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DATA DEFINITION TABLE

The following pages correspond to the "TABLE ID" column in the previous claim specifications. A description for specific fields is provided along with allowed values and defaults.

C-1 PARTICIPANT ID

Enter the MO HealthNet participant identification number. Allowed characters are 0 through 9. A 'P' may be used in the 1st position for Presumptive Eligibility. The participant ID must be 8 characters long.

NOTE: Reference the participant's MO HealthNet card for the correct MO HealthNet identification number.

Default: None, this is a required field.

C-2 PARTICIPANT NAME

Last Name

(HealthCare/Dental/Pharmacy)

Enter the first two letters of the participant's last name. The only characters allowed are A through Z. Do not enter apostrophes or spaces. You must enter a minimum of two characters.

First Name

Enter the first letter of the participant's first name. The only characters allowed are A through Z. Do not enter spaces.

(NSF)

You may enter the entire first name and last name of the participant as it appears on their MO HealthNet card. Only the first two letters of the participants last name and first letter of the first name will be verified against the participants MO HealthNet enrollment file. Allowed values are A through Z. Do not enter apostrophes or spaces.

Default: None, this is a required field.

C-3 YES/NO INDICATORS

If one of the following cases apply, a "Y" should be placed in the field. If that case does not apply, you may enter an "N" or leave the field blank. An "N" will be assumed if the field is left blank. For the NSF layout, reference the standard publications for additional information.

Other Insurance - Enter an "N" or leave blank if participant does not have other insurance. Enter a "Y" if payment has been received from other insurance carrier.

If a rejection from other insurance carrier has been received showing no payment will be made, the claim must be submitted on paper with proper documentation attached.

NOTE: If a "Y" was indicated in other insurance indicator, a payment amount must be entered in "Other Insurance Amount".

NSF (Dental and CMS-1500)

Enter the number which applies to this claim.

1 = Yes, patient has other insurance.

2 = Yes, patient has other insurance not reflected on this bill.

3 = No, patient does not have other insurance.

Default: Space for non-required fields.

C-4 PRESCRIPTION NUMBER

Enter the prescription number of the prescription filled or refilled. The only characters allowed are A through Z, 0 through 9, and hyphens. If less than 7 digits, left justify and fill the remaining positions to the right with spaces.

Default: None, this is a required field.

C-5 ORIGINAL/REFILL INDICATOR

The only valid values are:

0 = Original

R = Refill

NOTE: This is an alpha field. Numeric characters are not valid.

C-6 ADMISSION TYPE/SOURCE CODES

Admission Type

The only valid values are:

1 = Emergency

2 = Urgent

3 = Elective

4 = Newborn

9 = Information Not Available

Required for Inpatient claims.

C-7 PATIENT STATUS

Enter the code that represents the condition under which the participant was discharged. Two digits must be entered.

01 Home

02 Hospital

03 Skilled Nursing Facility (SNF)

04 Intermediate Care Facility (ICF)

05 Institution (Inst)

06 Home Health Agency (HHA)

07 Left

08 Other

20 Death

30 Still A Patient

50 Discharge from Hospice to Home

51 Discharge from Hospice to Another Medical Facility

62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

64 Discharged/transferred to a nursing facility certified under MO HealthNet but not certified under Medicare

65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

Default: None, this is a required field.

C-8 PROVIDER NUMBER

This is a required field in all record headings and contains the submitting provider's MO HealthNet ID Number. Allowed characters in this field are 0 through 9.

Default: None, this is a required field.

C-9 REVENUE CODE

Enter the three digit code from 100 to 999 which represents the services that are billed on this particular line item. The combined total number of accommodation and ancillary services billed can not exceed 28 lines per claim.

Accommodation revenue codes include UB-92 revenue codes 10X through 21X. Ancillary revenue codes include UB-92 revenue codes 22X through 99X.

Default: None, this is a required field.

C-10 CHARGES

For all charge amount fields, the decimal place is implied and must not be included. Therefore, if a charge field is less than the field length, the amount must be right justified and the remaining left positions filled with zeros.

For example: An amount of \$155.25 would be entered as "0015525". An amount of \$120.00 would be entered "0012000".

Detail Item Amount

Inpatient Claims - The total of all charges billed for a particular revenue code (covered and non-covered).

NOTE: When revenue code is an accommodation (codes 100 through 239) this must equal the Room Rate multiplied by the Units.

Health Care, Dental, Outpatient, Pharmacy Claims - Enter the amount that is billed for the services performed.

Total Amount

The sum of all Detail Item Amount(s).

Other Insurance Amount - Total Payor Amount Paid (NSF) - Payments Received (UB92)

The amount paid by another insurance.

Net Billed Amount

Total Amount minus Other Insurance Amount.

Default: Zeros for non-required fields.

C-11 TYPE OF SERVICE

Valid type of service codes are:

A DME Purchase

B Optical Services

D Post-operative Services

E Radiology Services (Professional Component)

F DME Replacement

G General Anesthesia

H Radiology Services (Technical Component)

I Laboratory Services (Technical Component)

J Alcohol and Drug Rehabilitation

K Rehabilitation Center

L Psychiatric Rehabilitation

M Healthy Children and Youth (HCY) Services

N Surgery Without Post-operative Services

Q Ambulance

R Laboratory Services (Professional Components)

- S Supervisor of Anesthesia
- T DME Rental
- V Audiology Services
- W Certified Registered Nurse Anesthetist
- Y Hospice
- Z Home Health
- 0 DME Repair
- 1 Medical Services
- 2 Surgery
- 3 Nurse/Midwife
- 4 Radiology Services (Professional and Technical)
- 5 Laboratory Services (Professional and Technical)
- 6 Podiatry
- 7 Dental Services
- 8 Assistant Surgery
- 9 Other Medical Services

Default: Space for non-required fields

NOTE: THIS FIELD IS NOT REQUIRED ON OUTPATIENT DETAIL PROCEDURES.

NSF Layout

The type of service is required for CMS-1500 and Dental claims. It must be in position 1 of this field to be recognized.

UB92 Layout

For Rural Health and Hospice billing, type of service is a required field. Position '1' of Form Locator 49 is used for the type of service.

C-12

C-13 ENTRY DATE

This is a required record heading field which contains the date the claim was created.

This date is stored in MMDDYY format with allowed characters of 0 through 9.

Default: Zeros for non-required fields.

C-14 PLACE OF SERVICE

01 Pharmacy

11	Office
12	Home
21	Inpatient Hospital
22	Outpatient
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birth Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Home
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
50	Federally Qualified Health Center (FQHC)
51	Inpatient Psychiatric Facility
52	Psychiatric Facility
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residence Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
97	Parochial/Private School
98	Public School
99	Other Locations (Unlisted Facility)

C-15 REFERRING AND PRESCRIBING PROVIDERS

Dental Claims/NSF Layout

Referring Physician

Enter the nine digit MO HealthNet provider number of the referring physician.

If the physician is "Out-of-State", but NOT a participant in the MO HealthNet program, enter nine twos (222222222).

NOTE: A referring physician number is required for the following conditions:

Provider type 70

Provider type 71, specialty 30 and type of service is 4.

Pharmacy Claims

Prescribing

Enter the MO HealthNet or DEA number of the prescribing physician.

Default: Spaces for non-required fields

C-16 DATES

UB92

Dates are stored in MMDDYY format with allowed characters of 0 through 9.

Admit Date

Enter the date the participant was admitted to the hospital for the services on the claim. Required for Inpatient claims.

Occurrence Dates

An occurrence date must be entered whenever an occurrence code is entered. The date entered must not exceed the current date.

Inpatient covered Period From and Thru Dates

Enter the date that this billing period begins/ends.

Health Care Claims (NSF)

NSF dates are in CCYYMMDD format.

Admit Date

Enter the date the participant was admitted to the hospital. This date cannot exceed the current date.

Discharge Date

Enter the date the participant was discharged from the hospital if there is an admission that relates to the service on the claim. If the patient is still in the hospital, enter the latest date of service which applies to this claim.

NOTE: Admit/discharge dates are required if any place of service on the claim is 21, 51, 55, 56 or 61.

Tables and Addenda

Service From and To Date

This is the date(s) the service was performed. This date cannot exceed the current date.

Default: Zeros for non-required fields.

C-17 DIAGNOSIS CODES

Primary Diagnosis

Health Care, Inpatient, Outpatient, Dental Claims & Pharmacy

Enter the ICD-9 diagnosis code of the participant's primary diagnosis. If the diagnosis code has less than five characters, the data must be left justified and fill the remaining positions to the right with spaces.

Any decimal point needed in the diagnosis code is implied and must not be included.

For example:

<u>DIAGNOSIS CODE</u>	<u>FIELD VALUE</u>
21	' 021 '
720.9	' 7209 '

A Primary diagnosis code is required unless:

1. The provider type is 70 or 71 or the provider specialty is 30 and the type of service is a 4 or 5.
2. The provider type is 20, 24, 50, 51, 52 or 59, place of service is 21 or 22 and the type of service is R.
3. The provider type is 20, 24, 50, 51, 52, 59, or 71, place of service is 21 or 22 and the type of service is E.

Additional diagnosis codes applicable to the claim should be entered in the same format as shown above.

Pharmacy Claims

The requirements for this field have not yet been issued by MO HealthNet Division. You will be notified when the field is applicable and a diagnosis code is needed as more information becomes available. Until further notice, leave this field blank.

Detail Diagnosis Codes

Medical

Enter the ICD-9 diagnosis code. Left justify and fill the remaining positions to the right with spaces.

This is a required field number unless:

The provider type is 70 or 71 or the provider specialty is 30 and the type of service is a 4 or 5.

The provider type is 20, 24, 50, 51, 52, or 59, place of service is 21 or 22 and the type of service is R.

The provider type is 20, 24, 50, 51, 52, 59, or 71, place of service is 21 or 22 and the type of service is E.

Default: Spaces for non-required fields.

C-18 CAUSE OF CONDITION

Enter one of the following letters if one of these conditions applies:

N = Not Related to employment.

R = Related to employment.

A = Automobile accident.

O = Other.

Leave field blank if none of the above conditions apply.

Default: Spaces for non-required fields.

C-19 PERFORMING/RENDERING PROVIDER NUMBER

Health Care Claims and NSF Layout

Enter the nine digit MO HealthNet provider number of the physician who performed the billed service. Allowed characters are O through 9 or spaces.

NOTE: A MO HealthNet provider number is required to be entered if the billing provider type is 50, 51, 52, 54, 55, or 56.

Default: Spaces for non-required fields.

C-20 ATTENDING/OTHER/REFERRING PROVIDERS

Inpatient/Outpatient Claims

Enter the ten digit MO HealthNet provider number or the license number of the attending/referring physician. If you enter the license number, do not enter the state abbreviation which usually precedes it.

These fields can contain any combination of numbers, letters, hyphens, or blanks.

If the physician is "Out-of-State", then enter nine threes (333333333).

If the physician is "in state", but NOT a participant in the MO HealthNet program, enter nine twos (222222222).

Requirements:

The attending physician number is required for inpatient claims only.

The referring provider number is required only for Lockin and PHP claims for both inpatient and outpatient claims. It must be in field number 7, Other Physician Number, of Record Type '80' on the UB-92 Record Layout.

C-21 CLAIM SEQUENCE NUMBER

NSF/UB92 Layout

Reference the CMS published layouts for fields on the NSF and the UB92 for all field definitions and validation information.

Default: None, this is a required field.

C-22 CONDITION CODES

A1 = EPSDT

A4 = Family Planning

99 = Child Abuse

PRO Approval Codes

C1 = Approved as billed

C3 = Partial approved

C1 or C3 is required for inpatient claims

Default: spaces

C-23 OCCURRENCE CODES

These codes must be two digits long.

Valid values:

01 Auto Accident

02 Auto Accident/No Default

03 Accident/Tort Liability

04 Accident/Employment Related

05 Other Accident

06 Crime Victim

10 Last Menstrual Period

11 On set of Symptoms/Illness

20 Guarantee of Payment Began

21 UB/PSRO Notice Received

22 Date Active Care Ended

23 Benefits Exhausted

24 Date Insurance Denied

25 Date Benefits Terminated By Primary Payer

26 Date SNF Bed Available

27 Date Home Health Plan Established

40 Scheduled Date of Admission

41 Date of First Test for Pre-Admission

42 Date of Discharge

Default: Spaces for non-required fields.

C-24 RECORD CODE

This is a required record heading field. The value in this field indicates the claim type and the record type. Claim types requiring multiple records must be submitted in the indicated record code order below:

File Identifier

File Identifier Code - 99

NOTE: This record exist once per file and is always the first record.

Pharmacy Claims

Leading Record Code - 10

NOTE: Pharmacy claims have leading records only.

