

UB-92

**NATIONAL UNIFORM BILLING
DATA ELEMENT SPECIFICATIONS
AS DEVELOPED BY THE
NATIONAL UNIFORM BILLING
COMMITTEE**

AS OF NOVEMBER 15, 2002

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One North Franklin
Chicago, Illinois 60606

Guide to Using the UB-92 Manual

The purpose of this section of the National Uniform Billing Data Element Specifications Manual is to provide basic information concerning the use of the manual.

Arrangement	The form locators in the manual correspond with the form locator fields on the UB-92 form. The UB-92 form includes Form Locators 1 - 86. The last page of the manual is a copy of the form. Form locators containing multiple pages are separately numbered.
Dates	Two dates are included on the top left hand corner of each form locator manual page. The effective date indicates the date that the most recent change made to that page is/was effective. The other date refers to the date that the most recent change was approved by the National Uniform Billing Committee (NUBC). Under some circumstances it may be necessary to make a technical correction to the manual to more accurately reflect an NUBC approved change. In this event, the NUBC decision date will remain unchanged, and a version number will be added to the right of the NUBC approval date. For example, "3/31/92 - 2." Non-substantive changes and/or clarifications that are immediately effective, but require a page update, are indicated "(New Page MM/DD/YY)" in the top left hand corner.
Unlabeled Fields	The UB-92 data specifications provide for numerous "unlabeled fields." The NUBC has reserved some of these fields for national assignment while other unlabeled fields have been designated for state use as defined by State Uniform Billing Committees (SUBCs). Specifications for all unlabeled fields are included in the manual under Form Locator 2, the first unlabeled field appearing on the form.
Paper Form Specifications	For reference, paper form specifications are included as the second to last page of the manual.
Applicability to EDI	The UB-92 data element specifications are developed and maintained by the NUBC. The data element specifications are for use in EDI billing and payment transactions and related business applications.
UB-92 Implementation	The UB-92 implementation date is October 1, 1993 with a three month "window" (ending December 31, 1993) where either the UB-82 or UB-92 will be accepted. After December 31, 1993 the UB-82 form will no longer be used.

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY FORM LOCATOR NUMBER**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL01	1	Provider Name/Address/Telephone	8/23/93	8/23/93	
FL01	2	Provider Name/Address/Telephone	11/9/94	4/1/95	
FL01	3	Provider Name/Address/Telephone	11/9/94	4/1/95	
FL02	1	Unlabeled Fields	1/8/93	10/1/93	
FL02	2	Unlabeled Fields	3/31/92	10/1/93	
FL03	1	Patient Control Number	1/8/93	1/8/93	
FL04	1	Type of Bill	5/21/82-2	5/21/82	
FL04	2	Type of Bill	2/18/98	2/18/98	
FL04	3	Type of Bill	2/13/01	10/1/01	
FL04	3.1	Type of Bill	2/13/01	10/1/01	
FL04	4	Type of Bill	1/8/93-2	10/1/93	
FL04	5	Type of Bill	2/16/00	10/1/00	
FL04	6	Type of Bill	2/13/01	10/1/01	
FL04	7	Type of Bill	2/16/00, 3/25/00,4/19/00	7/1/00, 8/1/00	
FL05	1	Federal Tax Number	1/8/93	1/8/93	
FL06	1	Statement Covers Period	10/27/83	10/27/83	
FL07	1	Covered Days	1/8/93	1/8/93	
FL08	1	Non-covered Days	1/8/93	1/8/93	
FL09	1	Coinsurance Days	8/23/93	10/1/93	
FL10	1	Lifetime Reserve Days	1/8/93	1/8/93	
FL11	-	Unlabeled - See FL02			
FL12	1	Patient Name	8/10/83	8/10/83	
FL13	1	Patient Address	8/23/93	8/23/93	
FL14	1	Patient Birthdate	8/10/83	8/10/83	
FL15	1	Patient Sex	8/10/83	8/10/83	
FL16	1	Patient Marital Status	11/9/94	4/1/95	
FL17	1	Admission Date	1/8/93	1/8/93	
FL18	1	Admission Hour	8/7/02	10/16/03	
FL19	1	Type of Admission/Visit	8/7/01	1/1/02	X
FL19	2	Type of Admission/Visit	8/7/01	1/1/02	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY FORM LOCATOR NUMBER**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL20	1	Source of Admission	1/8/93	1/8/93	
FL20	2	Source of Admission	7/18/90	1/1/91	X
FL20	3	Source of Admission	2/16/00	10/1/00	
FL21	1	Discharge Hour	8/7/02	10/16/03	
FL22	1	Patient Status	8/26/98	4/1/99	
FL22	2	Patient Status	5/9/02	5/9/02	
FL22	3	Patient Status	8/26/98	4/1/99	
FL22	4	Patient Status	8/7/02	4/1/03	
FL23	1	Medical/Health Record Number	11/5/91	10/1/93	
FL24	1	Condition Codes (FL24-FL30)	1/8/93	10/1/93	
FL24	2	Condition Codes (FL24-FL30)	1/8/93	1/8/93	
FL24	3	Condition Codes (FL24-FL30)	5/15/96	10/1/96	
FL24	4	Condition Codes (FL24-FL30)	10/25/00	4/1/01	
FL24	4.1	Condition Codes (FL24-FL30)	3/31/92-2	10/1/92	
FL24	5	Condition Codes (FL24-FL30)	6/18/98	10/1/98	
FL24	6	Condition Codes (FL24-FL30)	6/19/02	10/1/02	X
FL24	7	Condition Codes (FL24-FL30)	11/10/93	4/1/94	X
FL24	8	Condition Codes (FL24-FL30)	8/7/02	4/1/03	
FL24	8.1	Condition Codes (FL24-FL30)	8/7/02, 6/18/01	4/1/03, 10/16/03	
FL24	9	Condition Codes (FL24-FL30)	5/9/02	10/1/02	
FL24	10	Condition Codes (FL24-FL30)	5/19/00	10/1/00	
FL31	-	Unlabeled - See FL02			
FL32	1	Occurrence Codes (FL32-FL36)	8/23/93	10/1/93	
FL32	2	Occurrence Codes (FL32-FL35)	8/23/93	10/1/93	
FL32	3	Occurrence Codes (FL32-FL35)	8/7/02	10/1/02	
FL32	4	Occurrence Codes (FL32-FL35)	7/18/01	2/1/02	X
FL32	5	Occurrence Codes (FL32-FL35)	11/5/97	10/1/97	
FL32	6	Occurrence Codes (FL32-FL35)	10/1/89	10/1/89	
FL32	7	Occurrence Codes (FL32-FL35)	8/23/93	8/23/93	
FL32	8	Occurrence Codes (FL32-FL35)	11/10/93	4/1/94	X
FL32	9	Occurrence Codes (FL32-FL35)	11/10/93	4/1/94	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY FORM LOCATOR NUMBER**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL36	1	Occurrence Span Codes	8/23/93	10/1/93	
FL36	2	Occurrence Span Codes	8/11/98	4/1/99	
FL36	3	Occurrence Span Codes	11/8/99	4/1/00	
FL37	1	ICN/DCN (FL37 A,B,C)	1/8/93	10/1/93	
FL38	1	Responsible Party Name/Address	8/23/93	8/23/93	
FL39	1	Value Codes (FL39-FL41)	1/8/93	10/1/93	
FL39	2	Value Codes (FL39-FL41)	8/23/93	10/1/93	
FL39	3	Value Codes (FL39-FL41)	8/23/93	10/1/93	
FL39	4	Value Codes (FL39-FL41)	3/31/92-2	10/1/92	
FL39	5	Value Codes (FL39-FL41)	3/19/02	10/1/02	
FL39	6	Value Codes (FL39-FL41)	5/15/96	10/1/96	
FL39	7	Value Codes (FL39-FL41)	8/23/93	8/23/93	
FL39	8	Value Codes (FL39-FL41)	5/24/01	10/16/02	
FL39	9	Value Codes (FL39-FL41)	5/24/01	10/1/00	X
FL39	9.1	Value Codes (FL39-FL41)	11/15/02	4/1/03	X
FL39	10	Value Codes (FL39-FL41)	5/19/00,11/14/00	1/1/01	
FL39	11	Value Codes (FL39-FL41)	2/13/96	10/1/96	
FL39	12	Value Codes (FL39-FL41)	2/13/96	10/1/96	
FL42	1	Revenue Code	11/8/84-2	4/1/85	
FL42	2	Revenue Code	5/9/02	5/9/02	
FL42	2.1	Revenue Code	1/8/93	12/12/83	
FL42	3	Revenue Code	7/18/89	10/1/89	
FL42	4	Revenue Code	7/18/89	10/1/89	
FL42	5	Revenue Code	7/18/89	10/1/89	
FL42	6	Revenue Code	5/3/95	10/1/95	
FL42	6.1	Revenue Code	8/6/96	1/1/97	
FL42	7	Revenue Code	11/8/95	4/1/96	
FL42	8	Revenue Code	12/12/83	12/12/83	
FL42	9	Revenue Code	2/18/99	10/1/99	
FL42	10	Revenue Code	11/20/89	4/1/90	
FL42	11	Revenue Code	11/9/01	7/1/91	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY FORM LOCATOR NUMBER**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL42	12	Revenue Code	3/5/91	7/1/91	
FL42	13	Revenue Code	5/21/82	5/21/82	
FL42	14	Revenue Code	7/14/87	10/1/87	X
FL42	15	Revenue Code	5/21/82	5/21/82	
FL42	16	Revenue Code	7/18/89	10/1/89	
FL42	17	Revenue Code	5/9/02	5/9/02	
FL42	18	Revenue Code	11/5/91-2	4/1/92	
FL42	19	Revenue Code	12/9/86	4/1/87	
FL42	20	Revenue Code	11/5/97	4/1/98	
FL42	21	Revenue Code	8/13/99	4/1/00	
FL42	21.1	Revenue Code	11/8/95	4/1/96	
FL42	22	Revenue Code	2/22/94	10/1/94	
FL42	23	Revenue Code	8/23/93	8/23/93	
FL42	24	Revenue Code	8/13/99	4/1/00	
FL42	25	Revenue Code	10/3/89	4/1/90	
FL42	26	Revenue Code	7/15/91	10/1/91	
FL42	27	Revenue Code	7/15/91	10/1/91	
FL42	28	Revenue Code	10/2/02	4/1/03	
FL42	29	Revenue Code	5/8/98	10/1/98	
FL42	30	Revenue Code	5/7/97	10/1/97, 1/1/98	
FL42	31	Revenue Code	3/19/90	4/1/90	
FL42	32	Revenue Code	10/2/02	4/1/03	
FL42	33	Revenue Code	5/9/02	4/1/03	
FL42	34	Revenue Code	2/15/02	10/1/02	
FL42	35	Revenue Code	7/18/89	10/1/89	
FL42	36	Revenue Code	11/8/84	4/1/85	
FL42	37	Revenue Code	11/5/91	4/1/92	
FL42	38	Revenue Code	11/7/96	4/1/97	
FL42	39	Revenue Code	8/6/96	10/1/96	
FL42	40	Revenue Code	7/19/88	10/1/88	
FL42	41	Revenue Code	8/16/00	10/1/00	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY FORM LOCATOR NUMBER**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL42	42	Revenue Code	12/9/86	12/9/86	
FL42	43	Revenue Code	12/12/83	12/12/83	
FL42	44	Revenue Code	8/10/83	8/10/83	
FL42	45	Revenue Code	11/10/93	4/1/94	
FL42	46	Revenue Code	11/10/93	4/1/94	
FL42	47	Revenue Code	11/7/96	4/1/97	
FL42	48	Revenue Code	12/20/00	4/1/01	
FL42	49	Revenue Code	11/9/99	10/1/00	
FL42	50	Revenue Code	11/9/99	10/1/00	
FL42	51	Revenue Code	5/9/02	4/1/03	
FL42	52	Revenue Code	5/9/02	4/1/03	
FL43	1	Revenue Description	1/8/93	1/8/93	
FL44	1	HCPCS/Rates/HIPPS Rate Codes	5/8/98	7/1/98	
FL44	2	HCPCS/Rates/HIPPS Rate Codes	5/8/98	7/1/98	
FL44	3	HCPCS/Rates/HIPPS Rate Codes	5/8/98	7/1/98	
FL44	4	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	5	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	6	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	7	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	8	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	9	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	10	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	11	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL45	1	Service Date	5/8/98-2	7/1/98	
FL46	1	Units of Service	1/8/93	1/8/93	
FL47	1	Total Charges (by Revenue Code)	11/8/95	4/1/96	
FL48	1	Non-Covered Charges	1/8/93	1/8/93	
FL49	-	Unlabeled - See FL02			
FL50	1	Payer Identification	8/23/93	10/1/93	
FL50	2	Payer Identification	8/11/98	7/1/98	
FL50	3	Payer Identification	8/11/98	7/1/98	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY FORM LOCATOR NUMBER**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL50	4	Payer Identification	8/11/98	7/1/98	
FL50	5	Payer Identification	8/11/98	7/1/98	
FL50	6	Payer Identification	8/11/98	7/1/98	
FL51	1	Provider Number	1/8/93	10/1/93	
FL52	1	Release of Information	1/8/93	1/8/93	
FL53	1	Assignment of Benefits	1/8/93	1/8/93	
FL54	1	Prior Payments	5/15/96	10/1/96	
FL55	1	Estimated Amount Due	8/23/93	8/23/93	
FL56	-	Unlabeled - see FL02			
FL57	-	Unlabeled - see FL02			
FL58	1	Insured's Name	1/8/93	1/8/93	
FL58	2	Insured's Name	3/27/83-2	3/27/83	
FL59	1	Patient's Relationship	8/7/02	10/16/03	
FL59	2	Patient's Relationship	8/7/02	10/16/03	
FL59	3	Patient's Relationship	8/7/02	10/16/03	
FL60	1	CERT.-SSN-HIC.-ID No.	1/8/93	1/8/93	
FL61	1	Insurance Group Name	1/8/93	1/8/93	
FL62	1	Insurance Group Number	1/8/93	1/8/93	
FL63	1	Treatment Authorization Code	1/8/93	1/8/93	
FL64	1	Employment Status Code	8/23/93	10/1/93	
FL64	2	Employment Status Code	10/27/83	10/27/83	
FL65	1	Employer Name	8/23/93	10/1/93	
FL66	1	Employer Location	8/23/93	8/23/93	
FL67	1	Principal Diagnosis Code	8/23/93	10/1/93	
FL67	2	Principal Diagnosis Code	1/8/93	1/8/93	
FL68	1	Other Diagnoses (FL68-FL75)	3/19/02	3/19/02	
FL76	1	Admitting Diagnosis/Patient's Reason for Visit	8/13/99	4/1/00	
FL76	2	Admitting Diagnosis/Patient's Reason for Visit	8/13/99	4/1/00	
FL77	1	External Cause of Injury Code	3/31/92	10/1/92	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY FORM LOCATOR NUMBER**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL78	-	Unlabeled - See FL02			
FL79	1	Procedure Coding Method Used	8/10/83	8/10/83	
FL80	1	Principal Procedure Code and Date	1/8/93	10/1/93	
FL81	1	Other Procedures (FL81A-E)	1/8/93	10/1/93	
FL82	1	Attending Physician ID	11/5/91	1/1/92	
FL82	2	Attending Physician ID	1/8/93	1/8/93	
FL83	1	Other Physician ID (FL83 A, B)	7/15/91-2	1/1/92	
FL83	2	Other Physician ID (FL83 A, B)	7/15/91	1/1/92	
FL84	1	Remarks	1/8/93	10/1/93	
FL84	2	Remarks	10/27/83	10/27/83	
FL84	3	Remarks (Addendum)	10/27/83	10/27/83	
FL84	4	Remarks (Addendum)	10/27/83	10/27/83	
FL84	5	Remarks (Addendum)	10/27/83	10/27/83	
FL85	1	Provider Rep. Signature	5/21/82	5/21/82	
FL86	1	Date Bill Submitted	1/8/93	1/8/93	
ZZ1	1	UB-92 Print Specifications	4/15/93	10/1/93	
ZZ1	2	UB-92 Print Specifications	4/15/93	10/1/93	
ZZ2	1	UB-92 Form	2/23/93	10/1/93	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY DATA ELEMENT DESCRIPTION**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL17	1	Admission Date	1/8/93	1/8/93	
FL18	1	Admission Hour	8/7/02	10/16/03	
FL76	1	Admitting Diagnosis/Patient's Reason for Visit	8/13/99	4/1/00	
FL76	2	Admitting Diagnosis/Patient's Reason for Visit	8/13/99	4/1/00	
FL53	1	Assignment of Benefits	1/8/93	1/8/93	
FL82	1	Attending Physician ID	11/5/91	1/1/92	
FL82	2	Attending Physician ID	1/8/93	1/8/93	
FL60	1	CERT.-SSN-HIC.-ID No.	1/8/93	1/8/93	
FL09	1	Coinsurance Days	8/23/93	10/1/93	
FL24	1	Condition Codes (FL24-FL30)	1/8/93	10/1/93	
FL24	2	Condition Codes (FL24-FL30)	1/8/93	1/8/93	
FL24	3	Condition Codes (FL24-FL30)	5/15/96	10/1/96	
FL24	4	Condition Codes (FL24-FL30)	10/25/00	4/1/01	
FL24	4.1	Condition Codes (FL24-FL30)	3/31/92-2	10/1/92	
FL24	5	Condition Codes (FL24-FL30)	6/19/98	10/1/98	
FL24	6	Condition Codes (FL24-FL30)	6/19/02	10/1/02	X
FL24	7	Condition Codes (FL24-FL30)	11/10/93	4/1/94	X
FL24	8	Condition Codes (FL24-FL30)	5/9/02	10/1/02	
FL24	8.1	Condition Codes (FL24-FL30)	8/7/02, 6/18/01	4/1/03, 10/16/03	
FL24	9	Condition Codes (FL24-FL30)	5/9/02	10/1/02	
FL24	10	Condition Codes (FL24-FL30)	5/19/00	10/1/00	
FL07	1	Covered Days	1/8/93	1/8/93	
FL86	1	Date Bill Submitted	1/8/93	1/8/93	
FL21	1	Discharge Hour	8/7/02	10/16/03	
FL64	1	Employment Status Code	8/23/93	10/1/93	
FL64	2	Employment Status Code	10/27/83	10/27/83	
FL66	1	Employer Location	8/23/93	8/23/93	
FL65	1	Employer Name	8/23/93	10/1/93	
FL55	1	Estimated Amount Due	8/23/93	8/23/93	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY DATA ELEMENT DESCRIPTION**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL77	1	External Cause of Injury Code	3/31/92	10/1/92	
FL05	1	Federal Tax Number	1/8/93	1/8/93	
FL44	1	HCPCS/Rates/HIPPS Rate Codes	5/8/98	7/1/98	
FL44	2	HCPCS/Rates/HIPPS Rate Codes	5/8/98	7/1/98	
FL44	3	HCPCS/Rates/HIPPS Rate Codes	5/8/98	7/1/98	
FL44	4	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	5	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	6	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	7	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	8	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	9	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	10	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL44	11	HCPCS Modifiers (Appendix B)	2/18/99	10/1/98	
FL37	1	ICN/DCN (FL37 A,B,C)	1/8/93	10/1/93	
FL62	1	Insurance Group Number	1/8/93	1/8/93	
FL61	1	Insurance Group Name	1/8/93	1/8/93	
FL58	1	Insured's Name	1/8/93	1/8/93	
FL58	2	Insured's Name	3/27/83-2	3/27/83	
FL10	1	Lifetime Reserve Days	1/8/93	1/8/93	
FL23	1	Medical/Health Record Number	11/5/91	10/1/93	
FL48	1	Non-covered Charges	1/8/93	1/8/93	
FL08	1	Non-covered Days	1/8/93	1/8/93	
FL32	1	Occurrence Codes (FL32-FL36)	8/23/93	10/1/93	
FL32	2	Occurrence Codes (FL32-FL35)	8/23/93	10/1/93	
FL32	3	Occurrence Codes (FL32-FL35)	8/7/02	10/1/02	
FL32	4	Occurrence Codes (FL32-FL35)	7/18/01	1/1/02	X
FL32	5	Occurrence Codes (FL32-FL35)	11/5/97	10/1/97	
FL32	6	Occurrence Codes (FL32-FL35)	10/1/89-2	10/1/89	
FL32	7	Occurrence Codes (FL32-FL35)	8/23/93	8/23/93	
FL32	8	Occurrence Codes (FL32-FL35)	11/10/93	4/1/94	X
FL32	9	Occurrence Codes (FL32-FL35)	11/10/93	4/1/94	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY DATA ELEMENT DESCRIPTION**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL36	1	Occurrence Span Codes	8/23/93	8/23/93	
FL36	2	Occurrence Span Codes	8/11/98	4/1/99	
FL36	3	Occurrence Span Codes	11/9/99	4/1/00	
FL68	1	Other Diagnoses (FL68-FL75)	3/19/02	3/19/02	
FL83	1	Other Physician ID (FL83 A, B)	7/15/91-2	1/1/92	
FL83	2	Other Physician ID (FL83 A, B)	7/15/91	1/1/92	
FL81	1	Other Procedures (FL81A-E)	1/8/93	10/1/93	
FL13	1	Patient Address	8/23/93	8/23/93	
FL14	1	Patient Birthdate	8/10/83	8/10/83	
FL03	1	Patient Control Number	1/8/93	1/8/93	
FL16	1	Patient Marital Status	11/9/94	4/1/95	
FL12	1	Patient Name	8/10/83	8/10/83	
FL15	1	Patient Sex	8/10/83	8/10/83	
FL22	1	Patient Status	8/26/98	4/1/99	
FL22	2	Patient Status	5/9/02	5/9/02	
FL22	3	Patient Status	8/26/98	4/1/99	
FL22	4	Patient Status	8/7/02	4/1/03	
FL59	1	Patient's Relationship	8/7/02	10/16/03	
FL59	2	Patient's Relationship	8/7/02	10/16/03	
FL59	3	Patient's Relationship	8/7/02	10/16/03	
FL50	1	Payer Identification	8/23/93	10/1/93	
FL50	2	Payer Identification	8/11/98	7/1/98	
FL50	3	Payer Identification	8/11/98	7/1/98	
FL50	4	Payer Identification	8/11/98	7/1/98	
FL50	5	Payer Identification	8/11/98	7/1/98	
FL50	6	Payer Identification	8/11/98	7/1/98	
FL67	1	Principal Diagnosis Code	8/23/93	10/1/93	
FL67	2	Principal Diagnosis Code	1/8/93	1/8/93	
FL80	1	Principal Procedure Code and Date	1/8/93	10/1/93	
FL54	1	Prior Payments	5/15/96	10/1/96	
FL79	1	Procedure Coding Method Used	8/10/83	8/10/83	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY DATA ELEMENT DESCRIPTION**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL01	1	Provider Name/Address/Telephone	8/23/93	8/23/93	
FL01	2	Provider Name/Address/Telephone	11/9/94	4/1/95	
FL01	3	Provider Name/Address/Telephone	11/9/94	4/1/95	
FL51	1	Provider Number	1/8/93	10/1/93	
FL85	1	Provider Rep. Signature	5/21/82	5/21/82	
FL52	1	Release of Information	1/8/93	1/8/93	
FL84	1	Remarks	1/8/93	10/1/93	
FL84	2	Remarks	10/27/83	10/27/83	
FL84	3	Remarks (Addendum)	10/27/83	10/27/83	
FL84	4	Remarks (Addendum)	10/27/83	10/27/83	
FL84	5	Remarks (Addendum)	10/27/83	10/27/83	
FL38	1	Responsible Party Name/Address	8/23/93	8/23/93	
FL42	1	Revenue Code	11/8/84-2	4/1/85	
FL42	2	Revenue Code	5/9/02	5/9/02	
FL42	2.1	Revenue Code	1/8/93	12/12/83	
FL42	3	Revenue Code	7/18/89	10/1/89	
FL42	4	Revenue Code	7/18/89	10/1/89	
FL42	5	Revenue Code	7/18/89	10/1/89	
FL42	6	Revenue Code	5/3/95	10/1/95	
FL42	6.1	Revenue Code	8/6/96	1/1/97	
FL42	7	Revenue Code	8/10/83	8/10/83	
FL42	8	Revenue Code	12/12/83	12/12/83	
FL42	9	Revenue Code	2/18/99	10/1/99	
FL42	10	Revenue Code	11/20/89	4/1/90	
FL42	11	Revenue Code	11/9/01	7/1/91	
FL42	12	Revenue Code	3/5/91	7/1/91	
FL42	13	Revenue Code	5/21/82	5/21/82	
FL42	14	Revenue Code	7/14/87	10/1/87	X
FL42	15	Revenue Code	5/21/82	5/21/82	
FL42	16	Revenue Code	7/18/89	10/1/89	
FL42	17	Revenue Code	5/9/02	5/9/02	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY DATA ELEMENT DESCRIPTION**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL42	18	Revenue Code	11/5/91-2	4/1/92	
FL42	19	Revenue Code	12/9/86	4/1/87	
FL42	20	Revenue Code	4/1/98	11/5/97	
FL42	21	Revenue Code	8/13/99	4/1/00	
FL42	21.1	Revenue Code	11/8/95	4/1/96	
FL42	22	Revenue Code	2/22/94	10/1/94	
FL42	23	Revenue Code	8/23/93	8/23/93	
FL42	24	Revenue Code	8/13/99	4/1/00	
FL42	25	Revenue Code	10/3/89	4/1/90	
FL42	26	Revenue Code	7/15/91	10/1/91	
FL42	27	Revenue Code	7/15/91	10/1/91	
FL42	28	Revenue Code	10/2/02	4/1/03	
FL42	29	Revenue Code	5/8/98	10/1/98	
FL42	30	Revenue Code	5/7/97	10/1/97, 1/1/98	
FL42	31	Revenue Code	3/19/90	4/1/90	
FL42	32	Revenue Code	10/2/02	4/1/03	
FL42	33	Revenue Code	5/9/02	4/1/03	
FL42	34	Revenue Code	2/15/02	10/1/02	
FL42	35	Revenue Code	7/18/89	10/1/89	
FL42	36	Revenue Code	11/8/84	4/1/85	
FL42	37	Revenue Code	11/5/91	4/1/92	
FL42	38	Revenue Code	11/7/96	4/1/97	
FL42	39	Revenue Code	8/6/96	10/1/96	
FL42	40	Revenue Code	7/19/88	10/1/88	
FL42	41	Revenue Code	8/16/00	10/1/00	
FL42	42	Revenue Code	12/9/86	12/9/86	
FL42	43	Revenue Code	12/12/83	12/12/83	
FL42	44	Revenue Code	8/10/83	8/10/83	
FL42	45	Revenue Code	11/10/93	4/1/94	
FL42	46	Revenue Code	11/10/93	4/1/94	
FL42	47	Revenue Code	11/7/96	4/1/97	

