SPACES	217	236
19.0	X(12)	LEFT	SPACES	237	248
20.0	X(01)	LEFT	SPACES	249	249

DEFINITION: The supervising provider's name.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Name 1" entry.

REMARKS: N/A

RECORD/FIELD: FB1-21.0

DATA ELEMENT: Supervising Provider National Provider Identifier (SUPV PROV NPI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(15)	LEFT	SPACES	250	264

DEFINITION: The National Provider Identifier assigned to the supervising provider (who supervised the service).

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor. This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

See GENERAL INSTRUCTIONS for "Identification Numbers" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB1-22.0

DATA ELEMENT: Supervising Provider UPIN (SUPV PROV UPIN)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(15)	LEFT	SPACES	265	279

DEFINITION: The supervising provider's UPIN (unique provider identification number).

CODE VALUES: N/A

FORM LOCATION: N/A

VALIDATION: Must be entered if required by Payor.

See GENERAL INSTRUCTIONS for "Identification Number" entry.

REMARKS: N/A

RECORD/FIELD: FB1-23.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(41)	LEFT	SPACES	280	320

DEFINITION: Unused national reserved filler.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

**RECORD NAME: SERVICE LINE DETAIL
SEGMENT"**

RECORD TYPE FB2 "MEDICAL

Not Required by MO HealthNet

Must follow FB0 and FB1

Must be follow by FB3 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "FB2"	C-24	FB2
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used

04	LINE ITEM CONTROL NO		Not Used
05	PROV TYPE IND A		Not Used
06	PROV A ADDR 1		Not Used
07	PROV A ADDR 2		Not Used
08	PROV A CITY		Not Used
09	PROV A STATE		Not Used
10	PROV A ZIP		Not Used
11	PROV TYPE IND B		Not Used
12	PROV B ADDR 1		Not Used
13	PROV B ADDR 2		Not Used
14	PROV B CITY		Not Used
15	PROV B STATE		Not Used
16	PROV B ZIP		Not Used
17	PROV TYPE IND C		Not Used
18	PROV C ADDR 1		Not Used
19	PROV C ADDR 2		Not Used
20	PROV C CITY		Not Used
21	PROV C STATE		Not Used
22	PROV C ZIP		Not Used
23	FILLER-NATIONAL		YES

RECORD TYPE: FB2

LEVEL: CLAIM - MEDICAL SEGMENT

PURPOSE: To provide additional provider address information.

REQUIREMENTS: If required by payor, this record must be submitted.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	FA0, FB0, FB1, or FB3	FA0, FD0, FE0, CERT Records, HA0 or XA0

NOTES: There may be up to 99 FXX records entered for a claim. (All "F" records).

MEDICAL SEGMENT

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "FB2"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	PROV TYPE IND A	2	X	40	41
06.0	PROV A ADDR 1	30	X	42	71
07.0	PROV A ADDR 2	30	X	72	101
08.0	PROV A CITY	20	X	102	121
09.0	PROV A STATE	2	X	122	123
10.0	PROV A ZIP	9	X	124	132
11.0	PROV TYPE IND B	2	X	133	134
12.0	PROV B ADDR 1	30	X	135	164
13.0	PROV B ADDR 2	30	X	165	194
14.0	PROV B CITY	20	X	195	214
15.0	PROV B STATE	2	X	215	216
16.0	PROV B ZIP	9	X	217	225
17.0	PROV TYPE IND C	2	X	226	227
18.0	PROV C ADDR 1	30	X	228	257
19.0	PROV C ADDR 2	30	X	258	287
20.0	PROV C CITY	20	X	288	307
21.0	PROV C STATE	2	X	308	309
22.0	PROV C ZIP	9	X	310	318
23.0	FILLER-NATIONAL	2	X	319	320

RECORD/FIELD: FB2-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FB2")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Service Line Detail Record - FB2.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "FB2".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB2-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: FB2-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: FB2-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	LEFT	SPACES	23	39

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payor allowed.

If entered, value must match the "Line Item

Control Number" (FA0-04.0) submitted in the preceding FA0 record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB2-05.0

DATA ELEMENT: Provider Type Indicator A (PROV TYPE IND A)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(02)	LEFT	SPACES	40	41

DEFINITION: A code to indicate the type of provider to whom the address information in FB2-06.0 through FB2-10.0 applies.

CODE VALUES:

- OD = Ordering Provider
- RF = Referring Provider
- SP = Supervising Provider
- SU = Surrogate Provider
- CP = Consulting Provider
- AP = Attending Provider
- OO = Other Ordering Provider
- PE = Performing Provider

VALIDATION: Must be entered if required by Payor. If entered, must be a valid code value from the above list.

For DMEPOS claims, use only values of CP, AP or OO.

For Non-DMEPOS claims, use only values of OD, RF, SP, or SU.

FORM LOCATION: N/A

CP = Consulting Provider
 AP = Attending Provider
 OO = Other Ordering Provider
 PE = Performing Provider

VALIDATION: Must be entered if required by Payor.

If entered, must be a valid code value from the above list.

For DMEPOS claims, use only values of CP, AP or OO.

For Non-DMEPOS claims, use only values of OD, RF, SP, or SU.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB2-12.0, FB2-13.0, FB2-14.0, FB2-15.0, FB2-16.0

DATA ELEMENT:	Provider B Address 1	(PROV B ADDR 1)
	Provider B Address 2	(PROV B ADDR 2)
	Provider B City	(PROV B CITY)
	Provider B State	(PROV B STATE)
	Provider B Zip Code	(PROV B ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(30)	LEFT	SPACES	135	164
13.0	X(30)	LEFT	SPACES	165	194
14.0	X(20)	LEFT	SPACES	195	214
15.0	X(02)	LEFT	SPACES	215	216
16.0	X(09)	LEFT	SPACES	217	225

DEFINITION: The mailing address of the Provider identified in FB2-11.0.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Address" entry.

Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB2-17.0

DATA ELEMENT: Provider Type Indicator C (PROV TYPE IND C)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(02)	LEFT	SPACES	226	227

DEFINITION: A code to indicate the type of provider to whom the address information in FB2-18.0 through FB2-22.0 applies.

- CODE VALUES:
- OD = Ordering Provider
 - RF = Referring Provider
 - SP = Supervising Provider
 - SU = Surrogate Provider
 - CP = Consulting Provider
 - AP = Attending Provider
 - OO = Other Ordering Provider
 - PE = Performing Provider

VALIDATION: Must be entered if required by Payor.

If entered, must be a valid code value from the above list.

For DMEPOS claims, use only values of CP, AP or OO.

For Non-DMEPOS claims, use only values of OD, RF, SP, or SU.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB2-18.0 FB2-19.0 FB2-20.0 FB2-21.0 FB2-22.0

DATA ELEMENT:	Provider C Address 1	(PROV C ADDR 1)
	Provider C Address 2	(PROV C ADDR 2)
	Provider C City	(PROV C CITY)
	Provider C State	(PROV C STATE)
	Provider C Zip Code	(PROV C ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(30)	LEFT	SPACES	228	257
19.0	X(30)	LEFT	SPACES	258	287

20.0	X(20)	LEFT	SPACES	288	307
21.0	X(02)	LEFT	SPACES	308	309
22.0	X(09)	LEFT	SPACES	310	318

DEFINITION: The mailing address of the Provider identified in FB2-17.0.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Address" entry.

Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB2-23.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(02)	LEFT	SPACES	319	320

DEFINITION: Unused national reserved filler.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: SERVICE LINE DETAIL

RECORD TYPE FB3

Not Required by MO HealthNet

Must follow FB0 and FB2

Must be follow by FB3 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "FB3"	C-24	FB3
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	LINE ITEM CONTROL NO		Not Used
05	REASON CODE1		Not Used

06	DOLLAR AMOUNT1		Not Used
07	REASON CODE2		Not Used
08	DOLLAR AMOUNT2		Not Used
09	REASON CODE3		Not Used
10	DOLLAR AMOUNT		Not Used
11	REASON CODE4		Not Used
12	DOLLAR AMOUNT		Not Used
13	REASON CODE5		Not Used
14	DOLLAR AMOUNT		Not Used
15	REASON CODE6		Not Used
16	DOLLAR AMOUNT6		Not Used
17	REASON CODE7		Not Used
18	DOLLAR AMOUNT7		Not Used
19	FILLER-NATIONAL		YES

RECORD TYPE: FB3

PURPOSE: To supply prior adjudication status information from primary payors.

REQUIREMENTS: This record must be entered if this is a Coordination of Benefits file and service level adjustments have been applied.

ORDER: Preceding Record Type Following Record Type
 FB2 FA0 or XA0

NOTES: When requesting payment from a secondary payor it is extremely important that the EOB/remittance information be provided from the primary payor(s). This is of major importance in allowing the secondary claim to be processed without having to request a hardcopy EOB.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "FB3"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39

05.0	REASON CODE 1	6	X	40	45
06.0	DOLLAR AMOUNT 1	7	N	46	52
07.0	REASON CODE 2	6	X	53	58
08.0	DOLLAR AMOUNT 1	7	N	46	52
09.0	REASON CODE 3	6	X	53	58
10.0	DOLLAR AMOUNT 3	7	N	72	78
11.0	REASON CODE 4	6	X	79	84
12.0	DOLLAR AMOUNT 4	7	N	85	91
13.0	REASON CODES	6	X	92	97
14.0	DOLLAR AMOUNT 5	7	N	98	104
15.0	REASON CODE 6	6	X	105	110
16.0	DOLLAR AMOUNT 6	7	N	111	117
17.0	REASON CODE 7	6	X	118	123
18.0	DOLLAR AMOUNT 7	7	N	124	130
19.0	FILLER-NATIONAL	190	X	131	320

RECORD/FIELD: FB3-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FB3")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "SERVICE LINE DETAIL" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "FB3".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FB3-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: This is the record sequence number of the service line detail record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FB0-02.0) submitted in the preceding "FB0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FB0.04.

RECORD/FIELD: FB3-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

RECORD/FIELD: FB3-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	LEFT	SPACES	23	39

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payor required.

See GENERAL INSTRUCTIONS for "Patient Account Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The Patient Account Number field is used to associate all of the records for a single claim.

RECORD/FIELD: FB3-05.0 FB3-06.0

DATA ELEMENT: Reason Code 1 Dollar Amount 1

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(06)	LEFT	SPACES	40	45
06.0	S9(5)V99	RIGHT	ZEROS	46	52

DEFINITION: Service line adjustment reason code and amount of adjustment. The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on line items and may have a financial effect.

CODE VALUES: For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site

www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

Used for COB exchange.

RECORD/FIELD: FB3-07.0 FB3-08.0

DATA ELEMENT: Reason Code 2 Dollar Amount 2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(06)	LEFT	SPACES	53	58
08.0	S9(5)V99	RIGHT	ZEROS	59	65

DEFINITION: Service line adjustment reason code and amount of adjustment. The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

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676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position. Used for COB exchange.

RECORD/FIELD: FB3-09.0 FB3-10.0

DATA ELEMENT: Reason Code 3 Dollar Amount 3

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(06)	LEFT	SPACES	66	71
10.0	S9(5)V99	RIGHT	ZEROS	72	78

DEFINITION: Service line adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site

www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position. Used for COB exchange.

RECORD/FIELD: FB3-11.0 FB3-12.0

DATA ELEMENT: Reason Code 4 Dollar Amount 4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(06)	LEFT	SPACES	79	84
12.0	S9(5)V99	RIGHT	ZEROS	85	91

DEFINITION: Service line adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

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676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting Used for COB exchange.

RECORD/FIELD: FB3-13.0 FB3-14.0

DATA ELEMENT: Reason Code 5 Dollar Amount 5

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(06)	LEFT	SPACES	92	97

NSF (National Standard Format) User Manual 244

DEFINITION: Service line adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site

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Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

Used for COB exchange.

RECORD/FIELD: FB3-15.0 FB3-16.0

DATA ELEMENT: Reason Code 6 Dollar Amount 6

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(06)	LEFT	SPACES	105	110
16.0	S9(5)V99	RIGHT	ZEROS	111	117

DEFINITION: Service line adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site

www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

RECORD/FIELD: FB3-17.0 FB3-18.0

DATA ELEMENT: Reason Code 7 Dollar Amount 7

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(06)	LEFT	SPACES	118	123
18.0	S9(5)V99	RIGHT	ZEROS	124	130

DEFINITION: Service line adjustment reason code and amount of adjustment.

The code shows the reason for an adjustment, such as denial or reduction in payment from the amount billed, that are made on claims and may have a financial effect.

CODE VALUES: For Medicare, use the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 835 claim adjustment (CAS) codes and applicable group code.

VALIDATION: At least one reason code must be shown per claim. This can be at service or claim level.

REMARKS: Claim adjustment reason codes are available from:

Electronic File:

Washington Publishing Company World Wide Web Site

www.wpc-edi.com

Paper Copy:

Blue Cross and Blue Shield Association

Inter-Plan Teleprocessing Services Dept.

676 North St. Clair Street

Chicago, IL 60611

For Medicare, the first two positions contain the X12 835 group code which is part of the ANSI ASC X12 835 standard. The remaining positions contain the claim adjustment reason code, starting with the third position.

Used for COB exchange.

RECORD/FIELD: FB3-29.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(190)	LEFT	SPACES	131	320

DEFINITION: Unused record space. Reserved for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

**RECORD NAME: SERVICE LINE DETAIL
SEGMENT"**

RECORD TYPE FD0 "DENTAL

Required for MO HealthNet processing-Dental claims only

Must follow FB0 - FB3

Must be followed by FA0 OR XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "FD0"	C-24	FD0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	LINE ITEM CONTROL NO		Not Used
05	TOOTH CODE NUMBER 1	C-38	YES
06	TOOTH SURFACE(S) 1	C-39	NO
07	TOOTH CODE NUMBER 2		Not Used
08	TOOTH SURFACE(S) 2		Not Used
09	TOOTH CODE NUMBER 3		Not Used
10	TOOTH SURFACE(S) 3		Not Used
11	TOOTH CODE NUMBER 4		Not Used

12	TOOTH SURFACE(S) 4		Not Used
13	INITIAL PLACE IND	C-37	NO
14	PRIOR PLACE DATE		Not Used
15	IMPRESS/PRESCRIPT DT		Not Used
16	REPLACEMENT REASON		Not Used
17	ORTHO TREAT IND		Not Used
18	TREATMENT LENGTH		Not Used
19	DATE APPL INSERTED		Not Used
20	DATE APPL REMOVED		Not Used
21	RESERVED (FD0-21.0)		Not Used
22	DATE APPL REPLACED		Not Used
23	MOS TREAT REMAINING		Not Used
24	DT 1ST VISIT CUR SER		Not Used
25	RESERVED (FD0-25.0)		Not Used
26	PRE DETERMINATION ID		Not Used
27	RESERVED (FD0-27.0)		Not Used
28	MISSING PRIMARY TEETH		Not Used
29	MISSING PERM TOOTH		Not Used
30	MISSING PERM TOOTH		Not Used
31	MISSING PERM TOOTH		Not Used
32	MISSING PERM TOOTH		Not Used
33	MISSING PERM TOOTH		Not Used
34	MISSING PERM TOOTH		Not Used
35	MISSING PERM TOOTH		Not Used
36	MISSING PERM TOOTH		Not Used
37	MISSING PERM TOOTH		Not Used
38	MISSING PERM TOOTH		Not Used
39	MISSING PERM TOOTH		Not Used
40	MISSING PERM TOOTH		Not Used
41	MISSING PERM TOOTH		Not Used

42	MISSING PERM TOOTH		Not Used
43	MISSING PERM TOOTH		Not Used
44	MISSING PERM TOOTH		Not Used
45	MISSING PERM TOOTH		Not Used
46	MISSING PERM TOOTH		Not Used
47	MISSING PERM TOOTH		Not Used
48	MISSING PERM TOOTH		Not Used
49	MISSING PERM TOOTH		Not Used
50	MISSING PERM TOOTH		Not Used
51	MISSING PERM TOOTH		Not Used
52	MISSING PERM TOOTH		Not Used
53	MISSING PERM TOOTH		Not Used
54	MISSING PERM TOOTH		Not Used
55	MISSING PERM TOOTH		Not Used
56	MISSING PERM TOOTH		Not Used
57	MISSING PERM TOOTH		Not Used
58	MISSING PERM TOOTH		Not Used
59	MISSING PERM TOOTH		Not Used
60	MISSING PERM TOOTH		Not Used
61	MISSING PERM TOOTH		Not Used
62	QUADRANT		Not Used
63	TOOTH POCKET MEASURE		Not Used
64	FILLER-NATIONAL		YES

RECORD TYPE: FD0

LEVEL: CLAIM - DENTAL SEGMENT

PURPOSE: To provide information related to dental services rendered to the patient by the provider.

REQUIREMENTS: If required by the payor, this record must be submitted for dental claims.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1, FB2, FB3 or FD0 FE0, FA0, HA0 or XA0

NOTES: There may be up to 99 FXX records entered for a claim. (All "F" records).

DENTAL SEGMENT

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "FDO"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	TOOTH CODE NUMBER 1	2	X	40	41
06.0	TOOTH SURFACE (S) 1	5	X	42	46
07.0	TOOTH CODE NUMBER 2	2	X	47	48
08.0	TOOTH SURFACE (S) 2	5	X	49	53
09.0	TOOTH CODE NUMBER 3	2	X	54	55
10.0	TOOTH SURFACE (S) 3	5	X	56	60
11.0	TOOTH CODE NUMBER 4	2	X	61	62
12.0	TOOTH SURFAC (S) 4	5	X	63	67
13.0	INITIAL PLACE IND	1	X	68	68
14.0	PRIOR PLACE DATE	8	X	69	76
15.0	IMPRESS/PRESCRIPT DT	8	X	77	84
16.0	REPLACEMENT REASON	1	X	85	85
17.0	ORTHO TREAT IND	1	X	86	86
18.0	TREATMENT LENGTH	2	X	87	88
19.0	DATE APPL INSERTED	8	X	89	96
20.0	DATE APPL REMOVED	8	X	97	104
21.0	RESERVED (FDO-21.0)	10	X	105	114
22.0	DATE APPL REPLACED	8	X	115	122
23.0	MOS TREAT REMAINING	2	X	123	124
24.0	DT 1ST VISIT CUR SER	8	X	125	132
25.0	RESERVED (FD0-25.0)	10	X	133	142

26.0	PRE DETERMINATION ID	20	X	143	162
27.0	RESERVED (FD0-27.0)	10	X	163	172
28.0	MISSING PRIMARY TEETH	20	X	173	192
29.0	MISSING PERM TOOTH	2	X	193	194
30.0	MISSING PERM TOOTH	2	X	195	196
31.0	MISSING PERM TOOTH	2	X	197	198
32.0	MISSING PERM TOOTH	2	X	199	200
33.0	MISSING PERM TOOTH	2	X	201	202
34.0	MISSING PERM TOOTH	2	X	203	204
35.0	MISSING PERM TOOTH	2	X	205	206
36.0	MISSING PERM TOOTH	2	X	207	208
37.0	MISSING PERM TOOTH	2	X	209	210
38.0	MISSING PERM TOOTH	2	X	211	212
39.0	MISSING PERM TOOTH	2	X	213	214
40.0	MISSING PERM TOOTH	2	X	215	216
41.0	MISSING PERM TOOTH	2	X	217	218
42.0	MISSING PERM TOOTH	2	X	219	220
43.0	MISSING PERM TOOTH	2	X	221	222
44.0	MISSING PERM TOOTH	2	X	223	224
45.0	MISSING PERM TOOTH	2	X	225	226
46.0	MISSING PERM TOOTH	2	X	227	228
47.0	MISSING PERM TOOTH	2	X	229	230
48.0	MISSING PERM TOOTH	2	X	231	232
49.0	MISSING PERM TOOTH	2	X	233	234
50.0	MISSING PERM TOOTH	2	X	235	236
51.0	MISSING PERM TOOTH	2	X	237	238
52.0	MISSING PERM TOOTH	2	X	239	240
53.0	MISSING PERM TOOTH	2	X	241	242
54.0	MISSING PERM TOOTH	2	X	243	244
55.0	MISSING PERM TOOTH	2	X	245	246

56.0	MISSING PERM TOOTH	2	X	247	248
57.0	MISSING PERM TOOTH	2	X	249	250
58.0	MISSING PERM TOOTH	2	X	251	252
59.0	MISSING PERM TOOTH	2	X	253	254
60.0	MISSING PERM TOOTH	2	X	255	256
61.0	MISSING PERM TOOTH	2	X	257	258
62.0	QUADRANT	2	X	259	260
63.0	TOOTH POCKET MEASURE2	X	261	262	
64.0	FILLER-NATIONAL	58	X	263	320

RECORD/FIELD: FD0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "FD0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Service

Line Detail Record - FD0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "FD0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered. Must be a valid code from the above list. The value entered must match the "Sequence Number" (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: FD0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	LEFT	SPACES	23	39

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payor allowed.

If entered, value must match the "Line Item Control Number" (FA0-04.0) submitted in the preceding "FA0" record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-05.0

DATA ELEMENT: Tooth Code Number 1

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(02)	LEFT	SPACES	40	41

DEFINITION: An indication of the tooth on which services were performed or will be performed.

CODE VALUES: 01 Through 09 - Permanent
 10 Through 32 - Permanent
 A Through T - Primary
 SN - Supernumerary

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-06.0

DATA ELEMENT: Tooth Surface(s) 1

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(05)	LEFT	SPACES	42	46

DEFINITION: The surface(s) of the tooth on which services were performed or will be performed.

CODE VALUES: M - Mesial
 O - Occlusal
 D - Distal
 L - Lingual
 F - Facial
 I - Incisal
 B - Buccal

VALIDATION: If entered must be a valid code or combination of up to five codes from the above table.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-07.0

DATA ELEMENT: Tooth Code Number 2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(02)	LEFT	SPACES	47	48

DEFINITION: An indication of the tooth on which services were performed or will be performed.

CODE VALUES: 01 Through 09 - Permanent

10 Through 32 - Permanent
A Through T - Primary
SN - Supernumerary

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-08.0

DATA ELEMENT: Tooth Surface(s) 2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(05)	LEFT	SPACES	49	53

DEFINITION: The surface(s) of the tooth on which services were performed or will be performed.

CODE VALUES: M - Mesial
O - Occlusal
D - Distal
L - Lingual
F - Facial
I - Incisal
B - Buccal

VALIDATION: If entered must be valid code or combination of up to five codes from the above table.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-09.0

DATA ELEMENT: Tooth Code Number 3

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(02)	LEFT	SPACES	54	55

DEFINITION: An indication of the tooth on which services were performed or will be performed.

CODE VALUES: 01 Through 09 - Permanent 10 Through 32 - Permanent A Through T - Primary SN - Supernumerary

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-10.0

DATA ELEMENT: Tooth Surface(s) 3

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(05)	LEFT	SPACES	56	60

DEFINITION: The surface(s) of the tooth on which services were performed or will be performed.

CODE VALUES: M - Mesial
O - Occlusal
D - Distal
L - Lingual
F - Facial
I - Incisal
B - Buccal

VALIDATION: If entered must be a valid code or combination of up to five codes from the above table.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-11.0

DATA ELEMENT: Tooth Code Number 4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(02)	LEFT	SPACES	61	62

DEFINITION: An indication of the tooth on which services were performed or will be performed.

CODE VALUES: 01 Through 09 - Permanent
10 Through 32 - Permanent
A Through T - Primary
SN - Supernumerary

VALIDATION: If entered, must be a valid date code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-12.0

DATA ELEMENT: Tooth Surface(s) 4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(05)	LEFT	SPACES	63	67

DEFINITION: The surface(s) of the tooth on which services were performed or will be performed.

CODE VALUES: M - Mesial
O - Occlusal
D - Distal
L - Lingual
F - Facial
I - Incisal
B - Buccal

VALIDATION: If entered must be a valid code or combination of up to five codes from the above table.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-13.0

DATA ELEMENT: Initial Placement Indicator (INITIAL PLACE IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(01)	LEFT	SPACE	68	68

DEFINITION: A code to indicate whether the prosthesis or restorative service reported is an initial placement.

CODE VALUES: Y = Yes
N = No

VALIDATION: If entered, must be a valid code from the above list.

If "N", "Prior Placement Date" (FD0-14.0) must be completed according to payor instructions.