Health Care Claims

Leading Record Code - 20

Detail Record Code - 21

Trailing Record Code - 22

Dental Claims

Leading Record Code - 30

Detail Record Code - 31

Trailing Record Code - 32

Inpatient and Outpatient Claims

01 Processor Data

10 Provider Data

20 Patient Data

21 Noninsured Employment Information

22 Noninsured Employment Information

30 Third Party Payer

31 Third Party Payer

32 Third Pary Payer

34 Authorization

40 Claim Data Treatment Authorization/Occurrence

41 Claim Data Condition/Value

50 Accommodations Data (inpatient only)

60 Ancillary Data (inpatient only)
61 Outpatient Procedures (outpatient only)
70 Medical Data
74 Patient Information
80 Physician Data
81 Pacemaker Registry
90 Claim Control
91 Remarks
95 Provider Batch
99 File Control

NSF (Dental and CMS-1500)

AA0 Submitter Data
BA0 Provider Data 1
BA1 Provider Data 2
CA0 Patient Data
CB0 Legal Representative Data
DA0 Payor Data 1
DA1 Payor Data 2
DA2 Payor Data 3
EA0 Claim Record
EA1 Claim Record
EA2 Early Periodic Screening Diagnostic Testing-EPSDT
FA0 Service Line Detail "Root Segment"
FB0 Service Line Detail "Medical Segment"
FB1 Service Line Detail "Medical Segment"
FB2 Service Line Detail "Medical Segment"
FD0 Dental Segment
GA0 Ambulance Certification Record
GC0 Chiropractic Certification Record
GD0 Certification Record "Durable Medical Equipment"
GD1 Certification Record "Narrative Information for DME"

Tables and Addenda

GE0 Certification Record "Enteral Nutrition Therapy"
GP0 Certification Record "Parenteral Nutrition Therapy"
GU0 Certification Record "DMEPOS Items"
GX0 Certification Record "Medical Necessity for Oxygen"
GX1 Certification Record "Narrative Information for Oxygen"
GX2 Certification Record "Facility Information for Oxygen"
HA0 Narrative Record
XA0 Claim Trailer Record "Record Summary"
YA0 Batch Trailer Record
ZA0 File Trailer Record
Default: None, this is a required field.

C-26 NATIONAL DRUG CODE (NDC)

Enter the code designated for the drug dispensed. The field is 5-4-2 format. Right justify and left zero fill each section. Do not enter dashes or spaces to separate these eleven digits.

Default: None, this is a required field.

C-27 MEDICARE CONSTANT

This field must contain a space.

NSF (Dental and CMS-1500) - Source of Pay (NSF)

Enter a 'C' if this participant is covered by Medicare.

Default: This field must contain a space.

C-28 QUANTITY/UNITS

Pharmacy Claims

Metric Quantity

Enter the metric or non-metric quantity of the drug being dispensed. For example: A quantity of 100 would be 0100 Whole numbers only are accepted for quantities.

Health Care, Outpatient, and Dental Claims and NSF Layout

Quantity (Days/Units)

Enter the number of days or units of services performed. Whole numbers only are accepted for days or units.

Inpatient Claims

Units

Enter the number of days per room rate for both covered and non-covered accommodations (revenue codes 100 through 239). Whole numbers only are accepted for the days.

Default: Zeros for non-required fields.

Standard units of service = 0010 for 1 unit

not using standard = 0001 for 1 unit

C-29 DAYS SUPPLY

Pharmacy Claims

Enter the estimated number of days the dispensed amount represents.

If "as needed" (PRN) enter 077.

Default: None, this is a required field.

C-30 PROCEDURE CODES

Enter the HCPCS (CPT-4) procedure code that represents the service performed.

C-31 PATIENT ACCOUNT NUMBER

Enter the participant's account number used by your office. You may leave this field blank or use it for other purposes. Valid values are spaces, hyphens, or letters or numbers.

Default: Spaces for non-required fields.

C-32 DAYS COVERED/NOT COVERED

Days Covered

Enter the number of days elapsed between the Covered Period From Date and the Covered Period Thru Date.

Days Not Covered

Enter the number of non-covered accommodation days which are billed on the claim. The days shown here are not included in the calculation of Days Covered, they are a portion of that total.

Default: Zeros if it does not apply.

C-33 PROVIDER NAME

This field contains the first two characters of the submitting providers name. This must match the provider's MO HealthNet enrollment file.

Example:

Dr. James Smith - enter SM

Fourth Street Drug - enter FO

A. A. Clinic - enter "A."

A & B Clinic - enter "A "

For the NSF layout, you may enter the entire name, but only the first two letters will be verified against the provider enrollment file.

Default: None, this is a required field.

C-34 ROOM RATE

Enter the amount charged per day for this specific room and revenue code. For all charge amount fields, the decimal is implied and must not be entered. Therefore, if a charge field is less than the field length, the amount must be right justified and the remaining left positions filled with zeros.

For example: An amount of \$155.25 would be entered "000015525". An amount of \$120.00 would be entered "000012000".

Default: Zeros, unless the revenue code is 100 through 239, then this is a required field.

C-35 MODIFIERS

Enter one or both of the two digit modifiers if they apply to the service performed.

There are two modifier fields; each can hold two characters. You can enter O, 1, or 2 modifiers, but the second modifier cannot have a value if the first modifier is blank.

If a modifier field is used, it must be two characters long with a valid values of 0 through 9 and A through Z.

Default: Spaces for non-required fields.

C-36 FILLER

The value of this field must be spaces to pad the unused portion of a record.

Value: Spaces for non-required fields.

C-37 PROSTHESIS INDICATOR

Enter a "Y" if the services are an initial prosthesis placement.

Enter an "N" if the services are prosthesis related, but are not the initial placement.

Default: Spaces for non-required fields.

C-38 TOOTH NUMBER/LETTER

****For the NSF layout, reference the requirements as published by CMS.**

C-39 TOOTH SURFACE CODE

****For the NSF Layout, reference the requirements as published by CMS.**

C-40 END OF RECORD

This is the required end of record marker. The field value must contain HEX OD OA (Carriage Return/Line Feed).

Default: None, this is a required field.

C-41 PREVIOUS ICN

If date of service of the claim being filed is more than one year from the current date enter the Internal Control Number (ICN) originally assigned to this claim, left justify.

Default: Spaced for non-required fields.

C-42 CERTIFICATION NUMBER

Enter the 7 digit certification number that was issued by Medical Review Services.

Default: Zeros for non-required fields.

C-43 BILL TYPE

Valid bill type codes are:

Inpatient

11x
12x

Outpatient

13x
14x

Rural Health

71x

Hospice

81x
82x

Home Health

34X

Nursing Home (SNF/ICF)

21X
22X
23X
24X
25X
26X
27X
28X
29X
65X

Default: None, this is a required field.

C-44 YES/BLANK INDICATORS

If one of the following cases apply, a "Y" should be placed in the field. If that case does not apply, the field must be left blank.

NSF

Medical/Pharmacy/Dental EPSDT (Early Periodic Screening and Diagnostic Treatment)

Family Planning

Facility - If a Health Care claim has a place of service code 21, 51, 55, 56 or 61 on any detail, then a "Y" must be entered in the "Facility" field. However, this rule does not apply for provider types 28, 29, and 71.

Lab - If billing for laboratory charges, a "Y" should be placed in the field. If lab work is referred out, these services may not be billed by the referring provider.

If one of the following cases apply, a "Y" should be placed in the appropriate field.

Pharmacy Claims - Nursing Home Indicator

Enter a "Y" if the participant is in a Nursing Home or leave blank if the participant is not in a Nursing Home. Enter an "X" if the prescription is a controlled dose drug.

Default: Spaces for non-required fields.

C-45 Menstrual Cycle Date

This is a required field when billing Prenatal Procedure Codes.

The field contains the date of the Last Menstrual Period.

This date is stored in MMDDYY format with allowed characters of 0 through 9.

Default: Zeros for non-required fields.

C-46 PRIOR AUTHORIZATION NUMBER

Enter the 7 digit Prior Authorization (PA) Number that was issued by MO HealthNet Division.

Default: Spaces for non-required fields.

C-47 FILE IDENTIFIER RECORD

This record contains information identifying the creator or submitter of the file or diskette. The creator could be an Service Bureau (clearinghouse) or provider. The required contents of each field found on this record is outlined below.

Service Bureau (Submitter) Name - enter the name of the Service Bureau/Provider (Hospital, billing department name, or individual provider). Left justify the complete name in this field and fill the remaining area to the right with spaces.

Service Bureau (Submitter) Add - enter the address (P. O. Box or Suite number) of the Service Bureau/Provider (Hospital, billing department name, or individual provider). For inpatient or outpatient claims include the street address in this field. Left justify the complete address in this field and fill the remaining area to the right with spaces.

Service Bureau (Submitter) St - enter the street address of the Service Bureau/Provider (Hospital, billing department name, or individual provider). Left justify the complete address in this field and fill the remaining area to the right with spaces.

Service Bureau (Submitter) City - enter the city of the Service Bureau/Provider (Hospital, billing department name, or individual provider). Left justify the complete city in this field and fill the remaining area to the right with spaces.

Service Bureau (Submitter) State - enter the state abbreviation of the Service Bureau/Provider (Hospital, billing department name, or individual provider).

Service Bureau (Submitter) Zip - enter the five or nine digit zip code of the Service Bureau/Provider (Hospital, billing department name, or individual provider). Left justify the zip code in this field and fill the remaining area to the right with spaces.

Service Bureau (Submitter) Phone - enter the phone number of the Service Bureau/Provider (Hospital, billing department name, or individual provider).

C-48 MULTIPLE PROVIDER BILLING FILE INDICATOR

A code indicating whether bills for more than one provider are contained on this file submission, according to the following coding scheme.

1. Single Provider
2. Multiple Providers

C-49 SEX INDICATOR

Code indicating the sex of the patient.

- M Male
- F Female
- U Unknown

NSF Layout

If EA0 record, symptom indicator, field #6, is a '2', then the sex indicator is required on NSF record CA0, field #9.

C-50 PATIENT MARITAL STATUS

Marital status of the patient at date of admission, outpatient service or start of care.

- S Single
- M Married
- X Legally separated
- D Divorced
- W Widowed
- U Unknown

C-51 EMPLOYMENT STATUS CODE

Code used to define the employment status of the individual identified in record 30.

- 1 Employed full time
- 2 Employed part time
- 3 Not employed
- 4 Self-employed
- 5 Retired
- 6 On active military duty
- 9 Unknown

C-52 CERTIFICATE/SOCSECNUMBER/HEALTH INSURANCE CLAIM/IDENTIFICATION NUMBER

Unique identification number assigned by the payer organization. If payer is MO HealthNet, number entered must correspond with the number on the MO HealthNet ID card

C-53 PAYER NAME

Name identifying each payer organization from which the provider might expect some payment for the bill. If record reflects request for MO HealthNet payment enter 'MEDICAID' in the first eight positions of this field. Only one record with MEDICAID is allowed per claim.

C-54 FUNCTIONAL LIMITATION CODES

- 1 Amputation
- 2 Bowel/bladder (Incontinence)
- 3 Contracture
- 4 Hearing
- 5 Paralysis
- 6 Endurance
- 7 Ambulation
- 8 Speech
- 9 Legally blind
- A Dyspnea with minimal exertion
- B Other

C-55 ACTIVITIES PERMITTED CODES

- 1 Complete bedrest
- 2 Bedrest BRP
- 3 Up as tolerated

- 4 Transfer bed/chair
- 5 Exercises prescribed
- 6 Partial weight bearing
- 7 Independent at home
- 8 Crutches
- 9 Cane
- A Wheelchair
- B Walker
- C No restrictions
- D Other

C-56 MENTAL STATUS CODES

- 1 Oriented
- 2 Comatose
- 3 Forgetful
- 4 Depressed
- 5 Disoriented
- 6 Lethargic
- 7 Agitated
- 8 Other

C-57 PROGNOSIS

- 1 Poor
- 2 Guarded
- 3 Fair
- 4 Good
- 5 Excellent

C-58 TYPE OF FACILITY

Code indicating type of facility from which the patient was most recently discharged.

- A Acute
- S SNF
- I ICF

R Rehabilitation Facility

O Other

C-59 SURGICAL PROCEDURE CODE

Enter the HCPCS (CPT-4) procedure code that represents the service performed. If procedure code is entered, the surgical date field must also be completed.

Default: If a surgical procedure code does not apply to the claims then spaces may be placed in the field.

C-60 OCCURRENCE SPAN PRO/UR APPROVAL STAY DATES

PRO/UR Approval Dates

From - MMDDYY

Through- MMDDYY

Required if any condition code is equal to "C3"

C-61 BATCH TYPE

This is a required field that indicates the type of claims that are included within this batch. Valid values are:

100 - Medical

200 - Dental

C-62 SYMPTOM INDICATOR

An indicator as to whether the "Accident/Symptom Date" represents the date that symptoms were first experienced or the date of last menstrual period (LMP). Valid values are:

0 = No Symptom Date in EA0-07.0

1 = Date of first symptoms of illness

2 = Date of LMP

If code '2' is entered, then field #9 on the CA0 record must = 'F'(female).

C-63 ACCIDENT/SYMPTOM DATE

The date of the accident or the date that patient first experienced symptoms of illness or the date of the last menstrual period (LMP).