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY DATA ELEMENT DESCRIPTION**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL42	48	Revenue Code	12/20/00	4/1/01	
FL42	49	Revenue Code	11/9/99	10/1/00	
FL42	50	Revenue Code	11/9/99	10/1/00	
FL42	51	Revenue Code	5/9/02	4/1/03	
FL42	52	Revenue Code	5/9/02	4/1/03	
FL43	1	Revenue Description	1/8/93	1/8/93	
FL45	1	Service Date	5/8/98-2	7/1/98	
FL20	1	Source of Admission	1/8/93	1/8/93	
FL20	2	Source of Admission	7/18/90	1/1/91	X
FL20	3	Source of Admission	2/16/00	10/1/00	
FL06	1	Statement Covers Period	10/27/83	10/27/83	
FL47	1	Total Charges (by Revenue Code)	11/8/95	4/1/96	
FL63	1	Treatment Authorization	1/8/93	1/8/93	
FL19	1	Type of Admission/Visit	8/7/01	1/1/02	X
FL19	2	Type of Admission/Visit	8/7/01	1/1/02	
FL04	1	Type of Bill	5/21/82-2	5/21/82	
FL04	2	Type of Bill	2/18/98	2/18/98	
FL04	3	Type of Bill	2/13/01	10/1/01	
FL04	3.1	Type of Bill	2/13/01	10/1/01	
FL04	4	Type of Bill	1/8/93-2	10/1/93	
FL04	5	Type of Bill	12/6/99	10/1/00	
FL04	6	Type of Bill	2/13/01	10/1/00	
FL04	7	Type of Bill	2/16/00, 3/25/00,4/19/00	7/1/00, 8/1/00	
ZZ1	1	UB-92 Print Specifications	4/15/93	10/1/93	
ZZ1	2	UB-92 Print Specifications	4/15/93	10/1/93	
ZZ2	1	UB-92 Form	2/23/93	10/1/93	
FL46	1	Units of Service	1/8/93	1/8/93	
FL11	-	Unlabeled - See FL02			
FL31	-	Unlabeled - See FL02			
FL49	-	Unlabeled - See FL02			

**UB-92 NATIONAL UNIFORM DATA ELEMENT SPECIFICATIONS
INDEX OF MANUAL PAGES - BY DATA ELEMENT DESCRIPTION**

FORM LOCATOR NUMBER	PAGE NUMBER	DATA ELEMENT DESCRIPTION	APPROVAL DATE	EFFECTIVE DATE	NEW PAGE 11/15/02
FL78	-	Unlabeled - See FL02			
FL56	-	Unlabeled - see FL02			
FL57	-	Unlabeled - see FL02			
FL02	1	Unlabeled Fields	1/8/93	10/1/93	
FL02	2	Unlabeled Fields	3/31/92	10/1/93	
FL39	1	Value Codes (FL39-FL41)	1/8/93	10/1/93	
FL39	2	Value Codes (FL39-FL41)	8/23/93	10/1/93	
FL39	3	Value Codes (FL39-FL41)	8/23/93	10/1/93	
FL39	4	Value Codes (FL39-FL41)	3/31/92-2	10/1/92	
FL39	5	Value Codes (FL39-FL41)	3/19/02	10/1/02	
FL39	6	Value Codes (FL39-FL41)	5/15/96	10/1/96	
FL39	7	Value Codes (FL39-FL41)	8/23/93	8/23/93	
FL39	8	Value Codes (FL39-FL41)	5/24/01	10/16/02	
FL39	9	Value Codes (FL39-FL41)	5/24/01	10/1/00	X
FL39	9.1	Value Codes (FL39-FL41)	11/15/02	4/1/03	X
FL39	10	Value Codes (FL39-FL41)	5/19/00,11/14/00	1/1/01	
FL39	11	Value Codes (FL39-FL41)	2/13/96	10/1/96	
FL39	12	Value Codes (FL39-FL41)	2/13/96	10/1/96	

DATA ELEMENT: Provider Name, Address and Telephone Number

Definition: The name of the provider submitting the bill and the complete mailing address to which the provider wishes payment sent.

Procedures:

MEDICARE	Required. Minimum requirement is the provider's name, city, state and zip code.
MEDICAID	Required. Minimum requirement is the provider's name, city, state and zip code.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required. Minimum requirement is the provider's name, city, state and zip code. Phone number is desirable.
CHAMPUS	Required. Minimum requirement is the provider's name, city, state and zip code. Phone number is desirable.

Field Attributes: 1 field
4 lines
25 positions
alphanumeric
left-justified

Notes: Enter the information provided in Form Locator 1 on the appropriate line.

Line 1 - Provider name.

Line 2 - Street address or post office box.

Line 3 - City, state, and zip code

Address may include post office box or street name and number, city, state and zip code.

If a nine digit zip code is used, it should be entered XXXXX-XXXX, where the first five digits are the 5 digit zip code and the last 4 digits are the zip code extension. Example: "12345-6789"

Hospitals should abbreviate state in their address according to the Post Office standard abbreviations that appear on the following page.

Line 4 - Telephone - positions 1-10 (optional)
Fax number - positions 12-21 (optional)
Country Code - positions 23-25 (optional)

STANDARD POST OFFICE ABBREVIATIONS

States

Alabama	AL	Montana	MT
Alaska	AK	Nebraska	NE
Arizona	AZ	Nevada	NV
Arkansas	AR	New Hampshire	NH
California	CA	New Jersey	NJ
Colorado	CO	New Mexico	NM
Connecticut	CT	New York	NY
Delaware	DE	North Carolina	NC
District of Columbia	DC	North Dakota	ND
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Hawaii	HI	Oregon	OR
Idaho	ID	Pennsylvania	PA
Illinois	IL	Rhode Island	RI
Indiana	IN	South Carolina	SC
Iowa	IA	South Dakota	SD
Kansas	KS	Tennessee	TN
Kentucky	KY	Texas	TX
Louisiana	LA	Utah	UT
Maine	ME	Vermont	VT
Maryland	MD	Virginia	VA
Massachusetts	MA	Washington	WA
Michigan	MI	West Virginia	WV
Minnesota	MN	Wisconsin	WI
Mississippi	MS	Wyoming	WY
Missouri	MO		

American Territories

American Samoa	AS	Puerto Rico	PR
Canal Zone	CZ	Trust Territories	TT
Guam	GU	Virgin Islands	VI

**EFFECTIVE: APRIL 1, 1995
11/9/94**

FORM LOCATOR 1

Armed Forces (APO/FPO)

Armed Forces in America	AA	Armed Forces in the Pacific	AP
Armed Forces in Europe	AE		

Canadian Provinces

Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	QC
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT		

If other than the United States or Canada, use code - XX

DATA ELEMENT: Unlabeled Fields

Definition: These unlabeled fields are reserved for state and national use in accordance with the procedures below. State use fields (as specified below) may be assigned at the state level after negotiation with the payers and providers involved. National use fields are reserved for national assignment.

Procedures: To be determined for each payer at the state or national level as indicated below:

<u>Form Locator</u>	<u>Field Type</u>	<u>Field Attributes</u>
2	State	upper line 29 positions (optional); lower line 30 positions
11	State	upper line 12 positions (optional); lower line 13 positions
31	National	upper line 5 positions; lower line 6 positions
37	National	3 lines, 23 positions

Note: This nationally assigned field has been reserved for the Internal Control Number (ICN)/ Document Control Number (DCN) assigned to the original bill by the payer or the payer's intermediary (See Form Locator 37).

49	National	23 lines, 4 positions
56	State	1 line, 13 positions 4 lines, 14 positions
57	National	1 line, 27 positions
78	State	upper line, 2 positions (optional); lower line, 3 positions

Note: See the following page for recommendations for unlabeled field utilization. Left/Right justification of state use fields is to be defined by State Uniform Billing Committees (SUBCs).

**EFFECTIVE: OCTOBER 1, 1993
3/31/92**

FORM LOCATOR 2

**Recommendations For
Unlabeled Field Utilization**

The NUBC has recommended that the State Uniform Billing Committee (SUBCs) determine what information should be collected in state use fields. Data elements commonly collected include county, patient race, and patient employment status.

National use fields are reserved for national assignment.

EFFECTIVE: JANUARY 8, 1993
1/8/93

FORM LOCATOR 3

DATA ELEMENT: Patient Control Number

Definition: Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

Procedures:	MEDICARE	Required
	MEDICAID	Required
	BLUE CROSS	Required
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
1 line
20 positions
alphanumeric
left-justified

Note: To enable providers to identify payments, it is a requirement that payers include the patient control number on the payment check, remittance advice or voucher.

DATA ELEMENT: Type of Bill

Definition: A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.).

Procedures:	MEDICARE	Required
	MEDICAID	Required
	BLUE CROSS	Required. Types of bills which are to be accepted, will be locally determined.
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
1 line
3 positions
alphanumeric
left-justified (all positions fully coded)

Notes: This three digit code requires 1 digit each, in the following sequence:

1. Type of Facility
2. Bill Classification
3. Frequency

All positions must be fully coded.

Code Structure:

Type of Facility - 1st Digit

- 1 Hospital
- 2 Skilled Nursing
- 3 Home Health⁺
- 4 Religious Non-Medical Health Care Institutions - Hospital Inpatient (formerly referred to as Christian Science)
- 5 Religious Non-Medical Health Care Institutions - Post-Hospital Extended Care Services (formerly referred to as Christian Science)
- 6 Intermediate Care
- 7 Clinic*
- 8 Special Facility*
- 9 Reserved for National Assignment

Bill Classification (Except Clinics and Special Facilities) - 2nd Digit

- 1 Inpatient (Including Medicare Part A)
- 2 Inpatient (Medicare Part B only)
- 3 Outpatient
- 4 Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)**
- 5 Intermediate Care - Level I**
- 6 Intermediate Care - Level II**
- 7 Subacute Inpatient (Revenue Code 19X required when this bill type is used, however 19X may be used with other types of bills.)
- 8 Swing Beds
- 9 Reserved for National Assignment

Bill Classification (Clinics Only) - 2nd Digit

- 1 Rural Health
- 2 Hospital Based or Independent Renal Dialysis Center
- 3 Free Standing
- 4 Outpatient Rehabilitation Facility (ORF)
- 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- 6 Community Mental Health Center
- 7-8 Reserved for National Assignment
- 9 Other

Bill Classification (Special Facilities Only) - 2nd Digit

- 1 Hospice (non-hospital based)
- 2 Hospice (hospital-based)
- 3 Ambulatory Surgery Center
- 4 Free Standing Birthing Center
- 5 Critical Access Hospital
- 6 Residential Facility
- 7-8 Reserved for National Assignment
- 9 Other

Notes for Type of Facility (1st digit) and Bill Classification (2nd digit):

- + If Medicare Home Health:
Use 32X for visits under a plan of treatment under Part B.