FORM LOCATION: N/A

REMARKS: Must apply to all the tooth codes/numbers reported on this line (Ex: Initial placement indicator is reported "Y". All tooth codes/numbers reported on this line must be initial placement.)

RECORD/FIELD: FD0-14.0

DATA ELEMENT: Prior Placement Date (PRIOR PLACE DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(08)	LEFT	SPACES	69	76

DEFINITION: The date of Prior Placement of the Prosthesis, Crown or Inlay, if reason for service is replacement.

CODE VALUES: N/A

VALIDATION: If entered, must be a valid date.

If "Initial Placement Indicator" = "N", complete according to payor instructions.

See GENERAL INSTRUCTIONS for "date" entry.

FORM LOCATION: N/A

REMARKS: Must be completed according to payor instructions, if service involves replacement of a prosthesis, crown or inlay and the date of prior placement is known.

RECORD/FIELD: FD0-15.0

DATA ELEMENT: Impression/Prescription Date (IMPRESS/PRESCRIPT DT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(08)	LEFT	SPACES	77	84

DEFINITION: The date the impressions were taken for the prosthetic / restorative device.

CODE VALUES: N/A

VALIDATION: If entered, must be valid date.

See GENERAL INSTRUCTIONS for "date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-16.0

DATA ELEMENT: Replacement Reason

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(01)	LEFT	SPACE	85	85

DEFINITION: Reason the reported prosthetic/restorative device is being replaced.

CODE VALUES: 1 = Loot
 2 = Broken
 3 = Accident
 4 = No longer serviceable

VALIDATION: If replacement, must be completed according payor instructions.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: If services were rendered for orthodontic treatment, this field must be completed according to payor instructions.

RECORD/FIELD: FD0-17.0

DATA ELEMENT: Orthodontic Treatment Indicator (ORTHO TREAT IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(01)	LEFT	SPACE	86	86

DEFINITION: An indicator as to whether the services performed were or will be for orthodontic treatment.

CODE VALUES: Y = Yes

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-18.0

DATA ELEMENT: Treatment Length

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(02)	LEFT	SPACES	87	88

DEFINITION: Length of Treatment, in months, that the patient will be under orthodontic care.

CODE VALUES: 01 through 99.

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-19.0

DATA ELEMENT: Date Appliance Inserted (DT APPL INSERTED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(08)	LEFT	SPACES	89	96

DEFINITION: The Date an Orthodontic / Prosthetic Appliance was placed.

CODE VALUES: N/A

VALIDATION: If entered, must be valid date.

See GENERAL INSTRUCTIONS for "date" entry.

FORM LOCATION: N/A

REMARKS: If an orthodontic appliance was placed, this field must be completed according to payor instructions.

RECORD/FIELD: FD0-20.0

DATA ELEMENT: Date Appliance Removed (DT APPL REMOVED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(08)	LEFT	SPACES	97	104

DEFINITION: The date the Orthodontic / Prosthetic appliance was removed.

CODE VALUES: N/A

VALIDATION: If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-21.0

DATA ELEMENT: Reserved (FD0-21.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(10)	LEFT	SPACES	105	114

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-22.0

DATA ELEMENT: Date Appliance Replaced (DATE APPL REPLACED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(08)	LEFT	SPACES	115	122

DEFINITION: The date that the Orthodontic / Prosthetic appliance was replaced.

CODE VALUES: N/A

VALIDATION: If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-23.0

DATA ELEMENT: Months of Treatment Remaining (MOS TREAT REMAINING)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(02)	LEFT	SPACES	123	124

DEFINITION: The number of months remaining in the Orthodontic series.

CODE VALUES: 01 through 09
10 through 36

VALIDATION: If entered:

Must be numeric.

Must equal 01 through 36.

FORM LOCATION: N/A

REMARKS: Must be completed according to payor instructions if claim is for Dental Orthodontic treatment and this is the initial and/or transfer claim.

RECORD/FIELD: FD0-24.0

DATA ELEMENT: Date of First Visit Current Series (DT 1ST VISIT CUR SER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(08)	LEFT	SPACES	125	132

DEFINITION: Date course of treatment began or is expected to begin.

CODE VALUES: N/A

VALIDATION: If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-25.0

DATA ELEMENT: Reserved (FD0-25.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(10)	LEFT	SPACES	133	142

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-26.0

DATA ELEMENT: Pre Determination Identifier (PRE DETERMINATION ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(20)	LEFT	SPACES	143	162

DEFINITION: The unique number assigned by the third party payor which identifies the pre-treatment estimate of requested services for this patient.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: The assigned Pre-treatment Identification Number must be entered if a numbered Pre-treatment estimate was returned by the third party payor and any part of this claim is being presented for the actual completed services.

RECORD/FIELD: FD0-27.0

DATA ELEMENT: Reserved (FD0-27.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(10)	LEFT	SPACES	163	172

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-28.0

DATA ELEMENT: Missing Primary Teeth

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(20)	LEFT	SPACES	173	192

DEFINITION: This field identifies missing primary teeth by tooth letter.

CODE VALUES: A through T.

VALIDATION: If entered, must be a valid value from the above list. Twenty positions are provided to identify missing primary teeth. One character must be input for each missing tooth. Characters must be entered in sequence without regard for teeth which are not missing. Imbedded blanks are not allowed.

Example: 'ADT'

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-29.0, FD0-61.0

DATA ELEMENT: Missing Permanent Tooth (MISSING PERM TOOTH)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(02)	LEFT	SPACES	193	194
30.0	X(02)	LEFT	SPACES	195	196
31.0	X(02)	LEFT	SPACES	197	198
32.0	X(02)	LEFT	SPACES	199	200
33.0	X(02)	LEFT	SPACES	201	202
34.0	X(02)	LEFT	SPACES	203	204
35.0	X(02)	LEFT	SPACES	205	206
36.0	X(02)	LEFT	SPACES	207	208
37.0	X(02)	LEFT	SPACES	209	210
38.0	X(02)	LEFT	SPACES	211	212
39.0	X(02)	LEFT	SPACES	213	214
40.0	X(02)	LEFT	SPACES	215	216

41.0	X(02)	LEFT	SPACES	217	218
42.0	X(02)	LEFT	SPACES	219	220
43.0	X(02)	LEFT	SPACES	221	222
44.0	X(02)	LEFT	SPACES	223	224
45.0	X(02)	LEFT	SPACES	225	226
46.0	X(02)	LEFT	SPACES	227	228
47.0	X(02)	LEFT	SPACES	229	230
48.0	X(02)	LEFT	SPACES	231	232
49.0	X(02)	LEFT	SPACES	233	234
50.0	X(02)	LEFT	SPACES	235	236
51.0	X(02)	LEFT	SPACES	237	238
52.0	X(02)	LEFT	SPACES	239	240
53.0	X(02)	LEFT	SPACES	241	242
54.0	X(02)	LEFT	SPACES	243	244
55.0	X(02)	LEFT	SPACES	245	246
56.0	X(02)	LEFT	SPACES	247	248
57.0	X(02)	LEFT	SPACES	249	250
58.0	X(02)	LEFT	SPACES	251	252
59.0	X(02)	LEFT	SPACES	253	254
60.0	X(02)	LEFT	SPACES	255	256
61.0	X(02)	LEFT	SPACES	257	258

DEFINITION: A series of two digit fields identifying missing permanent teeth or a set of missing teeth by tooth number.

RECORD/FIELD: FD0-29.0, FD0-61.0

DATA ELEMENT: Missing Permanent Tooth (MISSING PERM TOOTH)

- CODE VALUES: 01 through 09
10 through 32
93 - All permanent teeth missing
94 - All upper permanent teeth missing.
95 - All lower permanent teeth missing.

VALIDATION: If entered:

Must be a valid code from the above list. Missing teeth must be entered in sequence without regard for teeth which are not missing. Beginning with FD0-29.0, individual fields cannot be entered unless the immediately preceding field is entered.

Tooth numbers 01 through 32 cannot be entered if 93 (all permanent teeth missing) is entered.

Tooth numbers 01 through 16 cannot be entered if 94 (all upper permanent teeth missing) is entered.

Tooth numbers 17 through 32 cannot be entered if 95 (all lower permanent teeth missing) is entered.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-62.0

DATA ELEMENT: Quadrant

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
62.0	X(02)	LEFT	SPACES	259	260

DEFINITION: The quadrant on which the service was performed or will be performed.

CODE VALUES: FM - Full Mouth
LL - Lower Left
LR - Lower Right
UL - Upper Left
UR - Upper Right

VALIDATION: If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: Must be completed according to payor instructions, if the corresponding procedure requires identification of a section of the mouth.

RECORD/FIELD: FD0-63.0

DATA ELEMENT: Tooth Pocket Measurement (TOOTH POCKET MEASURE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
63.0	X(02)	LEFT	SPACES	261	262

DEFINITION: Quantity measurement in millimeters of the distance between the gingival crest and the base of the tooth pocket.

CODE VALUES: 01 thru 99

VALIDATION: Must be entered if required by payor. If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FD0-64.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
64.0	X(48)	LEFT	SPACES	263	320

DEFINITION: Unused national reserved filler.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: THIRD PARTY ORGANIZATION RECORD TYPE FEO

Not Required by MO HealthNet

Must follow FB0 - FD0

Must be followed by GC0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "FEO"	C-24	FEO
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	LINE ITEM CONTROL NO		Not Used
05	TPO ID NUMBER		Not Used
06	TPO REFERENCE NUMBER		Not Used
07	PRICING METHODOLOGY 2		Not Used
08	ALLOWED AMOUNT		Not Used
09	SAVINGS AMOUNT		Not Used
10	APPROVED HCPCS		Not Used
11	APPROVED UNITS		Not Used
12	REJECTION MESSAGE		Not Used

13	AUTHORIZATION NUMBER		Not Used
14	POLICY COMPLIANCE CODE		Not Used
15	EXCEPTION CODE		Not Used
16	FILLER-NATIONAL		YES

RECORD TYPE: FE0

LEVEL: CLAIM - THIRD PARTY ORGANIZATION SEGMENT

PURPOSE: To provide information related to Third Party Organization (TPO) claims.

REQUIREMENTS: If required by payor, this record must be submitted.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1 FA0, CERT Records, HA0 or XA0
 FB2, or FD0

NOTES: There may be up to 99 FXX records entered for a claim. (All "F" records).

TPO SEGMENT

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "FEO"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	TPO ID NUMBER	9	X	40	48
06.0	TPO REFERENCE NUMBER	15	X	49	63
07.0	PRICING METHODOLOGY 2	X	64	65	
08.0	ALLOWED AMOUNT	7	N	66	72
09.0	SAVINGS AMOUNT	7	N	73	79
10.0	APPROVED HCPCS	5	X	80	84
11.0	APPROVED UNITS	4	N	85	88
12.0	REJECTION MESSAGE	2	X	89	90
13.0	AUTHORIZATION NUMBER	20	X	91	110

14.0	POLICY COMPLIANCE CODE	2	X	111	112
15.0	EXCEPTION CODE	2	X	113	114
16.0	FILLER-NATIONAL	206	X	115	320

RECORD/FIELD: FE0-01.0

DATA ELEMENT: Record Identifier (RECORD ID 'FE0')

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Service Line Detail Record - FE0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be 'FE0'.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: This is the record sequence number of the Service Line Detail Record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: FE0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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03.0 X(17) LEFT SPACES 06 22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: FE0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	LEFT	SPACES	23	39

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payor allowed.

If entered, value must match the "Line Item Control Number" (FA0-04.0) submitted in the preceding FA0 record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-05.0

DATA ELEMENT: Third Party Organization Identification Number (TPO ID NUMBER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(09)	LEFT	SPACES	40	48

DEFINITION: Repricing organization identification number.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-06.0

DATA ELEMENT: Third Party Organization Reference Number (TPO REFERENCE NUMBER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(15)	LEFT	SPACES	49	63

DEFINITION: TPO reference number.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-07.0

DATA ELEMENT: PRICING METHODOLOGY

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(02)	LEFT	SPACES	64	65

DEFINITION: Code specifying pricing methodology at which the claim or line item has been priced or repriced.

- CODE VALUES:
- 00 = Zero Pricing (Not Covered Under Contract)
 - 01 = Priced as Billed at 100%
 - 02 = Priced at the Standard Fee Schedule
 - 04 = Bundled Pricing
 - 05 = Peer Review Pricing
 - 10 = Other Pricing
 - 11 = Lower of Cost
 - 12 = Ratio of Cost
 - 13 = Cost Reimbursed
 - 14 = Adjustment Pricing

VALIDATION: Must be entered if required by Payor. If entered, must be a valid code value from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-08.0

DATA ELEMENT: ALLOWED AMOUNT

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	9(05)v99	IGHT	ZEROS	66	72

DEFINITION: The amount allowed by the payor.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

When entered, must be positive unsigned numeric value.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-09.0

DATA ELEMENT: SAVINGS AMOUNT

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	9(05)V99	RIGHT	ZEROS	73	79

DEFINITION: The amount of savings.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

When entered, must be positive unsigned numeric value.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-10.0

DATA ELEMENT: Approved HCPCS Procedure Code (APPROVED HCPCS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(05)	LEFT	SPACES	80	84

DEFINITION: The approved HCPCS code that describes the service.

CODE VALUES: HCPCS code set.

VALIDATION: Must be entered if required by Payor.

If entered, must be a valid HCPCS code.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-11.0

DATA ELEMENT: Approved Units of Service (APPROVED UNITS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	9(03)V9	RIGHT	ZEROS	85	88

DEFINITION: The approved number of services rendered in days or units.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

Must be positive unsigned numeric value.

FORM LOCATION: CMS-1500, Block 24G

REMARKS: In order to capture fractional services, use the fourth position with an assumed decimal position.

RECORD/FIELD: FE0-12.0

DATA ELEMENT: REJECTION MESSAGE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(02)	LEFT	SPACES	89	90

DEFINITION: The reject code returned from the Third Party Organization.

- CODE VALUES:
- T1 = Cannot Identify Provider as TPO Participant
 - T2 = Cannot Identify Payer as TPO Participant
 - T3 = Cannot Identify Insured as TPO Participant
 - T4 = Payer Name or Identifier Missing
 - T5 = Certification Information Missing
 - T6 = Claim Does Not Contain Enough Information for Repricing

VALIDATION: Must be entered if required by Payor.

If entered, must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-13.0

DATA ELEMENT: AUTHORIZATION NUMBER

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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13.0 X(20) LEFT SPACES 91 110

DEFINITION: The TPO authorization number.

CODE VALUES: N/A

VALIDATION: Must be entered if required by Payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-14.0

DATA ELEMENT: POLICY COMPLIANCE CODE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(02)	LEFT	SPACES	111	112

DEFINITION: The code specifying policy compliance.

CODE VALUES:

- 1 = Procedure Followed (Compliance)
- 2 = Not Followed - Call Not Made (Non-Compliance Call Not Made)
- 3 = Not Medically Necessary (Non-Compliance Non-Medically Necessary)
- 4 = Not Followed Other (Non-Compliance Other)
- 5 = Emergency Admit to Non-Network Hospital

FORM LOCATION: N/A

VALIDATION: Must be entered if required by Payor.

If entered, must be a valid code from the list above.

REMARKS: N/A

RECORD/FIELD: FE0-15.0

DATA ELEMENT: EXCEPTION CODE

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(02)	LEFT	SPACES	113	114

DEFINITION: Exception code generated by a third party organization.

CODE VALUES:

- 1 = Non-Network Professional Provider in Network Hospital
- 2 = Emergency Care
- 3 = Services or Specialist Not in Network

- 4 = Out of Service Area
- 5 = State Mandates
- 6 = Other

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: FE0-16.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(206)	LEFT	SPACES	115	320

DEFINITION: Unused national reserved filler.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: AMBULANCE CERT RECORD TYPE GA0

Not Required by MO HealthNet

Must follow FB0 - FD0

Must be followed by GC0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GA0"	C-24	GA0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	RESERVED (GA0-04.0)		Not Used
05	PATIENTS WEIGHT		Not Used
06	HOSPITAL ADMIT		Not Used
07	TYPE OF TRANSPORT		Not Used

08	BED CONFINED-BEFORE		Not Used
09	BED CONFINED-AFTER		Not Used
10	MOVED BY STRETCHER		Not Used
11	UNCONSCIOUS/SHOCK		Not Used
12	EMERGENCY SITUATION		Not Used
13	PHYSICAL RESTRAINTS		Not Used
14	VISIBLE HEMORRHAGING		Not Used
15	TRANSPORTED TO/FOR		Not Used
16	MEDICALLY NECESSARY		Not Used
17	MILES		Not Used
18	ORIGIN INFO		Not Used
19	DESTINATION INFO		Not Used
20	PURPOSE OF ROUND TRIP		Not Used
21	PURPOSE OF STRETCHER		Not Used
22	PATIENT DISCHARGED		Not Used
23	PATIENT ADMITTED		Not Used
24	SERVICES AVAILABLE		Not Used
25	FILLER-NATIONAL		YES

RECORD TYPE: GA0

LEVEL: SERVICE LINE

PURPOSE: To provide additional information related to the ambulance service rendered to the patient.

REQUIREMENTS: If required by the payor, this record must be submitted.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1, FB2 or FE0 FA0, HA0, or XA0

NOTES: When used, this record must follow the FA0, FB0, FB1, FB2, or FE0 record related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "GA0"	3	X	01	03

02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	RESERVED (GA0-04.0)	17	X	23	39
05.0	PATIENTS WEIGHT	3	X	40	42
06.0	HOSPITAL ADMIT	1	X	43	43
07.0	TYPE OF TRANSPORT	1	X	44	44
08.0	BED CONFINED-BEFORE	1	X	45	45
09.0	BED CONFINED-AFTER	1	X	46	46
10.0	MOVED BY STRETCHER	1	X	47	47
11.0	UNCONSCIOUS/SHOCK	1	X	48	48
12.0	EMERGENCY SITUATION	1	X	49	49
13.0	PHYSICAL RESTRAINTS	1	X	50	50
14.0	VISIBLE HEMORRHAGING	1	X	51	51
15.0	TRANSPORTED TO/FOR	1	X	52	52
16.0	MEDICALLY NECESSARY	1	X	53	53
17.0	MILES	4	X	54	57
18.0	ORIGIN INFO	40	X	58	97
19.0	DESTINATION INFO	40	X	98	137
20.0	PURPOSE OF ROUND TRIP	80	X	138	217
21.0	PURPOSE OF STRETCHER	80	X	218	297
22.0	PATIENT DISCHARGED	1	X	298	298
23.0	PATIENT ADMITTED	1	X	299	299
24.0	SERVICES AVAILABLE	1	X	300	300
25.0	FILLER-NATIONAL	20	X	301	320

RECORD/FIELD: GA0-01.0

DATA ELEMENT: Record Identification (RECORD ID "GA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Ambulance Cert Record - GA0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GA0" record to the corresponding "FA0" record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: GA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: GA0-04.0

DATA ELEMENT: Reserved Field (GAO 04.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	N/A	SPACES	23	39

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-05.0

DATA ELEMENT: Patient's Weight

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(03)	LEFT	SPACES	40	42

DEFINITION: Weight of patient at time of transport.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be numeric values.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-06.0

DATA ELEMENT: Hospital Admit

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(01)	N/A	SPACE	43	43

DEFINITION: A code to indicate if the patient was admitted to a hospital.

CODE VALUES: Y = Admitted.

N = Not admitted.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid value from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-07.0

DATA ELEMENT: Type of Transport

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(01)	N/A	SPACE	44	44

DEFINITION: A code to indicate the type of transport.

CODE VALUES: I = Initial Trip
R = Return Trip
T = Transfer Trip
X = Round Trip

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

If "X" is entered, complete GA0-20.0 according to payor requirements.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-08.0

DATA ELEMENT: Bed Confined-Before

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(01)	N/A	SPACE	45	45

DEFINITION: A code to indicate whether the patient was bed confined before the ambulance service.

CODE VALUES: Y = Patient was bed confined.
N = Patient was not bed confined.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-09.0

DATA ELEMENT: Bed Confined-After

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(01)	N/A	SPACE	46	46

DEFINITION: A code to indicate whether the patient was bed confined after the ambulance service.

CODE VALUES: Y = Patient was bed confined.

N = Patient was not bed confined.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-10.0

DATA ELEMENT: Moved by Stretcher

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(01)	N/A	SPACE	47	47

DEFINITION: A code to indicate whether the patient was moved by stretcher.

CODE VALUES: Y = Patient was moved by stretcher.

N = Patient was not moved by stretcher.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

If "Y" is entered, complete GA0-21.0 according to payor requirements.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-11.0

DATA ELEMENT: Unconscious/Shock

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(01)	N/A	SPACE	48	48

DEFINITION: A code to indicate whether the patient was unconscious or in shock.

CODE VALUES: Y = Patient was unconscious or in shock.

N = Patient was not unconscious or in shock.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-12.0

DATA ELEMENT: Emergency Situation

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(01)	N/A	SPACE	49	49

DEFINITION: A code to indicate whether the patient was transported in an emergency situation.

CODE VALUES: Y = Emergency situation.

N = Not an emergency situation.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-13.0

DATA ELEMENT: Physical Restraints

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(01)	N/A	SPACE	50	50

DEFINITION: A code to indicate whether the patient had to be physically restrained.

CODE VALUES: Y = Physical restraints needed.

N = No physical restraints used.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-14.0

DATA ELEMENT: Visible Hemorrhaging

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(01)	N/A	SPACE	51	51

DEFINITION: A code to indicate whether the patient had visible hemorrhaging.

CODE VALUES: Y = Visible hemorrhaging noted.

N = No visible hemorrhaging noted.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-15.0

DATA ELEMENT: Transported To/For

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	N/A	SPACE	52	52

DEFINITION: A code to indicate whether the patient was transported to the nearest facility or for other considerations.

CODE VALUES: Patient was transported:

A = To nearest facility for care of symptoms and/or complaints.

B = For the benefit of a preferred physician.

C = For the nearness of family members.

D = For the care of a specialist or for availability of specialized equipment.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-16.0

DATA ELEMENT: Medically Necessary

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
<u>NSF (National Standard Format) User Manual</u>					282

16.0 X(01) N/A SPACE 53 53

DEFINITION: A code to indicate whether the ambulance service was medically necessary.

CODE VALUES: Y = Medically necessary.

 N = Not medically necessary.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-17.0

DATA ELEMENT: Miles

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(04)	LEFT	SPACES	54	57

DEFINITION: Number of miles traveled during this ambulance service.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be numeric values.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-18.0

DATA ELEMENT: Origin Information (ORIGIN INFO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(40)	LEFT	SPACES	58	97

DEFINITION: Free form description to indicate address, etc.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-19.0

DATA ELEMENT: Destination Information (DESTINATION INFO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(40)	LEFT	SPACES	98	137

DEFINITION: Free form description to indicate address, etc.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-20.0

DATA ELEMENT: Purpose of Round Trip

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(80)	LEFT	SPACES	138	217

DEFINITION: Free form description to indicate the purpose for the round trip ambulance service.

CODE VALUES: N/A

VALIDATION: If "Type of Transport" (GA0-07.0) equals "X", must be completed according to payor requirements.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-21.0

DATA ELEMENT: Purpose of Stretcher

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(80)	LEFT	SPACES	218	297

DEFINITION: Free form description to indicate the purpose for the usage of a stretcher during the ambulance service.

CODE VALUES: N/A

VALIDATION: If "Moved by Stretcher" (GA0-10.0) equals "Y", must be completed according to payor requirements.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-22.0

DATA ELEMENT: Patient Discharged (PATIENT DISCHARGED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(01)	LEFT	SPACES	298	298

DEFINITION: A code to indicate if the patient was discharged from the first facility.

CODE VALUES: Y - Yes, patient was discharged
N - No, patient was not discharged

VALIDATION: Must be entered if required by payor.

If entered, must be a valid value from the above list. This applies only when the patient is being transported from one facility to another.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-23.0

DATA ELEMENT: Patient Admitted (PATIENT ADMITTED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(01)	LEFT	SPACES	299	299

DEFINITION: A code to indicate if the patient was admitted to the second facility.

CODE VALUES: Y - Yes, patient was admitted
N - No, patient was not admitted

VALIDATION: Must be entered if required by payor.