C-64 FACILITY/LAB NAME

The name of the Hospital, Nursing Facility, Laboratory or other facility where services being submitted on this claim were rendered.

C-65 LINE ITEM CONTROL NUMBER

An identifier assigned by the submitter/provider to this line item.

C-66 DIAGNOSIS CODE POINTER1

A pointer to the claim diagnosis code in the order of importance to this service.

<u>NEW MATERIAL</u>	<u>REVISED PAGES</u>	<u>REPLACED PAGES</u>
Addendum A	A-1 - A-34 (34 pp.)	A-1 - A-46 (46 pp.)
Addendum B	B-1 - B-19 (19 pp.)	B-1 - B-14 (14 pp.)

REVISED PROCEDURES--EFFECTIVE DATE: October 1, 1993

NOTE: Effective April 1, 1994 the preferred electronic format for Medicare bill processing will be the version 4 flat file or ANSI 837. There will be a six month grace period, October 1, 1993 to March 31, 1994, during which both versions 3 and 4 will be accepted by intermediaries from providers. Intermediaries should begin testing with their providers and shared system contractors immediately to ensure accurate implementation of version 4 or ANSI-837 by April 1, 1994. Current local electronic formats must be received in UB-92 format on and after April 1, 1994.

Beginning October 1, 1993, CWF will only accept the UB-92 CWF format. Medicare intermediaries will be required to convert all UB-82 records received during the grace period, October 1, 1993, to March 31, 1994, to the UB-92 CWF format for processing.

Effective October 1, 1996, the only electronic format accepted for Medicare bill processing will be the ANSI 837.

Addenda A and B have been completely revised and should be reviewed in their entirety. Redlining has not been used due to the comprehensiveness of the changes being made.

Addendum A, Provider Electronic Billing File and Record Formats, is revised to reflect the changes made to the HCFA-1450 with the move from the UB-82 to the UB-92.

All Unlabeled Fields on the UB-92 are assigned to a specific Record Type (RT) and field location in Version 4.

State use form locators 2, 11, 56 and 78 are on the new RT 22 which is titled Unassigned State Form Locators.

National use form locator 31 is on RT 41, form locator 37 (ICN/DCN) is on RT 31, form locator 49 is on RT 50, 60 or 61 and form locator 57 is on RT 70.

The Federal tax number or EIN is expanded to 10 positions on RTs 01 and 10. The file sequence and serial number fields are combined to a single 7 position field.

Provider identification numbers are retained on RT 10 and expanded to five iterations, as well as having provider number reiterated on RT 30. Use of multiple iterations of RT 30 permits you to show information for each payer, including the payer's provider identification number. The procedure coding method was removed from RT 10 and relocated to RT 70.

Accident hour was removed from RT 20, and is redefined as Value Code 45. Use one of the value codes and amounts in RT 41 to show accident hour. Medical record number has decreased from 18 positions to 17 positions to match the UB-92 for both RTs 20 and 74.

Employee identification number was removed from the UB-92, and hence from RT 21. The employment information code was also removed from the UB-92 and from RT 21.

The patient control number was expanded by 3 positions to 20 positions. Since this is the linking field for all patient/claim level records, all RTs 20-91 are affected.

Deductible and coinsurance were removed from the face of the UB-92 and redefined as value codes and amounts. All value codes and amounts are located on RT 41. Insured's address and employee's address were removed from the UB-92, but are retained in RT 31 of the EMC format.

Also on RT 31, employee identification number was deleted to coincide with its removal from the UB-92. The special program indicator was removed from RT 31 and redefined as a condition code, located on RT 41.

A new RT 34, Authorization, was added to the electronic data set at the request of some payers. The intent of this record is to permit transmission of any needed detail regarding any type of prior authorization from any payer. At this time there is no need to use this record for Medicare.

The old RT 40 was significantly revised and divided into 2 companion records. Treatment Authorization Code was expanded to 3 iterations and relocated to RT 40. The new RT 40, renamed Claim Data TAN-Occurrence, now contains: type of bill, 3 iterations of treatment authorization number, 10 iterations of occurrence code, and 2 iterations of occurrence span code.

RT 41, a new record type with this Version, is named Claim Data Condition-Value. It contains 10 iterations of condition code and 12 iterations of value code and amount.

Most claims consist of a single set of records 40 and 41.

Deleted from the 40 record are the following:

Data Element	Action	New Location
PRO Approval Indicator	Redefined as a condition code (C1-C7)	RT 41
PRO Approved Stay Days	Redefined as occurrence span code M0	RT 40
Blood Pts Furnished	Redefined as value code 37	RT 41
Blood Pts Deductible	Redefined as value code 38	RT 41
Blood Pts Replaced	Redefined as value code 39	RT 41
Blood Pts Unreplaced	Deleted from the UB-92	Not in V. 004
Grace Days	Redefined as value code 46	RT 41
Estimated Responsibility	Redefined as a value code (A3, B3, C3, or D3)	RT 41

RTs 50, 60, and 61 are revised to contain 4 positions for each iteration of revenue code.

RT 70 is revised to allow 6 positions for the principal diagnosis code and each iteration of other diagnosis code and 7 positions for the principal procedure code and each iteration of other procedure code.

All filler fields are reserved for either National Use or State Use, as indicated.

Directions for the use of RT 80 were changed to link the sequential iterations to the applicable payer and to link the physician numbers to the physician number qualifying codes .

RT 91 was added to allow for the coding of positions 111 - 192 of form locator 84, Remarks. The first 110 positions are coded on RT 90.

Addendum B, Alphabetic Listing of Data Elements, was revised to reflect new and revised data element definitions as a result of the changes made to the HCFA-1450 with the move from the UB-82 to the UB-92.

This transmittal contains Version 4 of Addendum A and the corresponding data element definitions in Addendum B. Continue to show 003 in field 19 of

RT 01 until you make the change to UB-92. Enter 004 in field 18 of RT 01 when you make the transition to UB-92.

PCDISC: 94 budget: AD-A.HO

CMowry:cm:7/16/92

revised:CM:cm:7/27/92

revised:ANSI-837WKGRP:cm:8/4/92

revised:PEBTAG&JL&CM:cm:12/2/92

revised:NUBC:SBarranco:sb:1/19/93

revised:AddRT22-DeIRT44:sb:1/23/93

revised:PEBTAG&jl&NUBC:sb:3/1/93

410-966-6152

ADDENDUM A - PROVIDER ELECTRONIC BILLING FILE AND RECORD FORMATS

	<u>Section</u>	<u>Page</u>
Recommended Physical File Specifications - Magnetic Tape	1	A-2
File Specifications - Media Other Than Magnetic Tape	2	A-2
File Logic Specifications	3	A-3
Key to Records	4	A-4
Record Layouts	5	A-5

1. Recommended Physical File Specifications - Magnetic Tape--Tape Characteristics -9 Track, 8 1/2" to 10 1/2" reels with silver mylar reflector (standard reels) with write ring removed or 3480 tape cartridges.

- Parity - Odd
- Recording Density - 6250 bytes per inch.
- Recording Code - Extended Binary Coded Decimal.
- File Label - None. The tape must have an end of file mark. The first data record on the file will identify the submitter and the receiver, and will serve the function of a file label.
- Physical Record Length - 192 characters.
- Block Size: 32,640 characters; i.e., a blocking factor of 170.
- Unfilled Final Block - Fill with spaces.
- The external label on the reel must appear as follows:

From a To b

Reel Number c Claim Types d

Billing Date e

f. // Medicare // MO HealthNet // Other

Recording Density 6250 BPI

- (a) Identification of submitter
- (b) Identification of intended participant
- (c) Unique number by which tape is identified in submitter's tape library
- (d) Types of claims on the tape; e.g., inpatient hospital, inpatient SNF, outpatient hospital
- (e) Date tape created (MMDDYY)
- (f) Check one: Medicare, MO HealthNet, or Other

2. File Specifications - Media Other Than Magnetic Tape.--

File Label - None

Physical Record Length - 192 characters

External Label - Same as magnetic tape, a through f, for media other than telecommunications.

Other specifications will be agreed upon between provider and intermediary with the concurrence of the appropriate Regional Administrator.

3. Record Specifications.--The logical claim record is made up of a series of 192 character physical records. The physical records for each claim are divided into logical subsets as follows:

Subset 1 - Patient Data - Record Codes 20-29

Subset 2 - Third Party Data - Record Codes 30-39

Subset 3 - Claim Request Data - Record Codes 40-49

Subset 4 - Inpatient Accommodations Data - Record Codes 50-59

Subset 5 - Ancillary Services Data - Record Codes 60-69

Subset 6 - Medical Data - Record Codes 70-79

Subset 7 - Physician Data - Record Codes 80-89

The record layouts that follow will provide the following data:

1. Record Name: The name of the data record.
2. Record Type: Code indicating the type of record.
3. Record Size: Physical length of record. Constant 192.
4. Field Number
5. Field Name

6. Picture: This will be the COBOL picture. Pic X will be initialized to blanks, and Pic 9 will be initialized to zeroes. All money fields and date fields will be Pic 9. All code fields that have a legitimate value of zero will be Pic X. This will make it possible to detect whether the field has been omitted.

7. Field Specification: This indicates how the data field is justified.

L = Left justification, and R = Right justification.

8. Position:

From = Leftmost position in the record (high order).

Thru = Rightmost position in the record (low order).

9. All filler fields are reserved for national use unless otherwise specified.

4. Key to Records

Record Name	Record Type Code
Processor Data	01
Reserved for National Assignment	02-04
Local Use	05-09
Provider Data	10
Reserved for National Assignment	11-14
Local Use	15-19
Patient Data	20
Noninsured Employment Information	21
Unassigned State Form Locators	22
Reserved for National Assignment	23-24
Local Use	25-29
Third Party Payer Data	30-31
Reserved for National Assignment	32-33
Authorization	34
Local Use	35-39
Claim Data TAN-Occurrence	40
Claim Data Condition-Value	41
Reserved for National Assignment	42-44
Local Use	45-49
IP Accommodations Data	50

Reserved for National Assignment	51-54
Local Use	55-59
IP Ancillary Services Data	60
Outpatient Procedures	61
Reserved for National Assignment	62-64
Local Use	65-69
Medical Data	70
Plan of Treatment and Patient Information	71
Specific Services and Treatments	72
Plan of Treatment/Medical Update Narrative	73
Reserved for National Assignment	74-78
Local Use	79
Physician Data	80
Pacemaker Registry Record	81
Reserved for National Assignment	82-84
Local Use	85-89
Claim Control Screen	90
Remarks (Overflow from RT 90)	91
Reserved for National Assignment	92-94
Provider Batch Control	95
Local Use	96-98
File Control	99

5. Record Layouts

RECORD TYPE 01 - PROCESSOR DATA

Must be first record on file.

Must be followed by RT 10.

NOTE: Files will be formatted so that this is a data record, not a conventional label. From a system standpoint, this will be a 'labelless' file.

The processor data record will be the first record on each reel.

This record indicates, in fields 5 through 7, the class and identification of the organization designated to receive this file or transmission. If the code in field 5 is a "Z", the file contains records for multiple primary payers. In this

case, the employer identification number (EIN), also known as the tax identification number (TIN), identifies the organization designated to receive this tape or transmission. Otherwise, the code in field 5 designates the types of primary payer. Field 6 contains the receiver/primary payer identification (NAIC number for commercials, Blue Cross number for PLANS, as indicated by each State agency for MO HealthNet, as assigned by CHAMPUS where applicable, etc.). For commercial insurers, Field 7 contains the specific office within the insurance carrier designated to receive this tape or transmission. For Blue Cross Plans this field will be used as designated by the Plan receiving the file.

It is recommended that billers and intermediaries establish a protocol limiting a file to a single reel of tape, single disk, cartridge, or cassette. In the event a file exceeds that limit, the reel, cartridge or disk must end in a batch control (record type (RT) 95).

RECORD TYPE 01 - PROCESSOR DATA

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '01'	XX	L	1	2
2	Submitter EIN	9(10)	R	3	12
3	Multiple Provider Billing				
	File Indicator		9	13	13
4	Filler (National Use)	X(17)	L	14	30
5	Receiver Type Code	X		31	31
6	Receiver Identification	9(5)	R	32	36
7	Receiver Sub-				
	Identification	X(4)	L	37	40
8	Processing Date ("Date Bill	9(6)	R	41	46
	Submitted" on HCFA-1450)				
9	Submitter Name	X(21)	L	47	67
	Submitter Address (Fields 10-13)				
10	Address	X(18)	L	68	85
11	City	X(15)	L	86	100
12	State	XX	L	101	102
13	ZIP Code	9(9)	R	103	111
14	Submitter FAX Number	9(10)	R	112	121
15	Country Code	X(4)	L	122	125
16	Submitter Telephone Number	9(10)	L	126	135
17	File Sequence & Serial Number	X(7)	L	136	142

18	Filler (National Use)	X(23)		143	165
19	Filler (Local Use)	X(24)		166	189
*20	Version Code	X(3)	L	190	192

*VERSION 004

RECORD TYPE 10 - PROVIDER DATA

Must follow either RT 01 or 95.