Use 33X for visits under a plan of treatment under Part A, including DME under Part A.

Use 34X for Medical and surgical services not under a plan of treatment.
- * If Type of Facility - code 7 (clinic) is used, then the Bill Classification (clinics) - 2nd Digits must be used.

If Type of Facility - code 8 (Special Facility) is used, then the Bill Classification (Special Facilities) - 2nd Digit must be used.
- ** To be defined at the state level.

Frequency - 3rd Digit (Definitions follow)

- 0 Non-Payment/Zero Claim
- 1 Admit thru Discharge Claim
- 2 Interim - First Claim
- 3* Interim - Continuing Claim
- 4* Interim - Last Claim
- 5 Late Charge(s) Only Claim
- 6 Reserved (Discontinued as of 10/01/00)
- 7 Replacement of Prior Claim
- 8 Void/Cancel of Prior Claim
- 9 Final Claim for a Home Health PPS Episode
- A Admission/Election Notice (a)

Effective 7/1/00:

- B Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution/Centers of Excellence Demonstration/Provider Partnerships Demonstration - Termination/Revocation Notice (a)
- C Hospice Change of Provider Notice
- D Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution/Centers of Excellence Demonstration/Provider Partnerships Demonstration - Void/Cancel (a)
- E Hospice Change of Ownership
- F Beneficiary Initiated Adjustment Claim
- G CWF Initiated Adjustment Claim
- H HCFA Initiated Adjustment Claim
- I Intermediary Adjustment Claim (Other Than Pro or Provider)
- J Initiated Adjustment Claim - Other
- K OIG Initiated Adjustment Claim
- L Reserved for National Assignment
- M MSP Initiated Adjustment Claim
- N PRO Adjustment Claim
- O Nonpayment/Zero Claims
- P - W Reserved for National Assignment

Effective 8/1/00:

- X Void/Cancel a Prior Abbreviated Encounter Submission
- Y Replacement of Prior Abbreviated Encounter Submission
- Z New Abbreviated Encounter Submission

Notes for Frequency (3rd digit):

- * Do not use for Medicare Inpatient Hospital PPS claims (For second and subsequent interim bills use code 7, and see Condition code D3 (FL24-FL30)).
- ** Not an acceptable Medicare Code.
- (a) For the Centers of Excellence Demonstration and Provider Partnerships Demonstration, usage of A, B, and D is approved for and during the demonstration project only and subject to further evaluation at their conclusion based on the findings/results of the project.

Definitions for Frequency

Non-Payment/Zero Claim (0)

This code is to be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill; but needs to inform the payer of the non-reimbursable periods of confinement or termination of care.

Admit Through Discharge Claim (1)

This code is to be used for a bill which is expected to be the only bill to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills which represent an entire benefit period of the primary third party payer.

Interim - First Claim (2)

This code is to be used for the first of a series of bills to the same third party payer for the same confinement or course of treatment.

Interim - Continuing Claim (3)*

This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted.

Interim - Last Claim (4)*

This code is to be used for the last of a series of bills, for which payment is expected, to the same third party payer for the same confinement or course of treatment.

However, this code is not intended to be used in lieu of a code for Late Charges, Adjustments, or Zero/Non-Payment Claims.

Late Charge(s) Only (5)

This code is to be used for submitting charges to the payer which were received by the provider after the Admit Through Discharge or the Last Interim Claim has been submitted.

* Do not use for Medicare PPS claims (For second and subsequent interim bills use code 7, and see Condition Code D3 (FL24-FL30).

** Not an acceptable Medicare Code.

**EFFECTIVE: OCTOBER 1, 2000
2/16/00**

FORM LOCATOR 4

However, this code is not intended to be used in lieu of an Adjustment Claim or a Replacement Claim.

Reserved (6) (Discontinued Effective October 1, 2000)

Replacement of Prior Claim (7)

This code is to be used when a specific bill has been issued for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill.

However, this code is not intended to be used in lieu of a Late Charge(s) Only claim.

Void/Cancel of Prior Claim (8)

This code reflects the elimination in its entirety of a previously submitted bill for a specific Provider, Patient, Payer, Insured and "Statement Covers Period." The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.

Final Claim for a Home Health PPS Episode (9)

This code indicates the HH bill should be processed as a debit or credit adjustment to the initial home health PPS bill. It is effective for services provided as of 10/1/00. This code is specific to home health and does not replace frequency codes 6, 7, or 8.

Admission/Election Notice (A)

This code is used when a hospice, home health agency, Medicare Coordinated Care Demonstration entity, Centers of Excellence Demonstration entity, Provider Partnerships Demonstration entity or Religious Non-medical Health Care Institution is submitting the UB-92 as an admission or election notice.

Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution/Centers of Excellence Demonstration/Provider Partnerships Demonstration - Termination/Revocation Notice (B)

Use when the UB-92 is used as a Termination/Revocation of a hospice, Medicare Coordinated Care Demonstration, Centers of Excellence Demonstration, Provider Partnerships Demonstration or Religious Non-medical Health Care Institution election.

Hospice Change of Provider Notice (C)

Use when the UB-92 is used as a Notice of Change to the hospice provider.

Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution/Centers of Excellence Demonstration/Provider Partnerships Demonstration - Void/Cancel (D)

Use when the UB-92 is used as a Notice of a Void/Cancel of a hospice, Medicare Coordinated Care Demonstration entity, Centers of Excellence Demonstration entity, Provider Partnerships Demonstration entity or Religious Non-medical Health Care Institution election.

Hospice Change of Ownership (E)

Use when the UB-92 is used as a Notice of Change in Ownership for the hospice.

Beneficiary Initiated Adjustment Claim (F)

Used to identify adjustments initiated by the beneficiary. For intermediary use only.

CWF Initiated Adjustment Claim (G)

Used to identify adjustments initiated by CWF. For intermediary use only.

HCFA Initiated Adjustment (H)

Used to identify adjustments initiated by HCFA. For intermediary use only.

Intermediary Adjustment Claim (Other Than PRO or Provider) (I)

Used to identify adjustments initiated by the intermediary. For intermediary use only.

Initiated Adjustment Claim - Other (J)

Used to identify adjustments initiated by other entities. For intermediary use only.

OIG Initiated Adjustment Claim (K)

Used to identify adjustments initiated by OIG. For intermediary use only.

Effective July 1, 2000:

MSP Initiated Adjustment Claim (M)

Used to identify adjustments initiated by MSP. For intermediary use only. Note: MSP takes precedence over other adjustment sources.

PRO Adjustment Claim (N)

Used to identify an adjustment initiated as a result of a PRO review. For intermediary use only.

Nonpayment/Zero Claims (O)

Use this code when you do not anticipate payment from the payer for the bill, but is informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned.

Effective 8/1/00:

Void/Cancel a Prior Abbreviated Encounter Submission (X)

This code is used by a Medicare+Choice contractor or other plan required to submit encounter data that indicates that this encounter data submission is an exact duplicate of an incorrect previous encounter data submission using the abbreviated UB-92 format. A code "Y" (Replacement of Prior Abbreviated Encounter Submission) is also submitted by the plan showing corrected information.

Replacement of Prior Abbreviated Encounter Submission (Y)

This code is used by a Medicare+Choice contractor or other plan required to submit encounter data when it wants to correct a previous encounter submission using the abbreviated UB-92 format. This is the code applied to the corrected or new encounter.

New Abbreviated Encounter Submission (Z)

This code is used by a Medicare+Choice contractor or other plan required to submit encounter data to indicate it is submitting new encounter data using the abbreviated UB-92 format. It is applicable for both inpatient and outpatient services.

DATA ELEMENT: Federal Tax Number

Definition: The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN). To identify affiliated subsidiaries using federal tax sub - ID see note below.

Procedures:

MEDICARE	Not Required
MEDICAID	Normally not necessary. Some states that do not have the tax number in the state data processing system may require an entry in this field.
BLUE CROSS	Enter information depending on Plan information needs and specific contract requirements required of non-member providers.
COMMERCIAL	Required
CHAMPUS	Required

Field Attributes: 1 field
upper line, 4 positions (optional)
alphanumeric
left-justified
lower line, 10 positions (include hyphen)
alphanumeric
left-justified

Note: Upper line - is designated federal tax sub - ID number as assigned by the provider. To be used by providers which assign a unique identifying number for their affiliated subsidiaries, e.g., hospital psychiatric pavilion.

Lower line - the federal tax number should be entered: NN-NNNNNNN.

EFFECTIVE: OCTOBER 27, 1983
10/27/83

FORM LOCATOR 6

DATA ELEMENT: Statement Covers Period

Definition: The beginning and ending service dates of the period included on this bill.

Procedures:	MEDICARE	Required
	MEDICAID	Required
	BLUE CROSS	Required
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
1 line
12 positions
numeric
right justified (all positions fully coded)

Note: For all services received on a single day, use both the "From" and "Through" dates, i.e., both will be the same date.

Enter both dates as month, day, and year (MMDDYY).

Example: 010192

EFFECTIVE: JANUARY 8, 1993
1/8/93

FORM LOCATOR 7

DATA ELEMENT: Covered Days

Definition: The number of days covered by the primary payer, as qualified by the payer organization.

Procedures:

MEDICARE	Required; enter the total number of covered Medicare patient days as applicable to the cost report. This should be the total number of accommodation units reported in Form Locator 46. Do not include leave of absence days in covered days.
MEDICAID	Complete as instructed by State Medicaid Agency.
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required when Medicare is identified as any one of the payers in FL50 A, B, or C.
CHAMPUS	Not Required

Field Attributes: 1 field
1 line
3 positions
numeric
right-justified

EFFECTIVE: JANUARY 8, 1993
1/8/93

FORM LOCATOR 8

DATA ELEMENT: Non-Covered Days

Definition: Days of care not covered by the primary payer.

Procedures:	MEDICARE	Enter the number of days within the from and through date that are not claimable as Medicare patient days on the cost report. The reason for noncoverage should be explained by occurrence codes, condition codes or remarks.
	MEDICAID	The State Medicaid Agency will decide on the necessity for reporting this information. If so, the State will provide instructions.
	BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
	COMMERCIAL	Required when Medicare is identified as any one of the payers in FL50 A, B, or C.
	CHAMPUS	Not Required

Field Attributes: 1 field
1 line
4 positions
numeric
right-justified

EFFECTIVE: OCTOBER 1, 1993
8/23/93

FORM LOCATOR 9

DATA ELEMENT: Coinsurance Days

Definition: The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/swing bed days occurring after the 20th and before the 101st day in a single spell of illness.

Procedures:	MEDICARE	Required, if applicable.
	MEDICAID	Complete as required by State Medicaid Agency if applicable.
	BLUE CROSS	Not Required
	COMMERCIAL	Required when Medicare is identified as any one of the payers in FL50 A, B, or C.
	CHAMPUS	Not Required

Field Attributes: 1 field
1 line
3 positions
numeric
right-justified

EFFECTIVE: JANUARY 8, 1993
1/8/93

FORM LOCATOR 10

DATA ELEMENT: Lifetime Reserve Days

Definition: 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.

Procedures:	MEDICARE	Enter the number of lifetime reserve days used, if the beneficiary elects to use them.
	MEDICAID	Not Required
	BLUE CROSS	Not Required
	COMMERCIAL	Required when Medicare is identified as any one of the payers in FL50 A, B, or C.
	CHAMPUS	Not Required

Field Attributes: 1 field
1 line
3 positions
numeric
right-justified

**EFFECTIVE: AUGUST 10, 1983
8/10/83**

FORM LOCATOR 12

DATA ELEMENT: Patient Name

Definition: Last name, first name and middle initial of the patient.

Procedures:	MEDICARE	Required
	MEDICAID	Required
	BLUE CROSS	Required
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
1 line
30 positions
alpha-numeric
left justified

Note: Use a comma or space to separate last and first names.

No space should be left between a prefix and a name as in MacBeth,
VonSchmidt, McEnroe.

Titles (such as Sir, Msgr, Dr.) should not be recorded in this data element.

Record hyphenated names with the hyphen as in Smith-Jones, Rebecca.

To record suffix of a name, write the last name, leave a space and write the
suffix, then write the first name as in Snyder III, Harold, or Addams Jr., Glen.

DATA ELEMENT: Patient Address

Definition: The address of the patient, as defined by the payer organization.

Procedures:

MEDICARE	Enter the following information: full mailing address including street number and name or post office box number or RFD; city name; state name; zip code.
MEDICAID	Enter the following information: full mailing address including street number and name or post office box number or RFD; city name; state name; zip code.
BLUE CROSS	Enter the following information: full mailing address including street number and name or post office box number or RFD; city name; state name; zip code.
COMMERCIAL	Enter the following information: full mailing address including street number and name or post office box number or RFD, city, state, and zip code.
CHAMPUS	Enter the following information: full mailing address including street number and name or post office box number or RFD; city name; state name; zip code. Zip code is required for processing.

Field Attributes: 1 field
1 line
50 positions
alphanumeric
left justified

Note: Use the Standard Post Office State Abbreviations as listed in Form Locator #1, Provider Name and Address.

If a nine digit zip code is used, it should be entered XXXXX-XXXX where the first five digits are the 5 digit zip code and the last 4 digits are the zip code extension.

DATA ELEMENT: Patient Birthdate

Definition: The date of birth of the patient.

Procedures:

MEDICARE	Enter the month, day and year of birth.
MEDICAID	Enter the month, day, and year of birth. An unknown birthdate is not acceptable.
BLUE CROSS	Enter the month, day and year of birth depending on plan information needs or specific contract requirements.
COMMERCIAL	Required
CHAMPUS	Enter the month, day and year of birth.

Field Attributes: 1 field
1 line
8 positions
numeric
right justified (all positions fully coded)

Note: If full birthdate is unknown, indicate zeros for all eight digits.

Enter: "MMDDYYYY"

Example: "01011992"

EFFECTIVE: AUGUST 10, 1983
8/10/83

FORM LOCATOR 15

DATA ELEMENT: Patient Sex

Definition: The sex of the patient as recorded at date of admission, outpatient service, or start of care.

Procedures:	MEDICARE	Required
	MEDICAID	Required
	BLUE CROSS	Required
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
1 line
1 position
alpha-numeric
left justified

Code Structure: M = Male
F = Female
U = Unknown

EFFECTIVE: APRIL 1, 1995
11/9/94

FORM LOCATOR 16

DATA ELEMENT: Patient Marital Status

Definition: The marital status of the patient at date of admission, outpatient service or start of care.

Procedures:	MEDICARE	Not Required
	MEDICAID	Not Required
	BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
	COMMERCIAL	Required
	CHAMPUS	Desirable

Field Attributes: 1 field
1 line
1 position
alphanumeric
left-justified

Code Structure: S = Single
M = Married
P = Life Partner
X = Legally Separated
D = Divorced
W = Widowed
U = Unknown

DATA ELEMENT: Admission/Start of Care Date

Definition: The date the patient was admitted to the provider for inpatient care, outpatient service or start of care.

Procedures:

MEDICARE	Required for inpatient services and to show the date care started for home health claims. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
MEDICAID	Enter the date of admission for inpatient services. Enter the date of service for an outpatient claim.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required
CHAMPUS	Required

Note: Enter the admission date as month, day and year (MMDDYY). Example: "010192"

Field Attributes: 1 field
1 line
6 positions
numeric
right-justified (all positions fully coded)

DATA ELEMENT: Admission Hour

Definition: The hour during which the patient was admitted for inpatient or outpatient care.

Procedures:

MEDICARE	Not Required
MEDICAID	The State Medicaid Agency will decide the necessity for reporting this information. Where required, the state will provide instructions for completion.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required
CHAMPUS	Desirable

Field Attributes: 1 field
1 line
2 positions
alphanumeric
left-justified (all positions fully coded, unless blank)

Note: Not required for home health care.

Code Structure:

<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>
00	12:00 - 12:59	12	12:00 - 12:59
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59
99	Hour Unknown (Discontinued as of 10/16/03)		

DATA ELEMENT: Type of Admission/Visit

Definition: A code indicating the priority of this admission/visit.

Procedures:	MEDICARE	Required
	MEDICAID	The state Medicaid Agency will decide on the necessity for reporting this information.
	BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
	COMMERCIAL	Required, codes 1 and 4.
	CHAMPUS	Required, codes 1 and 4.

Field Attributes: 1 field
1 line
1 position
alpha-numeric
left justified

Code Structure:

- 1 - Emergency The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
- 2 - Urgent The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
- 3 - Elective The patient's condition permits adequate time to schedule the availability of a suitable accommodation.

EFFECTIVE: JANUARY 1, 2002
8/7/01

FORM LOCATOR 19

- | | |
|------------------|--|
| 4 - Newborn | Use of this code necessitates the use of special Source of Admission codes - see Form Locator 20. |
| 5- Trauma Center | Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons <u>and</u> involving a trauma activation. |
| 6-8 | Reserved for National Assignment |
| 9 - | Information Not Available |

DATA ELEMENT: Source of Admission

Definition: A code indicating the source of this admission.

MEDICARE	Required for inpatient admissions and outpatient registrations.
MEDICAID	Not Required
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required for inpatient admissions.
CHAMPUS	Required for inpatients. Provider must submit two claims for delivery stays; one for the mother and one for baby.

Field Attributes: 1 field
1 line
1 position
alphanumeric
left-justified

Note: Newborn coding structure must be used when the Type of Admission Code in Form Locator 19 is code 4.