If entered, must be a valid value from the above list. This applies only when the patient is being transported from one facility to another.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-24.0

DATA ELEMENT: Services Available at Facility (SERVICES AVAILABLE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(01)	LEFT	SPACES	300	300

DEFINITION: A code to indicate if the services provided at the second facility were available at the first facility.

CODE VALUES: Y - Yes, services were available at first facility

N - No, services were not available at first facility

VALIDATION: Must be entered if required by payor.

If entered, must be a valid value from the above list.

This applies only when the patient is being transported from one facility to another.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GA0-25.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(20)	LEFT	SPACES	301	320

DEFINITION: Unused reserved filler for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CHIROPRACTIC CERT RECORD TYPE GC0

Not Required by MO HealthNet

Must follow FD0 - GA0

Must be followed by GD0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GC0"	C-24	GC0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	RESERVED (GC0-04.0)		Not Used
05	INITIAL TREATMENT DATE		Not Used
06	DATE OF LAST X-RAY		Not Used

07	NOIN SERIES		Not Used
08	LEVEL OF SUBLUXATION		Not Used
09	TREATMENT MONTHS/YEARS		Not Used
10	NOTREATMENTS - MONTH		Not Used
11	NATURE OF CONDITION		Not Used
12	DATE OF MANIFESTATION		Not Used
13	COMPLICATION IND		Not Used
14	SYMPTOMS DESCRIPTION		Not Used
15	X-RAY IND		Not Used
16	FILLER-NATIONAL		YES

RECORD TYPE: GC0

LEVEL: SERVICE LINE

PURPOSE: To provide additional information related to the chiropractic service rendered to the patient.

REQUIREMENTS: If required by the payor, this record must be submitted.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1, FB2 or FE0 FA0, HA0 or XA0

NOTES: When used, this record must follow the FA0, FB0, FB1, FB2, or FE0 record related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITION	
				FROM	TO
01.0	RECORD ID "GC0"	3	X	01	
02.0	SEQUENCE NO	2	X	04	
03.0	PAT CONTROL NO	17	X	06	
04.0	RESERVED (GC0-04.0)	17	X	23	
05.0	INITIAL TREATMENT DATE	8	X	40	
06.0	DATE OF LAST X-RAY	8	X	48	
07.0	NO IN SERIES	7	X	56	
08.0	LEVEL OF SUBLUXATION	7	X	63	
09.0	TREATMENT MONTHS/YEARS	3	X	70	

10.0	NO TREATMENTS - MONTH	2	X	73	
11.0	NATURE OF CONDITION	1	X	75	
12.0	DATE OF MANIFESTATION	8	X	76	
13.0	COMPLICATION IND	1	X	84	
14.0	SYMPTOMS DESCRIPTION	160	X	85	
15.0	X-RAY IND	1	X	245	
16.0	FILLER-NATIONAL	75	X	246	

RECORD/FIELD: GC0-01.0

DATA ELEMENT: Record Identification (RECORD ID "GC0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Chiropractic Cert Record - GC0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GC0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GC0" record to the corresponding "FA0" record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.05.

RECORD/FIELD: GC0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: GC0-04.0

DATA ELEMENT: Reserved Field (GC0 04.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	N/A	SPACES	23	39

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-05.0

DATA ELEMENT: Initial Treatment Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(08)	LEFT	SPACES	40	47

DEFINITION: Date that the patient initially sought treatment for this condition.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-06.0

DATA ELEMENT: Date of Last X-Ray

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(08)	LEFT	SPACES	48	55

DEFINITION: Date of last X-Ray.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-07.0

DATA ELEMENT: Number in Series (NO IN SERIES)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(07)	LEFT	SPACES	56	62

DEFINITION: Number in the series of treatment being submitted on this service line.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, positions 56 through 58 and 60 through 62 must be numeric, and position 59 must contain the value of dash (-).

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-08.0

DATA ELEMENT: Level of Subluxation

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(07)	LEFT	SPACES		9

DEFINITION: Code or codes to identify the specific level of subluxation.

CODE VALUES: OC = Occiput T7 = Thoracic 7
 C1 = Cervical 1 T8 = Thoracic 8
 C2 = Cervical 2 T9 = Thoracic 9
 C3 = Cervical 3 T10 = Thoracic 10
 C4 = Cervical 4 T11 = Thoracic 11
 C5 = Cervical 5 T12 = Thoracic 12
 C6 = Cervical 6 L1 = Lumbar 1
 C7 = Cervical 7 L2 = Lumbar 2
 T1 = Thoracic 1 L3 = Lumbar 3
 T2 = Thoracic 2 L4 = Lumbar 4
 T3 = Thoracic 3 L5 = Lumbar 5
 T4 = Thoracic 4 SA = Sacrum
 T5 = Thoracic 5 CO = Coccyx
 T6 = Thoracic 6 IL = Ilium

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

To report consecutive codes, position 66 must be the value of dash (-). Otherwise, blank fill.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-09.0

DATA ELEMENT: Treatment Months or Years for this Series

(TREATMENT MONTHS/YEARS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(03)	LEFT	SPACES	70	72

DEFINITION: Months or years involved in this series of treatments.

CODE VALUES: For position 70:

 M = Month(s).

 Y = Year(s).

 For positions 71-72:

01-12 if position 70 = M.

01-99 if position 70 = Y.

VALIDATION: Must be entered if required by payor.

If entered, must be valid values from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-10.0

DATA ELEMENT: Number of Treatments this Month (NO TREATMENTS - MONTH)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(02)	LEFT	SPACES	73	74

DEFINITION: Number of treatments rendered to the patient during this current month.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be numeric values.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-11.0

DATA ELEMENT: Nature of Condition

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(01)	LEFT	SPACES	75	75

DEFINITION: A code to indicate the Nature of the Patient's Condition.

CODE VALUES: A = Acute Condition

C = Chronic Condition

M = Acute Manifestation of a Chronic Condition

VALIDATION: Must be entered if required by payor.

If entered, must be a valid value from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-12.0

DATA ELEMENT: Date of Acute Manifestation

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(08)	LEFT	SPACES	76	83

DEFINITION: Date of Acute Manifestation of a Chronic Condition.

CODE VALUES: N/A

VALIDATION: If "Nature of Condition" (GC0-11.0) equals "M", this field must be completed according to payor requirements.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-13.0

DATA ELEMENT: Complication Indicator (COMPLICATION IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(01)	LEFT	SPACES	84	84

DEFINITION: A code to indicate whether the Patient's condition is Complicated or Uncomplicated.

CODE VALUES: C = Complicated Condition
U = Uncomplicated Condition

VALIDATION: Must be entered if required by payor.

If entered, must be a valid value from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-14.0

DATA ELEMENT: Symptoms Description

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(160)	LEFT	SPACES	85	244

DEFINITION: Free form Description of the Patient's condition.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-15.0

DATA ELEMENT: X-Ray Indicator (X-RAY IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	LEFT	SPACES	245	245

DEFINITION: An indicator of whether or not X-Rays are on file for chiropractor spinal manipulation.

CODE VALUES: Y - Yes, X-Rays are on file, maintained and ready for review.

N - No, X-Rays are not maintained and not available for review.

VALIDATION: Must be entered if required by payor.

If entered, must be valid values from above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GC0-16.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(75)	LEFT	SPACES	246	320

DEFINITION: Unused reserved filler for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CERTIFICATION RECORD TYPE GD0 "DURABLE MEDICAL EQUIPMENT"

Not Required by MO HealthNet

Must follow FB0 - GC0

Must be followed by GD1 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GD0"	C-24	GD0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	CERTIFICATION TYPE		Not Used
05	MEDICAL NECESSITY		Not Used
06	PROGNOSIS		Not Used
07	HCPCS PROCEDURE CODE		Not Used
08	AMBULATORY		Not Used
09	AMBULATION/THERAPY		Not Used
10	CONFINED BED/CHAIR		Not Used
11	ROOM CONFINED		Not Used
12	AMBULATION/MOBILITY		Not Used
13	BODY POSITIONING		Not Used
14	RESPIRATORY/OTHER		Not Used
15	BREATHING IMPAIRED		Not Used
16	FREQ/IMMED CHANGES		Not Used
17	OPERATE CONTROLS		Not Used
18	SIDERAILS PART/BED		Not Used
19	OWNS EQUIPMENT		Not Used
20	MATTRESS/SIDERAILS		Not Used
21	EQUIPMENT/ASSISTANCE		Not Used
22	ORTHOPEDIC IMPAIR		Not Used
23	PLANNED REGIMEN		Not Used
24	DECUBITUS ULCERS		Not Used
25	EQUIPMENT USE		Not Used
26	INSULIN DEPENDENT		Not Used
27	DIABETIC CONTROL		Not Used
28	APNEA EPISODES		Not Used

29	SURGERY ALTERNATIVE		Not Used
30	TOTAL KNEE REPLACE		Not Used
31	DATE SURGERY		Not Used
32	DATE CPM		Not Used
33	LYMPHEDEMA		Not Used
34	ORDERING PROV LAST		Not Used
35	ORDERING PROV FIRST		Not Used
36	ORDERING PROV MI		Not Used
37	ORDERING PROV ID		Not Used
38	ORDERING PROV PHONE		Not Used
39	DATE CERTIFICATION		Not Used
40	CERTIFICATION ON FILE		Not Used
41	DIAGNOSIS CODE-1		Not Used
42	DIAGNOSIS CODE-2		Not Used
43	DIAGNOSIS CODE-3		Not Used
44	DIAGNOSIS CODE-4		Not Used
45	NURSING HOME IND		Not Used
46	NH FROM DATE		Not Used
47	NH TO DATE		Not Used
48	RESPIRATORY TRACT		Not Used
49	SUPV OF EQUIPMENT USE		Not Used
50	PROPEL/LIFT CHAIR		Not Used
51	LEG ELEVATION		Not Used
52	PATIENT WEIGHT		Not Used
53	RECLINING WHEELCHAIR		Not Used
54	MANUAL OPERATION		Not Used
55	SIDE TRANSFER CHAIR		Not Used
56	FILLER-NATIONAL		YES

RECORD TYPE: GD0

LEVEL: SERVICE LINE

PURPOSE: To provide information regarding attending physician's certification for durable medical equipment.

REQUIREMENTS: If required by the payor, a "GD0" record must be submitted for the initial certification or renewal certification when billing for durable medical equipment.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	FA0, FB0, FB1, FB2	FA0, GD1, HA0 or XA0

NOTES: Multiple GD0 records can be submitted when billing for more than one durable medical equipment code which requires a certification for the initial billing. When used, this record must follow the FA0, FB0, FB1, or FB2 records related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "GD0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	CERTIFICATION TYPE	1	X	23	23
05.0	MEDICAL NECESSITY	2	X	24	25
06.0	PROGNOSIS	20	X	26	45
07.0	HCPCS PROCEDURE CODE	5	X	46	50
08.0	AMBULATORY	1	X	51	51
09.0	AMBULATION/THERAPY	1	X	52	52
10.0	CONFINED BED/CHAIR	1	X	53	53
11.0	ROOM CONFINED	1	X	54	54
12.0	AMBULATION/MOBILITY	1	X	55	55
13.0	BODY POSITIONING	1	X	56	56
14.0	RESPIRATORY/OTHER	1	X	57	57
15.0	BREATHING IMPAIRED	1	X	58	58
16.0	FREQ/IMMED CHANGES	1	X	59	59
17.0	OPERATE CONTROLS	1	X	60	60
18.0	SIDERAILS PART/BED	1	X	61	61
19.0	OWNS EQUIPMENT	1	X	62	62
20.0	MATTRESS/SIDERAILS	1	X	63	63

21.0	EQUIPMENT/ASSISTANCE	1	X	64	64
22.0	ORTHOPEDIC IMPAIR	1	X	65	65
23.0	PLANNED REGIMEN	1	X	66	66
24.0	DECUBITUS ULCERS	1	X	67	67
25.0	EQUIPMENT USE	1	X	68	68
26.0	INSULIN DEPENDENT	3	X	69	71
27.0	DIABETIC CONTROL	1	X	72	72
28.0	APNEA EPISODES	1	X	73	73
29.0	SURGERY ALTERNATIVE	1	X	74	74
30.0	TOTAL KNEE REPLACE	1	X	75	75
31.0	DATE SURGERY	8	X	76	83
32.0	DATE CPM	8	X	84	91
33.0	LYMPHEDEMA	1	X	92	92
34.0	ORDERING PROV LAST	20	X	93	112
35.0	ORDERING PROV FIRST	12	X	113	124
36.0	ORDERING PROV MI	1	X	125	125
37.0	ORDERING PROV ID	15	X	126	140
38.0	ORDERING PROV PHONE	10	X	141	150
39.0	DATE CERTIFICATION	8	X	151	158
40.0	CERTIFICATION ON FILE	1	X	159	159
41.0	DIAGNOSIS CODE-1	5	X	160	164
42.0	DIAGNOSIS CODE-2	5	X	165	169
43.0	DIAGNOSIS CODE-3	5	X	170	174
44.0	DIAGNOSIS CODE-4	5	X	175	179
45.0	NURSING HOME IND	1	X	180	180
46.0	NH FROM DATE	8	X	181	188
47.0	NH TO DATE	8	X	189	196
48.0	RESPIRATORY TRACT	1	X	197	197
49.0	SUPV OF EQUIPMENT USE	1	X	198	198

50.0	PROPEL/LIFT CHAIR	1	X	199	199
51.0	LEG ELEVATION	1	X	200	200
52.0	PATIENT WEIGHT	1	X	201	201
53.0	RECLINING WHEELCHAIR	1	X	202	202
54.0	MANUAL OPERATION	1	X	203	203
55.0	SIDE TRANSFER CHAIR	1	X	204	204
56.0	FILLER-NATIONAL	116	X	205	320

RECORD/FIELD: GD0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GD0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Durable Medical Equipment Certification" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GD0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GD0" records and to associate "GD0" records with "GD1" records.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: GD0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: GD0-04.0

DATA ELEMENT: Type of Certification (CERTIFICATION TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	N/A	SPACE	23	23

DEFINITION: The type of certification being billed.

CODE VALUES: I = Initial Certification

R = Renewal Certification

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-05.0

DATA ELEMENT: Period of Medical Necessity

(MEDICAL NECESSITY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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05.0 X(02) LEFT SPACES 24 25

DEFINITION: The number of months this certification covers as prescribed by the ordering physician.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Enter the number of months this certification covers. Cannot exceed 18 months, unless a lifetime certification; then enter 99.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-06.0

DATA ELEMENT: Prognosis

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(20)	LEFT	SPACES	26	45

DEFINITION: Enter the prognosis of the patient.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-07.0

DATA ELEMENT: HCPCS Procedure Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(05)	LEFT	SPACES	46	50

DEFINITION: Enter a HCPCS code describing the equipment prescribed by the physician.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid HCPCS code.

FORM LOCATION: N/A

REMARKS: This will be the same code as entered in the corresponding FA0 record field 09.0.

RECORD/FIELD: GD0-08.0

DATA ELEMENT: Patient Ambulatory (AMBULATORY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(01)	N/A	SPACE	51	51

DEFINITION: Is the patient ambulatory?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for cane, crutches, walker or wheelchair.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-09.0

DATA ELEMENT: Ambulation/Therapy

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(01)	N/A	SPACE	52	52

DEFINITION: Is ambulation impaired and is walking aid used for therapy or mobility?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be one a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for cane, crutches or walker.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-10.0

DATA ELEMENT: Confined to Bed or Chair (CONFINED BED/CHAIR)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(01)	N/A	SPACE	53	53

DEFINITION: Is the patient confined to a bed or chair?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for wheelchair, a special wheelchair, decubitus care, commode, bed pan/urinal, or trapeze bar.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-11.0

DATA ELEMENT: Room Confined

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(01)	N/A	SPACE	54	54

DEFINITION: Is patient confined to a room or area without bathroom facilities?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for commode.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-12.0

DATA ELEMENT: Ambulation Impaired/Mobility (AMBULATION/MOBILITY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(01)	N/A	SPACE	55	55

DEFINITION: Is ambulation impaired and is walking aid used for mobility?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for cane, walker or crutches.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-13.0

DATA ELEMENT: Body Positioning

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(01)	N/A	SPACE	56	56

DEFINITION: Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for standard hospital bed, variable height hospital bed or an electric hospital bed.

If No, explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-14.0

DATA ELEMENT: Respiratory Condition/Other (RESPIRATORY/OTHER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(01)	N/A	SPACE	57	57

DEFINITION: Does patient need a trapeze bar to sit up due to respiratory condition or change body positions for other medical reasons?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0 is for trapeze bar.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-15.0

DATA ELEMENT: Breathing Impaired

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	N/A	SPACE	58	58

DEFINITION: Is patient's ability to breathe severely impaired?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for compressor, IPPB or nebulizer.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-16.0

DATA ELEMENT: Frequent/Immediate Changes (FREQ/IMMED CHANGES)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(01)	N/A	SPACE	59	59

DEFINITION: Does patient condition require frequent and/or immediate changes in body positions.

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for an electric hospital bed.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-17.0

DATA ELEMENT: Operate Controls

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(01)	N/A	SPACE	60	60

DEFINITION: Can patient operate controls?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for an electric hospital bed.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-18.0

DATA ELEMENT: Siderails Part of Bed (SIDERAILS PART/BED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(01)	N/A	SPACE	61	61

DEFINITION: Are siderails to be attached to a hospital bed owned by the beneficiary?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0 is for siderails.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-19.0

DATA ELEMENT: Owns Equipment

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(01)	N/A	SPACE	62	62

DEFINITION: Does patient own equipment?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for repairs, replacement parts, siderails, or mattress.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-20.0

DATA ELEMENT: Mattress/Siderails Used (MATTRESS/SIDERAISL)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(01)	N/A	SPACE	63	63

DEFINITION: Are mattress/siderails being used with prescribed medically necessary hospital bed owned by the beneficiary?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for mattress or siderails.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-21.0

DATA ELEMENT: Equipment/Assistance

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(01)	N/A	SPACE	64	64

DEFINITION: Does patient need lift to get in or out of bed or to assist in transfer from bed to wheelchair?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for lift.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-22.0

DATA ELEMENT: Orthopedic Impairment (ORTHOPEdic IMPAIR)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(01)	N/A	SPACE	65	65

DEFINITION: Does patient have an orthopedic impairment requiring traction equipment which prevents ambulation during period of use?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for traction and fracture frame.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-23.0

DATA ELEMENT: Planned Regimen of Treatment (PLANNED REGIMEN)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(01)	N/A	SPACE	66	66

DEFINITION: Has item been prescribed as part of a planned regimen of treatment in patient home?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0 is for decubitus care, heat treatment or pneumatic pump.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-24.0

DATA ELEMENT: Decubitus Ulcers

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(01)	N/A	SPACE	67	67

DEFINITION: Is patient highly susceptible to decubitus ulcers?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0 is for decubitus care.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-25.0

DATA ELEMENT: Equipment Use

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(01)	N/A	SPACE	68	68

DEFINITION: Has patient or a care-giver been instructed in use of equipment?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0 is for pneumatic pump or glucose monitors.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-26.0

DATA ELEMENT: Insulin Dependent

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(03)	N/A	SPACE	69	71

DEFINITION: Describe the condition that demonstrates insulin dependence.

CODE VALUE: 1 - Widely fluctuating blood sugars
 2 = Frequent episodes of insulin reactions
 3 = Evidence of frequent significant ketosis
 N = Patient is not insulin dependent

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for blood glucose monitor.

FORM LOCATION: N/A

REMARKS: Entry of multiple codes is acceptable. Example: if both 1 and 2 apply, enter "12".

RECORD/FIELD: GD0-27.0

DATA ELEMENT: Poor Diabetic Control (DIABETIC CONTROL)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(01)	N/A	SPACE	72	72

DEFINITION: Does patient have poor diabetic control?

CODE VALUE: Y = Yes
 N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for blood glucose monitor.

If yes, explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-28.0

DATA ELEMENT: Episodes of Apnea (APNEA EPISODES)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(01)	N/A	SPACE	73	73

DEFINITION: Does a 6-7 hour nocturnal study document 30 episodes of apnea each lasting more than 10 seconds?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for nasal CPAP.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-29.0

DATA ELEMENT: Surgery Alternative

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(01)	N/A	SPACE	74	74

DEFINITION: Without the equipment, would the patient require surgery?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for nasal CPAP.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-30.0

DATA ELEMENT: Total Knee Replacement (TOTAL KNEE REPLACE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(01)	N/A	SPACE	75	75

DEFINITION: Has patient had a total knee replacement?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0 is for continuous positive motion device.

If yes, date of surgery, GD0-31.0, and date started CPM, GD0-32.0, must be completed.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-31.0

DATA ELEMENT: Date of Surgery (DATE SURGERY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(08)	LEFT	SPACES	76	83

DEFINITION: The date surgery was performed for total knee replacement.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

Must be entered if required by payor.

If entered, must be a valid date.

Must be entered if total knee replacement, GD0-30.0 is "Y".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-32.0

DATA ELEMENT: Date CPM Started (DATE CPM)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(08)	LEFT	SPACES	84	91

DEFINITION: The date the patient began using CPM.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

Must be entered if required by payor.

If entered, must be a valid date.

Must be entered if total knee replacement, GD0-30.0 is "Y".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-33.0

DATA ELEMENT: Intractable Lymphedema (LYMPHEDEMA)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
33.0	X(01)	N/A	SPACE	92	92

DEFINITION: Does patient have intractable lymphedema of the extremities?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for pneumatic pump.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-34.0 GD0-35.0 GD0-36.0

DATA ELEMENT:	Ordering Physician Last Name	(ORDERING PROV LAST)
	Ordering Physician First Name	(ORDERING PROV FIRST)
	Ordering Physician Middle Initial	(ORDERING PROV MI)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
34.0	X(20)	LEFT	SPACES	93	112
35.0	X(12)	LEFT	SPACES	113	124
36.0	X(01)	N/A	SPACE	125	125

DEFINITION: The name of the physician who prescribed the durable medical equipment.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Name 1" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-37.0

DATA ELEMENT: Ordering Provider ID (ORDERING PROV ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
37.0	X(15)	LEFT	SPACES	126	140

DEFINITION: The identifier assigned by the payor to the physician who prescribed the durable medical equipment.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-38.0

DATA ELEMENT: Ordering Provider Phone (ORDERING PROV PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
38.0	X(10)	LEFT	SPACES	141	150

DEFINITION: The telephone number of the physician who prescribed the durable medical equipment.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Phone" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-39.0

DATA ELEMENT: Date of Certification (DATE CERTIFICATION)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
39.0	X(08)	LEFT	SPACES	151	158

DEFINITION: The date the certification was completed by the prescribing physician.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

Must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.

Do not submit a decimal point. The decimal point is implied.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-45.0

DATA ELEMENT: Nursing Home Indicator (NURSING HOME IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
45.0	X(01)	N/A	SPACE	180	180

DEFINITION: Is the patient in a nursing home?

CODE VALUES: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-46.0 GD0-47.0

DATA ELEMENT: Nursing Home From Date (NH FROM DATE)
Nursing Home To Date (NH TO DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
46.0	X(08)	LEFT	SPACES	181	188
47.0	X(08)	LEFT	SPACES	189	196

DEFINITION: The from and to dates the patient was in a nursing home.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

Must be entered if required by payor.

If entered, must be a valid date.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-48.0

DATA ELEMENT: Respiratory Tract Secretions (RESPIRATORY TRACT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
48.0	X(01)	N/A	SPACE	197	197

DEFINITION: Does patient have mobilizing respiratory tract secretions?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for percussor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-49.0

DATA ELEMENT: Supervision of Equipment Use (SUPV OF EQUIPMENT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
49.0	X(01)	N/A	SPACE	198	198

DEFINITION: Is patient or care giver capable of using the equipment without technical or professional supervision?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for a suction machine.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-50.0

DATA ELEMENT: Propel/Lift Wheelchair (PROPEL/LIFT CHAIR)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
50.0	X(01)	N/A	SPACE	199	199

DEFINITION: Is patient or care giver unable to propel or lift a standard weight wheelchair?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for a light weight wheelchair.

Explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-51.0

DATA ELEMENT: Leg Elevation

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
51.0	X(01)	N/A	SPACE	200	200

DEFINITION: Does the patient require leg elevation edema or body alignment?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for an elevating legs wheelchair.

Explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-52.0

DATA ELEMENT: Patient's Weight (PATIENT WEIGHT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
52.0	X(01)	N/A	SPACE	201	201

DEFINITION: Does the patient's weight or usage needs necessitate a heavy duty wheelchair?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for an extra wide / heavy duty wheelchair.

Explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-53.0

DATA ELEMENT: Reclining Wheelchair

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
53.0	X(01)	N/A	SPACE	202	202

DEFINITION: Does patient require reclining function of wheelchair?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for a reclining wheelchair.

Explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-54.0

DATA ELEMENT: Manual Operation Chair (MANUAL OPERATION)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
54.0	X(01)	N/A	SPACE	203	203

DEFINITION: Is patient unable to operate a wheelchair manually?

CODE VALUE: Y = Yes
N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for a power/electric wheelchair.

Explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-55.0

DATA ELEMENT: Side Transfer Wheelchair (SIDE TRANSFER CHAIR)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
55.0	X(01)	N/A	SPACE	204	204

DEFINITION: Does patient or caregiver require side transfer into wheelchair, commode or other?

CODE VALUE: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

Must be entered if HCPCS code, GD0-07.0, is for a detachable arms wheelchair.

Explanation must be given in narrative, GD1-04.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD0-56.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
56.0	X(116)	LEFT	SPACES	205	320

DEFINITION: Reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

The following chart lists specific fields which must be completed for the various types of equipment.

EQUIPMENT	FIELD(S)
Cane, Crutches, Walker	GD0-08.0, GD0-09.0, GD0-12.0
Wheelchair	GD0-08.0, GD0-10.0
Special Wheelchair	GD0-08.0, GD0-10.0, GD0-50.0, GD0-51.0, GD0-52.0, GD0-53.0, GD0-54.0, GD0-55.0, GD1-04.0
Decubitus Care	GD0-10.0, GD0-23.0, GD0-24.0
Compressor, IPPB or Nebulizer	GD0-15.0
Repairs and Replacement Parts	GD0-19.0, GD1-04.0 and any other fields necessary to certify equipment
Traction and Fracture Frame	GD0-22.0
Continuous Passive Motion	GD0-30.0, GD0-31.0, GD0-32.0
Heat Application	GD0-23.0, GD1-04.0
Commode	GD0-10.0, GD0-11.0
Bed Pan/Urinal	GD0-10.0
Sitz Bath	GD1-04.0
Standard Hospital Bed	GD0-13.0
Variable Height Hospital Bed	GD0-13.0, GD1-04.0
Electric Hospital Bed	GD0-13.0, GD0-16.0, GD0-17.0, GD1-04.0
Mattress	GD0-19.0, GD0-20.0
Siderails	GD0-18.0, GD0-19.0, GD0-20.0
Trapeze Bar	GD0-10.0, GD0-14.0
Lift	GD0-21.0
Pneumatic Pump	GD0-23.0, GD0-25.0, GD0-33.0
Infusion Pump	GD1-04.0
Blood Glucose Monitors	GD0-25.0, GD0-26.0, GD0-27.0
Nasal CPAP	GD0-28.0, GD0-29.0, GD1-04.0
Percussor	GD0-48.0

RECORD NAME: CERTIFICATION RECORD TYPE GD1 "NARRATIVE INFORMATION FOR DME"

Not Required by MO HealthNet

Must follow FB0 - GD0

Must be followed by GE0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GD1"	C-24	GD1
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	NARRATIVE		Not Used
05	FILLER-NATIONAL		YES

RECORD TYPE: GD1

LEVEL: SERVICE LINE

PURPOSE: To provide NARRATIVE information regarding the attending physician's certification of durable medical equipment.

REQUIREMENTS: If required by payor a "GD1" record must be submitted the initial certification or renewal certification for the following:

1. Special wheelchair
2. Heat application
3. Sitz bath
4. Variable height hospital bed
5. Electric hospital bed
6. Nasal CPAP
7. Infusion pump
8. Repairs

ORDER: Preceding Record Type Following Record Type
 GD0 FA0, HA0 or XA0

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "GD1"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22

04.0	NARRATIVE	250	X	23	272
05.0	FILLER-NATIONAL	48	X	273	320

RECORD/FIELD: GD1-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GD1")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Narrative Information for DME" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GD1".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD1-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GD1" records and to associate "GD0" records with "GD1" records.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (GD0-02.2) submitted in the preceding "GD0" record.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD1-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number. Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: GD1-04.0

DATA ELEMENT: Narrative

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(250)	LEFT	SPACES	23	272

DEFINITION: Enter a detailed explanation for the medical necessity of the equipment including the following for listed equipment.

Special wheelchair, heat application equipment, Sitz bath, variable height hospital bed, electric hospital bed, nasal CPAP:

Explanation of how equipment is therapeutically beneficial to the patient's treatment program or necessary for the patient's condition.

Hospital bed:

What body position or special attachments are required?

Infusion pump:

Drugs or agents being administered with infusion pump.

Repairs:

HCPCS code and/or a complete narrative description of the item being repaired.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GD1-05.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(48)	LEFT	SPACES	273	320

DEFINITION: Reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CERTIFICATION RECORD TYPE GE0 "ENTERAL NUTRITION THERAPY"

Not Required by MO HealthNet

Must follow FB0 - GD1

Must be followed by GP0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GE0"	C-24	GE0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	CERTIFICATION TYPE		Not Used
05	ONSET DT OF THERAPY		Not Used
06	THERAPY DURATION		Not Used
07	LAST CERT DATE		Not Used
08	NO OF MONTHS CERT		Not Used
09	DT LAST SEEN BY PHY		Not Used
10	NON VISIT IND		Not Used
11	PAT AGE		Not Used
12	PAT HEIGHT		Not Used
13	PAT WEIGHT		Not Used
14	LEVEL OF CONS IND		Not Used
15	AMBULATORY IND		Not Used

16	OTHER FORMS OF NUTR IND		Not Used
17	METHOD ADMIN IND		Not Used
18	ADMIN TECH IND		Not Used
19	TOTAL CAL PER DAY		Not Used
20	PRODUCT NAME 1		Not Used
21	CAL PER PRODUCT 1		Not Used
22	HCPCS PROCEDURE CODE		Not Used
23	HCPCS MODIFIER 1		Not Used
24	HCPCS MODIFIER 2		Not Used
25	ENTERAL FREQ FED 1		Not Used
26	NARRATIVE FIELD		Not Used
27	PRODUCT NAME 2		Not Used
28	CAL PER PRODUCT 2		Not Used
29	ENTERAL FREQ FED 2		Not Used
30	FILLER-NATIONAL		YES

RECORD TYPE: GE0

LEVEL: SERVICE LINE

PURPOSE: To provide information regarding certification of medical necessity for ENTERAL Nutrition Therapy.

REQUIREMENTS: If required by the payor, the "GE0" record must be submitted for the initial certification, revised certification and renewal certification when billing for Enteral Nutrition Therapy.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1, or FB2 FA0, HA0 or XA0

NOTES: When used, this record must follow the FA0, FB0, FB1 or FB2 records related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "GE0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22

04.0	CERTIFICATION TYPE	1	X	23	23
05.0	ONSET DT OF THERAPY	8	X	24	31
06.0	THERAPY DURATION	2	X	32	33
07.0	LAST CERT DATE	8	X	34	41
08.0	NO OF MONTHS CERT	2	X	42	43
09.0	DT LAST SEEN BY PHY	8	X	44	51
10.0	NON VISIT IND	1	X	52	52
11.0	PAT AGE	3	X	53	55
12.0	PAT HEIGHT	3	X	56	58
13.0	PAT WEIGHT	3	X	59	61
14.0	LEVEL OF CONS IND	1	X	62	62
15.0	AMBULATORY IND	1	X	63	63
16.0	OTHER FORMS OF NUTR IND	1	X	64	64
17.0	METHOD ADMIN IND	1	X	65	65
18.0	ADMIN TECH IND	1	X	66	66
19.0	TOTAL CAL PER DAY	4	N	67	70
20.0	PRODUCT NAME 1	15	X	71	85
21.0	CAL PER PRODUCT 1	4	N	86	89
22.0	HCPCS PROCEDURE CODE	5	X	90	94
23.0	HCPCS MODIFIER 1	2	X	95	96
24.0	HCPCS MODIFIER 2	2	X	97	98
25.0	ENTERAL FREQ FED 1	3	X	99	101
26.0	NARRATIVE FIELD	100	X	102	201
27.0	PRODUCT NAME 2	15	X	202	216
28.0	CAL PER PRODUCT 2	4	N	217	220
29.0	ENTERAL FREQ FED 2	3	X	221	223
30.0	FILLER-NATIONAL	97	X	224	320

RECORD/FIELD: GE0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GE0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This field is used to identify the "ENTERAL NUTRITION THERAPY" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GE0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GE0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GE0" record to the corresponding "FA0" record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: GE0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS FOR "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 BLOCK 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all carrier's systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: GE0-04.0

DATA ELEMENT: Type of Certification (CERTIFICATION TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	N/A	SPACE	23	23

DEFINITION: The type of certification being billed.

CODE VALUES: I = Initial Certification
R = Renewal Certification
S = Revised Certification

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: OMB 09380233 Block A1-3

REMARKS: N/A

RECORD/FIELD: GE0-05.0

DATA ELEMENT: Date Therapy Began (ONSET DT OF THERAPY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(08)	LEFT	SPACES	24	31

DEFINITION: The date the patient began receiving Enteral Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: OMB 09380233, II.A.

REMARKS: N/A

RECORD/FIELD: GE0-06.0

DATA ELEMENT: Therapy Duration

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(02)	LEFT	SPACES	32	33

DEFINITION: The estimated duration of therapy. (number of months, years or life (99)).

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, II.A.

REMARKS: N/A

RECORD/FIELD: GE0-07.0

DATA ELEMENT: Last Date of Certification (LAST CERT DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(08)	LEFT	SPACES	34	41

DEFINITION: The date of the last certification.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry

FORM LOCATION: OMB 09380233

REMARKS: N/A

RECORD/FIELD: GE0-08.0

DATA ELEMENT: Number of Months of Certification (NO OF MONTHS CERT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(02)	LEFT	SPACES	42	43

DEFINITION: The number of months covered by this certification.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233

REMARKS: N/A

RECORD/FIELD: GE0-09.0

DATA ELEMENT: Date Last Seen By Physician (DT LAST SEEN BY PHY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(08)	LEFT	SPACES	44	51

DEFINITION: The date the patient was last seen by the referring/ordering physician during this certification/recertification period.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTION for "Date" entry.

FORM LOCATION: OMB 09380233, III.D.

REMARKS: If no visit, then provide reason in GE0-26.0.

RECORD/FIELD: GE0-10.0

DATA ELEMENT: Non Physician Visit Indicator (NON VISIT IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(01)	LEFT	SPACES	52	52

DEFINITION: A code used to describe what the medical evaluation is based on, when not based on physician visit.

CODE VALUES: N = Visiting Nurse
L = Lab/Clinical Reports
O = Other
Blank = Not applicable

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: OMB 09380233, III.D.

REMARKS: If the physician has not seen the patient during this certification/recertification period an entry must be made in this field and an additional explanation should be entered in the "Narrative Field" (GE0-26.0).

RECORD/FIELD: GE0-11.0

DATA ELEMENT: Patient Age (PAT AGE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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11.0 X(03) LEFT SPACES 53 55

DEFINITION: The patient's age.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GE0-12.0

DATA ELEMENT: Patient's Height (PAT HEIGHT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(03)	LEFT	SPACES	56	58

DEFINITION: The patient's height (inches).

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GE0-13.0

DATA ELEMENT: Patient's Weight (PAT WEIGHT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(03)	LEFT	SPACES	59	61

DEFINITION: The patient's weight in pounds.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GE0-14.0

DATA ELEMENT: Level of Consciousness Indicator (LEVEL OF CONS IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(01)	LEFT	SPACES	62	62

DEFINITION: An indicator used to describe the patient's level of consciousness.

CODE VALUES: C = Conscious

I = Consciousness Impaired

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GE0-15.0

DATA ELEMENT: Ambulatory Indicator (AMBULATORY IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	LEFT	SPACES	63	63

DEFINITION: An indicator used to describe whether or not the patient is ambulatory.

CODE VALUES: A = Ambulatory

N = Non-Ambulatory

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, II.C.

REMARKS: N/A

RECORD/FIELD: GE0-16.0

DATA ELEMENT: Other Forms of Nutrient Indicator (OTHER FORMS OF NUTR IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(01)	LEFT	SPACES	64	64

DEFINITION: An indicator used to describe whether or not this feeding is the only form of nutritional intake for this patient.

CODE VALUES: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, III.C.

REMARKS: If this field equals "N" an explanation should be entered in the "Narrative Field" (GE0-26.0) giving name, amount (calories or %), and method of consumption of the additional nutrients administered.

RECORD/FIELD: GE0-17.0

DATA ELEMENT: Method of Administration Indicator (METHOD ADMIN IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(01)	LEFT	SPACES	65	65

DEFINITION: An indicator used to describe the method used to administer the nutrient to the patient.

CODE VALUES: S = Syringe
G = Gravity
P = Pump

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, V.D.

REMARKS: If this field equals "P" an explanation should be entered in the "Narrative Field" (GE0-26.0) describing patient's condition that necessitates use of the pump.

RECORD/FIELD: GE0-18.0

DATA ELEMENT: Administration Technique Indicator (ADMIN TECH IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(01)	LEFT	SPACES	66	66

DEFINITION: An indicator used to describe the technique used to administer the nutrient to the patient.

CODE VALUES: N = Nasogastric Tube
G = Gastrostomy
J = Jejunostomy
O = Other

VALIDATION: Must be entered if required by payor.

If entered, must a be a valid code from the list above.

FORM LOCATION: OMB 09380233, V.F.

REMARKS: If "O" (other), provide information in "Narrative Field" (GE0-26.0).

RECORD/FIELD: GE0-19.0

DATA ELEMENT: Total Calories Per Day (TOTAL CAL PER DAY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	9(04)	RIGHT	ZEROS	67	70

DEFINITION: The total number of calories per day of all nutrients prescribed by the referring/rendering physician for this patient.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, V.B.

REMARKS: If number of calories is greater than "2000" an explanation should be entered in the "Narrative Field" (GE0-26.0).

RECORD/FIELD: GE0-20.0

DATA ELEMENT: Product Name 1

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(15)	LEFT	SPACES	71	85

DEFINITION: The name of the product (nutrient) being administered to the patient.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, V.A.

REMARKS: N/A

RECORD/FIELD: GE0-21.0

DATA ELEMENT: Calories Per Product 1 (CAL PER PRODUCT 1)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	9(04)	RIGHT	ZEROS	86	89

DEFINITION: The number of calories per day prescribed by the referring/ordering physician for this product, for this patient.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, V.B.

REMARKS: If number of calories is greater than "2000" an explanation should be entered in the "Narrative Field" (GE0-26.0).

RECORD/FIELD: GE0-22.0

DATA ELEMENT: HCPCS Procedure Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(05)	LEFT	SPACES	90	94

DEFINITION: This is the HCPCS/CPT-4 code that describes the service/nutrient.

CODE VALUES: HCPCS/CPT-4 Code Set.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid HCPCS/CPT-4 procedure code.

FORM LOCATION: CMS-1500 Block 24d

REMARKS: This will be the same code as entered in the corresponding FA0 record (FA0-09.0)

RECORD/FIELD: GE0-23.0

DATA ELEMENT: HCPCS Modifier 1
HCPCS Modifier 2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(02)	LEFT	SPACES	95	96
24.0	X(02)	LEFT	SPACES	97	98

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier Codes.

VALIDATION: Must be entered if required by payor for proper adjudication of the service.

FORM LOCATION: CMS-1500 Block 24D

REMARKS: N/A

RECORD/FIELD: GE0-25.0

DATA ELEMENT: Enteral Frequency Fed 1 (ENTERAL FREQ FED 1)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.	X(03)	LEFT	SPACES	99	101

DEFINITION: The number of times per day that the patient was fed.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, V.C.

REMARKS: N/A

RECORD/FIELD: GE0-26.0

DATA ELEMENT: Narrative Field

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(100)	LEFT	SPACES	102	201

DEFINITION: A narrative field use to describe special circumstances, medical justification or any additional comments necessary for proper adjudication of the claim.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor for proper adjudication of the claim.

FORM LOCATION: OMB 09380233

REMARKS: Some examples of when this field is needed are as follows:

1. If GE0-10.0 is other than "blank".
2. If GE0-16.0 is equal to "N".
3. If GE0-17.0 is equal to "P".
4. If GE0-18.0 is equal to "O".
5. If GE0-19.0, GE0-21.0 and/or GE0-28.0 is greater than "2000".

If additional information is needed, an "HA0" record can be used.

RECORD/FIELD: GE0-27.0

DATA ELEMENT: Product Name 2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(15)	LEFT	SPACES	202	216

DEFINITION: The name of the product (nutrient) being administered to the patient.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, V.A.

REMARKS: N/A

RECORD/FIELD: GE0-28.0

DATA ELEMENT: Calories Per Product 2 (CAL PER PRODUCT 2)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	9(04)	RIGHT	ZEROS	217	220

DEFINITION: The number of calories per day prescribed by the referring/ordering physician for this product, for this patient.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, V.B.

REMARKS: If number of calories is greater than "2000" an explanation should be entered in the "Narrative Field" (GE0-26.0).

RECORD/FIELD: GE0-29.0

DATA ELEMENT: Enteral Frequency Fed 2 (ENTERAL FREQ FED 2)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(03)	LEFT	SPACES	221	223

DEFINITION: The number of times per day that the patient was fed.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, V.C.

REMARKS: N/A

RECORD/FIELD: GE0-30.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(97)	LEFT	SPACES	224	320

DEFINITION: Unused reserved record space for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CERTIFICATION RECORD TYPE GP0 "PARENTERAL NUTRITION THERAPY"

Not Required by MO HealthNet

Must follow FB0 - GE0

Must be followed by GU0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GP0"	C-24	GP0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	CERTIFICATION TYPE		Not Used
05	ONSET DT OF THERAPY		Not Used
06	THERAPY DURATION		Not Used
07	LAST CERT DATE		Not Used
08	NO OF MONTHS CERT		Not Used
09	DT LAST SEEN BY PHY		Not Used
10	NON VISIT IND		Not Used
11	PAT AGE		Not Used
12	PAT HEIGHT		Not Used
13	PAT WEIGHT		Not Used
14	LEVEL OF CONS IND		Not Used
15	AMBULATORY IND		Not Used
16	OTHER FORMS OF NUTR IND		Not Used
17	TYPE OF MIX IND		Not Used
18	PARENTERAL FREQ FED		Not Used
19	HCPCS PROCEDURE CODE		Not Used
20	HCPCS MODIFIER 1		Not Used
21	HCPCS MODIFIER 2		Not Used
22	AMINO ACID NAME		Not Used
23	AMINO ACID VOLUME		Not Used
24	AMINO ACID CONC		Not Used

25	AMINO ACID WEIGHT		Not Used
26	DEXTROSE VOLUME		Not Used
27	DEXTROSE CONC		Not Used
28	LIPIDS VOLUME		Not Used
29	LIPIDS CONC		Not Used
30	LIPIDS FREQ		Not Used
31	NARRATIVE FIELD		Not Used
32	ADMIN TECH IND		Not Used
33	FILLER-NATIONAL		YES

RECORD TYPE: GP0

LEVEL: SERVICE LINE

PURPOSE: To provide information regarding certification of medical necessity for PARENTERAL Nutrition Therapy.

REQUIREMENTS: If required by the payor, the "GP0" record must be submitted for the initial certification, revised certification and renewal certification when billing for Parenteral Nutrition Therapy.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1 or FB2 FA0, HA0 or XA0

NOTES: When used, this record must follow the FA0, FB0, FB1 or FB2 records related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "GP0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	CERTIFICATION TYPE	1	X	23	23
05.0	ONSET DT OF THERAPY	8	X	24	31
06.0	THERAPY DURATION	2	X	32	33
07.0	LAST CERT DATE	8	X	34	41
08.0	NO OF MONTHS CERT	2	X	42	43
09.0	DT LAST SEEN BY PHY	8	X	44	51

10.0	NON VISIT IND	1	X	52	52
11.0	PAT AGE	3	X	53	55
12.0	PAT HEIGHT	3	X	56	58
13.0	PAT WEIGHT	3	X	59	61
14.0	LEVEL OF CONS IND	1	X	62	62
15.0	AMBULATORY IND	1	X	63	63
16.0	OTHER FORMS OF NUTR IND	1	X	64	64
17.0	TYPE OF MIX IND	1	X	65	65
18.0	PARENTERAL FREQ FED	3	X	66	68
19.0	HCPCS PROCEDURE CODE	5	X	69	73
20.0	HCPCS MODIFIER 1	2	X	74	75
21.0	HCPCS MODIFIER 2	2	X	76	77
22.0	AMINO ACID NAME	15	X	78	92
23.0	AMINO ACID VOLUME	4	N	93	96
24.0	AMINO ACID CONC	5	X	97	101
25.0	AMINO ACID WEIGHT	4	N	102	105
26.0	DEXTROSE VOLUME	4	N	106	109
27.0	DEXTROSE CONC	5	X	110	114
28.0	LIPIDS VOLUME	4	N	115	118
29.0	LIPIDS CONC	5	X	119	123
30.0	LIPIDS FREQ	3	N	124	126
31.0	NARRATIVE FIELD	100	X	127	226
32.0	ADMIN TECH IND	1	X	227	227
33.0	FILLER-NATIONAL	93	X	228	320

RECORD/FIELD: GP0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GP0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This field is used to identify the "PARENTERAL NUTRITION THERAPY" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GP0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GP0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GP0" record to the corresponding "FA0" record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list. The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: GP0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS FOR "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 BLOCK 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all carrier's systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: GP0-04.0

DATA ELEMENT: Type of Certification (CERTIFICATION TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	N/A	SPACE	23	23

DEFINITION: The type of certification being billed.

CODE VALUES: I = Initial Certification
R = Renewal Certification
S = Revised Certification

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: OMB 09380233

REMARKS: N/A

RECORD/FIELD: GP0-05.0

DATA ELEMENT: Date Therapy Began (ONSET DT OF THERAPY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(08)	LEFT	SPACES	24	31

DEFINITION: The date the patient began receiving Parenteral Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: OMB 09380233, II.A.

REMARKS: N/A

RECORD/FIELD: GP0-06.0

DATA ELEMENT: Therapy Duration

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(02)	LEFT	SPACES	32	33

DEFINITION: The estimated duration of therapy (number of months).

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, II.A.

REMARKS: N/A

RECORD/FIELD: GP0-07.0

DATA ELEMENT: Last Date of Certification (LAST CERT DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(08)	LEFT	SPACES	34	41

DEFINITION: The date of the last certification.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: OMB 09380233

REMARKS: N/A

RECORD/FIELD: GP0-08.0

DATA ELEMENT: Number Of Months Of Certification (NO OF MONTHS CERT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(02)	LEFT	SPACES	42	43

DEFINITION: The number of months covered by this certification.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233

REMARKS: N/A

RECORD/FIELD: GP0-09.0

DATA ELEMENT: Date Last Seen By Physician (DT LAST SEEN BY PHY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(08)	LEFT	SPACES	44	51

DEFINITION: The date the patient was last seen by the referring/ordering physician, during this certification/recertification period.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: OMB 09380233, III.D.

REMARKS: N/A

RECORD/FIELD: GP0-10.0

DATA ELEMENT: Non Physician Visit Indicator (NON VISIT IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(01)	LEFT	SPACES	52	52

DEFINITION: An code used to describe what the medical evaluation is based upon, when not based on physician visit.

CODE VALUES: N = Visiting Nurse
 L = Lab/Clinical Reports
 O = Other
 Blank = Not Applicable

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: OMB 09380233, III.D.

REMARKS: If the physician has not seen the patient during this certification/recertification period an entry must be made in this field and an additional explanation should be entered in the "Narrative Field" (GP0-31.0).

RECORD/FIELD: GP0-11.0

DATA ELEMENT: Patient's Age (PAT AGE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(03)	LEFT	SPACES	53	55

DEFINITION: The patient's age.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GP0-12.0

DATA ELEMENT: Patient's Height (PAT HEIGHT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(03)	LEFT	SPACES	56	58

DEFINITION: The patient's height (feet and inches).