Must be followed by RT 20.

NOTE: THIS RECORD MUST BE PRESENT FOR EACH PROVIDER BATCH COMBINATION.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '10'	XX	L	1	2
2	Type of Batch	XXX	L	3	5
3	Batch Number	99	R	6	7
4	Federal Tax Number or EIN	9(10)	R	8	17
5	Federal Tax Sub ID	X(4)	L	18	21
6	Medicare Provider Number	X(13)	L	22	34
7	Medicaid Provider Number	X(13)	L	35	47
8	CHAMPUS Insurer Provider Number	X(13)	L	48	60
9	Other Insurer Provider Number	X(13)	L	61	73
10	Other Insurer Provider Number	X(13)	L	74	86
11	Provider Telephone Number	9(10)	R	87	96
12	Provider Name	X(25)	L	97	121
	Provider Address(Fields 13-16)				
13	Address	X(25)	L	122	146
14	City	X(14)	L	147	160
15	State	XX	L	161	162
16	ZIP Code	9(9)	R	163	171
17	Provider FAX Number	9(10)	R	172	181
18	Country Code	X(4)	L	182	185
19	Filler (National Use)	X(4)		186	189

20	Filler (State Use)	X(3)		190	192
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RECORD TYPES 20-2N - Patient Data

Must follow either RT 10 or RT 90.

May be followed by RT 21-2N or 30.

All records following up through RT 90 must have the same patient control number.

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '20'	XX	L	1	2
2	Filler (National Use)	XX		3	4
3	Patient Control Number	X(20)	L	5	24
	Patient Name (Fields 4-6)				
4	Last Name	X(20)	L	25	44
5	First Name	X(9)	L	45	53
6	Middle Initial	X		54	54
7	Patient Sex	X		55	55
8	Patient Birthdate (MMDDCCYY)	9(8)	R	56	63
9	Patient Marital Status	X		64	64
10	Type of Admission	X		65	65
11	Source of Admission	X		66	66
	Patient Address (Fields 12-16)				
12	Address - Line 1	X(18)	L	67	84
13	Address - Line 2	X(18)	L	85	102
14	City	X(15)	L	103	117
15	State	XX	L	118	119
16	ZIP Code	9(9)	R	120	128
17	Admission/Start of Care Date	9(6)	R	129	134
18	Admission Hour	XX	R	135	136
	Statement Covers Period				
19	From (MMDDYY)	9(6)	R	137	142
20	Thru (MMDDYY)	9(6)	R	143	148

21	Patient Status	99	R	149	150
22	Discharge Hour	99	R	151	152
23	Payments Received (Patient line)	9(8)V99S	R	153	162
24	Estimated Amount Due(Patient line)	9(8)V99S	L	163	172
25	Medical Record Number	X(17)	L	173	189
26	Filler (National Use)	X(3)		190	192

RECORD TYPE 21 - NONINSURED EMPLOYMENT INFORMATION

Must follow RT 20.

May be followed by RT 21-2N or 30.

This record contains employment information pertaining to individuals not claiming insurance, but who may have some insurance coverage through their employer from which the patient may be eligible for benefits.

- There are four different individuals to whom this may apply: the patient, the patient's spouse, the patient's father, and the patient's mother. If more than two of these individuals are involved in this claim, use a second record type 21 to submit the relevant employment data for the third, and if applicable, the fourth party involved. The sequence number (field 2) of the second Type 21 record would be shown as "02".

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '21'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
	EMPLOYMENT INFORMATION PACKET ONE				
4	Employer Name	X(24)	L	25	48
	Employer Location (Fields 5 - 8)				
5	Employer Address	X(18)	L	49	66
6	Employer City	X(15)	L	67	81
7	Employer State	XX	L	82	83
8	Employer ZIP Code	9(9)	R	84	92
9	Employment Status Code	9		93	93
10	Filler (National Use)	X(15)		94	108
	EMPLOYMENT INFORMATION PACKET TWO				

11	Employer Name	X(24)	L	109	132
	Employer Location (Fields 12 - 15)				
12	Employer Address	X(18)	L	133	150
13	Employer City	X(15)	L	151	165
14	Employer State	XX	L	166	167
15	Employer ZIP Code	9(9)	R	168	176
16	Employment Status Code	9		177	177
17	Filler (National Use)	X(15)		178	192

RECORD TYPE 22 - UNASSIGNED STATE FORM LOCATORS

Not required by Medicare

Assignment and/or use of these form locators is the responsibility of individual State Uniform Billing Committees (SUBCs).

The state code in field 4 is used to identify the SUBC responsible for the definition of the form locators on this sequence of RT 22.

Must follow RT 20 or 21.

May be followed by RT 30.

Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '22'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	State Code	X(2)	L	25	26
5	Form Locator 2 (upper line)	X(29)	L	27	55
6	Form Locator 2 (lower line)	X(30)	L	56	85
7	Form Locator 11 (upper line)	X(12)	L	86	97
8	Form Locator 11 (lower line)	X(13)	L	98	110
9	Form Locator 56 (upper line)	X(13)	L	111	123
10	Form Locator 56 (2nd line)	X(14)	L	124	137
11	Form Locator 56 (3rd line)	X(14)	L	138	151
12	Form Locator 56 (4th line)	X(14)	L	152	165

13	Form Locator 56 (patient line)	X(14)	L	166	179
14	Form Locator 78 (upper line)	X(2)	L	180	181
15	Form Locator 78 (lower line)	X(3)	L	182	184
16	Filler (Local Use)	X(8)		185	192

RECORD TYPES 30-3N - Third Party Payer

One third party payer record packet (record types 30-3N) will appear in the bill record for each payer involved in the bill. Each third party payer packet must contain a record type 30. However, each record type 30 may or may not have an associated record type 31 depending on the specific third party payer data required by the particular payer.

There is an optional RT 34 that contains detailed authorization information. If a payer requires treatment or other authorization in advance of the beneficiary's receipt of services, it will issue an authorization number. If the authorization is for a limited period of time, the payer will inform you of the applicable dates. If the authorization number applies to the entire claim, enter it in RT 40 in the location for the payer issuing it. For further information regarding use of this record see page A-18.

Example: Medicare is primary, and the secondary payer requires the insured's address:

	Record Type Code	Sequence Number
Medicare	30	01
Secondary Payer	30	02
Secondary Payer	31	02
Secondary Payer	32	02
Authorization	34	02

Because the sequence number of the type 31 record for the secondary payer matches the sequence number of the secondary payer's type 30 record, it serves as a matching criterion for the specific third party payer record packet.

Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

RECORD TYPE 30 - THIRD PARTY PAYER DATA

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
1	Record type '30'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24

4	Source of Payment Code	X		25	25
5	Payer Identification	9(5)	R	26	30
6	Payer Sub-Identification	X(4)	L	31	34
7	Certificate/SocSecNumber/ Health Insurance Claim/ Identification Number > Medicaid Number	X(19)	L	35	53
8	Payer Name - Medicaid	X(25)	L	54	78
9	Primary Payer Code	X		79	79
10	Insurance Group Number	X(17)	L	80	96
11	Insured Group Name	X(14)	L	97	110
	Insured's Name (Fields 12-14)				
12	Last Name	X(20)	L	111	130
13	First Name	X(9)	L	131	139
14	Middle Initial	X		140	140
15	Insured's Sex	X		141	141
16	Release of Information Certification Indicator	X		142	142
17	Assignment of Benefits Certification Indicator	X		143	143
18	Patient's Relationship to Insured	99	R	144	145
19	Employment Status Code	9		146	146
20	Covered Days	9(3)	R	147	149
21	Noncovered Days	9(4)	R	150	153
22	Coinsurance Days	9(3)	R	154	156
23	Lifetime Reserve Days	9(3)	R	157	159
24	Provider Identification Number	X(13)	L	160	172
25	Payments Received	9(8)V99S	R	173	182
26	Estimated Amount Due	9(8)V99S	R	183	192

RECORD TYPE 31 - THIRD PARTY PAYER DATA

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU
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1	Record type '31'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Insured's Address (Fields 4-8)				
4	Address - Line 1	X(18)	L	25	42
5	Address - Line 2	X(18)	L	43	60
6	City	X(15)	L	61	75
7	State	XX	L	76	77
8	ZIP Code	9(9)	R	78	86
9	Employer Name	X(24)	L	87	110
	Employer Location				
	(Fields 10 - 13)				
10	Employer Address	X(18)	L	111	128
11	Employer City	X(15)	L	129	143
12	Employer State	XX	L	144	145
13	Employer ZIP Code	9(9)	R	146	154
14	Form Locator 37 (ICN/DCN)	X(23)	L	155	177
15	Filler (National Use)	X(15)		178	192

RECORD TYPE 32 - THIRD PARTY PAYER DATA

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '32'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Payer Name Payer Address (Fields 5-9)	X(25)	L	25	49
5	Address	X(18)	L	50	67
6	Address	X(18)	L	68	85
7	City	X(15)	L	86	100

8	State	XX)	L	101	102
9	Zip Code	X(9)	L	103	111
10	Filler (National Use)	X(81)	L	112	192

RECORD TYPE 34 - Authorization

For routine use of a treatment authorization number that applies to the entire claim use RT (RT) 40, Claim-TAN-Occurrence. For authorizations requiring dates, i.e., limited to a particular period of time, HCPCS or revenue code, use RT 34, Authorization. Use the same sequence numbers for RT 34 as are used for RT 30. The sequence 01 record must refer to the primary payer, Payer A. The sequence 02 must refer to the secondary payer, Payer B and the 03 must refer to the tertiary payer, Payer C.

Should you need to show authorization for only the secondary payer, complete an RT 34 for sequence 02 only. Do not complete an RT 34 for Payer A, sequence 01.

Use the revenue code and/or HCPCS procedure code to match the appropriate line item.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '34'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Authorization - 1	X(41)	L	25	65
4	Authorization Type	X(2)	L	25	26
5	Authorization Number	X(18)	L	27	44
6	Authorization From Date	9(6)	R	45	50
7	Authorization Thru Date	9(6)	R	51	56
8	Authorization Revenue Code	9(4)	R	57	60
9	Authorization HCPCS Procedure Code	X(5)	L	61	65
10	Authorization - 2	X(41)	L	66	106
11	Authorization - 3	X(41)	L	107	147
12	Authorization - 4	X(41)	L	148	188
13	Filler (National Use)	X(4)		189	192

RECORD TYPE 40 - 4N - CLAIM DATA

Generally, a claim contains a single set of type 40 and type 41 records. Each claim must contain a RT 40. The set may or may not contain a RT 41, depending on the information being submitted (i.e., if there are no condition or value codes to report for the particular claim, there is no need for an RT 41.) However, if one set is not sufficient to contain all iterations of a particular coding structure, e.g., more than 12 value codes are required, submit additional iterations of the appropriate record type, 40 or 41, to convey the additional codes.

For RTs 40 and 41, sequence numbers 02 or higher, all fields except the field or fields required to convey the additional code or codes that could not be contained on the sequence 01 record would be initialized to zeroes or blanks as appropriate, with the exception of the Record Type, Sequence, and Patient Control Number fields.

It is conceivable that a claim could require as many as 3 sequences of Claim-TAN-Occurrence and only 1 of Condition-Value, or vice versa; this is acceptable.

RECORD TYPE 40 - CLAIM DATA TAN-OCCURRENCE

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '40'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Type of Bill	999	R	25	27
TREATMENT AUTHORIZATION CODE					
Repeats 3 times					
5	Treatment Authorization Code-A Certification Number (7 digit number)	X(18)	L	28	45
6	Treatment Authorization Code-B	X(18)	L	46	63
7	Treatment Authorization Code-C	X(18)	L	64	81
OCCURRENCE CODE and DATE					
Repeats 10 times					
8	Occurrence Code - 1	X(2)	L	82	83
9	Occurrence Date - 1 (MMDDYY)	9(6)	R	84	89
10	Occurrence Code - 2	X(2)	L	90	91
11	Occurrence Date - 2 (MMDDYY)	9(6)	R	92	97
12	Occurrence Code - 3	X(2)	L	98	99
13	Occurrence Date - 3 (MMDDYY)	9(6)	R	100	105
14	Occurrence Code - 4	X(2)	L	106	107
15	Occurrence Date - 4 (MMDDYY)	9(6)	R	108	113

16	Occurrence Code - 5	X(2)	L	114	115
17	Occurrence Date - 5 (MMDDYY)	9(6)	R	116	121
18	Occurrence Code - 6	X(2)	L	122	123
19	Occurrence Date - 6 (MMDDYY)	9(6)	R	124	129
20	Occurrence Code - 7	X(2)	L	130	131
21	Occurrence Date - 7 (MMDDYY)	9(6)	R	132	137
22	Occurrence Code - 8	X(2)	L	138	139
23	Occurrence Date - 8 (MMDDYY)	9(6)	R	140	145
24	Occurrence Code - 9	X(2)	L	146	147
25	Occurrence Date - 9 (MMDDYY)	9(6)	R	148	153
26	Occurrence Code -10	X(2)	L	154	155
27	Occurrence Date -10 (MMDDYY)	9(6)	R	156	161
OCCURRENCE SPAN CODE and DATES					
Repeats 2 times					
28	Occurrence Span Code - 1	X(2)	L	162	163
29	Occurrence Span FROM DATE - 1 (MMDDYY)	9(6)	R	164	169
30	Occurrence Span THRU DATE - 1 (MMDDYY)	9(6)	R	170	175
31	Occurrence Span Code - 2	X(2)	L	176	177
32	Occurrence Span FROM DATE - 2 (MMDDYY)	9(6)	R	178	183
33	Occurrence Span THRU DATE - 2 (MMDDYY)	9(6)	R	184	
34	Filler (National Use)	X(3)		190	192

NOTE: IF THE CODE IN THE OCCURRENCE CODE FIELD IS OVER 69, THE TWO DATE FIELDS FOLLOWING THAT CODE ARE ASSOCIATED WITH IT, AND THE FIELD FOLLOWING THE FIRST DATE IS ZERO. IF THE CODE INDICATED IN THE OCCURRENCE SPAN CODE FIELD IS LESS THAN 70, ONLY THE OCCURRENCE SPAN FROM DATE WILL BE COMPLETED. THE CODE AND DATE WILL BE INTERPRETED AS AN OCCURRENCE CODE.