Code Structure (for Emergency, Elective or Other Type of Admission):

- 1 Physician Referral
Inpatient: The patient was admitted to this facility upon the recommendation of his or her personal physician
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).
- 2 Clinic Referral
Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician.
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

- | | | |
|---|--|---|
| 3 | HMO Referral | <p><u>Inpatient</u>: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.</p> <p><u>Outpatient</u>: The patient was referred to this facility for outpatient or referenced diagnostic services by a health maintenance physician.</p> |
| 4 | Transfer from a Hospital | <p><u>Inpatient</u>: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.</p> <p><u>Outpatient</u>: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) another acute care facility.</p> |
| 5 | Transfer from a Skilled Nursing Facility | <p><u>Inpatient</u>: The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.</p> <p><u>Outpatient</u>: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the skilled nursing facility where he or she is an inpatient.</p> |
| 6 | Transfer from Another Health Care Facility | <p><u>Inpatient</u>: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.</p> <p><u>Outpatient</u>: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) another health care facility where he or she is an inpatient.</p> |
| 7 | Emergency Room | <p><u>Inpatient</u>: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.</p> <p><u>Outpatient</u>: The patient received services in this facility's emergency department.</p> |
| 8 | Court/Law Enforcement | <p><u>Inpatient</u>: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.</p> <p><u>Outpatient</u>: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services</p> |

9	Information Not Available	<p><u>Inpatient</u>: The means by which the patient was admitted to this hospital is not known.</p> <p><u>Outpatient</u>: For Medicare outpatient bills this is not a valid code.</p>
A	Transfer From a Critical Access Hospital	<p><u>Inpatient</u>: The patient was admitted to this facility as a transfer from a Critical Access Hospital where he or she was an inpatient.</p> <p><u>Outpatient</u>: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the Critical Access Hospital where he or she was an inpatient.</p>
B	Transfer From Another Home Health Agency	The patient was admitted to this home health agency as a transfer from another home health agency.
C	Readmission to Same Home Health Agency	The patient was readmitted to this home health agency within the existing 60-day payment. (For use with Medicare bill type 32A.)
D-Z		Reserved for national assignment

Code Structure (for Newborn):

1	Normal Delivery	A baby delivered without complications.
2	Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
4	Extramural Birth	A newborn born in a non-sterile environment.
5-8		Reserved for national assignment
9		Information not available.

DATA ELEMENT: Discharge Hour

Definition: Hour that the patient was discharged from inpatient care.

Procedures:

MEDICARE	Not required
MEDICAID	The State Medicaid Agency will decide the necessity for reporting this information. Where required, the state will provide instructions for completion.
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required for inpatient
CHAMPUS	Desirable. Required for late discharges/transfers.

Field Attributes: 1 field
1 line
2 positions
alphanumeric
left-justified (all positions fully coded, unless blank)

Note: This data element is not necessary for outpatient bills.

Code Structure:

<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>
00	12:00 - 12:59 Midnight	12	12:00 - 12:59 Noon
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59
99	Hour Unknown (Discontinued as of 10/16/03)		

DATA ELEMENT: Patient Status

Definition: A code indicating patient status as of the ending service date of the period covered on this bill, as reported in FL6, Statement Covers Period.

Procedures:

MEDICARE	Required for inpatient and outpatient (13X and 83X) bills.
MEDICAID	The State Medicaid Agency will decide on the necessity for reporting this information. Where required, complete as described in the definition.
BLUE CROSS	Required for inpatient bills.
COMMERCIAL	Required for inpatient bills.
CHAMPUS	Required for inpatient bills.

Field Attributes: 1 field
1 line
2 positions
numeric
right-justified (all positions fully coded)

Code Structure:

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to another short-term general hospital for inpatient care

03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification.

Usage Note:

Medicare - indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61 - Swing Bed. For reporting other discharges/transfers to nursing facilities see 04 and 64 (64 is effective 10/1/02).

04 Discharged/transferred to an intermediate care facility (ICF)

Usage Note:

Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.

05 Discharged/transferred to another type of institution for inpatient care

Usage Note

Medicare - code is used whenever the patient is discharged/transferred to a Medicare distinct part unit or facility. These distinct part units or facilities must meet certain Medicare requirements and are exempt from the inpatient prospective payment system. They include psychiatric, children's hospitals, cancer hospitals and psychiatric distinct part units of a hospital. They do not include SNFs, rehabilitation facilities, rehabilitation distinct part units of a hospital, long-term care hospitals or acute care facilities/units which have specific patient status codes.

06 Discharged/transferred to home under care of organized home health service organization

Usage Note:

Report this code when the patient is discharged/transferred to home with a written plan of care for home care services. Not used for home health services provided by a DME supplier or from a Home IV provider for home IV services (see Code 08).

07 Left against medical advice or discontinued care

08 Discharged/transferred to home under care of a Home IV provider

09 Admitted as an inpatient to this hospital

Usage Note:

For use only on Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

10-19 Discharge to be defined at state level, if necessary

20 Expired

21-29 Expired to be defined at state level, if necessary

30 Still Patient

Usage Note:

Used when patient is still within the same facility; typically used when billing for leave of absence days or interim bills.

31-39 Still patient to be defined at state level, if necessary

40 Expired at home

Usage Note:

For use only on Medicare and CHAMPUS claims for hospice care.

41 Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)

Usage Note:

For use only on Medicare and CHAMPUS claims for hospice care.

42 Expired - place unknown

Usage Note:

For use only on Medicare and CHAMPUS claims for hospice care.

43-49 Reserved for national assignment

50 Hospice - home

51 Hospice - medical facility

52-60 Reserved for national assignment

- 61 Discharged/transferred within this institution to hospital-based Medicare approved swing bed
- Usage Note:
Medicare - used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital. (Effective retroactive to 1/1/02.)
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH). (Effective 5/9/02.)
- Usage Note:
For hospitals that meet the Medicare criteria for LTCH certification.
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. (Effective 10/1/02.)
- 65-70 Reserved for national assignment
- 71 Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (To be discontinued on 4/1/03)
- 72 Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (To be discontinued on 4/1/03)
- 73-99 Reserved for national assignment

EFFECTIVE: OCTOBER 1, 1993
11/5/91

FORM LOCATOR 23

DATA ELEMENT: Medical/Health Record Number

Definition: The number assigned to the patient's medical/health record by the provider.

Procedures:

MEDICARE	Required
MEDICAID	The state Medicaid Agency will decide the necessity for reporting this information.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Desirable
CHAMPUS	Required

Field Attributes: 1 field
 1 line
 17 positions
 alpha-numeric
 left justified

Note: The medical/health record number is typically used to do an audit of the history of treatment. It should not be substituted for the Patient Control Number (FL3) which is assigned by the provider to facilitate retrieval of the individual financial record.

DATA ELEMENT: Condition Codes

Definition: A code(s) used to identify conditions relating to this bill that may affect payer processing.

Procedures:

MEDICARE	Enter appropriate code(s).
MEDICAID	Enter appropriate code(s).
BLUE CROSS	Enter information depending on plan information needs and specific contract requirements.
COMMERCIAL	Required, if applicable.
CHAMPUS	Enter appropriate code(s).

Field Attributes: 7 fields
1 line
2 positions
alphanumeric
all positions fully coded

Note: No specific date is associated with this code.

Condition codes should be entered in alphanumeric sequence.

The letters appearing to the left of the code indicate the payer that has specifically required this code for the adjudication of a claim. The following indicates the payers requesting this code:

C-CHAMPUS
H-HIAA (for the Commercial Insurers)
M-Medicare
B-Blue Cross - to be determined at state level.
D-Medicaid - to be determined at state level.

EFFECTIVE: JANUARY 8, 1993
1/8/93

FORM LOCATORS 24-30

Code Structure:

Insurance Codes

H	01	Military Service Related	Medical condition incurred during military service.
CHM	02	Condition is Employment Related	Patient alleges that medical condition is due to environment/events resulting from employment.
CH	03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
M	04	HMO Enrollee	Indicates bill is submitted for information only and the Medicare beneficiary is enrolled in a risk-based HMO and the hospital expects to receive payment from the HMO.
DM	05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
MBH	06	ESRD Patient in First 18 months of Entitlement Covered by Employer Group Health Insurance	Code indicates Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during his first 18 months of end stage renal disease entitlement.
M	07	Treatment of Non-Terminal Condition for Hospice Patient	Code indicates the patient is a hospice enrollee, but the provider is not treating his terminal condition and is therefore, requesting regular Medicare reimbursement.
MC	08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Enter this code if the beneficiary would not provide information concerning other insurance coverage.
M	09	Neither Patient Nor Spouse is Employed	Indicates that in response to development questions, the patient and spouse have denied any employment.

EFFECTIVE: OCTOBER 1, 1996
5/15/96

FORM LOCATORS 24-30

M	10	Patient and/or Spouse is Employed but No EGHP Exists	Code indicates that in response to development questions, the patient and/or spouse have indicated that one is or both are employed but have no group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient.
M	11	Disabled Beneficiary but No LGHP	Code indicates that in response to development questions, the disabled beneficiary and/or family members have indicated that one is or more are employed but have no group health insurance from an LGHP or other employer sponsored or provided health insurance that covers the patient.
M	12-16	Payer Codes	CODES ARE FOR PAYER USE ONLY.
<u>Special Conditions</u>			
	17	Patient is Homeless	The patient is homeless.
CH	18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.
CH	19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits that does not have its father's last name.
M	20	Beneficiary Requested Billing	Provider realizes services are noncovered level of care or excluded, but beneficiary requests determination by payer.
M	21	Billing for Denial Notice	Provider realizes services are noncovered level of care or excluded, but requests notice from Medicare or other payer.
M	22	Patient on Multiple Drug Regimen	A patient who is receiving multiple intravenous drugs while on home IV therapy.
M	23	Home Care Giver Available	The patient has a care giver available to assist him or her during self-administration of an intravenous drug.
M	24	Home IV Patient Also Receiving-HHA Services	The patient is under the care of Home Health Agency while receiving home IV drug therapy services.
	25	Patient is Non-U.S. Resident	The patient is not a resident of the United States.

**EFFECTIVE: APRIL 1, 2001
10/25/00**

FORM LOCATORS 24-30

M	26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility	Indicates that the patient is a VA eligible patient and chooses to receive services in a Medicare certified provider instead of a VA facility.
M	27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	To be reported by Sole Community hospitals only. Report this code to indicate the patient was referred for a diagnostic laboratory test. Payment will be made at 62%. Do not report this code when a specimen only is referred.
M	28	Patient and/or Spouse's EGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or spouse have indicated that one is or both are employed and that there is group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part-time employees; or, (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
M	29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or family member(s) have indicated that one is or more are employed and there is group health insurance coverage from a LGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and that the employer has fewer than 100 full and part-time employees; or, (2), the LGHP is a multi or multiple employer plan and that <u>all</u> employers participating in the plan have fewer than 100 full and part-time employees.
	30	Non-research Services Provided to Patients Enrolled in a Qualified Clinical Trial.	<i>Full definition pending.</i>

Student Status (Required when patient is a dependent child over 18 years old)

Note: Use only one of the following codes - lowest code value number takes precedence.

CH	31	Patient is Student (Full Time - Day)	Patient declares that he or she is enrolled as a full time day student.
H	32	Patient is Student (Cooperative/Work Study Program)	Self-explanatory
CH	33	Patient is Student (Full Time - Night)	Patient declares that he or she is enrolled as a full time night student.
CH	34	Patient is Student (Part Time)	Patient declares that he or she is enrolled as a part time student.
	35		Reserved for national assignment

Accommodations

CHM	36	General Care Patient in a Special Unit	Patient temporarily placed in special care unit bed because no general care beds available.
HM	37	Ward Accommodation at Patient Request	Patient assigned to ward accommodations at patient's request.
CHM	38	Semi-Private Room Not Available	Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
CHM	39	Private Room Medically Necessary	Patient needs a private room for medical requirements.
M	40	Same Day Transfer	Patient transferred to another facility before midnight on the day of admission.
M	41	Partial Hospitalization	Indicates claim is for partial hospitalization services. For outpatient Medicare this includes a variety of psychiatric (such as drug and alcohol) programs. See Medicare Hospital Manual §§ 230.5C and D for coverage guidelines.

42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Postdischarge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the postdischarge window.
44-45		Reserved for national assignment

CHAMPUS Information

C	46	Non-Availability Statement on File	A nonavailability statement must be issued for each CHAMPUS claim for nonemergency inpatient care when the CHAMPUS beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.
	47		Reserved for CHAMPUS
C	48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a "CHAMPUS - authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
	49-54		Reserved for national assignment

SNF Information

MC	55	SNF Bed Not Available	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because an SNF bed was not available.
MC	56	Medical Appropriateness	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because his condition made it inappropriate to begin active care within that period.
M	57	SNF Readmission	Code indicates the patient was previously receiving Medicare covered SNF care within 30 days of this readmission.

58	Terminated Medicare+Choice Organization Enrollee	Code indicates that patient is a terminated enrollee in a Medicare+Choice Organization plan whose three-day inpatient hospital stay was waived.
59		Reserved for national assignment

Prospective Payment

MC	60	Day Outlier	A hospital being paid under a prospective payment system is reporting this stay as a day outlier.
MC	61	Cost Outlier	A hospital being paid under a prospective payment system is requesting additional payment for this stay as a cost outlier.
	62	Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the claim was paid under a DRG.
	63	Incarcerated Beneficiaries	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates services rendered to a prisoner or a patient in state or local custody meets the requirements of 42 CFR 411.4(b) for payment.
	64-65		THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
M	66	Provider Does Not Wish Cost Outlier Payment	A hospital being paid under a prospective payment system is NOT requesting additional payment for this stay as a cost outlier.
MC	67	Beneficiary Elects Not to Use Life Time Reserve (LTR) Days	Indicates beneficiary elects not to use LTR days.
MC	68	Beneficiary Elects to use Life Time Reserve (LTR) Days	Indicates beneficiary has elected to use LTR days when charges are less than LTR co-insurance amounts.
M	69	IME/DGME/N&AH Payment Only	Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health).

(Note: Condition Codes 70 and 71 moved to page 7 as of 11/15/02.)

Renal Dialysis Setting

M	70	Self-Administered EPO	Code indicates the billing is for a home dialysis patient who self-administers EPO.
M	71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
M	72	Self Care in Unit	Code indicates the billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
M	73	Self Care Training	Code indicates the billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
M	74	Home	Code indicates the billing is for a patient who received dialysis services at home, but where code 75 below does not apply.
M	75	Home - 100 Percent Reimbursement	Code indicates the billing is for a patient who received dialysis services at home, using a dialysis machine that was purchased by Medicare under the 100 percent program.
M	76	Back-up in Facility Dialysis	Code indicates the billing is for a home dialysis patient who received back-up.
MBHC	77	Provider Accepts or is Obligated/Required due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full.	Code indicates you have accepted or are obligated/required due to a contractual arrangement or law to accept payment as payment in full. Therefore no payment is due. (If Medicare, prepare the bill as a no payment bill See HIM 10, §§ 469-472, and 475.)
M	78	New Coverage Not Implemented by HMO	Billing is for a Medicare newly covered service for which the HMO does not pay. (Note: For outpatient bills Condition Code 04 should be omitted).
M	79	CORF Services Provided Offsite	Enter this code to indicate that physical therapy, occupational therapy, or speech pathology services were provided offsite.
	80-99		Reserved for state assignment

Special Program Indicator Codes

C	A0	CHAMPUS External Partnership Program	This code identifies CHAMPUS claims submitted under the External Partnership Program.
MD	A1	EPSDT/CHAP	Early and periodic Screening Diagnosis and Treatment.
MDC	A2	Physically Handicapped Children's Program	Services provided under this program receive special funding through Title VII of the Social Security Act or the CHAMPUS program for the Handicapped.
MD	A3	Special Federal Funding	This code has been designed for uniform use by state uniform billing committees.
MD	A4	Family Planning	This code has been designed for uniform use by state uniform billing committees.
MD	A5	Disability	This code has been designed for uniform use by state uniform billing committees.
MD	A6	Vaccines/Medicare 100% Payment	This code identifies that pneumococcal pneumonia and influenza vaccine services are reimbursed under special Medicare program provisions and Medicare deductible and coinsurance requirements do not apply.
MDC	A7	Induced Abortion - Danger to Life	Abortion was performed to avoid danger to woman's life. To be discontinued on 10/1/02.
MDC	A8	Induced Abortion - Victim Rape/Incest	Self-explanatory. To be discontinued on 10/1/02.
MD	A9	Second Opinion Surgery	Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
	AA	Abortion Performed due to Rape	Self-explanatory. Effective 10/1/02
	AB	Abortion Performed due to Incest	Self-explanatory. Effective 10/1/02
	AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Self-explanatory. Effective 10/1/02

**EFFECTIVE: APRIL 1, 2003,
OCTOBER 16, 2003
8/7/02, 6/18/01**

FORM LOCATORS 24-30

	AD	Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or Exacerbated by the Pregnancy Itself	Self-explanatory. Effective 10/1/02
	AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Self-explanatory. Effective 10/1/02
	AF	Abortion Performed due to Emotional/psychological Health of the Mother	Self-explanatory. Effective 10/1/02
	AG	Abortion Performed due to Social or Economic Reasons	Self-explanatory. Effective 10/1/02
	AH	Elective Abortion	Self-explanatory. Effective 10/1/02
	AI	Sterilization	Self-explanatory. Effective 10/1/02
	AJ	Payer Responsible for Co-payment	Self-explanatory. Effective 4/1/03
	AK-AZ		Reserved for national assignment
M	B0	Medicare Coordinated Care Demonstration Claim	Patient is participant in the Medicare Coordinated Care Demonstration. (Effective 10/1/00)
M	B1	Beneficiary is Ineligible for Demonstration Program	<i>Full definition pending.</i> (Effective 10/1/01)
M	B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption of the ambulance fee schedule.
	B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable law. Effective 10/16/03
	B4-BZ		Reserved for national assignment

PRO Approval Indicator Services

	C0		Reserved for national assignment
MDBHC	C1	Approved as Billed	The services provided for this billing period have been reviewed by the PRO/UR or intermediary, as appropriate, and are fully approved including any day or cost outlier.
CBHC	C2	Automatic Approval as Billed Based on Focused Review	This should include only categories of cases that the PRO/UR has determined it need not review under a focused review program. (No longer used for Medicare.)
MDBHC	C3	Partial Approval	The services provided for this billing period have been reviewed by the PRO/UR or intermediary, as appropriate, and some portion has been denied (days, or services).
MDBHC	C4	Admission/Services Denied	This should only be used to indicate that all of the services were denied by the PRO/UR.
MDBHC	C5	Postpayment Review Applicable	This should be used indicated that the PRO/UR review will take place after payment.
MDBHC	C6	Admission Preauthorization	The PRO/UR authorized this admission/service but has not reviewed the services provided.
MDBHC	C7	Extended Authorization	The PRO has authorized these services for an extended length of time but has not reviewed the services provided.
	C8-CZ		Reserved for national assignment

Claim Change Reasons

M	D0	Changes to Service Dates	
M	D1	Changes to Charges	
M	D2	Changes in Revenue Codes/ HCPCS/HIPPS Rate Codes	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/ HCPCS/HIPPS Rate Codes (FL44)
M	D3	Second or Subsequent Interim PPS Bill	
M	D4	Change in ICD-9-CM Diagnosis and/or Procedure Codes	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in diagnosis (FL67-77) and procedure codes (FL80-81)
M	D5	Cancel to Correct HICN or Provider ID	Cancel only to correct a HICN or provider identification number.