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Do not use punctuation for feet or inches. ex: 5 feet, 10 inches would be entered "510".

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GP0-13.0

DATA ELEMENT: Patient's Weight (PAT WEIGHT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(03)	LEFT	SPACES	59	61

DEFINITION: The patient's weight in pounds.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GP0-14.0

DATA ELEMENT: Level Of Consciousness Indicator (LEVEL OF CONS IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(01)	LEFT	SPACES	62	62

DEFINITION: An indicator used to describe the patient's level of consciousness.

CODE VALUES: C = Conscious

I = Consciousness Impaired

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, II.B.

REMARKS: N/A

RECORD/FIELD: GP0-15.0

DATA ELEMENT: Ambulatory Indicator (AMBULATORY IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(01)	LEFT	SPACES	63	63

DEFINITION: An indicator used to describe whether or not the patient is ambulatory.

CODE VALUES: A = Ambulatory

N = Non-Ambulatory

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, II.C.

REMARKS: N/A

RECORD/FIELD: GP0-16.0

DATA ELEMENT: Other Forms Of Nutrient Indicator (OTHER FORMS OF NUTR IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(01)	LEFT	SPACES	64	64

DEFINITION: An indicator used to describe whether or not this feeding is the only form of nutritional intake for this patient.

CODE VALUES: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, III.C.

REMARKS: If this field equals "N" an explanation should be entered in the "Narrative Field" (GP0-31.0) giving name, amount (calories or %), and method of consumption of the additional nutrients administered.

RECORD/FIELD: GP0-17.0

DATA ELEMENT: Type Of Mix Indicator (TYPE OF MIX IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	X(01)	LEFT	SPACES	65	65

DEFINITION: An indicator used to describe the type of mix administered to the patient.

CODE VALUES: H = Homemix

P = Premix

VALIDATION: Must be entered if required by the payor.

If entered, must be a valid code from the list above.

FORM LOCATION: OMB 09380233, IV.A.

REMARKS: If this field equals "P" an explanation should be entered in the "Narrative Field" (GP0-31.0) as to why beneficiary cannot use self-mix.

RECORD/FIELD: GP0-18.0

DATA ELEMENT: Parenteral Frequency Fed (PARENTERAL FREQ FED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(03)	LEFT	SPACES	66	68

DEFINITION: The number of times per week that the patient was fed.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, IV.B.

REMARKS: N/A

RECORD/FIELD: GP0-19.0

DATA ELEMENT: HCPCS Procedure Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(05)	LEFT	SPACES	69	73

DEFINITION: This is the HCPCS/CPT-4 code that describes the service/nutrient.

CODE VALUES: HCPCS/CPT-4 Code Set

VALIDATION: Must be entered if required by payor.

If entered, must be a valid HCPCS/CPT-4 procedure code.

FORM LOCATION: CMS-1500 Block 24D

REMARKS: This will be the same code as entered in the corresponding FA0 record (FA0-09.0).

RECORD/FIELD: GP0-20.0 GP0-21.0

DATA ELEMENT: HCPCS Modifier 1
HCPCS Modifier 2

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(02)	LEFT	SPACES	74	75
21.0	X(02)	LEFT	SPACES	76	77

DEFINITION: These codes identify special circumstances related to the performance of the service.

CODE VALUES: See current HCPCS Modifier codes.

VALIDATION: Must be entered if required by payor for proper adjudication of the service.

FORM LOCATION: CMS-1500 Block 24D

REMARKS: N/A

RECORD/FIELD: GP0-22.0

DATA ELEMENT: Amino Acid Name

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(15)	LEFT	SPACES	78	92

DEFINITION: The name of the Amino Acid prescribed by the referring/ordering physician for this patient.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233

REMARKS: N/A

RECORD/FIELD: GP0-23.0

DATA ELEMENT: Amino Acid Volume

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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23.0 9(04) RIGHT ZEROS 93 96

DEFINITION: The number of milliliters of Amino Acid Solution used in the RX per day for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: N/A

RECORD/FIELD: GP0-24.0

DATA ELEMENT: Amino Acid Concentration (AMINO ACID CONC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(05)	LEFT	SPACES	97	101

DEFINITION: The percentage of concentration of Amino Acid used in the RX for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Maximum of 5 characters - use "." (decimal) when necessary to give a percentage that is less than a whole percentage; i.e., 10.25.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: N/A

RECORD/FIELD: GP0-25.0

DATA ELEMENT: Amino Acid Weight (AMINO ACID WEIGHT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	9(04)	RIGHT	ZEROS	102	105

DEFINITION: The grams of Amino Acid used per day for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: If the number of grams per day is greater than "100", an explanation should be entered in the "Narrative Field" (GP0-31.0).

RECORD/FIELD: GP0-26.0

DATA ELEMENT: Dextrose Volume

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	9(04)	RIGHT	ZEROS	106	109

DEFINITION: The number of milliliters of Dextrose solution used in the RX per day for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: N/A

RECORD/FIELD: GP0-27.0

DATA ELEMENT: Dextrose Concentration (DEXTROSE CONC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(05)	LEFT	SPACES		14

DEFINITION: The percentage of concentration of Dextrose used in the RX for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Maximum of 5 characters - use "." (decimal) when necessary to give a percentage that is less than a whole percentage; i.e., 10.25.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: N/A

RECORD/FIELD: GP0-28.0

DATA ELEMENT: Lipids Volume

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	9(04)	RIGHT	ZEROS	115	118

DEFINITION: The number of milliliters of Lipids used in the RX for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: N/A

RECORD/FIELD: GP0-29.0

DATA ELEMENT: Lipids Concentration (LIPIDS CONC)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	x(05)	LEFT	SPACES	119	123

DEFINITION: The percentage of concentration of Lipids used in the RX for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Maximum of 5 characters - use "." (decimal) when necessary to give a percentage that is less than a whole percentage; i.e., 10.25.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: N/A

RECORD/FIELD: GP0-30.0

DATA ELEMENT: Lipids Frequency (LIPIDS FREQ)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	9(03)	RIGHT	ZEROS	124	126

DEFINITION: The number of times per week Lipids are used in the RX for Parenteral Nutrition Therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: OMB 09380233, IV.C.

REMARKS: N/A

RECORD/FIELD: GP0-31.0

DATA ELEMENT: Narrative Field

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(100)	LEFT	SPACES	127	226

DEFINITION: A narrative field use to describe special circumstances, medical justification or any additional comments necessary for proper adjudication of the claim.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor for proper adjudication of the claim.

FORM LOCATION: OMB 09380233

REMARKS: Some examples of when this field is needed are as follows:

1. If GP0-10.0 is other than "blank".
2. If GP0-16.0 is equal to "N".
3. If GP0-17.0 is equal to "P".
4. If GP0-25.0 is greater than "100".
5. If GP0-32.0 is equal to "O".

If additional information is needed, an "HA0" record can be used.

RECORD/FIELD: GP0-32.0

DATA ELEMENT: Administration Technique Indicator (ADMIN TECH IND)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(01)	LEFT	SPACES	227	227

DEFINITION: An indicator used to describe the technique used to administer the nutrient to the patient.

CODE VALUES: N = Nasogastric Tube
G = Gastrostomy
J = Jejunostomy
O = Other

VALIDATION: Must be entered if required by payor.

Must a be a valid code from the list above.

FORM LOCATION: OMB 09380233, V.F.

REMARKS: If "O" (other), provide narrative in GP0-31.0.

RECORD/FIELD: GP0-33.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
33.0	X(93)	LEFT	SPACES	228	320

DEFINITION: Unused reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CERTIFICATION RECORD TYPE GU0 "UNIVERSAL DMEPOS ITEMS"

Not Required by MO HealthNet

Must follow FB0 - GP0

Must be followed by GX0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GU0"	C-24	GU0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	CERTIFICATION TYPE		Not Used
05	PLACE OF SERVICE		Not Used
06	REPLACEMENT ITEM		Not Used
07	HCPCS PROCEDURE CODE		Not Used
08	HCPCS MODIFIER		Not Used
09	WARRANTY REPLY		Not Used
10	WARRANTY LENGTH		Not Used
11	WARRANTY TYPE		Not Used
12	DIAGNOSIS CODE-1		Not Used
13	DIAGNOSIS CODE-2		Not Used
14	DIAGNOSIS CODE-3		Not Used
15	DIAGNOSIS CODE-4		Not Used
16	PATIENT HEIGHT		Not Used
17	PATIENT WEIGHT		Not Used
18	DT LAST MEDICAL EXAM		Not Used
19	INITIAL DATE		Not Used
20	REV RECERT DATE		Not Used
21	LENGTH OF NEED		Not Used
22	DATE CERT SIGNED		Not Used

23	ORDERING PROV PHONE		Not Used
24	CERT ON FILE		Not Used
25	CERT FORM NUMBER		Not Used
26	REPLY ALN L01 N01		Not Used
27	REPLY ALN L01 N02		Not Used
28	REPLY ALN L01 N03		Not Used
29	REPLY ALN L01 N04		Not Used
30	REPLY ALN L01 N05		Not Used
31	REPLY ALN L01 N06		Not Used
32	REPLY ALN L01 N07		Not Used
33	REPLY ALN L01 N08		Not Used
34	REPLY ALN L01 N09		Not Used
35	REPLY ALN L01 N010		Not Used
36	REPLY ALN L01 N011		Not Used
37	REPLY ALN L01 N012		Not Used
38	REPLY ALN L01 N013		Not Used
39	REPLY ALN L01 N014		Not Used
40	REPLY ALN L01 N015		Not Used
41	REPLY ALN L01 N016		Not Used
42	REPLY ALN L01 N017		Not Used
43	REPLY ALN L01 N018		Not Used
44	REPLY ALN L01 N019		Not Used
45	REPLY ALN L01 N020		Not Used
46	REPLY ALN L01 N021		Not Used
47	REPLY ALN L01 N022		Not Used
48	REPLY ALN L01 N023		Not Used
49	REPLY ALN L01 N024		Not Used
50	REPLY ALN L05 N01		Not Used
51	REPLY ALN L05 N02		Not Used
52	REPLY ALN L05 N03		Not Used

53	REPLY ALN L08 N01		Not Used
54	REPLY ALN L08 N02		Not Used
55	REPLY ALN L08 N03		Not Used
56	REPLY ALN L08 N04		Not Used
57	REPLY ALN L20 N01		Not Used
58	REPLY ALN L60 N01		Not Used
59	REPLY NUM L01 N01		Not Used
60	REPLY NUM L01 N02		Not Used
61	REPLY NUM L01 N03		Not Used
62	REPLY NUM L04 N01		Not Used
63	REPLY NUM L04 N02		Not Used
64	REPLY NUM L04 N03		Not Used
65	REPLY NUM L04 N04		Not Used
66	REPLY NUM L04 N05		Not Used
67	REPLY NUM L04 N06		Not Used
68	REPLY NUM L04 N07		Not Used
69	REPLY PCT L04 N01		Not Used
70	REPLY PCT L04 N02		Not Used
71	REPLY PCT L04 N03		Not Used
72	FILLER-NATIONAL		YES

RECORD TYPE: GU0

LEVEL: SERVICE LINE

PURPOSE: To provide information regarding certification of medical necessity for DMEPOS ITEMS.

REQUIREMENTS: If required by the payor, the "GU0" record must be submitted for the initial certification, revised certification and renewal certification when billing for DMEPOS ITEMS.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1, FB2, FE0 FA0, HA0 or XA0

NOTES: When used, this record must follow the FA0, FB0, FB1 or FB2 or FE0 records related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "GU0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	CERTIFICATION TYPE	1	X	23	23
05.0	PLACE OF SERVICE	2	X	24	25
06.0	REPLACEMENT ITEM	1	X	26	26
07.0	HCPCS PROCEDURE CODE	5	X	27	31
08.0	HCPCS MODIFIER	2	X	32	33
09.0	WARRANTY REPLY	1	X	34	34
10.0	WARRANTY LENGTH	2	X	35	36
11.0	WARRANTY TYPE	1	X	37	37
12.0	DIAGNOSIS CODE-1	5	X	38	42
13.0	DIAGNOSIS CODE-2	5	X	43	47
14.0	DIAGNOSIS CODE-3	5	X	48	52
15.0	DIAGNOSIS CODE-4	5	X	53	57
16.0	PATIENT HEIGHT	2	N	58	59
17.0	PATIENT WEIGHT	3	N	60	62
18.0	DT LAST MEDICAL EXAM	8	X	63	70
19.0	INITIAL DATE	8	X	71	78
20.0	REV RECERT DATE	8	X	79	86
21.0	LENGTH OF NEED	2	N	87	88
22.0	DATE CERT SIGNED	8	X	89	96
23.0	ORDERING PROV PHONE	10	X	97	106
24.0	CERT ON FILE	1	X	107	107
25.0	CERT FORM NUMBER	4	N	108	111
26.0	REPLY ALN L01 N01	1	X	112	112
27.0	REPLY ALN L01 N02	1	X	113	113

28.0	REPLY ALN L01 N03	1	X	114	114
29.0	REPLY ALN L01 N04	1	X	115	115
30.0	REPLY ALN L01 N05	1	X	116	116
31.0	REPLY ALN L01 N06	1	X	117	117
32.0	REPLY ALN L01 N07	1	X	118	118
33.0	REPLY ALN L01 N08	1	X	119	119
34.0	REPLY ALN L01 N09	1	X	120	120
35.0	REPLY ALN L01 N10	1	X	121	121
36.0	REPLY ALN L01 N11	1	X	122	122
37.0	REPLY ALN L01 N12	1	X	123	123
38.0	REPLY ALN L01 N13	1	X	124	124
39.0	REPLY ALN L01 N14	1	X	125	125
40.0	REPLY ALN L01 N15	1	X	126	126
41.0	REPLY ALN L01 N16	1	X	127	127
42.0	REPLY ALN L01 N17	1	X	128	128
43.0	REPLY ALN L01 N18	1	X	129	129
44.0	REPLY ALN L01 N19	1	X	130	130
45.0	REPLY ALN L01 N20	1	X	131	131
46.0	REPLY ALN L01 N21	1	X	132	132
47.0	REPLY ALN L01 N22	1	X	133	133
48.0	REPLY ALN L01 N23	1	X	134	134
49.0	REPLY ALN L01 N24	1	X	135	135
50.0	REPLY ALN L05 N01	5	X	136	140
51.0	REPLY ALN L05 N02	5	X	141	145
52.0	REPLY ALN L05 N03	5	X	146	150
53.0	REPLY ALN L08 N01	8	X	151	158
54.0	REPLY ALN L08 N02	8	X	159	166
55.0	REPLY ALN L08 N03	8	X	167	174
56.0	REPLY ALN L08 N04	8	X	175	182
57.0	REPLY ALN L20 N01	20	X	183	202

58.0	REPLY ALN L60 N01	60	X	203	262
59.0	REPLY NUM L01 N01	1	N	263	263
60.0	REPLY NUM L01 N02	1	N	264	264
61.0	REPLY NUM L01 N03	1	N	265	265
62.0	REPLY NUM L04 N01	4	N	266	269
63.0	REPLY NUM L04 N02	4	N	270	273
64.0	REPLY NUM L04 N03	4	N	274	277
65.0	REPLY NUM L04 N04	4	N	278	281
66.0	REPLY NUM L04 N05	4	N	282	285
67.0	REPLY NUM L04 N06	4	N	286	289
68.0	REPLY NUM L04 N07	4	N	290	293
69.0	REPLY PCT L04 N01	4	N	294	297
70.0	REPLY PCT L04 N02	4	N	298	301
71.0	REPLY PCT L04 N03	4	N	302	305
72.0	FILLER - NATIONAL	15	X	306	320

RECORD/FIELD: GU0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GU0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Universal DMEPOS Item Certification" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GU0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GU0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GU0" records and to associate "GU0" records with "FA0" records.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the list above.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GU0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500, Block 26

REMARKS: N/A

RECORD/FIELD: GU0-04.0

DATA ELEMENT: Certification Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	N/A	SPACES	23	23

DEFINITION: Certification type

CODE VALUES: 1 = Initial certification
2 = Revision
3 = Recertification

VALIDATION: Must be entered.

Must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: The code value should correspond to the certification type box checked in Section A of the DMERC CMN form.

RECORD/FIELD: GU0-05.0

DATA ELEMENT: Place of Service

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(02)	LEFT	SPACES	24	25

DEFINITION: The code that identifies where the service was performed.

CODE VALUES: Refer to Field FA0-07.0

VALIDATION: Must be entered

FORM LOCATION: All DMERC CMNs, Section A

REMARKS: N/A

RECORD/FIELD: GU0-06.0

DATA ELEMENT: Replacement Item

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(01)	N/A	SPACES	26	26

DEFINITION: Indicates that this certification is for an item replacing a previously purchased item.

CODE VALUES: Y = Yes

N = No

VALIDATION: Must be entered for all CMNs except DMERC form 08.02.

Must be blank for DMERC form 08.02.

Must be a valid code from the list above.

FORM LOCATION: All DMERC CMNs, except 08.02 Section A

REMARKS: N/A

RECORD/FIELD: GU0-07.0

DATA ELEMENT: HCPCS Procedure Code

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(05)	LEFT	SPACES	27	31

DEFINITION: The HCPCS code describing the certified item.

CODE VALUES: HCPCS code set.

VALIDATION: Must be entered.

Must be a valid HCPCS code.

FORM LOCATION: DMERC 01.02, 02.02, 03.02, 04.02, 06.02, 07.02, 09.02 and 10.02; Section A
DMERC 05.02, Section B - Reserved for future use
DMERC 08.02, Section B - Question 1.A

REMARKS: N/A

RECORD/FIELD: GU0-08.0

DATA ELEMENT: HCPCS Modifier

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(02)	LEFT	SPACES	32	33

DEFINITION: The code that identifies special circumstances related to the equipment or supply.

CODE VALUES: See current HCPCS modifier codes.

VALIDATION: Must be entered if required by payor for proper adjudication of the equipment or supply.

FORM LOCATION: DMERC 01.02, 02.02, 03.02, 04.02, 06.02, 07.02, 09.02, AND 10.02, Section A

REMARKS: Must be blank for DMERC 05.02 (not currently in use) and 08.02.

RECORD/FIELD: GU0-09.0

DATA ELEMENT: Warranty Reply

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(01)	N/A	SPACES	34	34

DEFINITION: Code indicating whether the item is covered by a warranty.

CODE VALUES: Y = Yes

N = No

D = Does not apply

VALIDATION: If entered, must be a valid code from the list above.

Must be blank for DMERC form 08.02.

FORM LOCATION: All DMERC CMNs, Section A, except form 05.02 (not currently in use) and 08.02.

REMARKS: This response is implied on hardcopy CMNs when the warranty length and type are completed. However, it must be indicated electronically.

RECORD/FIELD: GU0-10.0

DATA ELEMENT: Warranty Length

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(02)	LEFT	SPACES	35	36

DEFINITION: Length of the warranty period in months.

CODE VALUES: 01 through 99

VALIDATION: Must be entered if required by payor and Field GU0-09.0 is equal to "Y".

Not required for DMERC forms 05.02 (not currently in use) and 08.02.

If entered, must be a valid code from the list above.

FORM LOCATION: All DMERC CMNs, Section A, except 05.02 and 08.02.

REMARKS: N/A

RECORD/FIELD: GU0-11.0

DATA ELEMENT: Warranty Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(01)	N/A	SPACES	37	37

DEFINITION: Code indicating the warranty type and coverage.

CODE VALUES:

- 1 = Full replacement
- 2 = Pro-rated replacement
- 3 = Parts and labor
- 4 = Parts only

VALIDATION: Must be entered if required by payor and Field GU0-09.0 is equal to "Y".

Must be blank for DMERC form 05.02 (not currently in use) and 08.02.

If entered, must be a valid code from the list above.

FORM LOCATION: All DMERC CMNs, Section A, except 05.02 and 08.02.

REMARKS: N/A

RECORD/FIELD: GU0-12.0 GU0-13.0 GU0-14.0 GU0-15.0

DATA ELEMENT: Diagnosis Code-1

Diagnosis Code-2

Diagnosis Code-3

Diagnosis Code-4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(05)	LEFT	SPACES	38	42
13.0	X(05)	LEFT	SPACES	43	47
14.0	X(05)	LEFT	SPACES	48	52
15.0	X(05)	LEFT	SPACES	53	57

DEFINITION: The ICD-9-CM diagnosis code identifying a diagnosed medical condition resulting in the medical necessity for this item.

CODE VALUES: N/A

VALIDATION: Must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.

Do not submit a decimal point. The decimal point is implied.

A diagnosis code must be entered in Field 12.0.

FORM LOCATION: All DMERC CMNs, Section B

REMARKS: All diagnosis codes provided in Section B of the DMERC CMN form should be entered in Fields 12.0 through 15.0

RECORD/FIELD: GU0-16.0

DATA ELEMENT: Patient Height

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	9(02)	RIGHT	ZEROS	58	59

DEFINITION: Patient height in inches.

CODE VALUES: N/A

VALIDATION: Must be entered for DMERC form 10.02.

FORM LOCATION: DMERC form 10.02, Section B

REMARKS: N/A

RECORD/FIELD: GU0-17.0

DATA ELEMENT: Patient Weight

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
<u>NSF (National Standard Format) User Manual</u>					

17.0 9(03) RIGHT ZEROS 60 62

DEFINITION: Patient weight in pounds.

CODE VALUES: N/A

VALIDATION: Must be entered for DMERC forms 02.02 and 10.02.

FORM LOCATION: DMERC forms 02.02 and 10.02, Section B

REMARKS: N/A

RECORD/FIELD: GU0-18.0

DATA ELEMENT: Date of Last Medical Examination (DT LAST MEDICAL EXAM)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	X(08)	LEFT	SPACES	63	70

DEFINITION: The date that the patient was last seen by the certifying physician.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

May be blank. Not required for DMERC claims.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GU0-19.0

DATA ELEMENT: Initial Date

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(08)	LEFT	SPACES	71	78

DEFINITION: The beginning date of certified period of medical necessity.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

Must be entered.

Must be a valid date.

FORM LOCATION: All DMERC CMNs, Section A

REMARKS: N/A

RECORD/FIELD: GU0-20.0

DATA ELEMENT: Revision or Recertification Date (REV RECERT DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	X(08)	LEFT	SPACES	79	86

DEFINITION: The effective date of the revision or recertification provided by the certifying physician.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

Must be entered if Field GU0-04.0 is equal to "2" or "3".

Must be a valid date.

FORM LOCATION: All DMERC CMNs, Section A

REMARKS: N/A

RECORD/FIELD: GU0-21.0

DATA ELEMENT: Length of Need

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	9(02)	RIGHT	ZEROS	87	88

DEFINITION: The number of months of medical necessity certified by the physician.

CODE VALUES: 01 through 99.

VALIDATION: Must be entered for all DMERC forms except form 08.02.

Must be a valid code from the list above.

FORM LOCATION: All DMERC CMNs, Section B, except 08.02.

REMARKS: Use 99 if the LIFETIME box in Section B of the DMERC CMN form is checked.

RECORD/FIELD: GU0-22.0

DATA ELEMENT: Date of Physician's Signature (DATE CERT SIGNED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(08)	LEFT	SPACES	89	96

DEFINITION: The date the certificate of medical necessity was completed and signed by the ordering physician.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Date" entry.

Must be entered.

Must be a valid date.

FORM LOCATION: All DMERC CMNs, Section B

REMARKS: N/A

RECORD/FIELD: GU0-23.0

DATA ELEMENT: Ordering Physician's Telephone Number (ORDERING PROV PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(10)	LEFT	SPACES	97	106

DEFINITION: The telephone number of the ordering physician who prescribed this item.

CODE VALUES: N/A

VALIDATION: Must be entered.

See GENERAL INSTRUCTIONS for "Phone" entry.

FORM LOCATION: All DMERC CMNs, Section B

REMARKS: N/A

RECORD/FIELD: GU0-24.0S

DATA ELEMENT: Certification on File (CERT ON FILE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(01)	N/A	SPACES	107	107

DEFINITION: The supplier's guarantee that a copy of the paper certification, signed and dated by the physician, is on file at the supplier's office.

CODE VALUES: Y = Yes, certification is on file.

N = No, certification is not on file.

VALIDATION: Must be entered.

Must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: A "N" response will cause the claim to reject as there must be a signed, dated CMN on file with the supplier in order for the claim to be adjudicated.