SIMILARLY, IF THE CODE IN THE OCCURRENCE CODE FIELD IS M0-Z9, THE TWO DATE FIELDS FOLLOWING THAT CODE ARE ASSOCIATED WITH IT, AND THE FIELD FOLLOWING THE FIRST DATE IS ZERO. IF THE CODE INDICATED IN THE OCCURRENCE SPAN CODE FIELD IS A1-L9, ONLY

THE OCCURRENCE SPAN FROM DATE WILL BE COMPLETED. THE CODE AND DATE WILL BE INTERPRETED AS AN OCCURRENCE CODE.

RECORD TYPE 41 - CLAIM DATA CONDITION-VALUE

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '41'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
CONDITION CODE					
Repeats 10 times					
4	Condition Code - 1	X(2)	L	25	26
5	Condition Code - 2	X(2)	L	27	28
6	Condition Code - 3	X(2)	L	29	30
7	Condition Code - 4	X(2)	L	31	32
8	Condition Code - 5	X(2)	L	33	34
9	Condition Code - 6	X(2)	L	35	36
10	Condition Code - 7	X(2)	L	37	38
11	Condition Code - 8	X(2)	L	39	40
12	Condition Code - 9	X(2)	L	41	42
13	Condition Code - 10	X(2)	L	43	44
14	Form Locator 31 (upper)	X(5)	L	45	49
15	Form Locator 31 (lower)	X(6)	L	50	55
VALUE CODE					
Repeats 12 times					
16	Value Code - 1	X(2)	L	56	57
17	Value Amount - 1	9(7)V99S	R	58	66
18	Value Code - 2	X(2)	L	67	68
19	Value Amount - 2	9(7)V99S	R	69	77
20	Value Code - 3	X(2)	L	78	79
21	Value Amount - 3	9(7)V99S	R	80	88

22	Value Code - 4	X(2)	L	89	90
23	Value Amount - 4	9(7)V99S	R	91	99
24	Value Code - 5	X(2)	L	100	101
25	Value Amount - 5	9(7)V99S	R	102	110
26	Value Code - 6	X(2)	L	111	112
27	Value Amount - 6	9(7)V99S	R	113	121
28	Value Code - 7	X(2)	L	122	123
29	Value Amount - 7	9(7)V99S	R	124	132
30	Value Code - 8	X(2)	L	133	134
31	Value Amount - 8	9(7)V99S	R	135	143
32	Value Code - 9	X(2)	L	144	145
33	Value Amount - 9	9(7)V99S	R	146	154
34	Value Code - 10	X(2)	L	155	156
35	Value Amount - 10	9(7)V99S	R	157	165
36	Value Code - 11	X(2)	L	166	167
37	Value Amount - 11	9(7)V99S	R	168	176
38	Value Code - 12	X(2)	L	177	178
39	Value Amount - 12	9(7)V99S	R	179	187
40	Filler (National Use)	X(5)		188	192

RECORD TYPE 50 - IP ACCOMMODATIONS DATA

May be preceded by RT 40 - 4n or 50 - 5n.

May be followed by RT 50 - 5n, 60, or 70.

Accommodations should be entered in numeric sequence.

The sequence number for record type 50 can go from 01 to 99, each such physical record containing four accommodations, thus making provision for reporting up to 396 accommodations on a single claim.

ACCOMMODATION REVENUE CODES: 100 THRU 21X

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
1	Record type '50'	XX	L	1	2

2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
Accommodations (occurs 4 times)					
	Accommodations - 1	9(42)	R	25	66
4	Accommodations Revenue Code	9(4)	R	25	28
5	Accommodations Rate	9(7)V99	R	29	37
6	Accommodations Days	9(4)	R	38	41
7	Accommodations Total				
	Charges	9(8)V99S	R	42	51
8	Accommodations Noncovered				
	Charges	9(8)V99S	R	52	61
9	Form Locator 49	X(4)	L	62	65
10	Filler (National Use)	X		66	66
11	Accommodations - 2	9(42)	R	67	108
12	Accommodations - 3	9(42)	R	109	150
13	Accommodations - 4	9(42)	R	151	192

RECORD TYPE 60 - IP Ancillary Services Data

May be preceded by RT 40, 41, 50 - 5n or 60 - 6n (excluding 61).

May be followed by RT 60 - 6n (excluding 61), 70 or 80.

The sequence number for record type 60 can go from 01 to 99, each such physical record containing three inpatient ancillary service codes, thus making provision for reporting up to 297 inpatient ancillary services on a single claim.

PAYER AND RELATED INFORMATION REVENUE CODES: CODES 001 - 099.

THESE CODES MAY BE REPORTED IN RT 60, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RTS 90 THRU 9N.

INPATIENT ANCILLARY SERVICES REVENUE CODES: CODES 220 - 99X.

INPATIENT ANCILLARY CODES SHOULD BE IN CODE NUMBER SEQUENCE.

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
1	Record type '60'	XX	L	1	2

2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Inpatient Ancillaries (occurs 3 times)				
	Inpatient Ancillaries - 1	X(56)	L	25	80
4	Inpatient Ancillary Revenue Code	9(4)	R	25	28
5	HCPCS Procedure Code	X(5)	L	29	33
6	Modifier 1 (HCPCS & CPT-4)	X(2)	L	34	35
7	Modifier 2 (HCPCS & CPT-4)	X(2)	L	36	37
8	Inpatient Ancillary Units of Service	9(7)	R	38	44
9	Inpatient Ancillary Total Charges	9(8)V99S	R	45	54
10	Inpatient Ancillary Noncovered Charges	9(8)V99S	R	55	64
11	Form Locator 49	X(4)	L	65	68
12	Filler (National Use)	X(12)		69	80
13	Inpatient Ancillaries - 2	X(56)	L	81	136
14	Inpatient Ancillaries - 3	X(56)	L	137	192

RECORD TYPE 61 - OUTPATIENT PROCEDURES

May be preceded by RT 40, 41, or 61.

May be followed by RT 61 - 6n, 70 or 80.

The sequence number for record type 61 can go from 01 to 99, each such physical record containing three procedure codes, thus making provision for reporting up to 297 procedures on a single claim.

If 61 record is used, then field # 15 is used on record 90

OUTPATIENT ANCILLARY CODES SHOULD BE IN CODE NUMBER SEQUENCE

FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '61'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Revenue Center (occurs 3 times)				
	Revenue Center - 1	X(56)		25	80

4	Revenue Center Code	9(4)	R	25	28
5	HCPCS Procedure Code	X(5)	L	29	33
6	Modifier 1 (HCPCS & CPT-4)	X(2)	L	34	35
7	Modifier 2 (HCPCS & CPT-4)	X(2)	L	36	37
8	Units of Service	9(7)	R	38	44
9	Date of Service (MMDDYY)	9(6)	R	45	50
10	Outpatient Total Charges	9(8)V99S	R	51	60
11	Outpatient Noncovered Charges	9(8)V99S	R	61	70
12	Form Locator 49	X(4)	L	71	74
13	Filler (National Use)	X(6)		75	80
*14	Revenue Center - 2	X(56)		81	136
*15	Revenue Center - 3	X(56)		137	192

*Revenue Centers 2 and 3 have the same format as fields 4-13 in Revenue Center 1.

RECORD TYPE 70 - 7N - MEDICAL DATA

May be preceded by RT 50, 60, or 61.

May be followed by RT 7N, 80, or 90.

The sequence number for record type 70 can be 01 or 02. The 01 record is for the reporting of five diagnoses and three procedures leaving filler (positions 86-192) for local use. Use an 02 record when reporting more than five diagnoses and/or more than three procedures.

Fields 4-8 in the second record of the sequence will be used to report Other Diagnosis Codes and fields 10-23 will be used to report Other Procedure Codes and dates.

NOTE: ICD-9-CM coding is required for all bill types. Do not report the decimal in the code. The ICD-9-CM diagnosis codes have been assigned a Cobol picture of X. The actual code will be formatted in one of four general ways.

If you report 99999, it translates to 999.99.

If you report V9999, it translates to V99.99.

If you report E9999, it translates to E999.9.

If you report M99999, it translates to M9999/9.

To determine the location of the decimal position and the potential number of decimal positions it is necessary only to examine the high order (left most) position of the field.

RECORD TYPE 70 - MEDICAL DATA (SEQUENCE 1 & 2)

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FIELD NO	FIELD NAME	PICTURE	FIELD SPECIFICATION		
SEQUENCE 1					
1	Record Type '70'	XX	L	1	2
2	Sequence	01	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Principal Diagnosis Code	X(6)	L	25	30
5	Other Diagnosis Code - 1	X(6)	L	31	36
6	Other Diagnosis Code - 2	X(6)	L	37	42
7	Other Diagnosis Code - 3	X(6)	L	43	48
8	Other Diagnosis Code - 4	X(6)	L	49	54
9	Other Diagnosis Code - 5	X(6)	L	55	60
10	Other Diagnosis Code - 6	X(6)	L	61	66
11	Other Diagnosis Code - 7	X(6)	L	67	72
12	Other Diagnosis Code - 8	X(6)	L	73	78
13	Principal Procedure Code	X(7)	L	79	85
14	Principal Procedure Date (MMDDYY)	9(6)	R	86	91
15	Other Procedure Code - 1	X(7)	L	92	98
16	Other Procedure Date - 1 (MMDDYY)	9(6)	R	99	104
17	Other Procedure Code - 2	X(7)	L	105	111
18	Other Procedure Date - 2 (MMDDYY)	9(6)	R	112	117
19	Other Procedure Code - 3	X(7)	L	118	124
20	Other Procedure Date - 3 (MMDDYY)	9(6)	R	125	130
21	Other Procedure Code - 4	X(7)	L	131	137
22	Other Procedure Date - 4 (MMDDYY)	9(6)	R	138	143
23	Other Procedure Code - 5	X(7)	L	144	150
24	Other Procedure Date - 5 (MMDDYY)	9(6)	R	151	156
25	Admitting Diagnosis Code	X(6)	L	157	162
26	External Cause of Injury (E-Code)	X(6)	L	163	168
27	Procedure Coding Method Used	9	R	169	169

28	Filler (National Use)	X(23)		170	192
SEQUENCE 2					
1	Record Type '70'	XX	L	1	2
2	Sequence	02	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Form Locator 57	X(27)	L	25	51
5	Filler (National Use)	X(141)		52	192

RECORD TYPES 71-73 - HOME HEALTH DATA ELEMENTS FOR MEDICAL REVIEW OF HOME HEALTH CLAIMS

Must be preceded by RT 70.

May be followed by RT 74, 7N, 80, or 90.

RECORD TYPE 71 - Plan Of Treatment and Patient Information

(FORMS HCFA-485/486)

RECORD TYPE 72 - Specific Services and Treatments

(FORM HCFA-486)

RECORD TYPE 73 - Plan Of Treatment/Medical Update Narrative

(FORMS HCFA-485/486)

For use by HHAs to submit data from forms HCFA-485 and 486. Data is required with the initial home health bill and with subsequent bills closest to the recertification dates. RTs 71, 72, and 73 must be present. However, when submitting data from the HCFA-486 only (i.e., on interim claims), complete only the following fields on RT 71: Fields 1-6, 24-26; and 28-31. Zeroes are present in numeric fields and blanks in alphanumeric fields which do not contain data.

Retain signed copies of forms HCFA-485 and 486 in your files. The Provider Representative Certification must be submitted with the initial batch of claims containing the HCFA-485 and HCFA-486 data elements. Subsequent certifications are to be submitted in accordance with §499.1.