EFFECTIVE: OCTOBER 1, 2000
5/19/00

FORM LOCATORS 24-30

M	D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
M	D7	Change to Make Medicare the Secondary Payer	
M	D8	Change to Make Medicare the Primary Payer	
M	D9	Any Other Change	
M	E0	Change in Patient Status	
	E1-E9		Reserved for national assignment
M	G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under OPSS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.
	G1-G9		Reserved for national assignment
	H0	Delayed Filing, Statement of Intent Submitted	Code indicates that a Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
	H1-LZ		Reserved for national assignment
	M0-MZ		Reserved for payer assignment
	N0-WZ		Reserved for national assignment
	X0-ZZ		Reserved for state assignment

**GUIDELINES FOR OCCURRENCE AND
OCCURRENCE SPAN UTILIZATION**

Due to the varied nature of occurrence and occurrence span codes, provisions have been made to allow the use of both type codes within each. The occurrence span code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as 10 occurrence codes to be utilized.

With respect to occurrence codes, fields 32a - 35a (line level) must be completed before the b. fields. If all the occurrence code fields 32a&b - 35a&b are filled, then 36a followed by 36b may be used to capture additional occurrence codes. When FL36 is used in this way, the "Through" date is left blank.

With respect to occurrence span codes when Form Locators 36a&b are utilized then Form Locators 32 & 33 and/or 34 & 35 may also be utilized to contain the "From" and "Through" dates of additional occurrence span codes. Assuming that there are no occurrence codes and dates, the sequence for additional occurrence span codes should be to use 32-33a (line-level), then 34-35a (line-level), then 32-33b (line-level), then 34-35b (line-level), with the first overflow occurrence span code being assigned to the first pair of available fields (Note: pairs are as defined above - do not pair 33 and 34 or 35a with 32b). For example, if there were no occurrence codes and there were three occurrence spans then the third occurrence span code would be assigned to Form Locator 32a and the "From" date will be in the date field. Form Locator 33a would contain the same occurrence span code as the code in Form Locator 32a and the occurrence span "Through" date will be in the date field. If, on the other hand, there was an occurrence code in 32a then the third occurrence span would be assigned to the next available pair of occurrence codes, i.e., 34a and 35a. That is, the program should always search for the next available pair of occurrence codes (as defined above). If there are more occurrence span codes than available pairs of fields as described above, the additional occurrence span codes and dates should be entered in Remarks (FL84).

This scheme necessitates that the occurrence and occurrence span codes be mutually exclusive. Occurrence codes have values from 01 - 69 and A0 - L9. Occurrence span codes have values from 70 through 99 and M0 - Z9.

Example of occurrence code use: A Medicare beneficiary was confined in hospital from January 1, 1992 to January 10, 1992, however, his Medicare Part A benefits were exhausted as of January 8, 1992, and he was not entitled to Part B benefits. Therefore, Form Locator 32 should contain code 23 and the date 010892.

DATA ELEMENT: Occurrence Codes and Dates

Definition: The code and associated date defining a significant event relating to this bill that may affect payer processing.

Procedures:

MEDICARE	Required, if applicable.
MEDICAID	Required, if applicable. The State Medicaid Agency will provide a listing of the occurrence codes that need to be reported.
BLUE CROSS	Required, if applicable.
COMMERCIAL	Required, if applicable.
CHAMPUS	Enter correct occurrence code(s).

Field Attributes:

4 fields (codes)
2 lines
2 positions
alphanumeric
left-justified (all positions fully coded)

4 fields (dates)
2 lines
6 positions
numeric (all positions)

Notes: The letters appearing to the left of the code indicate the payer that has specifically required this code for the adjudication of a claim. The following indicates the payers requesting this code:

- C - CHAMPUS
- H - HIAA (for the Commercial Insurers)
- M - Medicare
- B - Blue Cross - to be determined at state level.
- D - Medicaid - to be determined at state level.

Enter all dates as month, day, and year (MMDDYY). Example: "010192"

Occurrence Codes should be entered in alphanumeric sequence (numbered codes precede alpha codes). See "Guidelines" on the preceding page.

Code Structure:

Accident Related Codes

MDHC	01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.
MDHC	02	No Fault Insurance Involved - Including Auto Accident/ Other	Code indicating the date of an accident including auto or other where state has applicable no fault liability laws (i.e., legal basis for settlement without admission of proof of guilt).
MDHC	03	Accident/ Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability.
MDHC	04	Accident/ Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
MDHC	05	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of accident/injury.
DHC	06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action omitted by one or more parties.
	07-08		Reserved for national assignment.

Medical Condition Codes

B	09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle.
H	10	Last Menstrual Period	Code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity related condition.
MH	11	Onset of Symptoms/ Illness	Code indicating the date the patient first became aware of symptoms/illness.

7/18/01 (New Page 11/15/02)

Respite Care - (HHA Only)

M	12	Date of Onset for a Chronically Dependent Individual	(HHA Claims only) Code Indicates the date the patient/beneficiary becomes a Chronically Dependent Individual (CDI). This is the first month of the 3-month period immediately prior to eligibility under respite care benefit.
	13-15		Reserved for national assignment

Insurance Related Codes

M	16	Date of Last Therapy	Code indicates the last day of therapy services (e.g., physical therapy, occupational therapy, speech therapy).
M	17	Date Outpatient Occupational Therapy Plan Established or Last Reviewed	Code indicating the date an occupational therapy plan was established or last reviewed.
M	18	Date of Retirement Patient/Beneficiary	The date of retirement for the patient/beneficiary.
M	19	Date of Retirement Spouse	The date of retirement for the patient's spouse.
M	20	Date Guarantee of Payment Began	Code indicating the date on which the provider began claiming Medicare payment under the guarantee of payment provision (HIM 10, § 286).
CM	21	Date UR Notice Received	Code indicating the date of receipt by the provider of the UR Committee's finding that the admission or future stay was not medically necessary.
CM	22	Date Active Care Ended	Code indicates the date covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital, or date on which patient was released on a trial basis from a residential facility. Code not required when code 21 is used.
M	23	Date of Cancellation of Hospice Election Period	FOR INTERMEDIARY USE ONLY. PROVIDERS DO NOT REPORT.
CDM	24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the health care facility from any insurer.

**EFFECTIVE: OCTOBER 1, 1997
11/5/97**

FORM LOCATORS 32-35

CD	25	Date Benefits Terminated by Primary Payer	Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
CHM	26	Date SNF Bed Became Available	Code indicating the date on which a SNF bed became available to hospital inpatient who requires only SNF level care. (HIM 10, § 290.3).
CHMD	27	Date of Hospice Certification or Re-Certification	Code indicating the date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
CM	28	Date Comprehensive Outpatient Rehabilitation Plan Established or Last Reviewed	Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed.
CM	29	Date Outpatient Physical Therapy Plan Established or Last Reviewed	Code indicating the date a physical therapy plan established or established or last reviewed.
CM	30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Code indicating the date a speech pathology plan was established or last reviewed.
CM	31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date of notice provided by the hospital to the patient that inpatient care is no longer required.
CM	32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	The date of notice provided to the beneficiary that requested care (diagnostic procedures or treatments) is not reasonable or necessary under Medicare.

**EFFECTIVE: OCTOBER 1, 1989
10/1/89-2**

FORM LOCATORS 32-35

CM	33	First Day of the Medicare Co-ordination Period for ESRD Beneficiaries Covered by EGHP	Code indicates the first day of the Medicare coordination for which Medicare or CHAMPUS benefits are secondary to benefits payable under an employer group health plan. Required only for ESRD beneficiaries.
M	34	Date of Election of Extended Care Facilities	Code indicates the date the guest elected to receive extended care services (used by Christian Science Sanatoria only).
M	35	Date Treatment Started for Physical Therapy	Code indicates the date services were initiated by the billing provider for physical therapy.
M	36	Date of Inpatient Hospital Discharge for Covered Transplant Patients	Code indicates the date of discharge for inpatient hospital stay in which the patient received a covered transplant procedure when the hospital is billing for immunosuppressive drugs. <u>Note:</u> When the patient received a covered and a non-covered transplant, the covered transplant predominates.
M	37	Date of Inpatient Hospital Discharge for Noncovered Transplant Patient	Code indicates the date of discharge for the inpatient hospital stay in which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
M	38	Date Treatment Started for Home IV Therapy	Date the patient was first treated at home for IV therapy. (Home IV providers- Bill Type 85X.)
M	39	Date Discharged on a Continuous Course of IV Therapy	Date the patient was discharged from the hospital on continuous course IV therapy of IV therapy. (Home IV providers - Bill Type 85X.)

Service Related Codes

H	40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
H	41	Date of First Test Pre-admission Testing	The date on which the first outpatient diagnostic test for was performed as part of a PAT program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).
DM	42	Date of Discharge	To be used when "Through" date in Form Locator 6 (Statement Covers Period) is <u>not</u> the actual discharge date <u>and</u> the frequency code in Form Locator 4 is that of a final bill. For final bill for hospice care, enter the date the Medicare beneficiary terminated his election of hospice care.
	43	Scheduled Date of Canceled Surgery	The date for which ambulatory surgery was scheduled.
M	44	Date Treatment Started Occupational Therapy	The date services were initiated by the billing for provider for occupational therapy.
M	45	Date Treatment Started for Speech Therapy	The date services were initiated by the billing provider for speech therapy.
M	46	Date Treatment Started for Cardiac Rehabilitation	The date services were initiated by the billing provider for cardiac rehabilitation.
M	47	Date Cost Outlier Status Begins	Code indicates that this is the first day after the day the Cost outlier threshold is reached. For Medicare purposes, a beneficiary must have regular, coinsurance and /or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making a cost outlier payment.
	48-49	Payer Codes	THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
	50-69		Reserved for State Assignment
	70-99		See instruction in Form Locator 36 - Occurrence Span Codes and Dates.

	A0		Reserved for national assignment
	A1	Birthdate - Insured A	The birthdate of the individual in whose name the insurance is carried.
	A2	Effective Date - Insured A Policy	A code indicating the first date insurance is in force.
M	A3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer A (HIM 10, § 415.3E).
	A4		Reserved by NUBC for date patient became Medicaid eligible due to medically needy spend down. Final language and effective date pending.
	A5-A9		Reserved for national assignment
	B0		Reserved for national assignment
	B1	Birthdate - Insured B	The birthdate of the individual in whose name the insurance is carried.
	B2	Effective Date - Insured B Policy	A code indicating the first date insurance is in force.
M	B3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer B (HIM 10, § 415.3E).
	B4-B9		Reserved for national assignment
	C0		Reserved for national assignment
	C1	Birthdate - Insured C	The birthdate of the individual in whose name the insurance is carried.
	C2	Effective Date - Insured C Policy	A code indicating the first date insurance is in force.
M	C3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer C (HIM 10, § 415.3E).
	C4-C9		Reserved for national assignment
	D0-D9		Reserved for national assignment

**EFFECTIVE: APRIL 1, 1994
11/10/93**

FORM LOCATORS 32-35

	E0		Reserved for national assignment
	E1	Birthdate - Insured D	The birthdate of the individual in whose name the insurance is carried.
	E2	Effective Date - Insured D Policy	A code indicating the first date insurance is in force.
M	E3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer D (HIM 10, § 415.3E).
	E4-E9		Reserved for national assignment
	F0		Reserved for national assignment
	F1	Birthdate - Insured E	The birthdate of the individual in whose name the insurance is carried.
	F2	Effective Date - Insured E Policy	A code indicating the first date insurance is in force.
M	F3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer E (HIM 10, § 415.3E).
	F4-F9		Reserved for national assignment
	G0		Reserved for national assignment
	G1	Birthdate - Insured F	The birthdate of the individual in whose name the insurance is carried.
	G2	Effective Date - Insured F Policy	A code indicating the first date insurance is in force.
M	G3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer F (HIM 10, § 415.3E).
	G4-G9		Reserved for national assignment
	H0-I9		Reserved for national assignment
	J0-L9		Reserved for state assignment
	M0-Z9		See instructions in Form Locator 36 - Occurrence Span Codes and Dates

DATA ELEMENT: Occurrence Span Code and Dates

Definition: A code and the related dates that identify an event that relates to the payment of the claim.

Procedures:

MEDICARE	Required, if applicable.
MEDICAID	Required, if applicable. The State Medicaid Agency will provide a listing of the occurrence span codes that need to be reported.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required, if applicable.
CHAMPUS	Required, if applicable.

Field Attributes:

1 field (codes)	2 fields (dates)
2 lines	2 lines
2 positions	6 positions
alphanumeric	numeric
all positions fully coded	all positions fully coded

Notes: These codes identify occurrences that happened over a span of time.

Enter all dates as month, day, and year (MMDDYY). Example: "010192"

Occurrence Span Codes must be entered in alphanumeric sequence starting with code 70 and ending with Z9 (numbered codes precede alpha codes). If 36 a & b have been filled and additional occurrence span codes are required see the page preceding FL32 - FL35 a & b "Guidelines for Occurrence and Occurrence Span Utilization."

The letters appearing to the left of the code indicate the payer that has specifically required this code for the adjudication of a claim. The following indicates the payer(s) requesting each code:

C-CHAMPUS
H-HIAA (for the Commercial Insurers)
M-Medicare
B-Blue Cross-to be determined at state level
D-Medicaid-to be determined at state level

Code Structure:

M	70	Qualifying Stay Dates For SNF Use Only	The from/through date of at least a 3-day hospital stay that qualifies the patient for Medicare payment of SNF services billed. Code can be used only by SNF for billing. (HIM 12, §§ 212.1 and 560)
	70	Nonutilization Dates For Payer Use Only on Hospital Bills	THIS CODE IS FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
MC	71	Prior Stay Dates	The from/through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
MH	72	First/Last Visit	The from/through dates of outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual From/Through service dates of Form Locator 6 (Statement Covers Period).
C	73	Benefit Eligibility Period	The inclusive dates during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
CM	74	Noncovered Level of Care/Leave of Absence	The from/through dates of a period at a noncovered level of care or leave of absence in an otherwise covered stay, excluding any period reported by occurrence span code 76, 77, or 79 below.
CM	75	SNF Level of Care	The from/through dates of a period of SNF level of care during an inpatient hospital stay. Code should be used only when the PSRO/PRO has approved the patient remaining in the hospital because of the nonavailability of an SNF bed. Code is not applicable to swing-bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.

M	76	Patient Liability	The from/through dates of a period of non-covered care for which the hospital is permitted to charge the Medicare beneficiary. Code should be used only where the PRO or intermediary has approved such charges in advance and patient has been notified in writing at least 3 days prior to the from date of this period.
M	77	Provider Liability Period	The from/through dates of a period of non-covered care for which the provider is liable. Utilization is charged.
M	78	SNF Prior Stay Dates	The from/through dates given by the patient of any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission.
M	79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
	80-99		Reserved for state assignment.
CHMBD	M0	PRO/UR Approved Stay Dates	The first and last days that were approved where not all of the stay was approved. (Use when Condition Code C3 is used in Form Locators 24-30.)
M	M1	Provider Liability - No Utilization	Code indicates the From/Through dates of a period of noncovered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M	M2	Inpatient Respite Dates	The from/through dates of a period of inpatient respite care.
	M3-WZ		Reserved for national assignment.
	X0-ZZ		Reserved for state assignment.

DATA ELEMENT: Internal Control Number (ICN)/ Document Control Number (DCN)

Definition: The control number assigned to the original bill by the payer or the payer's intermediary.

Procedures:

MEDICARE	Required for all provider types on adjustment requests (Bill Type/FL4 = XX7). All providers requesting an adjustment to a previously processed claim insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN should be shown on line "A" of FL37. Similarly, the ICN/DCN for Payers B and C should be shown on lines B and C respectively, of FL37.
MEDICAID	The State Medicaid Agency will decide on the necessity of reporting this information.
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Not Required
CHAMPUS	Desirable for claim changes (See Medicare procedures above).

Field Attributes: 1 field
3 lines
23 positions
alphanumeric
left-justified

Note: A = Primary payer
B = Secondary payer
C = Tertiary payer

As specified in Form Locator 50 A,B,C (Payer Identification)

DATA ELEMENT: Responsible Party Name and Address

Definition: The name and address of the party responsible for the bill.

Procedures:	MEDICARE	Not Required
	MEDICAID	Not Required
	BLUE CROSS	Not Required
	COMMERCIAL	Desirable
	CHAMPUS	Not Required

Field Attributes: 1 field
5 lines
40 positions
alphanumeric
left-justified

Notes: Address may include post office box or street name and number, city, state and zip code.

Hospitals should abbreviate state in the address according to the post office standard abbreviations appearing in the instructions for Form Locator 1.

If a nine-digit zip code is used, it should be entered XXXXX-XXXX wherein the first 5 digits are the 5 digit zip code and the last 4 digits are the zip code extension. Example: "12345-6789"

DATA ELEMENT: Value Codes and Amounts

Definition: A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization.

Procedures:

MEDICARE	Required, if applicable
MEDICAID	Complete as directed by the State Medicaid agency.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required, if applicable.
CHAMPUS	Enter if applicable.

Field Attributes:

3 fields (codes)	3 fields (amounts)
4 lines	4 lines
2 positions	9 positions
alphanumeric	numeric
all positions fully coded	right-justified (see note)

Notes: The letters appearing to the left of the code indicate the payer that has specifically required this code for the adjudication of a claim. The following indicates the payers requesting this code:

- C - CHAMPUS
- H - HIAA (for the Commercial Insurers)
- M - Medicare
- B - Blue Cross - to be determined at state level
- D - Medicaid - to be determined at state level

Whole numbers or nondollar amounts are right justified to the left of the dollars/cents delimiter. Do not zero fill the positions to the left of the delimiter. However, some values are reported as cents, thus reference to the instructions for specific codes is necessary. Value codes should be entered in alphanumeric sequence. Fields 39a through 41a must be completed before the b fields, etc. Negative numbers are not allowed except in Form Locator 41.