RECORD/FIELD: GU0-25.0

DATA ELEMENT: Certification Form Number (CERT FORM NUMBER)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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DEFINITION: Form Number of the DMERC Certification of Medical Necessity used as the source of input to this DMEPOS certification record.

CODE VALUES:	01.02	Hospital Bed and Support Services
	02.03	Manual and Motorized Wheelchairs
	03.02	Continuous Positive Airway Pressure System
	04.03	Lymphedema Pump, Osteogenesis Stimulator
	05.02	Reserved for Future Use
	06.02	TENS
	07.02	Seat Lift Mechanisms and Power Operated Vehicle (POV)
	08.02	Immunosuppressive Drugs
	09.02	External Infusion Pump
	10.02	Parenteral and Enteral Nutrition

VALIDATION: Must be entered.

Must be a valid code from the list above.

FORM LOCATION: DMERC Certification Form

REMARKS: N/A

RECORD/FIELD: GU0-26.0S

DATA ELEMENT: REPLY ALN L01 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(01)	N/A	SPACES	112	112

DEFINITION: Reply to the first question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02, 02.03, 04.03, 06.02, 07.02, and 09.02:

Y = Yes

N = No

D = Does not apply

DMERC 08.02 & 10.02:

Y = Yes

N = No

DMERC Form 03.02 & 05.02:

Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 1
 DMERC 02.03, Question 1
 DMERC 04.03, Question 1 (Lymphedema Pumps)
 DMERC 04.03, Question 6 (Osteogenesis Stimulator)
 DMERC 06.02, Question 1
 DMERC 07.02, Question 1
 DMERC 08.02, Question 4
 DMERC 09.02, Question 7
 DMERC 10.02, Question 1

REMARKS: N/A

RECORD/FIELD: GU0-27.0S

DATA ELEMENT: REPLY ALN L01 N02

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(01)	N/A	SPACES	113	113

DEFINITION: Reply to the second question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 02.03, 04.03, 06.02, and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC Form 08.02:

Y = Yes

N = No

DMERC Forms 01.02, 03.02, 05.02

09.02 and 10.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 02.03, Question 2
 DMERC 04.03, Question 2 (Lymphedema Pump)
 DMERC 04.03, Question 7 (Osteogenesis Stimulator)
 DMERC 06.02, Question 3
 DMERC 07.02, Question 2
 DMERC 08.02, Question 12

REMARKS: N/A

RECORD/FIELD: GU0-28.0

DATA ELEMENT: REPLY ALN L01 N03

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	X(01)	N/A	SPACES	114	114

DEFINITION: Reply to the third question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02, 02.03, 04.03 and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC form 06.02:

1 = Headache

2 = Visceral abdominal pain

3 = Pelvic pain

4 = Temporomandibular joint (TMJ) pain

5 = None of the above

DMERC form 03.02 and 09.02: Reserved for Future Use

DMERC form 10.02:

1 = Central line

3 = Hemodialysis Access Line

7 = Peripherally Inserted Catheter (PIC) line

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 3
 DMERC 02.03, Question 3
 DMERC 04.03, Question 3 (Lymphedema Pump)
 DMERC 04.03, Question 8 (Osteogenesis Stimulator)
 DMERC 06.02, Question 5
 DMERC 07.03, Question 3
 DMERC 10.02, Question 5

REMARKS: N/A

RECORD/FIELD: GU0-29.0

DATA ELEMENT: REPLY ALN L01 N04

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(01)	N/A	SPACES	115	115

DEFINITION: Reply to the fourth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02, 02.03, 04.03, 06.02, and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC Form 03.02, 09.02, and 10.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 4
 DMERC 02.03, Question 4
 DMERC 04.03, Question 4 (Lymphedema Pump)

DMERC 04.03, Question 9 (Osteogenesis Stimulator)
DMERC 06.02, Question 6
DMERC 07.02, Question 4

REMARKS: N/A

RECORD/FIELD: GU0-30.0

DATA ELEMENT: REPLY ALN L01 N05

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(01)	N/A	SPACES	116	116

DEFINITION: Reply to the fifth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02, 02.03, 04.03, 06.02, and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC Form 10.02:

Y = Yes

N = No

DMERC Form 03.02 & 09.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 5
DMERC 02.03, Question 8 (Manual Wheelchairs)
DMERC 02.03, Question 6 (Motorized Wheelchairs)
DMERC 04.03, Question 5 (Lymphedema Pump)
DMERC 04.03, Question 10 (Osteogenesis Stimulator)
DMERC 06.02, Question 7
DMERC 07.02, Question 5
DMERC 10.02, Question 7

REMARKS: N/A

RECORD/FIELD: GU0-31.0

DATA ELEMENT: REPLY ALN L01 N06

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(01)	N/A	SPACES	117	117

DEFINITION: Reply to the sixth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02, 02.03, 04.03, and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC form 10.02:

Y = Yes

N = No

DMERC Form 03.02 & 09.02: Reserved for future use.

DMERC form 06.02:

1 = Daily

2 = 3 to 6 days per week

3 = 2 or less days per week

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 6
DMERC 02.03, Question 9 (Manual wheelchairs)
DMERC 02.03, Question 7 (Motorized Wheelchairs)
DMERC 04.03, Question 11 (Osteogenesis Stimulator)
DMERC 06.02, Question 10
DMERC 07.02, Question 6
DMERC 10.02, Question 8

REMARKS: N/A

RECORD/FIELD: GU0-32.0

DATA ELEMENT: REPLY ALN L01 N07

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
32.0	X(01)	N/A	SPACES	118	118

DEFINITION: Reply to the seventh question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02, 06.02 and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC Form 03.02 and 10.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 7
DMERC 06.02, Question 11
DMERC 07.02, Question 7

REMARKS: N/A

RECORD/FIELD: GU0-33.0

DATA ELEMENT: REPLY ALN L01 N08

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
33.0	X(01)	N/A	SPACES	119	119

DEFINITION: Reply to the eighth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC form 07.02:

Y = Yes

N = No

D = Does not apply

DMERC Forms 01.02 and 03.02: Reserved for future use.

DMERC form 06.02:

2 = 2 leads

4 = 4 leads

DMERC form 10.02:

1 = syringe

2 = gravity

3 = pump

4 = does not apply

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 06.02, Question 12
 DMERC 07.02, Question 8
 DMERC 10.02, Question 13

REMARKS: N/A

RECORD/FIELD: GU0-34.0

DATA ELEMENT: REPLY ALN L01 N09

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
34.0	X(01)	N/A	SPACES	120	120

DEFINITION: Reply to the ninth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC form 10.02:

Y = Yes

N = No

D = Does not apply

DMERC Forms 01.02, 03.02 and 07.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 10.02, Question 14

REMARKS: N/A

RECORD/FIELD: GU0-35.0 ITEMS

DATA ELEMENT: REPLY ALN L01 N10

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
35.0	X(01)	N/A	SPACES	121	121

DEFINITION: Reply to the tenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC form (reserved for future use)

Y = Yes

N = No

D = Does not apply

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: Reserved for Future Use

RECORD/FIELD: GU0-36.0

DATA ELEMENT: REPLY ALN L01 N11

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
36.0	X(01)	N/A	SPACES	122	122

DEFINITION: Reply to the eleventh question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC form 01.02:

Y = Yes

N = No

D = Does not apply

DMERC forms 03.02 and 07.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 12

REMARKS: N/A

RECORD/FIELD: GU0-37.0

DATA ELEMENT: REPLY ALN L01 N12

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
37.0	X(01)	N/A	SPACES	123	123

DEFINITION: Reply to the twelfth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02, 03.02, and 07.02:

Y = Yes

N = No

D = Does not apply

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 13

DMERC 03.02, Question 14

DMERC 07.02, Question 12

REMARKS: N/A

RECORD/FIELD: GU0-38.0

DATA ELEMENT: REPLY ALN L01 N13

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
38.0	X(01)	N/A	SPACES	124	124

DEFINITION: Reply to the thirteenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02 and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC Form 03.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 14

DMERC 07.02, Question 13

REMARKS: N/A

RECORD/FIELD: GU0-39.0

DATA ELEMENT: REPLY ALN L01 N14

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
39.0	X(01)	N/A	SPACES	125	125

DEFINITION: Reply to the fourteenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02 and 07.02:

Y = Yes

N = No

D = Does not apply

DMERC Form 03.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 15

DMERC 07.02, Question 14

REMARKS: N/A

RECORD/FIELD: GU0-40.0

DATA ELEMENT: REPLY ALN L01 N15

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
40.0	X(01)	N/A	SPACES	126	126

DEFINITION: Reply to the fifteenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02:

Y = Yes

N = No

D = Does not apply

DMERC Form 03.02 and 04.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 16

REMARKS: N/A

RECORD/FIELD: GU0-41.0

DATA ELEMENT: REPLY ALN L01 N16

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
41.0	X(01)	N/A	SPACES	127	127

DEFINITION: Reply to the sixteenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC form (reserved for future use)

Y = Yes

N = No

D = Does not apply

DMERC forms 01.02 and 03.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: Reserved for Future Use

RECORD/FIELD: GU0-42.0

DATA ELEMENT: REPLY ALN L01 N17

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
42.0	X(01)	N/A	SPACES	128	128

DEFINITION: Reply to the seventeenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: Y = Yes

N = No

D = Does not apply

DMERC forms 01.02 and 03.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: Reserved for future use.

RECORD/FIELD: GU0-43.0

DATA ELEMENT: REPLY ALN L01 N18

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
43.0	X(01)	N/A	SPACES	129	129

DEFINITION: Reply to the eighteenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02:

Y = Yes

N = No

D = Does not apply

DMERC form 03.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 19

REMARKS: N/A

RECORD/FIELD: GU0-44.0

DATA ELEMENT: REPLY ALN L01 N19

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
44.0	X(01)	N/A	SPACES	130	130

DEFINITION: Reply to the nineteenth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC forms 01.02:

Y = Yes

N = No

D = Does not apply

DMERC form 03.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 20

REMARKS: N/A

RECORD/FIELD: GU0-45.0

DATA ELEMENT: REPLY ALN L01 N20

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
45.0	X(01)	N/A	SPACES	131	131

DEFINITION: Reply to the twentieth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC form 01.02:

1 = Improved

2 = Remained same

3 = Worsened

DMERC form 03.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 22

REMARKS: N/A

RECORD/FIELD: GU0-46.0

DATA ELEMENT: REPLY ALN L01 N21

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
46.0	X(01)	N/A	SPACES	132	132

DEFINITION: Reply to the twenty-first question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: DMERC form (reserved for future use)

Y = Yes

N = No

D = Does not apply

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: N/A

REMARKS: Reserved for future use

RECORD/FIELD: GU0-47.0

DATA ELEMENT: REPLY ALN L01 N22

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
47.0	X(01)	N/A	SPACES	133	133

DEFINITION: Reply to the twenty-second question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Reserved for future use.

RECORD/FIELD: GU0-48.0

DATA ELEMENT: REPLY ALN L01 N23

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
48.0	X(01)	N/A	SPACES	134	134

DEFINITION: Reply to the twenty-third question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Reserved for future use.

RECORD/FIELD: GU0-49.0

DATA ELEMENT: REPLY ALN L01 N24

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
49.0	X(01)	N/A	SPACES	135	135

DEFINITION: Reply to the twenty-fourth question on any DMERC Certification of Medical Necessity form that requires a one position alphanumeric response.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: Reserved for future use.

RECORD/FIELD: GU0-50.0

DATA ELEMENT: REPLY ALN L05 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
50.0	X(05)	LEFT	SPACES	136	140

DEFINITION: Reply to the first question on any DMERC Certification of Medical Necessity form that requires a five position alphanumeric response.

CODE VALUES: DMERC form 08.02: Reserved for future use.

DMERC form 09.02: HCPCS code

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 09.02, Question 2

REMARKS: DMERC 09.02: HCPCS code for drug that requires use of pump.

RECORD/FIELD: GU0-51.0

DATA ELEMENT: REPLY ALN L05 N02

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
51.0	X(05)	LEFT	SPACES	141	145

DEFINITION: Reply to the second question on any DMERC Certification of Medical Necessity form that requires a five position alphanumeric response.

CODE VALUES: DMERC form 08.02: U.S. Postal Service state abbreviation.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 08.02, Question 10

REMARKS: DMERC 08.02: U.S. Postal Service state abbreviation for the state in which the transplant operation was performed.

RECORD/FIELD: GU0-52.0

DATA ELEMENT: REPLY ALN L05 N03

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
52.0	X(05)	LEFT	SPACES	146	150

DEFINITION: Reply to the third question on any DMERC Certification of Medical Necessity form that requires a five position alphanumeric response.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: Reserved for future use.

RECORD/FIELD: GU0-53.0

DATA ELEMENT: REPLY ALN L08 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
53.0	X(08)	LEFT	SPACES	151	158

DEFINITION: Reply to the first question on any DMERC Certification of Medical Necessity form that requires a eight position alphanumeric response.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Date" entry.

Must be a valid date.

DMERC form 05.02 and 08.02: Reserved for future use.

DMERC form 06.02: If questions 1 (GU0.26.0) on form 06.02 equals 'N' or 'D', this may be blank.

FORM LOCATION: DMERC 06.02, Question 2

REMARKS: DMERC 06.02: Date of surgery resulting in acute post-operative pain.

RECORD/FIELD: GU0-54.0

DATA ELEMENT: REPLY ALN L08 N02

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
54.0	X(08)	LEFT	SPACES	159	166

DEFINITION: Reply to the second question on any DMERC Certification of Medical Necessity form that requires a eight position alphanumeric response.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Date" entry.

Must be a valid date.

FORM LOCATION: DMERC 06.02, Question 8.A
DMERC 08.02, Question 11

REMARKS: DMERC 06.02: Start date of TENS trial.

DMERC 08.02: Date patient discharged from hospital following transplant surgery.

RECORD/FIELD: GU0-55.0

DATA ELEMENT: REPLY ALN L08 N03

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
55.0	X(08)	LEFT	SPACES	167	174

DEFINITION: Reply to the third question on any DMERC Certification of Medical Necessity form that requires a eight position alphanumeric response.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Date" entry.

Must be a valid date.

FORM LOCATION: DMERC 06.02, Question 8.B

REMARKS: DMERC 06.02: Ending date of TENS trial.

RECORD/FIELD: GU0-56.0

DATA ELEMENT: REPLY ALN L08 N04

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
56.0	X(08)	LEFT	SPACES	175	182

DEFINITION: Reply to the fourth question on any DMERC Certification of Medical Necessity form that requires a eight position alphanumeric response.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

See GENERAL INSTRUCTIONS for "Date" entry.

Must be a valid date.

FORM LOCATION: DMERC 06.02, Question 9

REMARKS: DMERC 06.02: Date that ordering physician saw and evaluated patient following TENS unit trial.

RECORD/FIELD: GU0-57.0

DATA ELEMENT: REPLY ALN L20 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
57.0	X(20)	LEFT	SPACES	183	202

DEFINITION: Reply to the first DMERC Certification form question that requires a twenty position alphanumeric answer.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

DMERC form 05.02: Reserved for future use.

FORM LOCATION: DMERC 08.02, Question 9
 DMERC 09.02, Question 3
 DMERC 10.02, Question 10

REMARKS: DMERC 08.02: City where transplant facility located.
 DMERC 09.02: Name of drug with non-specific HCPCS code.
 DMERC 10.02: Product name.

RECORD/FIELD: GU0-58.0

DATA ELEMENT: REPLY ALN L60 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
58.0	X(60)	LEFT	SPACES	203	262

DEFINITION: Reply to the first DMERC Certification form question that requires a sixty position alphanumeric answer.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: DMERC 08.02, Question 8

DMERC 10.02, Question 15

REMARKS: DMERC 08.02: Name of transplant facility (maximum of 30 characters).
DMERC 10.02: Additional information when required by policy.

RECORD/FIELD: GU0-59.0

DATA ELEMENT: REPLY NUM L01 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
59.0	9(01)	RIGHT	ZEROS	263	263

DEFINITION: Reply to the first DMERC Certification form question that requires a one position numeric answer.

CODE VALUES: DMERC form 01.02:

- 1 = Stage One
- 2 = Stage Two
- 3 = Stage Three
- 4 = Stage Four
- 9 = No Ulcer or Pressure Area

DMERC form 08.02:

- 1 = Heart
- 2 = Liver
- 3 = Kidney
- 4 = Bone marrow
- 5 = Lung

DMERC form 09.02:

- 1 = External infusion pump (non-disposable)
- 3 = Implantable infusion pump
- 4 = Disposable infusion pump (e.g., elastomeric)

DMERC form 10.02: 1 through 7

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.A
DMERC 08.02, Question 5.A
DMERC 09.02, Question 1
DMERC 10.02, Question 3

REMARKS: DMERC 01.02: Stage of pressure area/ulcer #1.
DMERC 08.02: Transplanted organ code #1.
DMERC 09.02: Type of prescribed pump code.
DMERC 10.02: Days per week infused.

RECORD/FIELD: GU0-60.0

DATA ELEMENT: REPLY NUM L01 N02

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
60.0	9(01)	RIGHT	ZEROS	264	264

DEFINITION: Reply to the second DMERC Certification form question that requires a one position numeric answer.

CODE VALUES: DMERC form 01.02: 1 through 4
DMERC form 08.02:
1 = Heart
2 = Liver
3 = Kidney
4 = Bone marrow
5 = Lung
DMERC form 09.02:
1 = Intravenous
3 = Epidural
4 = Subcutaneous
DMERC form 10.02: 1 through 7

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.D
DMERC 08.02, Question 5.B
DMERC 09.02, Question 4
DMERC 10.02, Question 12

REMARKS: DMERC 01.02: Stage of pressure area/ulcer #2.
DMERC 08.02: Transplanted organ code #2.
DMERC 09.02: Route of administration.
DMERC 10.02: Days per week administered.

RECORD/FIELD: GU0-61.0

DATA ELEMENT: REPLY NUM L01 N03

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
61.0	9(01)	RIGHT	ZEROS	265	265

DEFINITION: Reply to the third DMERC Certification form question that requires a one position numeric answer.

CODE VALUES: DMERC form 01.02: 1 through 4

DMERC form 08.02:

1 = Heart

2 = Liver

3 = Kidney

4 = Bone marrow

5 = Lung

DMERC form 09.02:

1 = Continuous

2 = Intermittent

3 = Bolus

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.G

DMERC 08.02, Question 5.C

DMERC 09.02, Question 5

REMARKS: DMERC 01.02: Stage of pressure area/ulcer #3.
DMERC 08.02: Transplanted organ code #3.
DMERC 09.02: Method of administration.

RECORD/FIELD: GU0-62.0

DATA ELEMENT: REPLY NUM L04 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
62.0	9(04)	RIGHT	ZEROS	266	269

DEFINITION: Reply to the first DMERC Certification form question that requires a four position numeric answer.

CODE VALUES: DMERC forms 02.03 and 09.02: 0001 through 0024
DMERC forms 03.02, 08.02 and 10.02: 0000 through 9999
DMERC form 04.03: 0001 through 0099
DMERC form 06.02: 0001 through 0099 - If GU0-27.0 is 'N' or 'D' this must be zero filled.
DMERC form 01.02 and 05.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 02.03, Question 5
DMERC 03.02, Question 12
DMERC 04.03, Question 6.B (Osteogenesis Stimulators)
DMERC 06.02, Question 4
DMERC 08.02, Question 1.B
DMERC 09.02, Question 6
DMERC 10.02, Question 4.A

REMARKS: DMERC 02.03: Hours per day patient usually spends in the wheelchair.
DMERC 03.02: Number of episodes apnea lasting more than 10 seconds in seven hours or less.
DMERC 04.03: Number of months prior to ordering device did patient sustained the fracture.

DMERC 06.02: Number of months patient has had intractable pain.

DMERC 08.02: Milligram dosage of each drug administered.

DMERC 09.02: Number of hours of drug infusion per day.

DMERC 10.02: Milliliters per day of amino acid.

RECORD/FIELD: GU0-63.0

DATA ELEMENT: REPLY NUM L04 N02

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
63.0	9(04)	RIGHT	ZEROS	270	273

DEFINITION: Reply to the second DMERC Certification form question that requires a four position numeric answer.

CODE VALUES: DMERC forms 01.02 and 08.02: 0000 through 9999
DMERC form 10.02: 0000 through 0999
DMERC form 04.03: 0001 through 0099
DMERC form 05.02 and 09.02: Reserved for future use.

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.B
DMERC 04.03, Question 7.B
DMERC 08.02, Question 1.C
DMERC 10.02, Question 4.C

REMARKS: DMERC 01.02: Maximum length in centimeters of pressure area/ulcer #1.
DMERC 04.03: Number of months, prior to ordering the device did the patient have the fusion (other than spine).
DMERC 08.02: Times per day of drug administration.
DMERC 10.02: Grams of protein per day.

RECORD/FIELD: GU0-64.0

DATA ELEMENT: REPLY NUM L04 N03

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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64.0 9(04) RIGHT ZEROS 274 277

DEFINITION: Reply to the third DMERC Certification form question that requires a four position numeric answer.

CODE VALUES: DMERC forms 01.02 and 10.02: 0000 through 9999
 DMERC form 04.03: 0001 through 0099

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.C
 DMERC 04.03, Question 9.B
 DMERC 10.02, Question 4.D

REMARKS: DMERC 01.02: Maximum width in centimeters of pressure area/ulcer #1.
 DMERC 04.03: Number of months, prior to ordering the device, did the patient have the spinal fusion.
 DMERC 10.02: Milliliters per day of dextrose.

RECORD/FIELD: GU0-65.0

DATA ELEMENT: REPLY NUM L04 N04

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
65.0	9(04)	RIGHT	ZEROS	278	281

DEFINITION: Reply to the fourth DMERC Certification form question that requires a four position numeric answer.

CODE VALUES: DMERC forms 01.02 and 10.02: 0000 through 9999
 DMERC form 04.03: 0001 through 0099

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.E
 DMERC 04.03, Question 10.B
 DMERC 10.02, Question 4.F

REMARKS: DMERC 01.02: Maximum length in centimeters of pressure area/ulcer #2.
 DMERC 04.03: Number of months, prior to ordering the device, did the patient have repeat fusion.
 DMERC 10.02: Milliliters per day of lipids.

RECORD/FIELD: GU0-66.0

DATA ELEMENT: REPLY NUM L04 N05

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
66.0	9(04)	RIGHT	ZEROS	282	285

DEFINITION: Reply to the fifth DMERC Certification form question that requires a four position numeric answer.

CODE VALUES: DMERC form 01.02: 0000 through 9999
 DMERC form 04.03: 0001 through 0099
 DMERC form 10.02: 0000 through 0007

VALIDATION: Must be entered if required by payor.
 Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.F
 DMERC 04.03, Question 10.C
 DMERC 10.02, Question 4.G

REMARKS: DMERC 01.02: Maximum width in centimeters of pressure area/ulcer #2.
 DMERC 04.03: Number of months prior to ordering the device did the patient have the previously failed fusion.
 DMERC 10.02: Days per week lipids administered.

RECORD/FIELD: GU0-67.0

DATA ELEMENT: REPLY NUM L04 N06

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
67.0	9(04)	RIGHT	ZEROS	286	289

DEFINITION: Reply to the sixth DMERC Certification form question that requires a four position numeric answer.

CODE VALUES: DMERC form 01.02 and 10.02: 0000 through 9999
DMERC form 04.03: 0001 through 0099

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.H
DMERC 04.03, Question 11.B
DMERC 10.02, Question 11

REMARKS: DMERC 01.02: Maximum length in centimeters of pressure area/ulcer #3.
DMERC 04.03: Number of months prior to ordering the device did the patient have the multi-level fusion.
DMERC 10.02: Calories per day.

RECORD/FIELD: GU0-68.0

DATA ELEMENT: REPLY NUM L04 N07

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
68.0	9(04)	RIGHT	ZEROS	290	293

DEFINITION: Reply to the seventh DMERC Certification form question that requires a four position numeric answer.

CODE VALUES: DMERC form 01.02: 0000 through 9999

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 01.02, Question 21.I

REMARKS: DMERC 01.02: Maximum width in centimeters of pressure area/ulcer #3.