RECORD TYPE 71 - PLAN OF TREATMENT AND PATIENT INFORMATION

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '71'	XX	L	1	2
2	Filler (National Use)	XX	L	3	4
*3	Patient Control Number	X(20)	L	5	24

*4	Data ID	X		25	25
*5	SOC Date (MMDDYY)	9(6)	R	26	31
	Certification Period				
*6	From (MMDDYY)	9(6)	R	32	37
*7	To (MMDDYY)	9(6)	R	38	43
*8	Date of Onset or Exacerbation of Principal Diagnosis (MMDDYY)	9(6)	R	44	49
*9	Surgical Procedure Code	X(7)	L	50	56
*10	Date Surgical Procedure Performed (MMDDYY)	9(6)	R	57	62
	Dates of Onset/Exacerbation of Secondary Diagnoses (occurs 4 times)				
11	Date Secondary Diagnosis-1	9(6)	R	63	68
12	Date Secondary Diagnosis-2	9(6)	R	69	74
13	Date Secondary Diagnosis-3	9(6)	R	75	80
14	Date Secondary Diagnosis-4	9(6)	R	81	86
*15	Functional Limitation Code (occurs 13 times)	X(13)	L	87	99
*16	Activities Permitted Code (occurs 13 times)	X(13)	L	100	112
*17	Mental Status Code (occurs 8 times)	X(8)	L	113	120
18	Prognosis	X		121	121
19	Verbal SOC Date (MMDDYY)	9(6)	R	122	127
20	Physician's Last Name	X(16)	L	128	143
21	Physician's First Name	X(8)	L	144	151
22	Physician's Initial	X		152	152
23	Physician's ZIP Code	9(9)	R	153	161
24	Medicare Covered	X		162	162
25	Date Physician Last	9(6)	R	163	168
	Saw Patient (MMDDYY)				
26	Date Last Contacted	9(6)	R	169	174
	Physician (MMDDYY)				

27	Patient Receiving Care in 1861(J)(1) Facility	X		175	175
28	Cert/Recert/Mod	X		176	176
29	Admission (MMDDYY)	9(6)	R	177	182
30	Discharge (MMDDYY)	9(6)	R	183	188
*31	Type of Facility	X		189	189
*32	Filler (National Use)	X(3)		190	192

* This denotes the data elements that are required for the abbreviated format for the HCFA-485/486.

RECORD TYPE 72 - SPECIFIC SERVICES AND TREATMENTS

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
1	Record Type '72'	XX	L	1	2
*2	Sequence Number	99	R	3	4
*3	Patient Control Number	X(20)	L	5	24
*4	Discipline	XX	L	25	26
*5	Visits (This Bill)	99	R	27	28
Related to Prior Certification Frequency and Duration (Occurs 12 Times)					
*6	Frequency of Visits - 1	X(6)	L	29	34
	Frequency Number - 1	9	R	29	29
	Frequency Period - 1	XX	L	30	31
	Duration - 1	X(3)	L	32	34
*7	Frequency of Visits - 2	X(6)	L	35	40
*8	Frequency of Visits - 3	X(6)	L	41	46
*9	Frequency of Visits - 4	X(6)	L	47	52
*10	Frequency of Visits - 5	X(6)	L	53	58
*11	Frequency of Visits - 6	X(6)	L	59	64
*12	Frequency of Visits - 7	X(6)	L	65	70
*13	Frequency of Visits - 8	X(6)	L	71	76
*14	Frequency of Visits - 9	X(6)	L	77	82

*15	Frequency of Visits -10	X(6)	L	83	88
*16	Frequency of Visits -11	X(6)	L	89	94
*17	Frequency of Visits -12	X(6)	L	95	100
	Treatment Codes(Occurs 25 Times)	X(75)	L	101	175
*18	Code - 1	X(3)	L	101	103
*19	Code - 2	X(3)	L	104	106
*20	Code - 3	X(3)	L	107	109
*21	Code - 4	X(3)	L	110	112
*22	Code - 5	X(3)	L	113	115
*23	Code - 6	X(3)	L	116	118
*24	Code - 7	X(3)	L	119	121
*25	Code - 8	X(3)	L	122	124
*26	Code - 9	X(3)	L	125	127
*27	Code -10	X(3)	L	128	130
*28	Code -11	X(3)	L	131	133
*29	Code -12	X(3)	L	134	136
*30	Code -13	X(3)	L	137	139
*31	Code -14	X(3)	L	140	142
*32	Code -15	X(3)	L	143	145
*33	Code -16	X(3)	L	146	148
*34	Code -17	X(3)	L	149	151
*35	Code -18	X(3)	L	152	154
*36	Code -19	X(3)	L	155	157
*37	Code -20	X(3)	L	158	160
*38	Code -21	X(3)	L	161	1630
*39	Code -22	X(3)	L	164	166
*40	Code -23	X(3)	L	167	169
*41	Code -24	X(3)	L	170	172
*42	Code -25	X(3)	L	173	175

*43	Total Visits Projected This Cert.	99	R	176	177
44	Filler (National Use)	X(7)		178	184
45	Filler (Local Use)	X(8)		185	192

* This denotes the data elements that are required for the abbreviated format for the HCFA-485/486.

RECORD TYPE 73 - PLAN OF TREATMENT/MEDICAL UPDATE NARRATIVE

This record(s) contains narrative information from the forms "Home Health Certification and Plan of Treatment" and "Medical Update and Patient Information." This record is used to provide information requested on the HCFA-485 and 486 forms and to elaborate on any item on the forms. The HHA should not provide narrative instead of completing fields on RTs 71 and 72. A separate 73 Record for each item is completed. As many 73 records as necessary are used. A sequence number is increased by one for each record present (i.e., 01-99). Listed below are items which may require a narrative record. An "R" is reflected for data which is always required.

Data Element	Data ID Number	Required Element
Medications	48510	R
DME and Supplies	48514	Not required if no DME or supplies will be billed.
Safety Measures	48515	If present.
Nutritional Requirements	48516	R
Allergies	48517	If present.
Orders for Discipline and Treatments	48521	R
Goals/Rehabilitation	48522	R
Potential/Discharge Plans Updated Information	48616	R
Functional Limitations	48617	R
Reason Homebound		
Supplementary Plan of Treatment	48618	If applicable.
Unusual Home/Social Environment	48619	If applicable.
Times and Reasons Patient. Not at Home	48620	If affirmative.
Medical/Nonmedical Reasons Patient Leaves Home	48621	R

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(20)	L	5	24

4	Filler (National Use)	XX		25	26
5	Data ID Number	X(5)	L	27	31
6	Corresponding Data	X(161)	L	32	192

RECORD TYPE 74 - PATIENT INFORMATION

This record is used to give patient information when the agency submits HCFA-485/486 data separately from billing records. HCFA-485/486 data (i.e., RTs 71-73) submitted separately must be preceded by RT 10 - "Provider." Enter in Field 2 - Type of Batch "3M blank" to identify that the batch contains only HCFA-485/486 data.

You must receive permission from your intermediary prior to submitting separate data. Your intermediary will advise you how to submit these batches.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
1	Record Type '74'	XX	L	1	2
2	Filler (National Use)	XX		3	4
3	Patient Control Number	X(20)	L	5	24
4	Filler (National Use)	XX		25	26
5	HICN	X(19)	L	27	45
6	Medical Record Number	X(17)	L	46	62
Patient Name					
7	Last Name	X(20)	L	63	82
8	First Name	X(9)	L	83	91
9	Middle Initial	X		92	92
10	Patient Birthdate (MMDDCCYY)	9(8)	R	93	100
11	Patient Sex	X		101	101
12	Principal Diagnosis Code	X(6)	L	102	107
13	Other Diagnosis Code-1	X(6)	L	108	113
14	Other Diagnosis Code-2	X(6)	L	114	119

15	Other Diagnosis Code-3	X(6)	L	120	125
16	Other Diagnosis Code-4	X(6)	L	126	131
17	Filler (National Use)	X(61)		132	192

RECORD TYPE 80 - 8N - PHYSICIAN DATA

May follow RT 50, 60, 61 or 70 - 7N.

May be followed by RT 81, 90 or 9N.

The sequence number for record type 80 can be 01 - 20. The 01 record is always for the primary payer. If the secondary payer uses a different physician identification numbering scheme from the primary payer, show the secondary payer's physician identification number on the 02 sequence record. If the tertiary payer uses a different physician identification numbering scheme from the primary or secondary payer, show the tertiary payer's physician identification number on the 03 sequence record. If a primary payer requests multiple physician numbers, use sequence number 11. If a secondary payer requests multiple physician numbers, use sequence number 12. If a tertiary payer requests multiple physician numbers, use sequence number 13.

The sequences must match those on RT 30.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
1	Record Type '80'	XX	L	1	2
2	Sequence	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Physician Number Qualifying Codes	X(2)	L	25	26
5	Attending Physician Number*	X(16)	L	27	42
6	Operating Physician Number*	X(16)	L	43	58
7	Other Physician Number*	X(16)	L	59	74
8	Other Physician Number*	X(16)	L	75	90
9	Attending Physician Name**	X(25)	L	91	115
10	Operating Physician Name**	X(25)	L	116	140
11	Other Physician Name**	X(25)	L	141	165
12	Other Physician Name**	X(25)	L	166	190

13	Filler (National Use)	X(2)		191	192
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* The six position UPIN is the required physician number on Medicare claims.

Other payers may use longer Physician Identification Numbers.

** On Medicare claims, Physician Name is broken down as follows:

Last Name	Positions	1-16
First Name	Positions	17-24
Middle Initial	Position	25

Physician Number Qualifying Codes:

UP = UPIN

FI = Federal Taxpayer's Identification Number

SL = State License Number

SP = Specialty License Number

RECORD TYPE 81 - PACEMAKER REGISTRY RECORD

May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80.

Must be followed by RT 20 or 95.

The sequence for this record is not related to payer A, B, or C.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '81'	XX	L	1	2
2	Sequence	99	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Ordering Physician Number*	X(16)	L	25	40
5	Ordering Physician Name**	X(13)	L	41	53
6	Operating Physician Number*	X(16)	L	54	69
7	Operating Physician Name**	X(13)	L	70	82

8	Record Identification Code 1 = Implanted Pulse Generator 2 = Implanted Atrial Lead 3 = Implanted Ventricular Lead 5 = Explanted Pulse Generator 6 = Explanted Atrial Lead 7 = Explanted Ventricular Lead	X		83	83
9	Manufacturer Identification	X(3)	L	84	86
10	Model Number	X(15)	L	87	101
11	Serial Number	X(20)	L	102	121
12	Warranty Expiration Date (MMDDYY)	9(6)	R	122	127
13	Implant Date (MMDDYY)	9(6)	R	128	133
14	Leads Left In Patient Y=Yes, N=No	X		134	134
15	Returned to Manufacturer Y=Yes, N=No	X		135	135
16	Filler (National Use)	X(29)	L	136	164
17	Filler (Local Use)	X(28)	L	165	192

* The six position UPIN is the required physician number.

** Unlike the physician names on RT 80, fields 9-12, which are 25 positions each, the physician names on RT 81, fields 5 and 7, are 13 positions each to conform to FDA data requirements. On RT 81 these fields contain the physician's last name only.

RECORD TYPE 90 - CLAIM CONTROL SCREEN

May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80 - 8N.

Must be followed by RT 20 or 95.

If more than 110 characters are required for Form Locator 84, use RT 91 to report the additional characters and code a "1" in field 12 of RT 90.

If 61 record is used, then field # 15 is used

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU

1	Record Type '90'	XX	L	1	2
2	Filler (National Use)	XX	L	3	4
3	Patient Control Number	X(20)	L	5	24
4	Physical Record Count(Excluding RT 90 + 91)	9(3)	R	25	27
	Record Type nn Count (Fields 5-11)				
5	Record Type 2n Count	99	R	28	29
6	Record Type 3n Count	99	R	30	31
7	Record Type 4n Count	99	R	32	33
8	Record Type 5n Count	99	R	34	35
9	Record Type 6n Count	99	R	36	37
10	Record Type 7n Count	99	R	38	39
11	Record Type 8n Count	99	R	40	41
12	Record Type 91 Qualifier	9	R	42	42
13	Total Accommodation Charges Revenue Centers	9(8)V99S	R	43	52
14	Noncovered Accommodation Charges -Revenue Centers	9(8)V99S	R	53	62
15	Total Ancillary Charges Revenue Centers	9(8)V99S	R	63	72
16	Noncovered Ancillary Charges - Revenue Centers	9(8)V99S	R	73	82
17	Remarks	X(110)		83	192

RECORD TYPE 91 = REMARKS

The first 110 characters from Form Locator 84, Remarks, that are required to provide additional information on the claim should be entered on RT 90. If more than 110 characters are required, use field 4 of RT 91 to report them.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM THRU	
2	Filler (National Use)	XX		3	4
3	Patient Control Number	X(20)	L	5	24

4	Remarks (Additional)	X(82)	L	25	106
5	Filler (National Use)	X(86)		107	192

RECORD TYPE 95 - PROVIDER BATCH CONTROL

Must be preceded by RT 90.