Code Structure:

CH	01	Most Common Semi-private Rate	To provide for the recording of hospital's most common semi-private rate.
CH	02	Hospital Has No Semi-private Rooms	Entering this code requires \$0.00 amount.
	03		Reserved for national assignment.
M	04	Inpatient Professional Component Charges Which are Combined Billed	Code indicates the amount shown is the sum of the inpatient charges which are combined billed. Medicare uses this information in internal processes and also in the HCFA notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. <u>(Used only by some all inclusive rate hospitals.)</u>
CMD	05	Professional Component included in Charges and also Billed Separate to Carrier	For use on Medicare or CHAMPUS bills and all Medicaid bills if state specifies need for this information.
M	06	Medicare Blood Deductible	Total cash blood deductible. If appropriate, enter the Part A or Part B blood deductible amount. (To report other than the blood deductible, that is to report the program deductible, see Value Codes (FL39-FL41) A1, B1, and C1.)
	07		Reserved for national assignment.
M	08	Medicare Life Time Reserve Amount in the First Calendar Year	Medicare life time reserve amount charged in the year of admission. Note: For Medicare, use this code only for Part A bills. For Part B Coinsurance use Value Codes (FL39-41) A2, B2, and C2.

M	09#	Medicare Coinsurance Amount in the First Calendar Year	Medicare coinsurance amounts, charged in the year of admission.
M	10#	Lifetime Reserve Amount in the Second Calendar Year	Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
M	11#	Coinsurance Amount in the Second Calendar Year	Medicare coinsurance amount charged in the year of discharge where the inpatient bill spans two calendar years.
M	12*	Working Aged Beneficiary/Spouse With Employer Group Health Plan	Amount shown is that portion of a payment from a higher priority employer group health insurance made on behalf of an aged beneficiary that the provider is applying to Medicare covered services on this bill (HIM 10, §§ 472-473).
M	13*	ESRD Beneficiary in a Medicare Coordination Period With an Employer Group Health Plan	Amount shown is that portion of a payment from a higher priority employer group health insurance payment made on behalf of an ESRD beneficiary that the provider is applying to Medicare covered services on this bill (HIM 10, §§ 471 and 473).
M	14*	No-Fault, Including Auto/Other	Amount shown is that portion from a higher priority no-fault insurance, including auto/other made on behalf of the patient or insured. For Medicare beneficiaries the provider should apply this amount to the Medicare covered services on this bill (HIM 10, § 289). Enter six zeros (0000.00) in the amount field if you are claiming conditional payment. Note: The decimal is implied and refers to the dollar and cents delimiter.
M	15*	Worker's Compensation	Amount shown is that portion of a payment from a higher priority worker's compensation insurance made on behalf of the patient or insured. For Medicare beneficiaries the provider should apply this amount to Medicare covered services on this bill (HIM 10, § 289).

For Medicare, use Value Codes 8-11 only for Part A bills. (For Part B coinsurance amounts use Value Codes A2, B2, and C2.)

* **Failure to File a Proper Claim**
For situations where you (the hospital) received a reduced payment because of failure to file a proper claim, indicate the amount that would have been payable if you had filed a proper claim.

**EFFECTIVE: OCTOBER 1, 1992
3/31/92-2**

FORM LOCATORS 39-41

M	16	PHS, or Other Federal Agency	Amount shown is that portion of a payment from a higher priority Public Health Service or the Federal Agency made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill (HIM 10, § 260.3D1).
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Note: A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (000000).

	17	Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY.
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	18-20		These codes are set for payer use only. Providers do not report these codes.
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Medicaid-Specific Codes

D	21	Catastrophic	Medicaid-eligibility requirements to be determined at state level.
D	22	Surplus	Medicaid-eligibility requirements to be determined at state level.
D	23	Recurring Monthly Income	Medicaid-eligibility requirements to be determined at state level.
D	24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at state level.

Reserved Codes

	25-29		Reserved for national assignment - Medicaid
BHC	30	Preadmission Testing	This code reflects charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.

Code Structure:

MC	31	Patient Liability Amount	The amount approved to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
M	32	Multiple Patient Ambulance Transport	If more than one patient is transported in a single ambulance trip, report the total number of patients transported.
	33-36		Reserved for national assignment.
CHMBD	37	Pints of Blood Furnished	
MD	38	Blood Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.
MD	39	Pints of 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.
M	40	New Coverage Not Implemented by HMO (for inpatient service only)	Amount shown is for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services which are not paid by the HMO.) Note: Condition Codes 04 and 78 should also be reported.
M	41*	Black Lung	Code indicates the amount shown is that portion of a higher priority Black Lung payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. If six zeros (000000) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in its payment (See HIM 10, §289.)
M	42	VA	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. (See HIM 10, §260.3B.)
M	43*	Disabled Beneficiary Under Age 65 with LGHP	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that you are applying to covered Medicare charges on this bill.

* **Failure to File a Proper Claim (See full note on next page)**

EFFECTIVE: OCTOBER 1, 1996
5/15/96

FORM LOCATORS 39-41

MC	44	Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received.	The amount the provider was obligated to accept from a primary payer. When a lesser amount is actually received, and that amount is less than charges, a Medicare secondary or CHAMPUS secondary payment is due. (See HIM 10, § 472 for more information.)
DBH	45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below right justified to the left of the dollars/cents delimiter.

00	12:00 - 12:59 (Midnight)
01	01:00 - 01:59
02	02:00 - 02:59
03	03:00 - 03:59
04	04:00 - 04:59
05	05:00 - 05:59
06	06:00 - 06:59
07	07:00 - 07:59
08	08:00 - 08:59
09	09:00 - 09:59
10	10:00 - 10:59
11	11:00 - 11:59
12	12:00 - 12:59 (Noon)
13	01:00 - 01:59
14	02:00 - 02:59
15	03:00 - 03:59
16	04:00 - 04:59
17	05:00 - 05:59
18	06:00 - 06:59
19	07:00 - 07:59
20	08:00 - 08:59
21	09:00 - 09:59
22	10:00 - 10:59
23	11:00 - 11:59
99	unknown

* **Failure to File a Proper Claim**
For situations where you (the hospital) received a reduced payment because of failure to file a proper claim, indicate the amount that would have been payable if you had filed a proper claim.

**EFFECTIVE: AUGUST 23, 1993
8/23/93**

FORM LOCATORS 39-41

MDBHC	46*	Number of Grace Days	Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care. (For Medicare see HIM 10 § 297.)
M	47	Any Liability Insurance	Amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill (HIM 10 § 262). Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment. (Note: The decimal is implied and refers to the dollar and cents delimiter.)
M	48	Hemoglobin Reading	The latest Hemoglobin reading taken during this billing cycle. Whole numbers, i.e., two digits are to be right-justified to the left of the dollar/cents delimiter; decimals, i.e., one digit, is to be reported to the right.
M	49	Hematocrit Reading	Hematocrit reading taken prior to the last administration of EPO, during the billing cycle, related to the use of erythropoietin. Whole numbers, i.e., two digits are to be right justified to the left of the dollar/cents delimiter; decimals, i.e., one digit, is to be reported to the right.
M	50	Physical Therapy Visit	Number of physical therapy visits from onset (at the billing provider) through this billing period. Report the number in the dollar portion of the form locator (right justified to the left of the dollar/cents delimiter.)
M	51	Occupational Therapy Visits	Number of occupational therapy visits from onset of symptoms (at the billing provider) through this billing period. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
M	52	Speech Therapy Visits	Number of speech therapy visits from the onset of symptoms (at the billing provider) through this period. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter.

***UB-92 Code Only:** Effective 10/1/93

M	53	Cardiac Rehab Visits	Number of cardiac rehabilitation visits from the onset of symptoms (at the billing provider) through this billing period. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
	54	Newborn birth weight in grams	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of 4 and on other claims as required by state law.
	55		Reserved for national assignment.

Home Health - Specific Codes

M	56	Skilled Nurse - Home Visit Hours (HHA only)	The number of hours of skilled nursing provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)
M	57	Home Health Aide - Home Visit Hours (HHA only)	The number of hours of home health aide services provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)
M	58	Arterial Blood Gas (PO2/PA2)	Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill. Report right justified in the cents area rounded to the nearest whole number (Report two digits). Example: A value of 56.5 should be reported as 000000 57, i.e., with the 57 reported in the cents area.
M	59	Oxygen Saturation (O2 Sat/Oximetry)	Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill. Report right justified in the cents area. Round to the nearest whole percent (report two digits). Example: 93.5 percent should be reported as 000000 94, i.e., with 94 being reported in the cents area. A value of 100 percent would be reported as 000001 00.

EFFECTIVE: OCOBER 1, 2000
5/24/01 (New Page 11/15/02)

FORM LOCATORS 39-41

M	60	HHA Branch MSA	MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's - Report the MSA number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
MD	61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
M	62-65	Payer Codes	THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
	66		Reserved by NUBC for Medicaid client spend down liability.
M	67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justify to the left of the dollar/cent delimiter. (Round to the nearest whole hour.)
M	68	EPO-Drug	Number of units of EPO administered and/or supplied relating to the billing period. Report amount in whole units right-justified to the left of the dollar/cents delimiter.
	69		Reserved for national assignment.
M	70-72	Payer Codes	THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
M	73	Payer Code	(For internal use by third party payers only.) <u>Medicare: Drug Deductible</u> Report the amount of the drug deductible to be applied to the claim.

(Note: Condition Codes 74 through 99 moved to page 9.1 as of 11/15/02.)

**EFFECTIVE: APRIL 1, 2003
11/15/02**

FORM LOCATORS 39-41

M 74 Payer Code

(For internal use by third party payers only.)
Medicare: Drug Coinsurance
Report the amount of drug coinsurance to be applied to the claim.

M 75-76 Payer Codes

THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.

M 77 Payer Code

(For internal use by third party payers only.)
Medicare: New Technology Add-On Payment
(**Effective 4/1/03**)

M 78-79 Payer Codes

THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.

80-99

Reserved for state assignment.

	A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
MDB	A1#	Deductible Payer A	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer.
MDB	A2*	Coinsurance Payer A	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
	A3	Estimated Responsibility Payer A	The amount estimated by the provider to be paid by the indicated payer.
	A4 [@]	Covered Self-Administrable Drugs - Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation (e.g., diabetic coma).
	A5 [@]	Covered Self-Administrable Drugs - Not Self-Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient.
	A6 [@]	Covered Self-Administrable Drugs - Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reason (e.g., the drug is specifically covered by the payer).
	A7-AZ		Reserved for national assignment
	B0		Reserved for national assignment
MDB	B1#	Deductible Payer B	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer.
MDB	B2*	Coinsurance Payer B	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
	B3	Estimated Responsibility Payer B	The amount estimated by the provider to be paid by the indicated payer.

Note: Medicare blood deductibles should be reported under Value Code 6 (FL39-FL41).

* Note: For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11 (FL39-FL41).

@ For use with Revenue Code 637.

**EFFECTIVE: OCTOBER 1, 1996
2/13/96**

FORM LOCATORS 39-41

	B4-BZ		Reserved for national assignment
	C0		Reserved for national assignment
MDB	C1#	Deductible Payer C	The amount assumed by the provider to be applied to the patient's policy/program deductible involving the indicated payer.
MDB	C2*	Coinsurance Payer C	The amount assumed by the provider to be applied toward the patients coinsurance amount involving the indicated payer.
	C3	Estimated Responsibility Payer C	The amount estimated by the provider to be paid by the indicated payer.
	C4-CZ		Reserved for national assignment
	D0-D2		Reserved for national assignment
	D3	Patient Estimated Responsibility	The amount estimated by the provider to be paid by the indicated patient.
	D4-DZ		Reserved for national assignment
	E0		Reserved for national assignment
MDB	E1#	Deductible Payer D	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer.
MDB	E2*	Coinsurance Payer D	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
	E3	Estimated Responsibility Payer D	The amount estimated by the provider to be paid by the indicated payer.
	E4-EZ		Reserved for national assignment

Note: Medicare blood deductibles should be reported under Value Code 6 (FL39-FL41).

* Note: For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11 (FL39-FL41).

**EFFECTIVE: OCTOBER 1, 1996
2/13/96**

FORM LOCATORS 39-41

	F0		Reserved for national assignment
MDB	F1#	Deductible Payer E	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer.
MDB	F2*	Coinsurance Payer E	The amount assumed by the provider to be applied toward the patients coinsurance amount involving the indicated payer.
	F3	Estimated Responsibility Payer E	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
	F4-FZ		Reserved for national assignment
	G0		Reserved for national assignment
MDB	G1#	Deductible Payer F	The amount assumed by the provider to be applied to the patient's policy/program deductible involving the indicated payer.
MDB	G2*	Coinsurance Payer F	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
	G3	Estimated Responsibility Payer F	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
	G4-GZ		Reserved for national assignment
	H0-WZ		Reserved for national assignment
	X0-ZZ		Reserved for state assignment

Note: Medicare blood deductibles should be reported under Value Code 6 (FL39-FL41).

* Note: For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11 (FL39-FL41).

DATA ELEMENT: Revenue Code

Definition: A code which identifies a specific accommodation, ancillary service or billing calculation.

Procedures:

MEDICARE	Required
MEDICAID	Required
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required
CHAMPUS	Required

Field Attributes: 1 field
23 lines
4 positions
numeric
right-justified

Notes: The “other” codes (XX9) will be assigned at a state level in order to meet local needs. National payers will read these codes at the zero level (i.e., general classification).

All subcategory codes not used, except the “other” codes, are reserved for national assignment. The NUBC approved the expansion of this field from three to four characters to accommodate possible future needs.

Unit Requirements: Unit requirements for Medicare, CHAMPUS, and commercial insurers have been indicated below each revenue code category. SUBCs are encouraged to indicate the needs of Medicaid and Blue Cross plans.

Unit Requirement Notes:

- IP - ONLY required on inpatient claims
- OP - ONLY required on outpatient claims
- HH - ONLY required on home health claims
- x - Requirements apply to all applicable claims
- V - Medicare requires visits for services other than inpatient.
- * - Medicaid requirements vary by state, and were not noted.

Enter Blue Cross information depending on Plan needs and specific contract requirements. (Continued on next page.)

Unit Requirement Notes (Continued):

Payer Categories:

- C = CHAMPUS
- H = Commercial Insurance
- M = Medicare
- B = Blue Cross
- D = Medicaid

Code Structure:

Major Category

Payer and Related Information

Rationale: To group items by payer and to assign similar items the same number.

0001 Total Charge

For use on paper or paper facsimile (e.g., "print images") claims only. For electronic transactions, report the total charge in the appropriate data segment/field.

001X Reserved for Internal Payer Use

002X Health Insurance - Prospective Payment System (HIPPS)

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - RESERVED	
1 - RESERVED	
2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
3 - Home Health Prospective Payment System	HH PPS (HRG)
4 - Inpatient Rehab Facility Prospective Payment System	REHAB PPS (CMG)
5 - RESERVED	
6 - RESERVED	
7 - RESERVED	
8 - RESERVED	
9 - RESERVED	

003X

to

006X Reserved for National Assignment

007X

to

009X Reserved for State Use

Assignment of "nonrevenue" codes only, e.g., deductible, coinsurance, payments, credits, subtotals. DO NOT ASSIGN ACCOMMODATION OR ANCILLARY SERVICE REVENUE CODE.

EFFECTIVE: DECEMBER 12, 1983
1/8/93

FORM LOCATOR 42

010X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

<u>Subcategory</u>						<u>Standard Abbreviation</u>					
0 - All-Inclusive Room and Board Plus Ancillary						ALL INCL R&B/ANC					
1 - All-inclusive Room and Board						ALL INCL R&B					
<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x	x			

**011X Room & Board - Private
(Medical or General)**

Routine service charges for single bed rooms.

Rationale: Most third party payers require that private rooms be separately identified.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
8 - Rehabilitation	REHAB/PVT
9 - Other	OTHER/PVT

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x	114			
								115			
								116			

**012X Room & Board - Semi-private Two Bed
(Medical or General)**

Routine service charges incurred for accommodations with two beds.

Rationale: Most third party payers require that semi-private rooms be identified.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ROOM-BOARD/SEMI
1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
2 - OB	OB/2BED
3 - Pediatric	PEDS/2BED
4 - Psychiatric	PSTAY/2BED
5 - Hospice	HOSPICE/2BED
6 - Detoxification	DETOX/2BED
7 - Oncology	ONCOLOGY/2BED
8 - Rehabilitation	REHAB/2BED
9 - Other	OTHER/2BED

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x	124			
								125			
								126			

013X Room & Board - Semi-Private - Three and Four Beds

Routine service charges incurred for accommodations with three and four beds.

<u>Subcategory</u>							<u>Standard Abbreviation</u>				
0 - General Classification							ROOM-BOARD/3&4BED				
1 - Medical/Surgical/Gyn							MED-SUR-GY/3&4				
2 - OB							OB/3&4BED				
3 - Pediatric							PEDS/3&4BED				
4 - Psychiatric							PSYCH/3&4BED				
5 - Hospice							HOSPICE/3&4BED				
6 - Detoxification							DETOX/3&4BED				
7 - Oncology							ONCOLOGY/3&4BED				
8 - Rehabilitation							REHAB/3&4BED				
9 - Other							OTHER/3&4BED				
<u>Units Required</u>							<u>4 - Digit Detail Required</u>				
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x	134			
								135			
								136			

014X Room & Board - Private (Deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

<u>Subcategory</u>							<u>Standard Abbreviation</u>				
0 - General Classification							ROOM-BOARD/PVT/DLX				
1 - Medical/Surgical/Gyn							MED-SUR-GY/DLX				
2 - OB							OB/DLX				
3 - Pediatric							PEDS/DLX				
4 - Psychiatric							PSYCH/DLX				
5 - Hospice							HOSPICE/DLX				
6 - Detoxification							DETOX/DLX				
7 - Oncology							ONCOLOGY/DLX				
8 - Rehabilitation							REHAB/DLX				
9 - Other							OTHER/DLX				
<u>Units Required</u>							<u>4 - Digit Detail Required</u>				
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x	144			
								145			
								146			

**015X Room & Board - Ward
(Medical or General)**

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/WARD
2 - OB	OB/WARD
3 - Pediatric	PEDS/WARD
4 - Psychiatric	PSYCH/WARD
5 - Hospice	HOSPICE/WARD
6 - Detoxification	DETOX/WARD
7 - Oncology	ONCOLOGY/WARD
8 - Rehabilitation	REHAB/WARD
9 - Other	OTHER/WARD

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x	154			
								155			
								156			

016X Room & Board - Other

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	R&B
4 - Sterile Environment	R&B/STERILE
7 - Self Care	R&B/SELF
9 - Other	R&B/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP				x	x			

017X Nursery

Accommodation charges for nursing care to newborn and premature infants in nurseries.

Subcategories 1 - 4 to be used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under state regulations or other statutes supersede the following guidelines. For example, some states may have fewer than four levels of care or may have multiple levels within a category such as intensive care.