RECORD/FIELD: GU0-69.0

DATA ELEMENT: REPLY PCT L04 N01

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
69.0	9(3)V9	RIGHT	ZEROS	294	297

DEFINITION: Reply to the first DMERC Certification form question that requires a four position numeric percentage answer containing an implied decimal place.

CODE VALUES: DMERC form 03.02: Reserved for future use.
DMERC form 10.02: 000.0% through 099.9%

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 10.02, Question 4.B

REMARKS: DMERC 10.02: Amino acid percentage of concentration.

RECORD/FIELD: GU0-70.0

DATA ELEMENT: REPLY PCT L04 N02

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
70.0	9(3)V9	RIGHT	ZEROS	298	301

DEFINITION: Reply to the second DMERC Certification form question that requires a four position numeric percentage answer containing an implied decimal place.

CODE VALUES: DMERC form 10.02: 000.0% through 099.9%

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 10.02, Question 4.E

REMARKS: DMERC 10.02: Dextrose percentage of concentration.

RECORD/FIELD: GU0-71.0

DATA ELEMENT: REPLY PCT L04 N03

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
71.0	9(3)V9	RIGHT	ZEROS	302	305

DEFINITION: Reply to the third DMERC Certification form question that requires a four position numeric percentage answer containing an implied decimal place.

CODE VALUES: DMERC form 10.02: 000.0% through 099.9%

VALIDATION: Must be entered if required by payor.

Must be a valid code from the list above.

FORM LOCATION: DMERC 10.02, Question 4.H

REMARKS: DMERC 10.02: Lipids percentage of concentration.

RECORD/FIELD: GU0-72.0S

DATA ELEMENT: Filler - National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
72.0	X(15)	LEFT	SPACES	306	320

DEFINITION: Unused reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CERTIFICATION RECORD TYPE GX0 "MEDICAL NECESSITY FOR OXYGEN"

Not Required by MO HealthNet

Must follow FB0 - GU0

Must be followed by GX1 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GX0"	C-24	GX0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	CERTIFICATION TYPE		Not Used
05	OXYGEN SYSTEM		Not Used
06	LENGTH OF NEED		Not Used
07	EQUIPMENT TYPE 1		Not Used
08	EQUIPMENT TYPE 2		Not Used
09	EQUIPMENT REASON		Not Used
10	PRESCRIBED FROM DATE		Not Used
11	PRESCRIBED TO DATE		Not Used
12	DATE PRESCRIBED		Not Used
13	DATE EVALUATED		Not Used
14	OXY FLOW RATE		Not Used
15	FREQUENCY OF USE		Not Used

16	DURATION		Not Used
17	ARTERIAL BLOOD GAS 4LPM		Not Used
18	OXIMETRY 4LPM		Not Used
19	DATE TESTED 4LPM		Not Used
20	INPATIENT/OUTPATIENT IND		Not Used
21	FILLER		Not Used
22	ARTERIAL BLOOD GAS		Not Used
23	OXIMETRY		Not Used
24	DATE TESTED		Not Used
25	ENTITY PERF OXIMETRY TST		Not Used
26	TEST CONDITIONS		Not Used
27	CLINICAL FINDINGS		Not Used
28	PORT OXY FLOW RATE		Not Used
29	ORDERING PROV ID		Not Used
30	ORDERING PROV PHONE		Not Used
31	DIAGNOSIS CODE-1		Not Used
32	DIAGNOSIS CODE-2		Not Used
33	DIAGNOSIS CODE-3		Not Used
34	DIAGNOSIS CODE-4		Not Used
35	CERT ON FILE		Not Used
36	DELIVERY SYSTEM TYPE		Not Used
37	FILLER-NATIONAL		YES

RECORD TYPE: GX0

LEVEL: SERVICE LINE

PURPOSE: To provide information regarding attending physician's certification of medical necessity for home oxygen therapy (Form HCFA-484).

REQUIREMENTS: If required by payor, a "GX0" record must be submitted for the initial certification, revised certification or renewal certification when billing for home oxygen therapy.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	FA0, FB0, FB1, FB2, or FE0	FA0, GX1, GX2, HA0 or XA0

NOTES: When used, this record must follow the FA0, FB0, FB1, FB2, or FE0 records related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "GX0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	CERTIFICATION TYPE	1	X	23	23
05.0	OXYGEN SYSTEM	1	X	24	24
06.0	LENGTH OF NEED	2	X	25	26
07.0	EQUIPMENT TYPE 1	1	X	27	27
08.0	EQUIPMENT TYPE 2	1	X	28	28
09.0	EQUIPMENT REASON	64	X	29	92
10.0	PRESCRIBED FROM DATE	8	X	93	100
11.0	PRESCRIBED TO DATE	8	X	101	108
12.0	DATE PRESCRIBED	8	X	109	116
13.0	DATE EVALUATED	8	X	117	124
14.0	OXY FLOW RATE	3	N	125	127
15.0	FREQUENCY OF USE	2	X	128	129
16.0	DURATION	2	X	130	131
17.0	ARTERIAL BLOOD GAS 4LPM	3	N	132	134
18.0	OXIMETRY 4LPM	3	N	135	137
19.0	DATE TESTED 4LPM	8	X	138	145
20.0	INPATIENT/OUTPATIENT IND	1	X	146	146
21.0	FILLER	65	X	147	211
22.0	ARTERIAL BLOOD GAS	3	N	212	214
23.0	OXIMETRY	3	N	215	217
24.0	DATE TESTED	8	X	218	225
25.0	ENTITY PERF OXIMETRY TST	33	X	226	258
26.0	TEST CONDITIONS	1	X	259	259

27.0	CLINICAL FINDINGS	3	X	260	262
28.0	PORT OXY FLOW RATE	3	N	263	265
29.0	ORDERING PROV ID	15	X	266	280
30.0	ORDERING PROV PHONE	10	X	281	290
31.0	DIAGNOSIS CODE-1	5	X	291	295
32.0	DIAGNOSIS CODE-2	5	X	296	300
33.0	DIAGNOSIS CODE-3	5	X	301	305
34.0	DIAGNOSIS CODE-4	5	X	306	310
35.0	CERT ON FILE	1	X	311	311
36.0	DELIVERY SYSTEM TYPE	1	X	312	312
37.0	FILLER-NATIONAL	8	X	313	320

RECORD/FIELD: GX0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GX0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Medical Necessity for Oxygen" record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "GX0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GX0" records and to associate "GX0" records with "GX1" and "GX2" records.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: GX0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: GX0-04.0

DATA ELEMENT: Type of Certification (CERTIFICATION TYPE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(01)	N/A	SPACE	23	23

DEFINITION: The type of certification being billed.

CODE VALUES: I = Initial Certification
R = Renewal Certification
S = Revised Certification

OR

1 = Initial Certification
2 = Revised Certification

3 = Renewal Certification

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: HCFA-484

REMARKS: Values 1, 2, and 3 are currently used by the Medicare Durable Medical Equipment Regional Carriers (DMERCs) only.

RECORD/FIELD: GX0-05.0

DATA ELEMENT: Type of Oxygen System (OXYGEN SYSTEM)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(01)	N/A	SPACE	24	24

DEFINITION: To indicate if the patient is mobile within the home when ordering portable oxygen.

CODE VALUES: Y = Yes, ordering portable oxygen and patient is mobile within the home.

N = No, ordering portable oxygen and patient is NOT mobile within the home.

D = Does Not Apply. (Not ordering portable oxygen)

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: HCFA-484, Question 5

REMARKS: N/A

RECORD/FIELD: GX0-06.0

DATA ELEMENT: Length of Need

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(02)	LEFT	SPACES	26	26

DEFINITION: Estimate of length of time oxygen therapy will be required.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Enter the number of months covered by this certification. If lifetime, enter 99.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX0-07.0

DATA ELEMENT: Type of Equipment 1 (EQUIPMENT TYPE 1)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(01)	N/A	SPACE	27	27

DEFINITION: Enter a description of the specific type of equipment being prescribed for the delivery of oxygen.

CODE VALUES: A = Concentrator
 B = Liquid Stationary
 C = Gaseous Stationary
 D = Liquid Portable
 E = Gaseous Portable
 O = Other

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: If the prescribing physician ordered both a portable and stationary system, or a concentrator with a system, enter the second system in "Equipment Type 2" (GX0.08.0).

RECORD/FIELD: GX0-08.0

DATA ELEMENT: Type of Equipment 2 (EQUIPMENT TYPE 2)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	X(01)	N/A	SPACE	28	28

DEFINITION: Enter a description of the specific type of equipment being prescribed for the delivery of oxygen.

CODE VALUES: A = Concentrator
 B = Liquid Stationary
 C = Gaseous Stationary
 D = Liquid Portable
 E = Gaseous Portable
 O = Other

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: If the prescribing physician ordered both a portable and stationary system, or a concentrator with a system, enter the second system in this field.

RECORD/FIELD: GX0-09.0

DATA ELEMENT: Reason for Equipment (EQUIPMENT REASON)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	X(64)	LEFT	SPACES	29	92

DEFINITION: The reasons why a particular system or piece of equipment is required.

CODE VALUE: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-10.0 GX0-11.0

DATA ELEMENT: Oxygen Prescribed From Date
(PRESCRIBED FROM DATE)
Oxygen Prescribed To Date
(PRESCRIBED TO DATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	X(08)	LEFT	SPACES	93	100
11.0	X(08)	LEFT	SPACES	101	108

DEFINITION: The from and to dates for which oxygen was prescribed.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX0-12.0

DATA ELEMENT: Date Oxygen Prescribed (DATE PRESCRIBED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(08)	LEFT	SPACES	109	116

DEFINITION: The date oxygen was prescribed. On renewal prescriptions, enter the date the physician signed the renewal.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX0-13.0

DATA ELEMENT: Date Patient Evaluated (DATE EVALUATED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	X(08)	LEFT	SPACES	117	124

DEFINITION: The date the patient was last examined by the physician to determine the need for oxygen therapy.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: N/A

REMARKS: A lab test to evaluate the continued need for oxygen is not necessary for all recertification, but the results of any such test since the last prior certification should be entered.

RECORD/FIELD: GX0-14.0

DATA ELEMENT: Oxygen Flow Rate (OXY FLOW RATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	X(03)	RIGHT	ZEROES	125	127

DEFINITION: The oxygen flow rate (stationary equipment liters per minute).

CODE VALUES: 001 - 999 LPM

00X = less than 1 LPM

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484, Question 6

REMARKS: For oxygen concentrators, the concentrator supplied must accommodate the flow rate prescribed by the physician. If billing oxygen in excess of 4LPM, or less than 1LPM, the prescription must support the liter flow output.

If billing oxygen is greater than 4 LPM also Enter the date the test was performed (GX0-20.0).

Claims with flow rates of more than 2 liters per minute usually require review by the insurance carrier's medical staff.

RECORD/FIELD: GX0-15.0

DATA ELEMENT: Frequency of Use

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(02)	LEFT	SPACES	128	129

DEFINITION: The number of times per day the patient must use oxygen.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: This field is normally used only if the physician has prescribed oxygen for a particular period of use (i.e. during exercise, nocturnally, etc).

RECORD/FIELD: GX0-16.0

DATA ELEMENT: Duration

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	X(02)	LEFT	SPACES	130	131

DEFINITION: The hours per period of use.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-17.0

DATA ELEMENT: Arterial Blood Gas on 4LPM

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	9(2)V9	RIGHT	ZEROES	132	134

DEFINITION: The arterial blood gas test results taken on 4 LPM.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484, Question 7a

REMARKS: N/A

RECORD/FIELD: GX0-18.0

DATA ELEMENT: Oxygen Saturation on 4LPM

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	9(2)V9	RIGHT	ZEROES	135	137

DEFINITION: The oxygen saturation test results taken on 4 LPM with patient in a chronic stable state.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484, Question 7b

REMARKS: N/A

RECORD/FIELD: GX0-19.0

DATA ELEMENT: Date Test Performed on 4 LPM

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	X(08)	LEFT	SPACES	138	145

DEFINITION: The date the patient was tested for Arterial blood gas and/or oxygen saturation on 4 LPM.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484, Question 7c

REMARKS: N/A

RECORD/FIELD: GX0-20.0

DATA ELEMENT: Inpatient/Outpatient Indicator

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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20.0 X(01) LEFT SPACES 146 146

DEFINITION: Were the test(s) reported in GX0-22 and/or GX0-23 Performed within ONE day of discharge from an inpatient facility to home or with the patient in a chronic stable state as an outpatient?

CODE VALUES: Y = Yes
 N = No

VALIDATION: Must be entered is required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: HCFA-484, Question 2

REMARKS: N/A

RECORD/FIELD: GX0-21.0

DATA ELEMENT: Filler

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(65)	LEFT	SPACES	147	211

DEFINITION: Reserved for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-22.0

DATA ELEMENT: Arterial Blood Gas

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	9(2)V9	RIGHT	ZEROES	212	214

DEFINITION: The Arterial Blood Gas test results taken on or before the certification date (furnish results of recent hospital tests).

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484, Question 1a

REMARKS: N/A

RECORD/FIELD: GX0-23.0

DATA ELEMENT: Oxygen Saturation (OXIMETRY)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	9(2)V9	RIGHT	ZEROES	215	217

DEFINITION: The oxygen saturation (oximetry) test results taken on or before the certification date(furnish results of recent hospital tests).

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484, Question 1b

REMARKS: N/A

RECORD/FIELD: GX0-24.0

DATA ELEMENT: Date Test Performed (DATE TESTED)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
24.0	X(08)	LEFT	SPACES	218	225

DEFINITION: The date the patient was tested for arterial blood gas and/or oxygen saturation.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, must be a valid date.

See GENERAL INSTRUCTIONS for "Date" entry.

FORM LOCATION: HCFA-484, Question 1c

REMARKS: N/A

RECORD/FIELD: GX0-25.0

DATA ELEMENT: Entity Performing Oximetry Testing (ENTITY PERF OXIMETRY TST)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
25.0	X(33)	LEFT	SPACES	226	258

DEFINITION: The name of the entity who performed the ABG and/or oximetry tests.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Name 2" entry.

Must be entered if required by payor.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX0-26.0

DATA ELEMENT: Test Conditions

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
26.0	X(01)	N/A	SPACES	259	259

DEFINITION: Code indicating the conditions under which the patient was tested.

CODE VALUES: 1 = At rest
 2 = Exercising
 3 = Sleeping

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: HCFA-484, Question 3

REMARKS: N/A

RECORD/FIELD: GX0-27.0

DATA ELEMENT: Clinical Findings

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
27.0	X(03)	LEFT	SPACES	260	262

DEFINITION: If the patient's arterial PO₂ is over 55 mm Hg and under 60 mm Hg or the oxygen saturation is over 88 percent, does the patient have (see validation):

CODE VALUES: Y = Yes
 N = No
 (Blank) = Does Not Apply

VALIDATION: Must be entered if required by payor.

If entered, must be valid code from the above list.

Enter Y, N, or (blank) to the following questions:

Position 1 = dependent edema due to congestive heart failure?

Position 2 = cor pulmonale or pulmonary hypertension documented by P pulmonate on EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?

Position 3 = a hematocrit greater than 56 percent?

FORM LOCATION: HCFA-484, Question 8, 9, 10

REMARKS: Up to three codes can be entered in this field. For example, if 1 and 3 are applicable, enter "Y Y". A "space" means does not apply.

NOTE: Clinical findings are subject to later verification as necessary.

RECORD/FIELD: GX0-28.0

DATA ELEMENT: Portable Oxygen Flow Rate (PORT OXY FLOW RATE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
28.0	9(2)V9	RIGHT	ZEROES	263	265

DEFINITION: The oxygen flow rate (liters per minute) for a portable oxygen system.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered, the medical therapeutic purpose to be served by the portable system that cannot be met by a stationary system must be entered in segment GX1-06.0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-29.0

DATA ELEMENT: Ordering Physician ID (ORDERING PROVIDER ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
29.0	X(15)	LEFT	SPACES	266	280

DEFINITION: The identifier assigned by the Payor to the physician who prescribed the oxygen.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-30.0

DATA ELEMENT: Ordering Provider Phone (ORDERING PROV PHONE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
30.0	X(10)	LEFT	SPACES	281	290

DEFINITION: The telephone number of the ordering physician who prescribed the oxygen.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Telephone" entry.

Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-31.0 GX0-32.0 GX0-33.0 GX0-34.0

DATA ELEMENT: Diagnosis Code-1
 Diagnosis Code-2
 Diagnosis Code-3
 Diagnosis Code-4

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
31.0	X(05)	LEFT	SPACES	291	295
32.0	X(05)	LEFT	SPACES	296	300
33.0	X(05)	LEFT	SPACES	301	305
34.0	X(05)	LEFT	SPACES	306	310

DEFINITION: The ICD-9-CM Diagnosis Code identifying a diagnosed medical condition resulting in the prescription for oxygen.

CODE VALUES: N/A

VALIDATION: Must be the most specific/precise 3 digit, 4 digit or 5 digit code allowed for in the ICD-9-CM coding format.

Do not submit a decimal point. The decimal point is implied because each ICD-9-CM code is unique.

The submission of "V", "E", and/or "M" diagnosis codes may or may not be accepted by a payor.

Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-35.0

DATA ELEMENT: Certification on File (CERT ON FILE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
35.0	X(01)	LEFT	SPACES	311	311

DEFINITION: The certification completed and signed by the physician is on file at the supplier's office.

CODE VALUES: Y = Yes

N = No

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-36.0

DATA ELEMENT: Delivery System Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
36.0	X(01)	N/A	SPACES	312	312

DEFINITION: To indicate if a particular form of delivery was prescribed.

CODE VALUES: A = Nasal Cannula

B = 02 Conserving Device

C = 02 Conserving Device with Pulse 02 System

D = 02 Conserving Device with Reservoir System

E = Transtracheal Catheter

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from the above list.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX0-37.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
37.0	X(08)	LEFT	SPACES	313	320

DEFINITION: Unused reserved filler for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

OXYGEN CERTIFICATION RECORD

RECORD TYPE: GX1

"NARRATIVE INFORMATION FOR OXYGEN"

RECORD NAME: CERTIFICATION RECORD TYPE GX1 "NARRATIVE INFORMATION FOR OXYGEN"

Not Required by MO HealthNet

Must follow FB0 - GX0

Must be followed by GX2 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GX1"	C-24	GX1
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	TEST RESULTS		Not Used
05	MEDICAL FINDINGS		Not Used
06	EXERCISE ROUTINE		Not Used
07	FILLER-NATIONAL		YES

RECORD TYPE: GX1

LEVEL: SERVICE LINE

PURPOSE: To provide NARRATIVE information regarding the attending physician's certification of medical necessity for home oxygen therapy (Form HCFA-484).

REQUIREMENTS: If required by the payor, a "GX1" record must be submitted for the initial certification, revised certification or renewal certification when billing for home oxygen therapy.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	GX0	FA0, GX2, HA0 or XA0

NOTES:

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS
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				FROM	THRU
01.0	RECORD ID "GX1"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	TEST RESULTS	90	X	23	112
05.0	MEDICAL FINDINGS	90	X	113	202
06.0	EXERCISE ROUTINE	90	X	203	292
07.0	FILLER-NATIONAL	28	X	293	320

RECORD/FIELD: GX1-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GX1")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Medical Necessity for Oxygen" record.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Must be "GX1".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX1-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GX1" records and to associate "GX1" records with "GX0" and "GX2" records.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (GA0-02.0) submitted in the preceding "GA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: GX1-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: GX1-04.0

DATA ELEMENT: Test Results

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(90)	LEFT	SPACES	23	112

DEFINITION: If tests are performed under other conditions such as oxygen, give test results and information necessary for interpreting the tests and why performed under these conditions.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX1-05.0

DATA ELEMENT: Additional Medical Findings (MEDICAL FINDINGS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(90)	LEFT	SPACES	113	202

DEFINITION: Enter the additional medical findings justifying the need for oxygen if the PO2 levels are 60 mm Hg or above, or arterial blood oxygen saturation is 90 percent or above.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX1-06.0

DATA ELEMENT: Exercise Routine

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(90)	LEFT	SPACES	203	292

DEFINITION: Description of activities or exercise routine that patient undertakes on a regular basis that requires the portable system in the home that cannot be met by a stationary system (e.g. amount and frequency of ambulation).

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX1-07.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(28)	LEFT	SPACES	293	320

DEFINITION: Reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CERTIFICATION RECORD TYPE GX2 "FACILITY INFORMATION FOR OXYGEN"

Not Required by MO HealthNet

Must follow FB0 - GX1

Must be followed by HA0 - XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "GX2"	C-24	GX2
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used
04	TEST FACILITY ADDR 1		Not Used
05	TEST FACILITY ADDR 2		Not Used
06	TEST FACILITY CITY		Not Used
07	TEST FACILITY STATE		Not Used
08	TEST FACILITY ZIP		Not Used
09	PAT FACILITY NAME		Not Used
10	PAT FACILITY ADDR 1		Not Used
11	PAT FACILITY ADDR 2		Not Used
12	PAT FACILITY CITY		Not Used
13	PAT FACILITY STATE		Not Used
14	PAT FACILITY ZIP		Not Used
15	FILLER-NATIONAL		YES

RECORD TYPE: GX2

LEVEL: SERVICE LINE

PURPOSE: To provide FACILITY information regarding where the test was performed or where the patient resides if other than home.

REQUIREMENTS: If required by payor, a "GX2" record must be submitted for the initial certification, revised certification or renewal certification when billing for home oxygen therapy.

ORDER:	<u>Preceding Record Type</u>	<u>Following Record Type</u>
	GX0 or GX1	FA0, HA0, or XA0

NOTES: N/A

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU

01.0	RECORD ID "GX2"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	TEST FACILITY ADDR 1	30	X	23	52
05.0	TEST FACILITY ADDR 2	30	X	53	82
06.0	TEST FACILITY CITY	20	X	83	102
07.0	TEST FACILITY STATE	2	X	103	104
08.0	TEST FACILITY ZIP	9	X	105	113
09.0	PAT FACILITY NAME	33	X	114	146
10.0	PAT FACILITY ADDR 1	30	X	147	176
11.0	PAT FACILITY ADDR 2	30	X	177	206
12.0	PAT FACILITY CITY	20	X	207	226
13.0	PAT FACILITY STATE	2	X	227	228
14.0	PAT FACILITY ZIP	9	X	229	237
15.0	FILLER-NATIONAL	83	X	238	320

RECORD/FIELD: GX2-01.0

DATA ELEMENT: Record Identifier (RECORD ID "GX2")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Code used to identify the "Facility Information for Oxygen" record.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

Must be "GX2".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: GX2-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	ZEROS	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "GX2" records and to associate "GX2" records with "GX0" and "GX1" records.

CODE VALUES: 01 through 99

VALIDATION: Must be entered .

Must be a valid code from the above list.

The value entered must match the SEQUENCE NUMBER (GA0-02.0) submitted in the preceding "GA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: GX2-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: An identification assigned to the patient by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Patient Control Number".

Must be entered.

FORM LOCATION: CMS-1500 Block 26

REMARKS: The patient control number is used by the EMC system to link all records for a claim. All records between the record type CA0, up to and including the record type XA0, must have the same patient control number.

Although up to seventeen characters are allowed, not all payors' systems will record and return seventeen characters on remittance advices or other documents.