Must be followed by RT 10 or 99.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '95'	XX	L	1	2
2	Federal Tax Number (EIN)	9(10)	R	3	12
3	Receiver Identification	9(5)	R	13	17
4	Receiver Sub-Identification	X(4)	L	18	21
5	Type of Batch	XXX	L	22	24
6	Number of Claims	9(6)	R	25	30
7	Filler (National Use)	X(6)		31	36
8	Accommodations Total Charges for the Batch	9(10)V99S	R	37	48
9	Accommodations Noncovered Charges for the Batch	9(10)V99S	R	49	60
10	Ancillary Total Charges for the Batch	9(10)V99S	R	61	72
11	Ancillary Noncovered Charges for the Batch	9(10)V99S	R	73	84
12	Filler (National Use)	X(54)		85	138
13	Filler (Local Use)	X(54)		139	192

RECORD TYPE 99 - FILE CONTROL

Must be preceded by RT 95.

Must be last valid record on file.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '99'	XX	L	1	2

2	Submitter EIN	9(10)	R	3	12
3	Receiver Identification	9(5)	R	13	17
4	Receiver Sub - Identification	X(4)	L	18	21
5	Number of Batches - Billed this File	9999	R	22	25
6	Accommodations Total Charges for the File	9(11)V99S	R	26	38
7	Accommodations Noncovered Charges for the File	9(11)V99S	R	39	51
8	Ancillary Total Charges for the File	9(11)V99S	R	52	64
9	Ancillary Noncovered Charges for the File	9(11)V99S	R	65	77
10	Filler (National Use)	X(58)		78	135
11	Filler (Local Use)	X(57)		136	192

BILLING PROCEDURES ADDENDUM B

ADDENDUM B - ALPHABETIC LISTING OF DATA ELEMENTS:

Data Element	Definition	Record	Field
*Accident Hour	The hour when the accident occurred that necessitated medical treatment. Shown as value code 45 and amount.	41	16-39
Accommodations Days	A numeric count of accommodations days in accordance with payer instructions. Includes UB-92 revenue codes 10X through 21X.	50	6
Three additional iterations in related locations for record 50, fields 11-13.			

Accommodations Non-Covered Charges	Accommodations charges pertaining to the related UB-92 Accommodations revenue code that are not covered by the primary payor as determined by the provider.	50	8
Three additional iterations in related locations for record 50, fields 11-13.			
Accommodations Non-covered Charges for the Batch	Sum of charges recorded in related field in record type 90, field 14.	95	9
Accommodations Non-covered Charges for the File	Sum of charges recorded in related field in record type 95, field 9.	99	7

Accommodations Rate	Per diem rate for related UB-92 accommodations revenue codes.	50 5	Three additional iterations in related locations for record 50, fields 11 - 13.
Accommodations Revenue Code	UB-92 revenue center code for the accommodation provided. Includes codes 10X through 21X.	50	4

Three additional iterations in related locations for record 50, fields 11 – 13.			
Accommodations Total Charges	Total charges for the related revenue code.	50	7
Three additional iterations in related locations for record 50, fields 11 – 13.			
Accommodations Total Charges	Sum of charges recorded in related field in record type 90, field 13 for the Batch.	95	8
Accommodations Total Charges	Sum of charges recorded in related field in record type 95, field 8 for the File	99	6

Activities Permitted	<p>Codes describing the activities permitted by the physician or for which physician's orders are present. "Other" is described in Record Type 73.</p> <p>1= Complete Bedrest 2= Bedrest BRP 3= Up as Tolerated 4= Transfer Bed\Chair 5= Exercises Prescribed 6= Partial Weight Bearing 7= Independent at Home 8= Crutches 9= Cane A= Wheelchair B= Walker C= No Restrictions D= Other A minimum of one must be present for the abbreviated POC</p>	71	16
Admission Date\Start	The date the patient was admitted to the provider for inpatient care, of Care outpatient service or start of care.	20	17

Date	For an admission notice for hospice care enter the effective date of election of hospice benefits.	71	29
Admission Hour	The hour during which the patient was admitted for inpatient care.	20	18
Admitting Diagnosis	The ICD-9-CM diagnosis code provided by the physician at the time of admission as stated	70	24
Ancillary Non-Covered Charges for the Batch	Sum of charges recorded in related field, record type 90, field 16.	95	11
Ancillary Non-Covered Charges for the File	Sum of charges recorded in related field, record type 95, field 11.	99	9

Ancillary Total Charges	Sum of charges recorded in related field in record type 90, field 15 for the Batch	95	10
Ancillary Total Charges for the File	Sum of charges recorded in related field in record type 95, field 10.	99	8
*Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y=Benefits assigned N=Benefits not assigned	30	17
Attending Physician Name	Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.	80 71	9 20-22
Attending Physician Number	Number assigned to identify physician named in Record 80, field 8. For Medicare this must be the UPIN.	80	5
Attending Physician's Zip Code	The nine-digit ZIP code from the address field on the HCFA-485.	71	23
*Authorization	Any of 4 iterations of the authorization data contained in Record 34 used to provide detailed information regarding an authorization by a PRO or a payer.	34	4 - 12

*Authorization From Date	Beginning date of a period being authorized for a stay extension, admission, or performance of a procedure.	34	6
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	Three additional iterations in related locations for record type 34, fields 10-12.		
*Authorization HCPCS Number	A reference on the 34 record that indicates the HCPCS being authorized by the PRO or payer.	34	9
Three additional iterations in related locations for record type 34, fields 11-13.			
*Authorization Number	A number or other code issued to the provider by the payer or the PRO granting permission to the provider for a procedure, admission, or extension of stay.	34	5
Three additional iterations in related locations for record type 34, fields 10-12.			
*Authorization Revenue Code	A reference on the 34 record that indicates the RC being authorized by the PRO or payer.	34	8
Three additional iterations in related locations for record type 34, fields 11-13.			
Authorization Thru Date	Ending date of a period being authorized for a stay extension, admission, or performance of a procedure.	34	7
Three additional iterations in related locations for record type 34, fields 10-12.			
*Authorization Type	A code that specifies the type of authorization contained in the particular iteration of the authorization for this payer.	34	4
Three additional iterations in related locations for record type 34, fields 10-12.			
Batch Number	Number assigned by the provider sequentially from 01 to nn to each batch of bills of a given type.	10	3
Blood- Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. Shown as value code 38.	41	16-39
Blood- Furnished Pints	Total number of pints of whole blood or units of packed red cells furnished to the patient. Shown as value code 37.	41	16-39
Blood- Replaced	The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. Shown as value code 39.	41	16-39

Certificate/ Social Security Number/Health Insurance Claim Identification Number	Insured's unique identification number assigned by the payer organization. Medicare: Enter the patient's Medicare HIC Medicare: Enter the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.	30	7
Certification Period	From\To dates of period to be covered by this plan of treatment.	71	6-7
Cert\Recert\ Mod	One of the following applicable codes C= Certification R= Recertification M= Modified	71	28
*CHAMPUS Insurer Provider Number	The number assigned to the provider by CHAMPUS. Provider number also appears on Record Type 30 in field 24. The 30 record may be repeated for each payer, A, B, and C.	10	8
Co-Insurance	That amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer. Shown as value code 09, 11, A2, B2 or C2.	41	16-39
Coinsurance Days	The inpatient Medicare days occurring after the 60 th day and before the 91 st day in a single spell of illness.	30	22
Condition Codes	Code(s) used to identify condition(s) relating to this bill that may affect payer processing (See Addendum C).	41	4-13

Corresponding Data	Narrative data from the plan of treatment.	73	6
*Country Code	Four position code indicating the geographic location of the submitter or provider.	01 10	15 18
Covered Days	The number of days covered by the primary payer, as qualified by the payer organization.	30	20
Data ID	Identifies submittal of 485 and 486 data or 486 data only 1= 485 and 486 2= 486 only	71	4
Required for abbreviated POC			

Data ID Number	Number corresponding to the data element narrative on plan of treatment.	73	5
Date (Agency) Last Contacted The Physician	Date of agency's most recent physician contact. Purpose stated in Record Type 73.	71	26
Dates of Onset Exacerbation	The date of onset or exacerbation of the secondary diagnosis shown in record type 70 or 74. The related dates are entered in the same order as the secondary diagnosis codes.	71	11-14

Date of Onset Exacerbation of Principal Diagnosis	The date of onset or date of exacerbation of the diagnosis shown as Record Type 70 or 74.	71	8
Date of Surgical Procedure	The date the surgery (field 9) was performed.	71	10
Date Physician Last Saw the Patient	Date (if known) that the patient was last seen by the physician.	71	25
Deductible	The amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payer (A, B and/or C). Shown as value code 06, A1, B1 or C1.	41	16-39
Discharge Date	Date that the patient was discharged from inpatient care.	71	30
*Discharge Hour	Hour that the patient was discharged from inpatient care. (Addendum C)	20	22
Discipline	Code indicating discipline(s) ordered by physician. SN= Skilled Nursing PT= Physical Therapy ST= Speech Therapy OT= Occupational Therapy MS= Medical Social Worker AI= Home Health Aide	72	4
Employer Location	The specific location for the employer of the individual identified in record 30.	21 21 31	5-8 12-15 10-13
Employer Name	The name of the employer that might or does provide health care coverage for the individual identified in record 30.	21 21 31	4 11 9
Employment Status Code	A code used to define the employment status of the individual identified by the name in record 30. (See Addendum C).	21 21 30	9 16 19

Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payer.	20 30	24 26
*Estimated Responsibility	The amount estimated by the hospital to be paid by the indicated payer or patient. Shown as value code A3, B3, C3 or D3.	41	16-39

*External Cause Injury(E-code)	The ICD-9-CM code which describes the external cause of the injury, poisoning or adverse effect. Use of this data element is voluntary in States where E-coding is not required.	70	25
Federal Tax Number (EIN)	The number assigned to the provider by the federal government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).	10 95	4 2
*Federal Tax Sub ID	Four position modifier to Federal Tax ID listed above.	10	5
File Sequence and Serial Number	Sequence number from 01 to nn assigned to each file in this submission of records, followed by the inventory number of the file.	01	17
Frequency of Visits	6 position code indicating the frequency and duration of visits during the period covered by the plan of treatment. Position 1 is the number of visits. Positions 2-3 are an alpha expression of the period of time. Positions 4-6 are the duration of the plan. Enter the frequency codes in the order being rendered. Position 1 codes = 1-9 = n Position 2-3 codes = DA, WK, MO, Q DA= day, WK= week, MO= month, Q= every n days Position 4-6 = duration in days = 001-999 Examples: 1 daily visit for 10 days = 1DA010 2 visits every 9 days for 3 months = 2 Q090 A minimum of one group must be present for the abbreviated POC.	72	7

Functional Limitation Code	Codes describing the patient's functional limitations as assessed by the physician. Other is described in Record Type 73. 1= Amputation 2= Bowel\Bladder (Incontinence) 3= Contracture 4= Hearing 5= Paralysis 6= Endurance 7= Ambulation 8= Speech 9= Legally Blind A= Dyspnea with Minimal Exertion B= Other A minimum of one must be present on abbreviated POC.	71	15
HCPCS/ Procedure Code	Procedure code reported in record types identify services so that appropriate reimbursement can be made. HCFA Common Procedural Coding System (HCPCS) is required for many specific types of outpatient and a very few inpatient services. May include up to two modifiers.	60 61	5-7 5-7
Two additional iterations in related locations for record 60 & 61, fields 14-15.			
HICN	Health Insurance Claim Identification Number	74	5
Implant Date	For explanted or implanted devices only. Date of implant for the explanted or replaced device.	81	13
Inpatient Ancillary Non-Covered Charges	Charges pertaining to the related UB-92 inpatient ancillary revenue center code that the primary payer will not cover.	60	10
Two additional iterations in related locations for record 60, fields 13-14.			
Inpatient Ancillary Revenue Code	UB-92 revenue center code for the inpatient ancillary services provided. Includes codes 22X through 99X.	60 4	Two additional iterations in related locations for record 60, fields 13-14. 4
Inpatient Ancillary Total Charges	Total charges pertaining to the related UB-92 inpatient ancillary revenue center code.	60	9

Inpatient Ancillary Units of Service	A quantitative measure of services rendered by inpatient UB-92 revenue center category to or for the patient which includes such items as number of miles, pints of blood, number of renal dialysis treatments, etc.	60 8	Two additional iterations in related locations for record 60, fields 13-14. 8
*Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	30	10
Insured Address	Insured's current mailing address. Address Line 1 Address Line 2 City State Zip	31 31 31 31 31 31	4 – 8 4 5 6 7 8
*Insured Group Name	Name of the group or plan through which the insurance is provided to the insured.	30	11
*Insured's Name	Name of the individual in whose name the insurance is carried. Last Name First Name Middle Initial	30 30 30 30	12-14 12 13 14
*Insured's Sex	A code indicating the sex of the insured. M=Male F=Female U=Unknown	30	15
Leads Left In Patient	A code to indicate whether former lead was left in patient, explanted, or did not exist.	81	14
Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	30	23
Manufacturer ID	Code that identifies manufacturer of the pacemaker.	81	9