Level I: Routine care of apparently normal full-term or preterm neonates. (“Newborn Nursery”**)

Level II: Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates. (“Continuing Care”**)

Level III: Sick neonates, who do not require intensive care, but require 6-12 hours of nursing each day. (“Intermediate Care”**)

Level IV: Constant nursing and continuous cardiopulmonary and other support for severely ill infants. (“Intensive Care”**)

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	NURSERY
1 - Newborn - Level I	NURSERY/LEVELI
2 - Newborn - Level II	NURSERY/LEVELII
3 - Newborn - Level III	NURSERY/LEVELIII
4 - Newborn - Level IV	NURSERY/LEVELIV
9 - Other Nursery	NURSERY/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Days IP IP	x x

** Guidelines adapted from Chapter 2 (Physical Facilities) of *Guidelines for Perinatal Care, Second Edition*, published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (1988).

018X Leave of Absence

Charges for holding a room while the patient is temporarily away from the provider.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	LEAVE OF ABSENCE OR LOA
1 - RESERVED	
2 - Patient Convenience	LOA/PT CONV
3 - Therapeutic Leave	LOA/THERAPEUTIC
4 - ICF/MR - Any Reason	LOA/ICF/MR
5 - Nursing Home (for Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Days IP	x x

019X Subacute Care

Accommodation charges for subacute care to inpatients in hospitals or skilled nursing facilities.

Level I - Skilled Care:

Minimal nursing intervention. Comorbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.

Level II - Comprehensive Care:

Moderate nursing intervention. Active treatment of comorbidities. Assessment of vitals and body systems required 2-3 times per day.

Level III - Complex Care:

Moderate to extensive nursing intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 3-4 times per day.

Level IV - Intensive Care:

Extensive nursing and technical intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.

Subcategory

0 - General Classification
1 - Subacute Care -Level I
2 - Subacute Care -Level II
3 - Subacute Care -Level III
4 - Subacute Care -Level IV
9 - Other Subacute Care

Standard Abbreviation

SUBACUTE
SUBACUTE/LEVELI
SUBACUTE/LEVELII
SUBACUTE/LEVELIII
SUBACUTE/LEVELIV
SUBACUTE/OTHER

Units Required

Units By: C H M B D*

4 - Digit Detail Required

C H M B D

Days

Usage Note

Revenue Code 19X may be used in multiple types of bills. However, if Bill Type X7X is used in Form Locator 4, Revenue Code 19X must be used.

020X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are to be identified.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	INTENSIVE CARE (or ICU)
1 - Surgical	ICU/SURGICAL
2 - Medical	ICU/MEDICAL
3 - Pediatric	ICU PEDS
4 - Psychiatric	ICU/PSTAY
6 - Intermediate ICU	ICU/INTERMEDIATE
7 - Burn Care	ICU/BURN CARE
8 - Trauma	ICU/TRAMA
9 - Other Intensive Care	ICU/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x	x			

021X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for rendering such services, the hospital or third party may wish to identify the service.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	CORONARY CARE (or CCU)
1 - Myocardial Infarction	CCU/MYO INFARC
2 - Pulmonary Care	CCU/PULMONARY
3 - Heart Transplant	CCU/TRANSPLANT
4 - Intermediate CCU	CCU/INTERMEDIATE
9 - Other Coronary Care	CCU/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days		IP	IP	IP			x				

022X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services rendered in greater detail and thus break out charges for items that normally would be considered part of routine services.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPORT CHG
3 - U.R. Service Charge	UR CHARGE
4 - Late Discharge, Medically Necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG
<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x x

023X Incremental Nursing Charge Rate

Charge for nursing service assessed in addition to room and board.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	NURSING INCREM
1 - Nursery	NUR INCR/NURSERY
2 - OB	NUR INCR/OB
3 - ICU	NUR INCR/ICU
4 - CCU	NUR INCR/CCU
5 - Hospice	NUR INCR/HOSPICE
9 - Other	NUR INCR/OTHER
<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x

024X All Inclusive Ancillary

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ALL INCL ANCIL
1 - Basic	ALL INCL BASIC
2 - Comprehensive	ALL INCL COMP
3 - Specialty	ALL INCL SPECIAL
9 - Other All Inclusive Ancillary	ALL INCL ANCIL/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x

Usage Note
 Revenue Codes 241, 242 and 243 are designed for use by Special Residential Facilities only.
 See Form Locator 4, Bill Type 86X.

025X Pharmacy (Also see 063X, an extension of 025X)

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements. Subcode 4 is for providers that cannot bill drugs used for other diagnostic services under Revenue Code 929. Subcode 5 is for providers that cannot bill drugs used for radiology under Revenue Code 329 or 339.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Non-generic Drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Non-prescription	DRGS/NONPSRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRGS/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x
255	
OP	

026X IV Therapy

Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, Providers must identify the actual cost for each type of pump for updating of the per diem.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	IV THERAPY
1 - Infusion Pump	IV THER/INFSN PUMP
2 - IV Therapy/Pharmacy Svcs	IV THER/PHARM/SVC
3 - IV Therapy/Drug/Supply Delivery	IV THER/DRUG/SUPPLY DELV
4 - IV Therapy/Supplies	IV THER/SUPPLIES
9 - Other IV Therapy	IV THERAPY/OTHER

Note: Billing, for Home IV providers, requires the HCPCS code which describes the pump to be entered, in Form Locator 44.

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
							x				

027X Medical/Surgical Supplies and Devices (also see 062X, an extension of 027X)

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal third party payer requirements.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	MED-SUR SUPPLIES
1 - Non Sterile Supply	NON-STER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 - Pacemaker	PACE MAKER
6 - Intraocular Lens	INTRA OC LENS
7 - Oxygen-Take Home	O2/TAKEHOME
8 - Other Implant (a)	SUPPLY/IMPLANTS
9 - Other Supplies/Devices	SUPPLY/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Items				274		x	x		274		
				OP					OP		

(a) Implantables:

That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.

Examples of Other Implants (not all-inclusive):

Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds

Experimental devices that are implantable and have been granted an FDA Investigational Device Exemption (IDE) number, should be billed with revenue code 624.

028X Oncology

Charges for the treatment of tumors and related diseases.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
							x				

029X Durable Medical Equipment (Other Than Renal)

Charge for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

<u>Subcategory</u>						<u>Standard Abbreviation</u>				
0 - General Classification						MED EQUIP/DURAB				
1 - Rental						MED EQUIP/RENT				
2 - Purchase of New DME						MED EQUIP/NEW				
3 - Purchase of Used DME						MED EQUIP/USED				
4 - Supplies/Drugs for DME						MED EQUIP/SUPPLIES/DRUGS				
Effectiveness (Home Health Agency only)										
9 - Other Equipment						MED EQUIP/OTHER				

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Items				291		x	x	x			
				293							
				HH							

030X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

<u>Subcategory</u>						<u>Standard Abbreviation</u>				
0 - General Classification						LABORATORY or (LAB)				
1 - Chemistry						LAB/CHEMISTRY				
2 - Immunology						LAB/IMMUNOLOGY				
3 - Renal Patient (Home)						LAB/RENAL HOME				
4 - Non-Routine Dialysis						LAB/NR DIALYSIS				
5 - Hematology						LAB/HEMATOLOGY				
6 - Bacteriology & Microbiology						LAB/BACT-MICRO				
7 - Urology						LAB/UROLOGY				
9 - Other Laboratory						LAB/OTHER				

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Tests			OP	OP			x	x			

EFFECTIVE: MAY 21, 1982
5/21/82

FORM LOCATOR 42

031X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory

0 - General Classification
1 - Cytology
2 - Histology
4 - Biopsy
9 - Other Laboratory Pathological

Standard Abbreviation

PATHOLOGY LAB or (PATH LAB)
PATHOL/CYTOLOGY
PATHOL/HYSTOL
PATHOL/BIOPSY
PATHOL/OTHER

Units Required

Units By: C H M B D*
OP

4 - Digit Detail Required

C H M B D
x

7/14/87 (New Page 11/15/02)

032X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures that individual hospitals or third party payers may wish to identify.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	DX X-RAY
1 - Angiocardiology	DX X-RAY/ANGIO
2 - Arthrography	DX X-RAY/ARTH
3 - Arteriography	DX X-RAY/ARTER
4 - Chest X-Ray	DX X-RAY/CHEST
9 - Other Radiology - Diagnostic	DX X-RAY/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Tests				OP			x				

033X Radiology - Therapeutic and/or Chemotherapy Administration

Charges for therapeutic radiology services and chemotherapy administration are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances. **Excludes charges for chemotherapy drugs, which should be reported under the appropriate revenue code (025X/063X).**

Rationale: A breakdown is provided of the major areas that hospitals or third parties may wish to identify.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	RX X-RAY
1 - Chemotherapy Administration - Injected	CHEMOTHER/INJ
2 - Chemotherapy Administration - Oral	CHEMOTHER/ORAL
3 - Radiation Therapy	RADIATION RX
5 - Chemotherapy Administration - IV	CHEMOTHERP-IV
9 - Other Radiology - Therapeutic	RX X-RAY/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Tests				OP			x		333		
									OP		

036X Operating Room Services

Charges for services provided to patients by specifically trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Rationale: Permits identification of particular services.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	OR SERVICES
1 - Minor Surgery	OR/MINOR
2 - Organ Transplant-Other Than Kidney	OR/ORGAN TRANS
7 - Kidney Transplant	OR/KIDNEY TRANS
9 - Other Operating Room Services	OR/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x 367

037X Anesthesia

Charges for anesthesia services in the hospital.

Rationale: Provides additional identification of services. In particular, acupuncture was identified because it is not covered by some payers, including Medicare. Subcode 1 is for providers that cannot bill anesthesia administered for radiology procedures under radiology. Subcode 2 is for providers that cannot bill anesthesia administered for other diagnostic procedures.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ANESTHESIA
1 - Anesthesia Incident to Radiology	ANESTHE/INCIDENT RAD
2 - Anesthesia Incident to Other Diagnostic Services	ANESTHE/INCDNT OTHER DX
4 - Acupuncture	ANESTHE/ACUPUNC
9 - Other Anesthesia	ANESTHE/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x

038X Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

<u>Subcategory</u>						<u>Standard Abbreviation</u>					
0 - General Classification						BLOOD					
1 - Packed Red Cells						BLOOD/PKD RED					
2 - Whole Blood						BLOOD/WHOLE					
3 - Plasma						BLOOD/PLASMA					
4 - Platelets						BLOOD/PLATELETS					
5 - Leucocytes						BLOOD/LEUCOCYTES					
6 - Other Components						BLOOD/COMPONENTS					
7 - Other Derivatives (Cryoprecipitates)						BLOOD/DERIVATIVES					
9 - Other Blood						BLOOD/OTHER					
<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Pints				381		x	x				
				x							

039X Blood and Blood Component Administration, Processing and Storage

Charges for administration, processing and storage of whole blood, red blood cells, platelets, and other blood components (such as, plasma and plasma derivatives).

<u>Subcategory</u>						<u>Standard Abbreviation</u>					
0 - General Classification						BLOOD/STOR-PROC					
1 - Administration (e.g., Transfusions)						BLOOD/ADMIN					
9 - Other Processing and Storage						BLOOD/OTHER STOR					
<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
							x				

040X Other Imaging Services

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	IMAGE SERVICE
1 - Diagnostic Mammography	DIAG MAMMOGRAPHY
2 - Ultrasound	ULTRASOUND
3 - Screening Mammography*	SCRN MAMMOGRAPHY
4 - Positron Emission Tomography	PET SCAN
9 - Other Imaging Service	OTHER IMAG SVS

*Note: Medicare will require the hospitals to report the ICD-9 diagnosis codes (Form Locator code 67) to substantiate those beneficiaries considered high risks. These high risk codes are as follows:

<u>ICD-9 Codes</u>	<u>Definitions</u>	<u>High Risk Indicator</u>
V10.3	Personal History - Malignant neoplasm breast cancer	A personal history of breast cancer
V16.3	Family History - Malignant neoplasm breast cancer	A mother, sister or daughter who has had breast cancer
V15.89	Other specified personal history, representing hazards to health	Not given birth prior to 30
*V15.89	Other specified personal history, representing hazards to health	A personal history of biopsy-proven benign breast disease

*Must be coded to the appropriate 4th or 5th digit.

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Tests				OP			x				

041X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

<u>Subcategory</u>						<u>Standard Abbreviation</u>					
0 - General Classification						RESPIRATORY SVC					
2 - Inhalation Services						INHALATION SVC					
3 - Hyperbaric Oxygen Therapy						HYPERBARIC O2					
9 - Other Respiratory Services						OTHER RESPIR SVS					
<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
#Treatments			x	V			x		OP		

042X Physical Therapy

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

<u>Subcategory</u>						<u>Standard Abbreviation</u>					
0 - General Classification						PHYSICAL THERP					
1 - Visit Charge						PHYS THERP/VISIT					
2 - Hourly Charge						PHYS THERP/HOUR					
3 - Group Rate						PHYS THERP/GROUP					
4 - Evaluation or Re-evaluation						PHYS THERP/EVAL					
9 - Other Physical Therapy						OTHER PHYS THERP					
<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
#Treatments			OP	V			x	x	OP		

043X Occupational Therapy

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy	OTHER OCCUP THER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Treatments OP V	x x OP

044X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Treatments OP V	x x OP

045X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale:

Permits identification of particular items for payers. Under the provisions of EMTALA (the Emergency Medical Treatment and Active Labor Act) a hospital with an emergency department must provide upon request and within the capabilities of the hospital, an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985).

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	EMERG ROOM
1 - EMTALA Emergency Medical Screening Services	ER/EMTALA
2 - ER Beyond EMTALA Screening	ER/BEYOND EMTALA
6 - Urgent Care	URGENT CARE
9 - Other Emergency Room	OTHER EMER ROOM

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Visits OP OP	x

Usage Notes:

1. FL 76 - Patient's Reason for Visit should be reported in conjunction with 45X.
2. An "X" in the matrix below indicates an acceptable coding combination.

	450 (a)	451 (b)	452 (c)	456	459
450					
451			X	X	X
452		X			
456		X			X
459		X		X	

- (a) General Classification code 450 should not be used in conjunction with any subcategory. The sum of 451 and 452 is equivalent to 450. Payers that do not require a breakdown should roll-up 451 and 452 into 450.
- (b) Stand alone usage of 451 is acceptable when no services beyond an initial screening/assessment are rendered.
- (c) Stand alone usage of 452 is not acceptable.

EFFECTIVE: APRIL 1, 1996
11/8/95

FORM LOCATOR 42

046X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory

0 - General Classification
9 - Other Pulmonary Function

Standard Abbreviation

PULMONARY FUNC
OTHER PULMON FUNC

Units Required

Units By: C H M B D*
Tests OP

4 - Digit Detail Required

C H M B D
x

047X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

<u>Subcategory</u>						<u>Standard Abbreviation</u>					
0 - General Classification						AUDIOLOGY					
1 - Diagnostic						AUDIOLOGY/DX					
2 - Treatment						AUDIOLOGY/RX					
9 - Other Audiology						OTHER AUDIOL					
<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Tests				OP			x		471		OP

048X Cardiology

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

<u>Subcategory</u>						<u>Standard Abbreviation</u>					
0 - General Classification						CARDIOLOGY					
1 - Cardiac Cath Lab						CARDIAC CATH LAB					
2 - Stress Test						STRESS TEST					
3 - Echocardiology						ECHOCARDIOLOGY					
9 - Other Cardiology						OTHER CARDIOL					
<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Tests				OP			x		481		482
(b)									OP		

049X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by other categories.

Subcategory

0 - General Classification
9 - Other Ambulatory Surgical
Care

Standard Abbreviation

AMBUL SURG
OTHER AMBL SURG

Units Required

Units By: C H M B D*

4 - Digit Detail Required

C H M B D
x

050X Outpatient Services

Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. (Note: This revenue code is no longer required by Medicare.)

Subcategory

0 - General Classification
9 - Other Outpatient Service

Standard Abbreviation

OUTPATIENT SVS
OUTPATIENT/OTHER

Units Required

Units By: C H M B D*

4 - Digit Detail Required

C H M B D
x

051X Clinic

Clinic (non-emergency outpatient visit) charges for providing diagnostic, preventive curative, rehabilitative, and education services to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	CLINIC
1 - Chronic Pain Center	CHRONIC PAIN CL
2 - Dental Clinic	DENTAL CLINIC
3 - Psychiatric Clinic	PSYCH CLINIC
4 - OB-GYN Clinic	OB-GYN CLINIC
5 - Pediatric Clinic	PEDS CLINIC
6 - Urgent Care Clinic*	URGENT CLINIC
7 - Family Practice Clinic	FAMILY CLINIC
9 - Other Clinic	OTHER CLINIC

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Visits		OP	OP	OP			x	x			

*Usage Note:
FL 76 - Patient's Reason for Visit should be reported in conjunction with 516.

052X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require due to physical location or licensure.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic	RURAL/CLINIC
2 - Rural Health-Home	RURAL/HOME
3 - Family Practice Clinic	FR/STD FAMILY CLINIC
6 - Urgent Care Clinic*	FR/STD URGENT CLINIC
9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Visits		OP	OP	OP			x	x			

*Usage Note:
FL 76 - Patient's Reason for Visit should be reported in conjunction with 526.

EFFECTIVE: APRIL 1, 1990
10/3/89

FORM LOCATOR 42

053X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Rationale: There is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.

Subcategory

0 - General Classification
1 - Osteopathic Therapy
9 - Other Osteopathic Services

Standard Abbreviation

OSTEOPATH SVS
OSTEOPATH RX
OTHER OSTEOPATH

Units Required

Units By: C H M B D*
Visits OP OP OP

4 - Digit Detail Required

C H M B D
x

054X Ambulance

Charges for ambulance service, usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specifically designed ambulance transport for cardiac patients.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	AMBULANCE
1 - Supplies	AMBUL/SUPPLY
2 - Medical Transport	AMBUL/MED TRANS
3 - Heart Mobile	AMBUL/HEARTMOBL
4 - Oxygen	AMBUL/OXY
5 - Air Ambulance	AIR AMBULANCE
6 - Neonatal Ambulance Services	AMBUL/NEONAT
7 - Pharmacy	AMBUL/PHARMACY
8 - Telephone Transmission EKG	AMBUL/TELEPHONIC EKG
9 - Other Ambulance	OTHER AMBULANCE

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Miles		x	x	x			x	x			

055X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services, CORFS, or a service charge for home health billing.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Visits		IP	IP	HH			x	x			

056X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times are required by hospital.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERVS/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Social Service	MED SOC SERV/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Visits HH HH x	x

057X Home Health - Home Health Aide

Charges made by a home health agency for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	AID/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Visits HH HH x	x

058X Home Health - Other Visits

Charges by a home health agency for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: Necessary for Medicare home health billing requirements.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
3 - Assessment	VISIT/HOME HLTH/ASSESS
9 - Other Home Health Visit	VISIT/HOME HLTH/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Visits			HH	HH		x					x

059X Home Health - Units of Service

Revenue code used by a home health agency that bills on the basis of units of service.