RECORD/FIELD: GX2-04.0 GX2-05.0 GX2-06.0 GX2-07.0 GX2-08.0

DATA ELEMENT: Test Facility Street Address 1
 (TEST FACILITY ADDR 1)
 Test Facility Street Address 2
 (TEST FACILITY ADDR 2)
 Test Facility City
 (TEST FACILITY CITY)
 Test Facility State

(TEST FACILITY STATE)

Test Facility Zip Code

(TEST FACILITY ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(30)	LEFT	SPACES	23	52
05.0	X(30)	LEFT	SPACES	53	82
06.0	X(20)	LEFT	SPACES	83	102
07.0	X(02)	LEFT	SPACES	103	104
08.0	X(09)	LEFT	SPACES	105	113

DEFINITION: Enter the address of the facility where the tests were performed. If conducted in the patient's home, enter the name and address of the physician or the laboratory performing the tests.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX2-09.0 GX2-10.0 GX2-11.0 GX2-12.0 GX2-13.0 GX2-14.0

DATA ELEMENT: PAT Facility Name
(PAT FACILITY NAME)
PAT Facility Street Address 1
(PAT FACILITY ADDR 1)
PAT Facility Street Address 2
(PAT FACILITY ADDR 2)
PAT Facility City
(PAT FACILITY CITY)
PAT Facility State
(PAT FACILITY STATE)
PAT Facility Zip Code
(PAT FACILITY ZIP)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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09.0	X(33)	LEFT	SPACES	114	146
10.0	X(30)	LEFT	SPACES	147	176
11.0	X(30)	LEFT	SPACES	177	206
12.0	X(20)	LEFT	SPACES	207	226
13.0	X(02)	LEFT	SPACES	227	228
14.0	X(09)	LEFT	SPACES	229	237

DEFINITION: Enter the name and address of the facility where the patient resides if other than home.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: HCFA-484

REMARKS: N/A

RECORD/FIELD: GX2-15.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	X(83)	LEFT	SPACES	238	320

DEFINITION: Reserved record space for national use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: NARRATIVE RECORD TYPE HA0 "CLAIM DATA"

Not Required by MO HealthNet

Must follow FB0 - GX2

Must be followed by XA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "HA0"	C-24	HA0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		Not Used

04	LINE ITEM CONTROL NO		Not Used
05	EXTRA NARRATIVE DATA		Not Used

RECORD TYPE: HA0

LEVEL: SERVICE LINE

PURPOSE: To provide additional information related to the service rendered to the patient by the provider.

REQUIREMENTS: If required by the payor, this record must be submitted.

ORDER: Preceding Record Type Following Record Type
 FA0, FB0, FB1, FB2, FE0, FD0, FA0 or XA0
 GA0, GC0, GD0, GD1, GE0, GP0,
 GU0, GX0, GX1 or GX2

NOTES: When used, this record must follow the FA0, FB0, FB1, FB2, FD0, FE0, GA0, GC0, GD0, GE0, GP0, GU0, GX0, GX1 or GX2 record related to this service.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "HA0"	3	X	01	03
02.0	SEQUENCE NO	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	LINE ITEM CONTROL NO	17	X	23	39
05.0	EXTRA NARRATIVE DATA	281	X	40	320

RECORD/FIELD: HA0-01.0

DATA ELEMENT: Record Identification (RECORD ID "HA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: This is the record identifier for the Narrative Record - HA0.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "HA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: HA0-02.0

DATA ELEMENT: Sequence Number (SEQUENCE NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: A numeric value from 01 through 99 used to sequence the "HA0" record to the corresponding "FA0" record.

CODE VALUES: 01 through 99

VALIDATION: Must be entered.

Must be a valid value from the above list.

The value entered must match the SEQUENCE NUMBER (FA0-02.0) submitted in the preceding "FA0" record.

FORM LOCATION: N/A

REMARKS: See sequencing instructions on page FA0.04.

RECORD/FIELD: HA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the "Patient Control Number" (CA0-03.0) of this claim.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: HA0-04.0

DATA ELEMENT: Line Item Control Number (LINE ITEM CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(17)	LEFT	SPACES	23	39

DEFINITION: An identifier assigned by the submitter/provider to this line item.

CODE VALUES: N/A

VALIDATION: May be entered if payor allowed.

If entered, value must match the "Line Item Control Number" submitted in the preceding FA0-04.0 record.

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: HA0-05.0

DATA ELEMENT: Extra Narrative Data

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(281)	LEFT	SPACES	40	320

DEFINITION: Free form narrative record to submit additional information that may assist in the adjudication of the Service Line Item in the preceding FA0 record.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: This field may be used as follows:

1. To describe the service being submitted as an Unlisted/NOC HCPCS Procedure Code in the preceding FA0 record.
2. To report the substitute physician's UPIN (six bytes in length, alpha numeric) for "Reciprocal" or "Locum Tenens" billing arrangements.

Consult the Matrix/Users Guide supplied by the Payor/Receiver for additional details regarding submission instructions.

RECORD NAME: CLAIM TRAILER RECORD TYPE XA0 "RECORD SUMMARY"

Required for MO HealthNet processing

Must follow FB0 - AA0

Must be followed by CA0, YA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "XA0"	C-24	XA0
02	RESERVED (XA0-02.0)		Not Used

03	PAT CONTROL NO		Not Used
04	RECORD CXX COUNT		Not Used
05	RECORD DXX COUNT		Not Used
06	RECORD EXX COUNT		Not Used
07	RECORD FXX COUNT		Not Used
08	RECORD GXX COUNT		Not Used
09	RECORD HXX COUNT		Not Used
10	CLAIM RECORD COUNT		Not Used
11	RESERVED (XA0-11.0)		Not Used
12	TOTAL CLAIM CHARGES	C-10	YES
13	TOTAL DISAL COST CONT CHG		Not Used
14	TOTAL DISAL OTHER CHARGES		Not Used
15	TOTAL ALLOWED AMOUNT		Not Used
16	TOTAL DEDUCTIBLE AMOUNT		Not Used
17	TOTAL COINSURANCE AMOUNT		Not Used
18	TOTAL PAYOR AMOUNT PAID	C-10	NO
19	PAT AMOUNT PAID		Not Used
20	TOTAL PURCHASE SVC CHARGES		Not Used
21	PROV DISCOUNT INFORMATION		Not Used
22	REMARKS		Not Used
23	FILLER-NATIONAL		YES

NOTE: Only positive numeric values are accepted as input, negative values are not allowed.

RECORD TYPE: XA0

LEVEL: CLAIM

PURPOSE: The last record of every claim submitted electronically, it contains information pertinent to the balancing of each claim (i.e. claim record counts, claim charges) within a batch.

REQUIREMENTS: An 'XA0' Record is a REQUIRED record since it is the CLAIM TRAILER

ORDER:	Preceding Record Type	Following Record Type
	FA0, FB0, FB1, FB2, FD0, FE0, GA0 (CERT RECORDS), HA0 (NARRATIVE RECORD)	CA0, YA0

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type FA0 (SERVICE LINE DETAIL RECORD).

There may be multiple claims per batch.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "XA0"	3	X	01	03
02.0	RESERVED (XA0-02.0)	2	X	04	05
03.0	PAT CONTROL NO	17	X	06	22
04.0	RECORD CXX COUNT	2	N	23	24
05.0	RECORD DXX COUNT	2	N	25	26
06.0	RECORD EXX COUNT	2	N	27	28
07.0	RECORD FXX COUNT	2	N	29	30
08.0	RECORD GXX COUNT	2	N	31	32
09.0	RECORD HXX COUNT	2	N	33	34
10.0	CLAIM RECORD COUNT	3	N	35	37
11.0	RESERVED (XA0-11.0)	40	X	38	77
12.0	TOTAL CLAIM CHARGES	7	N	78	84
13.0	TOTAL DISAL COST CONT CHGS	7	N	85	91
14.0	TOTAL DISAL OTHER CHARGES	7	N	92	98
15.0	TOTAL ALLOWED AMOUNT	7	N	99	105
16.0	TOTAL DEDUCTIBLE AMOUNT	7	N	106	112
17.0	TOTAL COINSURANCE AMOUNT	7	N	113	119
18.0	TOTAL PAYOR AMOUNT PAID	7	N	120	126
19.0	PAT AMOUNT PAID	7	N	127	133
20.0	TOTAL PURCHASE SVC CHARGES	7	N	134	140
21.0	PROV DISCOUNT INFORMATION	16	X	141	156
22.0	REMARKS	103	X	157	259
23.0	FILLER-NATIONAL	61	X	260	320

NOTE: Only positive numeric values are accepted as input, negative values are not allowable.

RECORD/FIELD: XA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "XA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "Claim Trailer Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "XA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-02.0

DATA ELEMENT: RESERVED (XA0-02.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(02)	LEFT	SPACES	04	05

DEFINITION: Reserved for national use to maintain file sequence.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-03.0

DATA ELEMENT: Patient Control Number (PAT CONTROL NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(17)	LEFT	SPACES	06	22

DEFINITION: A unique number assigned by the provider to identify the patient.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the PATIENT CONTROL NUMBER found in Claim Header Record (CA0-03.0).

See GENERAL INSTRUCTIONS for "Patient Control Number" entry.

FORM LOCATION: CMS-1500 Block 26

REMARKS: N/A

RECORD/FIELD: XA0-04.0 XA0-05.0, XA0-06.0, XA0-07.0, XA0-08.0, XA0-09.0

DATA ELEMENT: Record Type Cxx Count
Record Type Dxx Count
Record Type Exx Count
Record Type Fxx Count
Record Type Gxx Count
Record Type Hxx Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	9(02)	RIGHT	ZEROS	23	24
05.0	9(02)	RIGHT	ZEROS	25	26
06.0	9(02)	RIGHT	ZEROS	27	28
07.0	9(02)	RIGHT	ZEROS	29	30
08.0	9(02)	RIGHT	ZEROS	31	32
09.0	9(02)	RIGHT	ZEROS	33	34

DEFINITION: A summarization by Record Type for all records included in this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Each field must equal the sum of all records of the type indicated, within the claim.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-10.0

DATA ELEMENT: Claim Record Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	9(03)	RIGHT	ZEROS	35	37

DEFINITION: The total number of records submitted for this claim excluding this record.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all records processed from the Claim Header Record (CA0) to the Claim Trailer Record (XA0).

This DOES NOT include this record.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-11.0

DATA ELEMENT: Reserved (XA0-11.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	X(40)	LEFT	SPACES	38	77

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-12.0

DATA ELEMENT: Total Claim Charges

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	9(05)V99	RIGHT	ZEROS	78	84

DEFINITION: The sum of all line item charges included within this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all LINE CHARGES fields (FA0-13.0) included for this claim.

FORM LOCATION: CMS-1500 Block 28

REMARKS: N/A

RECORD/FIELD: XA0-13.0

DATA ELEMENT: Total Disallowed Cost Containment Charges (TOTAL DISAL COST CONT CHGS)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
13.0	9(05)V99	RIGHT	ZEROS	85	91

DEFINITION: The sum of all the disallowed cost containment charges associated with this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all the DISALLOWED COST CONTAINMENT CHARGES fields (FA0-27.0) included in this claim.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-14.0

DATA ELEMENT: Total Disallowed Other Charges (TOTAL DISAL OTHER CHARGES)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
14.0	9(05)V99	RIGHT	ZEROS	92	98

DEFINITION: The sum of any additional disallowed charges associated with this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all the DISALLOWED OTHER CHARGES fields (FA0-28.0) included in this claim.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-15.0

DATA ELEMENT: Total Allowed Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
15.0	9(05)V99	RIGHT	ZEROS	99	105

DEFINITION: The sum of all the allowed charges associated with this claims.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all ALLOWED AMOUNT fields (FB0-06.0) included in this claim.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-16.0

DATA ELEMENT: Total Deductible Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
16.0	9(05)V99	RIGHT	ZEROS	106	112

DEFINITION: The total amount applied to the patient's deductible by previous payor(s).

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all the DEDUCTIBLE AMOUNT fields (FB0.07.0) included in this claim.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-17.0

DATA ELEMENT: Total Coinsurance Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
17.0	9(05)V99	RIGHT	ZEROS	113	119

DEFINITION: The total amount applied toward the patient's co-insurance by previous payor(s).

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all COINSURANCE AMOUNT fields (FB0-08.0) included in this claim.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-18.0

DATA ELEMENT: Total Payor Amount Paid

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
18.0	9(05)V99	RIGHT	ZEROS	120	126

DEFINITION: The amount the provider has received from the payor(s) toward payment of this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all PAYOR AMOUNT PAID fields (DA1-14.0) included in this claim.

Must not exceed TOTAL CLAIM CHARGES (XA0-12.0).

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-19.0

DATA ELEMENT: Patient Amount Paid (PAT AMOUNT PAID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
19.0	9(05)V99	RIGHT	ZEROS	127	133

DEFINITION: The amount the provider has received from the patient (or insured) toward payment of this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must not exceed TOTAL CLAIM CHARGES (XA0-12.0).

FORM LOCATION: CMS-1500 Block 29

REMARKS: N/A

RECORD/FIELD: XA0-20.0

DATA ELEMENT: Total Purchase Service Charges (TOTAL PURCHASE SVC CHARGE)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
20.0	9(05)V99	RIGHT	ZEROS	134	140

DEFINITION: The sum of all purchase service charges associated with this claim.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all PURCHASE SERVICE CHARGES fields (FB0-05.0).

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-21.0

DATA ELEMENT: Provider Discount Information (PROV DISCOUNT INFORMATION)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
21.0	X(16)	LEFT	SPACES	141	156

DEFINITION: Details on a prompt payment discount program offered by the provider.

CODE VALUES: If a prompt payment discount program applies, program details must be input "%/#" where:

% = rate of Discount

= the number of days to which that rate applies.

Example: 2/30 (Two percent discount if paid within 30 days).

Free form input must be utilized for other types of discount.

VALIDATION: Must be entered if required by payor.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-22.0

DATA ELEMENT: Remarks

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
22.0	X(103)	LEFT	SPACES	157	259

DEFINITION: A free form area designed to be used in those situations where supplementary data would be helpful in processing this claim.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: XA0-23.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
23.0	X(61)	LEFT	SPACES	260	320

DEFINITION: Unused record space reserved for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: BATCH TRAILER RECORD TYPE YA0

Required to show end of batch

Must follow XA0

Must be followed by BA0 or ZA0

Field No.	Field Name	Table Value	Default
01	RECORD ID "YA0"	C-24	YA0
02	EMC PROV ID		Not Used
03	BATCH TYPE		Not Used
04	BATCH NO		Not Used
05	BATCH ID		Not Used
06	PROV TAX ID		Not Used
07	RESERVED (YA0-07.0)		Not Used
08	BATCH SVC LINE COUNT		Not Used
09	BATCH RECORD COUNT		Not Used
10	BATCH CLAIM COUNT		Not Used
11	BATCH TOTAL CHARGES		Not Used
12	FILLER-NATIONAL		YES

NOTE: Only positive numeric values are acceptable as input, negative values are not allowed.

RECORD TYPE: YA0

LEVEL: BATCH

PURPOSE: The last record of any batch submitted electronically, it contains information pertinent to the balancing of each batch (i.e., batch record count, batch charges) within a file.

REQUIREMENTS: A 'YA0' Record is a REQUIRED record since it is the BATCH TRAILER.

ORDER: Preceding Record Type Following Record Type
 XA0 BA0, ZA0

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type XA0 (CLAIM TRAILER RECORD).

There may be multiple batches per file.

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "YA0"	3	X	01	03
02.0	EMC PROV ID	15	X	04	18
03.0	BATCH TYPE	3	X	19	21
04.0	BATCH NO	4	N	22	25
05.0	BATCH ID	6	X	26	31
06.0	PROV TAX ID	9	X	32	40
07.0	RESERVED (YA0-07.0)	6	X	41	46
08.0	BATCH SVC LINE COUNT	7	N	47	53
09.0	BATCH RECORD COUNT	7	N	54	60
10.0	BATCH CLAIM COUNT	7	N	61	67
11.0	BATCH TOTAL CHARGES	9	N	68	76
12.0	FILLER-NATIONAL	244	X	77	320

NOTE: Only positive numeric values are acceptable as input, negative values are not allowable.

RECORD/FIELD: YA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "YA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "Provider Batch Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "YA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-02.0

DATA ELEMENT: EMC Provider Identifier (EMC PROV ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(15)	LEFT	SPACES	04	18

DEFINITION: Identifies the provider as defined by the receiver.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the EMC PROVIDER IDENTIFIER in the corresponding Batch Header Record (BA0-02.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-03.0

DATA ELEMENT: Batch Type

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(03)	LEFT	SPACES	19	21

DEFINITION: This field indicates the type of claims that are included within this batch.

CODE VALUES: 100 - All Others
200 - Dental

VALIDATION: Must be entered.

Must be a valid code from the above list.

Must be identical to the BATCH TYPE entered in the corresponding Batch Header Record (BA0-03.0).

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-04.0

DATA ELEMENT: Batch Number (BATCH NO)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	9(04)	RIGHT	ZEROS	22	25

DEFINITION: A sequential number assigned by the submitter to each batch of claims.

CODE VALUES: Must be "0001" through "9999".

VALIDATION: Must be entered.

Must be numeric.

First occurrence must be "0001".

Must be identical to the BATCH NUMBER entered in the corresponding Batch Header Record (BA0-04.0).

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-05.0

DATA ELEMENT: Batch Identifier (BATCH ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	X(06)	LEFT	SPACES	26	31

DEFINITION: An identifier assigned by the provider/ submitter to identify a batch in its own system.

CODE VALUES: N/A

VALIDATION: Optional at the provider/submitter's discretion.

FORM LOCATION: N/A

REMARKS: Used to facilitate the communication between the receiver and provider/submitter concerning problem batches as well as the reporting of claims with errors and accepted claims.

RECORD/FIELD: YA0-06.0

DATA ELEMENT: Provider Tax ID (PROV TAX ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	X(09)	LEFT	SPACES	32	40

DEFINITION: The federally assigned Tax Identification Number (T.I.N.) of the billing provider. This can be either the Employer Identification Number (EIN) or the Social Security Number (S.S.N.) of the provider.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be identical to the PROVIDER TAX ID entered in the corresponding Batch Header Record (BA0-06.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: CMS-1500 Block 25

REMARKS: N/A

RECORD/FIELD: YA0-07.0

DATA ELEMENT: Reserved (YA0-07.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	X(06)	LEFT	SPACES	41	46

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-08.0

DATA ELEMENT: Batch Service Line Count (BATCH SVC LINE COUNT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	9(07)	RIGHT	ZEROS	47	53

DEFINITION: The number of line items included in this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Type FA0's within this batch.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-09.0

DATA ELEMENT: Batch Record Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	9(07)	RIGHT	ZEROS	54	60

DEFINITION: The number of records included in this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Types BA0 through YA0.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-10.0

DATA ELEMENT: Batch Claim Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	9(07)	RIGHT	ZEROS	61	67

DEFINITION: The number of claims that are included within this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all the Record Type CA0's included between this Batch Trailer Record (YA0) and the preceding Batch Header Record (BA0).

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-11.0

DATA ELEMENT: Batch Total Charges

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11.0	9(07)V99	RIGHT	ZEROS	68	76

DEFINITION: The sum of all "Total Claim Charges" fields included within this batch.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all the TOTAL CLAIM CHARGES fields (XA0-12.0) included within this batch.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: YA0-12.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
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DEFINITION: Unused record space reserved for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: FILE TRAILER RECORD TYPE ZA0

Required to show end of file

Must follow YA0

Last record

Field No.	Field Name	Table Value	Default
01	RECORD ID "ZA0"	C-24	ZA0
02	SUB ID		Not Used
03	RESERVED (ZA0-03.0)		Not Used
04	RECEIVER ID		Not Used
05	FILE SVC LINE COUNT		Not Used
06	FILE RECORD COUNT		Not Used
07	FILE CLAIM COUNT		Not Used
08	BATCH COUNT		Not Used
09	FILE TOTAL CHARGES		Not Used
10	FILE TOTAL PAID AMT		Not Used
11	FILE TOTAL ALLOWED AMT		Not Used
12	FILLER-NATIONAL		YES

RECORD TYPE: ZA0

LEVEL: FILE

PURPOSE: The last record of any file submitted electronically, it contains information pertinent to the balancing of the file (i.e. file record counts, file charges).

REQUIREMENTS: A "ZA0" Record is a REQUIRED record since it is the FILE TRAILER RECORD.

ORDER: Preceding Record Type Following Record Type
 YA0 NONE

NOTES: Fields that require balancing should be the sum of all the corresponding fields in Record Type YA0 (BATCH TRAILER RECORD).

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
01.0	RECORD ID "ZA0"	3	X	01	03
02.0	SUB ID	16	X	04	19
03.0	RESERVED (ZA0-03.0)	9	X	20	28
04.0	RECEIVER ID	16	X	29	44
05.0	FILE SVC LINE COUNT	7	N	45	51
06.0	FILE RECORD COUNT	7	N	52	58
07.0	FILE CLAIM COUNT	7	N	59	65
08.0	BATCH COUNT	4	N	66	69
09.0	FILE TOTAL CHARGES	11	N	70	80
10.0	FILE TOTAL PAID AMT	11	N	81	91
11.0	FILE TOTAL ALLOWED AMT	11	N	92	102
12.0	FILLER-NATIONAL	218	X	103	320

NOTE: Only positive numeric values are accepted as input, negative values are not allowable.

RECORD/FIELD: ZA0-01.0

DATA ELEMENT: Record Identifier (RECORD ID "ZA0")

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
01.0	X(03)	LEFT	SPACES	01	03

DEFINITION: Field used to identify the "File Trailer Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "ZA0".

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: ZA0-02.0

DATA ELEMENT: Submitter Identifier (SUB ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
02.0	X(16)	LEFT	SPACES	04	19

DEFINITION: Identifies the submitter as defined by receiver.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be identical to the SUBMITTER ID entered in the File Header Record (AA0-02.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: May be a Federally assigned Employer Identification Number (EIN). EIN is also referred to as Tax Identification Number (TIN) depending on the receiver's requirements.

RECORD/FIELD: ZA0-03.0

DATA ELEMENT: Reserved (ZA0-03.0)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
03.0	X(09)	LEFT	SPACES	20	28

DEFINITION: Unused reserved record space.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: ZA0-04.0

DATA ELEMENT: Receiver Identification (RECEIVER ID)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
04.0	X(16)	LEFT	SPACES	29	44

DEFINITION: A value assigned by the receiver/payor to identify the organization designated to ultimately receive this file to prevent misrouting of claim data.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor / receiver.

Must be identical to the RECEIVER IDENTIFICATION value in the File Header Record (AA0-17.0).

See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: ZA0-05.0

DATA ELEMENT: File Service Line Count (FILE SVC LINE COUNT)

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
05.0	9(07)	RIGHT	ZEROS	45	51

DEFINITION: The number of service lines included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

Must be the computed sum of all BATCH SERVICE LINE COUNT fields (YA0-08.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: ZA0-06.0

DATA ELEMENT: File Record Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
06.0	9(07)	RIGHT	ZEROS	52	58

DEFINITION: The number of records included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

Must be the computed sum of all BATCH RECORD COUNT fields (YA0-09.0) within this file.

FORM LOCATION: N/A

REMARKS: This field does not include any count of the AA0 or the ZA0 records.

RECORD/FIELD: ZA0-07.0

DATA ELEMENT: File Claim Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
07.0	9(07)	RIGHT	ZEROS	59	65

DEFINITION: The number of claims included in this file.

CODE VALUES: N/A

VALIDATION: Must be numeric.

Must be the computed sum of all BATCH CLAIM COUNT fields (YA0-10.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: ZA0-08.0

DATA ELEMENT: Batch Count

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
08.0	9(04)	RIGHT	ZEROS	66	69

DEFINITION: The number of batches included within this file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be numeric.

Must be the computed sum of all Record Type YA0's within this file.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: ZA0-09.0

DATA ELEMENT: File Total Charges

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
09.0	9(09)V99	RIGHT	ZEROS	70	80

DEFINITION: The sum of all total charges from each batch contained within this file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all BATCH TOTAL CHARGES fields (YA0-11.0) included within this file.

FORM LOCATION: N/A

REMARKS: N/A

RECORD/FIELD: ZA0-10.0

DATA ELEMENT: File Total Paid Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
10.0	9(09)V99	RIGHT	ZEROS	81	91

DEFINITION: The sum of all total amount paid from each batch contained within this file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all Amount Paid to Bene fields (DA1-30.0) and Amount Paid to Provider fields (DA1-33.0) included within this file.

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange.

RECORD/FIELD: ZA0-11.0

DATA ELEMENT: File Total Approved Amount

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
11	9(09)V99	RIGHT	ZEROS	92	102

DEFINITION: The sum of all total approved amounts from each batch contained within this file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be a positive, unsigned numeric value.

Must be the computed sum of all Payor Amount Approved fields (DA1-37.0) included within this file.

FORM LOCATION: N/A

REMARKS: Required for Coordination of Benefits exchange.

RECORD/FIELD: ZA0-12.0

DATA ELEMENT: Filler-National

<u>FIELD</u>	<u>COBOL PICTURE</u>	<u>JUSTIFY</u>	<u>INITIAL</u>	<u>FROM</u>	<u>THRU</u>
12.0	X(218)	LEFT	SPACES	103	320

DEFINITION: Unused record space reserved for National use.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: N/A

REMARKS: N/A