*Medicaid Provider Number	The number assigned to the provider by MO HealthNet. Provider number also appears on Record Type 30 in field 24. The 30 record may be repeated for each payer, A, B, and C.	10 30	7 24
Medical Record Number	Number assigned to patient by hospital or other provider to assist in retrieval of medical records.	20 74	25 6
Medicare Covered	The following are applicable codes Y= Covered, N= Noncovered	71	24
Medicare Provider Number	The number assigned to the provider by Medicare. The provider number also appears in record type 30 in field 24. The 30 record may be repeated for each payer, A, B, and C.	10 30	6 24
Mental Status Code	Codes describing the patient's mental condition. "Other" is described in Record Type 73. 1= Oriented 2= Comatose 3= Forgetful 4= Depressed 5= Disoriented 6= Lethargic 7= Agitated 8= Other A minimum of one must be present for the abbreviated POC.	71	17
Model Number	Model number of the device implanted or explanted during the procedure.	81	10
*Modifier	Two position codes serving as modifier to HCPCS procedure.	60 61	6-7 6-7
Multiple Provider Billing File Indicator	A code indicating whether bills for more than one provider are contained on this file submission, according to the following coding scheme. 1=Single Provider 2=Multiple Providers	01	3

Non-Covered Accommodation Charges-Revenue Centers	Sum of accommodation charges not covered by primary payer for this bill as reflected in record type 50, field 8, and subsequent accommodation packets in record type 50, field 11-13.	90	14
Non-Covered Ancillary Charges-Revenue Centers	Sum of "Ancillary Charges-Noncovered" for this bill as reflected in record type 60, field 10. Or, if an outpatient batch, sum of "Noncovered Charges" for this bill as reflected in record type 61, field 11, 14 or 15.	90	16
Non-Covered Days	Days of care not covered by the primary payer.	30	21
Number of Batches Billed this File	A count of the number of batches billed on this file or transmission.	99	5
Number of Claims	A count of the number of record type 20 entries for this provider batch. (record type 10 to record type 95)	95	6
Number of Grace Days	The number of days determined by the PRO to be necessary to arrange for the patient's post discharge care. Shown as value code 46.	41	16-39
Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing (See Addendum C). Occurrence code and occurrence date repeat for a total of 10 iterations.	40	8-26
Occurrence Date	Date associated with the Occurrence Code in the preceding field. (See Addendum C.) Both occurrence code and occurrence date repeat for a total of 10 iterations.	40	9-27
Occurrence Span Code	A code that identifies an event that relates to the payment of the claim. (See Addendum C.) The occurrence span code and both of the associated dates are repeated for a total of 2 iterations.	40	28 & 31
Occurrence Span Dates	The dates related to the occurrence span code shown in the preceding field.	40	29 & 30 32 & 33
Operating Physician Name	Name used by the provider to identify the operating physician in the provider records.	80 81 71	10 7 20-22

Operating Physician Number	Number used by the provider to identify the operating physician in the provider records. For Medicare this must be the UPIN. The UPIN must be left justified in the field.	80 81	6 6
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Ordering Physician Name	Name used by the provider to identify the physician who ordered the procedure in the provider records.	81	5
Ordering Physician Number	Number used by the provider to identify the physician who ordered the procedure in the provider records. For Medicare this must be the UPIN.	81	4
Other Diagnosis Codes	The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.	70seq1 70seq2 74	5-11 4 13-16
*Other Insurer Provider Number	The number assigned to the provider by an insurer other than Medicare, MO HealthNet or CHAMPUS.	10	9-10
Other Physician ID Name\Number	The name and\ or number of the licensed physician other than the attending physician as defined by the payer organization. For Medicare purposes the number must be the UPIN.	80	7,8 11,12
Other Procedure Code	The codes identifying the procedures, other than the principal procedure, performed during the billing period covered by this bill.	70seq1 14-22	
Other Procedure Dates	Date that the procedure indicated by the related code (preceding field) was performed.	70seq1	15-23
Outpatient Date of Service	The date the associated service as identified by the outpatient UB-92 revenue center code was delivered.	61 9	Two additional iterations in related locations for record 61, fields 14,15.
Outpatient Non-Covered Charges	Charges pertaining to the related outpatient UB-92 revenue center code that the primary payer will not cover.	61 11	Two additional iterations in related locations for Record 61, fields 14-15.
Outpatient Revenue Center Code	UB-92 revenue center code for out- patient ancillary services provided.	61	4, 14-15
Outpatient Total Charges	Total charges for this bill (revenue code 0001)	61	10

Outpatient Units of Service	A quantitative measure of services rendered by outpatient UB-92 revenue center category to or for the patient which includes such items as number of miles, pints of blood, number of renal dialysis treatments, etc.	61	8
Patient Address	The address of the patient as qualified by the payer organization. Address Line 1 Address Line 2 City State (P.O. Code) Zip	20	12-16 12 13 14 15 16

Patient Birthdate	The date of birth of the patient. Includes 4 pos. Year. (MMDDCCYY).	20 74	8 10
Patient Control Number	Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment. Also used by intermediaries to link multiple records for a single claim.	20-90	3
*Patient Marital Status	The marital status of the patient at date of admission, outpatient service, or start of care. (See Addendum C).	20	9
Patient Name	Last name, first name, and middle initial of the patient. Last name First name Middle Initial Last name First name Middle initial	20 20 20 20 74 74 74 74	4-6 40 5 6 7-9 7 8 9
Patient Receiving Care in 1861 J1 Facility	Y= Yes, N= No, D= Do not know	71	27
Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured. (See Addendum C).	30	18
Patient Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care.	20 74	7 11

Patient Status	A code indicating patient's status as of the statement covers thru date. (See Addendum C).	20	21
Payer Identification	Number identifying the payer an organization from which the provider might expect some payment for the bill. Reiterates in sequences 02 and 03 for Payers B and C.	30	5
Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.	30	8
*Payer Sub-identification	The identification of the specific office within the insurance carrier designated as responsible for this claim.	30	6
Payments Received	Amount patient has paid to the provider towards this bill.	20 30	23 25
Physical Record Count(Excluding Screen)	The total number of physical records submitted for this bill, including all record types 20 through 8n, and excluding record type 90.	90	4

Physician Number Qualifying Codes	The type of physician number being submitted. UP = UPIN FI = Federal Taxpayer ID Number SL = State License ID Number SP = Specialty License Number	80	4
Primary Payer Code	Identifies reason another payer is primary to Medicare. (See Addendum C).	30	9
Principal Diagnosis Code	The ICD-9-CM diagnosis code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization).	70 74	4 12
Principal Procedure Code	The code that identifies the principal procedure performed during the period covered by this bill.	70	12
Principal Procedure Date	The date on which the principal procedure described on the bill was performed.	70	13
Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on the bill. (See Addendum C).	70	26

Processing Date("Date Bill Submitted" on HCFA-1450).	Date submitter prepares file.	01	8
Prognosis	Code indicating physician's prognosis or the patient. 1= Poor 2= Guarded 3= Fair 4= Good 5= Excellent	71	18
Provider Address	Complete mailing address to which the provider wishes payment sent. Street address or box number City State (P.O. abbreviations) Zip	10 10 10 10 10	13-16 13 14 15 16
*Provider FAX Number	FAX number for provider.	10	17
Provider Identification	Six digit number assigned by Medicare Number.	30	24

Provider Name	Name of provider submitting this batch of bills.	10	12
*Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.	10	11
PRO Approval Indicator	An indicator describing the determination arrived at by the PRO. Shown as condition code C1 - C7.	41	4-13
PRO Approved Stay Dates	The first and last days that were approved where not all of the stay has been approved by the PRO. Shown as occurrence span code M0.	40	28,31
Receiver Identification	Number identifying to the provider the organization designated to receive this file. (See Addendum C).	01 95 99	6 3 3
*Receiver Sub- Identification	The identification of the specific location within the receiver organization designated to receive the tape or transmission.	95 99 01	4 4 7

Receiver Type Code	A code indicating the class of organization designated to receive this tape or transmission.(See Addendum C).	01	5
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Record Identification Code	Identifies all components implanted or explanted in a specific procedure.	81	8
Record Type nn Count	A count of record types 20-2n through 81, fields 5 through 11 of this record. These fields are reflected in the total of field 4 of this record.	90	5-11
Record Type 91 Qualifier	Indicates if Record Type 91 is present. Code "0" if not written or "1" if written.	90	12
Release of Information Certification Indicator	A code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim. (See Addendum C).	30	16
*Remarks	Notations relating specific state and local needs providing additional in-formation necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Also used for overflow data for any element for which there is not enough space.	90 91	17 4
Returned to Manufacturer	Code to indicate if explanted device has been returned to the manufacturer.	81	15
Sequence Number	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 21-2n do not have a sequence number greater than 01. Records 01, 10, 90, 91, 95 and 99 do not have sequence numbers. The sequence number for record types 30, 31, 34, 80 and 81 are used as matching criteria to determine which type 30, type 31, type 34, type 80 and/or type 81 records are associated, like sequence numbers indicating the records are associated.	21-2n 30-3n 40-41 50-5n 60-6n 70-7n 80-8n	2 2 2 2 2 2 2

Serial Number	Number that uniquely identifies the specific device; Serial number of the pacemaker.	81	11
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SOC Date	Date covered home health services began. Required for abbreviated POC.	71	5
Source of Admission	A code indicating the source of this admission. (See Addendum C).	20	11
Source of Payment Code	A code indicating source of payment associated with this payer record. (See Addendum C).	30	4
Special Program Indicator	A code indicating that the services included on this bill are related to a special program. Shown as condition codes A0-A9. (See Addendum C).	41	4-13
State Code	Code that indicates the state coding structure to which the form locators apply.	22	4
Statement Covers Period	The beginning and ending service dates of the period covered by this bill.	20	19-20
Submitter Address	Mailing address of the submitter of this file. Address City State Zip	01 10 11 12 13	10-13
Submitter EIN	Federally assigned Employer Identification Number (EIN) of file submitter. EIN is also referred to as the Tax Identification Number (TIN).	01 99	2 2
*Submitter FAX Number	FAX number for the submitter	01	14
Submitter Name	Name of provider, third party billing service, or other organization to which the receiver/processor should direct inquiries regarding this transmittal.	01	9
Submitter Telephone Number	Telephone number, including area code, at which the submitter wishes to be contacted for claim development.	01	16
Surgical Procedure Code	The ICD-9-CM code describing the surgical procedure (if any) most relevant to the care being rendered.	71	9

Total Accommodations Charges Revenue Centers	Total accommodation charges for this bill.	90	13
Total Ancillary Charges- Revenue Centers	Total ancillary charges for this bill.	90	15

Total Visits Projected This Cert.	Total covered visits to be rendered by each discipline during the period covered by the plan of treatment. Include PRN visits. Required for abbreviated POC.	72	44
Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill has been authorized by the PRO or by the payer. Three iterations, one each for Payer A, B and/or C.	40	5-7
Treatment Codes	Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A30= Skilled Nursing B01-B15= Physical Therapy C01-C09= Speech Therapy D01-D11= Occupational Therapy E01-E06= Medical School Services F01-F15= Home Health Aide One or more codes must be present for each discipline (e.g. SN, PT, etc.). Required for abbreviated POC.	72	18-43
Type of Admission	A code indicating the priority of this admission. (See Addendum C).	20	10
Type of Batch	A code indicating the types of bills that occur in this batch; i.e., between a provider record (record type 10), and a provider batch control (record type 95).(See Addendum C).	10 95	2 5
Type of Bill	A code indicating the specific type of bill (hospital inpatient, SNF outpatient, adjustments, voids, etc.). (See Addendum C).	40	4
Type Of Facility	Coding indicating type of facility from which the patient was most recently discharged. A= Acute S= SNF I= ICF R= Rehabilitation Facility O= Other	71	31
Value Amount	Amount of money related to the associated value code. (See Addendum C for Value Codes).	41	17-39
Value Code	A code that identifies data of a monetary nature that is necessary for processing this claim as required by the payer organization. (See Addendum C).	41	16-38

Verbal Start of Care Date MMDDYY	The date the agency received the verbal orders from the physician, if this is prior to the date care started.	71	19
Version Code	A code that indicates the version of the National Specifications submitted on this file, disk, etc. 001 = UB-82 data set as finally approved 08/17/82. 003 = UB-82 data set as revised to handle \$1,000,000 charges, bigger fields for units and UPINs. Effective 01/01/92 and 04/01/92. 004 = UB-92 data set as approved by NUBC 2/92. Effective 10/01/93.	01	20
Visits (This Bill) Rel. to Prior Certification	Total visits on this bill rendered prior to recertification "to" date. If applicable, required for abbreviated POC.	72	5
Warranty Expiration Date	Expiration date of the warranty on a specific device.	81	12

* Not required for Medicare