Rationale: Necessary for Medicare home health billing requirements.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Visits			HH	HH		x					x

060X Home Health - Oxygen

Charges by a home health agency for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary has purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply. DME (other than oxygen systems) is billed under current revenue codes 291, 292 or 293.

Rationale: Medicare requires detailed revenue coding; therefore, codes for this series may not be summed at the zero level.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	O2/HOME HEALTH
1 - Oxygen - State/Equip/Suppl/or Cont	O2/STAT EQUIP/SUPPL/CONT
2 - Oxygen - State/Equip/Suppl/ Under 1 LPM	O2/STAT EQUIP/UNDER 1 LPM
3 - Oxygen - State/Equip/Over 4 LPM	O2/STAT EQUIP/OVER 4 LPM
4 - Oxygen - Portable Add-on	O2/PORTABLE ADD-ON
9 - Other Oxygen	O2 - OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Rental months HH	x 601
# Ft/lbs (601)	HH

061X Magnetic Resonance Technology (MRT)

Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body.

Rationale: Due to coverage limitations some third party payers require that the specific test be identified.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	MRT
1 - MRI - Brain (Including Brainstem)	MRI - BRAIN
2 - MRI - Spinal Cord (Including Spine)	MRI - SPINE
3 - RESERVED	
4 - MRI - Other	MRI - OTHER
5 - MRA - Head and Neck	MRA - HEAD AND NECK
6 - MRA - Lower Extremities	MRA - LOWER EXT
7 - RESERVED	
8 - MRA - Other	MRA - OTHER
9 - Other MRT	MRT - OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Tests OP	x

062X Medical/Surgical Supplies - Extension of 027X

Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
1 - Supplies Incident to Radiology	MED-SUR SUPP/INCDNT RAD
2 - Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/INCDNT ODX
3 - Surgical Dressings	SURG DRESSING
4 - FDA Investigational Devices	FDA INVEST DEVICE
<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Days	x OP

063X Pharmacy-Extension of 025X

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist. The category is an extension of 25X for reporting additional breakdown where needed.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - RESERVED (Effective 1/1/98)	
1 - Single Source Drug	DRUG/SNGLE
2 - Multiple Source Drug	DRUG/MULT
3 - Restrictive Prescription	DRUG/RSTR
4 - Erythropoietin (EPO) Less Than 10,000 Units	DRUG/EPO≤10,000 Units
5 - Erythropoietin (EPO) 10,000 or More Units	DRUG/EPO≥10,000 Units
6 - Drugs Requiring Detailed Coding (a)	DRUGS/DETAIL CODE
7 - Self-administrable Drugs (b)	DRUGS/SELF ADMIN
<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units: By: C H M B D*	C H M B D
# Units	x

Usage Notes

(a) Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in Form Locator 44. The specified units of service to be reported should be in hundreds (100s), rounded to the nearest hundred (no decimal).

(b) Charges for self-administrable drugs not requiring detailed coding. Use Value Codes A4, A5 and A6 to indicate the dollar amount included in covered charges for self-administrable drugs. Amounts for non-covered self-administrable drugs should be charged using Revenue Code 637 in the non-covered column. **(Effective 10/1/97)**

064X Home IV Therapy Services

Charge for intravenous drug therapy services which are performed in the patient's residence. For Home IV providers the HCPCS code must be entered for all equipment, and all types of covered therapy.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	IV THERAPY SVC
1 - Nonroutine Nursing, Central Line	NON RT NURSING/CENTRAL
2 - IV Site Care, Central Line (See note)	IV SITE CARE/CENTRAL
3 - IV Start/Change, Peripheral Line	IV STRT/ CHNG/PERIPHAL
4 - Nonroutine Nursing, Peripheral Line	NONRT NURSING/PERIPHRL
5 - Training Patient/Caregiver, Central Line	TRNG PT/CAREGVR/CENTRL
6 - Training, Disabled Patient, Central Line	TRNG DSBLPT/CENTRAL
7 - Training, Patient/ Caregiver, Peripheral Line	TRNG/PT/CARGVR/PERIPHRL
8 - Training, Disabled Patient, Peripheral Line	TRNG/DSBLPAT/PERIPHRL
9 - Other IV Therapy Services	OTHER IV THERAPY SVC

Note: Units need to be reported in one hour increments. Revenue code 642 relates to the HCPCS code.

<u>Units Required</u>		<u>4 - Digit Detail Required</u>
Units By: C H M B D*		C H M B D
# Units OP		
(Home IV - see note)		

EFFECTIVE:
10/2/02

FORM LOCATOR 42

065X Hospice Service

Charges for hospice care services for a terminally ill patient if he elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care	HOSPICE/CTNS HOME
3 - RESERVED	
4 - RESERVED	
5 - Inpatient Respite Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (Non-respite)	HOSPICE/IP NON-RESPITE
7 - Physician Services	HOSPICE/PHYSICIAN
8 - Hospice Room & Board - Nursing Facility	HOSPICE/R&B/NURS FAC
9 - Other Hospice Service	HOSPICE/OTHER

Note: To receive the Continuous Home Care rate from Medicare under code 652, a minimum of 8 hours of care, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is reported under code 651. A portion of an hour counts as an hour for this determination.

Billing to Medicare under code 657 must be accompanied by a physician procedure code, which must be entered in Form Locator 44. This code is used by the hospice to bill for charges for physician services furnished to hospice patients by a physician employed by the hospice or receiving compensation from the hospice for services rendered.

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
# Days			x				x	x	x		

066X Respite Care

Charges for non-hospice respite care.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	RESPITE CARE
1 - Hourly Charge/Nursing	RESPITE/NURSE
2 - Hourly Charge/Aide/Homemaker/ Companion	RESPITE/AIDE/HMEMKR/COMP
3 - Daily Respite Charge	RESPITE DAILY
9 - Other Respite Care	RESPITE OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Hours HH	

067X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	OP SPEC RES
1 - Hospital Based	OP SPEC RES/HOSP BASED
2 - Contracted	OP SPEC RES/CONTRACTED
9 - Other Special Residence Charge	OP SPEC RES/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D

068X Trauma Response

Charges for a trauma team activation.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - Not Used	
1 - Level I	TRAUMA LEVEL I
2 - Level II	TRAUMA LEVEL II
3 - Level III	TRAUMA LEVEL III
4 - Level IV	TRAUMA LEVEL IV
9 - Other Trauma Response	TRAUMA OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D

Usage Notes:

1. To be used by trauma center/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
2. Revenue Category 068X is used for patients for whom a trauma activation occurred. A trauma team activation/response is a “ Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient’s arrival.”
3. Revenue Category 068X is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045X and 068X revenue code reported.
4. Revenue Category 068X is not limited to admitted patients.
5. Revenue Category 068X must be used in conjunction with FL19 Type of Admission/Visit code 05 (“Trauma Center”), however FL 19 Code 05 can be used alone.

Only patients for whom there has been **pre-hospital** notification, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are “drive-by” or arrive without notification cannot be charged for activations, but can be classified as trauma under Type of Admission Code 5 for statistical and follow-up purposes.

6. Levels I, II, III, or IV refer to designations by the state or local government authority or as verified by the American College of Surgeons.
7. Subcategory 9 is for states or local authorities with levels beyond IV.

069X Not Assigned

070X Cast Room

Charges for services related to the application, maintenance and removal of casts.

Rationale: Permits identification of this service if necessary.

Subcategory

0 - General Classification
9 - Other Cast Room

Standard Abbreviation

CAST ROOM
OTHER CAST ROOM

Units Required

Units By: C H M B D*

4 - Digit Detail Required

C H M B D
x

071X Recovery Room

Rationale: Permits identification of particular services as necessary.

Subcategory

0 - General Classification
9 - Other Recovery Room

Standard Abbreviation

RECOVERY ROOM
OTHER RECOV RM

Units Required

Units By: C H M B D*

4 - Digit Detail Required

C H M B D
x

072X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because it is not covered by all third party payers.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	DELIVERROOM/LABOR
1 - Labor	LABOR
2 - Delivery	DELIVERY ROOM
3 - Circumcision	CIRCUMCISION
4 - Birthing Center	BIRTHING CENTER
9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

<u>Units Required</u>						<u>4 - Digit Detail Required</u>
Units By:	C	H	M	B	D*	C H M B D
# Days (724)		x	x			x 723 x x x

073X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for diagnosis of heart ailments.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

<u>Units Required</u>						<u>4 - Digit Detail Required</u>
Units By:	C	H	M	B	D*	C H M B D
# Tests			OP			OP 732 OP

074X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory

0 - General Classification
9 - Other EEG

Standard Abbreviation

EEG
OTHER EEG

Units Required

Units By: C H M B D*
#Tests OP

4 - Digit Detail Required

C H M B D
x

075X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in the operating room.

Subcategory

0 - General Classification
9 - Other Gastro-Intestinal

Standard Abbreviation

GASTR-INST SVS
OTHER GASTRO-INTS

Units Required

Units By: C H M B D*
#Tests OP

4 - Digit Detail Required

C H M B D
x

076X Treatment/Observation Room

Charges for the use of a treatment room; or for the room charge associated with outpatient observation services.

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be stated in the orders for observation. Payers should establish written guidelines which identify coverage of observation services.

Subcategory

0 - General Classification
1 - Treatment Room
2 - Observation Room
9 - Other Treatment/Observation Room

Standard Abbreviation

TREATMENT/OBSERVATION RM
TREATMENT RM
OBSERVATION RM
OTHER TREAT/OBSERV RM

Units Required

Units By: C H M B D*

4 - Digit Detail Required

C H M B D
x

077X Preventive Care Services

Revenue Code used to capture preventive care services established by payers.

Subcategory

0 - General Classification
1 - Vaccine Administration
9 - Other Preventive Care Services

Standard Abbreviation

PREVENT CARE SVS
VACCINE ADMIN
OTHER PREVENT

Units Required

Units By: C H M B D*
x

4 - Digit Detail Required

C H M B D
x

078X Telemedicine

Reserved for facility telemedicine charges related to a three year Medicare demonstration project commencing October 1, 1996.

<u>Subcategory</u>		<u>Standard Abbreviation</u>
0 - General Classification		TELEMEDICINE
9 - Other Telemedicine		TELEMEDICINE/OTHER
<u>Units Required</u>		<u>4 - Digit Detail Required</u>
Units By: C H M B D*		C H M B D

079X Lithotripsy

Charges for the use of lithotripsy in the treatment of kidney stones.

<u>Subcategory</u>		<u>Standard Abbreviation</u>
0 - General Classification		LITHOTRIPSY
9 - Other Lithotripsy		LITHOTRIPSY/OTHER
<u>Units Required</u>		<u>4 - Digit Detail Required</u>
Units By: C H M B D*		C H M B D
		x

080X Inpatient Renal Dialysis

A waste removal process performed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9 - Other Inpatient Dialysis	DIALY/INPT/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
#Sessions		x	x	x			x	x			

081X Acquisition of Body Components

The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.

Note: To reference the specific organ(s) used in the transplantation procedure, see the specific ICD-9-CM codes.

Rationale: Living donor is a living person from whom an organ may be collected and used for transplantation purposes. Cadaver is an individual, who has been pronounced dead according to medical and legal criteria, and whose organs may be harvested for transplantation. Use the unknown subcategory whenever the status of the individual source of the organ cannot be determined. The other category should be used whenever the organ is non-human.

Medicare requires detailed revenue coding; therefore, codes for this series may not be summed at the zero level.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ORGAN ACQUISIT
1 - Living Donor	LIVING DONOR
2 - Cadaver Donor	CADAVER DONOR
3 - Unknown donor	UNKNOWN DONOR
4 - Unsuccessful Organ Search - Donor Bank Charges*	UNSUCCESSFUL SEARCH
9 - Other Donor	OTHER DONOR

*Note: Revenue code 0814 is to be used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation.

<u>Units Required</u>						<u>4 - Digit Detail Required</u>
Units By:	C	H	M	B	D*	C H M B D
	x	x	x			x x x

082X Hemodialysis - Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidney's have failed. Waste is removed directly from the blood.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	HEMO/OP OR HOME
1 - Hemodialysis/Composite or Other Rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance/100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Outpatient Hemodialysis	HEMO/HOME/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Sessions OP x	x x x

083X Peritoneal Dialysis - Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or Other Rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance/100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 - Other Outpatient Peritoneal Dialysis	PERTNL/HOME/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Sessions OP x	x x x

084X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting which uses the patient peritoneal membrane as a dialyzer.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or Other Rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 - Other Outpatient CAPD	CAPD/HOME/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Days OP x	x x x

085X Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting which uses a machine to make automatic exchanges at night.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or Other Rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 - Other Outpatient CCPD	CCPD/HOME/OTHER

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
# Days OP x	x x x

EFFECTIVE: AUGUST 10, 1983
8/10/83

FORM LOCATOR 42

086X Reserved for Dialysis (National Assignment)

087X Reserved for Dialysis (National Assignment)

088X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory

- 0 - General Classification
- 1 - Ultrafiltration
- 2 - Home Dialysis Aid Visit
- 9 - Other Miscellaneous Dialysis

Standard Abbreviation

- DIALY/MISC
- DIALY/ULTRAFILT
- HOME DIALYSIS AID VISIT
- DIALY/MISC/OTHER

Units Required

Units By: C H M B D*
#Sessions OP

4 - Digit Detail Required

C H M B D
x x x

089X Reserved for National Assignment

EFFECTIVE: APRIL 1, 1994
11/10/93

FORM LOCATOR 42

090X Psychiatric/Psychological Treatments

Subcategory

- 0 - General Classification
- 1 - Electroshock Treatment
- 2 - Milieu Therapy
- 3 - Play Therapy
- 4 - Activity Therapy
- 9 - Other Psychiatric/Psychological Treatment

Standard Abbreviation

- PSYCH TREATMENT
- ELECTRO SHOCK
- MILIEU THERAPY
- PLAY THERAPY
- ACTIVITY THERAPY
- OTHER PSYCH RX

Units Required

Units	By:	C	H	M	B	D*
# Visits		x	x			

4 - Digit Detail Required

C	H	M	B	D
x	x			

091X Psychiatric/Psychological Services

Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

Subcategories 912 and 913 are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	PSYCH SERVICES
1 - Rehabilitation	PSYCH/REHAB
2 - Partial Hospitalization - Less Intensive	PSYCH/PARTIAL HOSP
3 - Partial Hospitalization - Intensive	PSYCH/PARTIAL INTENSIVE
4 - Individual Therapy	PSYCH/INDIV RX
5 - Group Therapy	PSYCH/GROUP RX
6 - Family Therapy	PSYCH/FAMILY RX
7 - Bio Feedback	PSYCH/BIOFEED
8 - Testing	PSYCH/TESTING
9 - Other Psychiatric/Psychological Service	PSYCH/OTHER

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
Visits		x	x	V			x	x			

092X Other Diagnostic Services

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	OTHER DX SVS
1 - Peripheral Vascular Lab	PERI VASCUL LAB
2 - Electromyelogram	EMG
3 - Pap Smear	PAP SMEAR
4 - Allergy Test	ALLERGY TEST
5 - Pregnancy Test	PREG TEST
9 - Other Diagnostic Service	ADDITIONAL DX SVS

<u>Units Required</u>						<u>4 - Digit Detail Required</u>					
Units	By:	C	H	M	B	D*	C	H	M	B	D
Tests		x	x	OP			x	x	921		
									922		
									OP		

093X Medical Rehabilitation Day Program

Medical rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy and speech therapy.

The subcategories of 93X are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported for in FL47 and the number of hours provided would be reported in FL46. The specific rehabilitation services would be reported under the applicable therapy revenue codes as normal.

<u>Subcategory</u>		<u>Standard Abbreviation</u>
1 - Half Day		HALF DAY
2 - Full Day		FULL DAY
<u>Units Required</u>		<u>4 - Digit Detail Required</u>
Units By: C H M B D*		C H M B D
Hours		

094X Other Therapeutic Services (Also see 095X, an extension of 094X)

Charges for other therapeutic services not otherwise categorized.

<u>Subcategory</u>		<u>Standard Abbreviation</u>
0 - General Classification		OTHER RX SVS
1 - Recreational Therapy		RECREATION RX
2 - Education/Training		EDUC/TRAINING
3 - Cardiac Rehabilitation		CARDIAC REHAB
4 - Drug Rehabilitation		DRUG REHAB
5 - Alcohol Rehabilitation		ALCOHOL REHAB
6 - Complex Medical Equipment - Routine		CMPLX MED EQUIP-ROUT
7 - Complex Medical Equipment - Ancillary		CMPLX MED EQUIP-ANC
9 - Other Therapeutic Service		ADDITIONAL RX SVS
<u>Units Required</u>		<u>4 - Digit Detail Required</u>
Units By: C H M B D*		C H M B D
Visits	x x 943 x	x OP
	V	

095X Other Therapeutic Services-Extension of 094X

Charges for other therapeutic services not otherwise categorized.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - RESERVED	
1 - Athletic Training	ATHLETIC TRAINING
2 - Kinesiotherapy	KINESIOTHERAPY
<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D

096X Professional Fees (also see 097X and 098X)

Charges for medical professionals that the hospitals or third party payers require to be separately identified on the billing form.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSYCH
2 - Ophthalmology	PRO FEE/EYE
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 - Other Professional Fee	OTHER PRO FEE
<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x x

097X Professionals Fees (Extension of 096X)

<u>Subcategory</u>	<u>Standard Abbreviation</u>
1 - Laboratory	PRO FEE/LAB
2 - Radiology - Diagnostic	PRO FEE/RAD/DX
3 - Radiology - Therapeutic	PRO FEE/RAD/RX
4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
5 - Operating Room	PRO FEE/OR
6 - Respiratory Therapy	PRO FEE/RESPIR
7 - Physical Therapy	PRO FEE/PHYSI
8 - Occupational Therapy	PRO FEE/OCCUPA
9 - Speech Pathology	PRO FEE/SPEECH

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x x

098X Professional Fees (Extension of 096X and 097X)

<u>Subcategory</u>	<u>Standard Abbreviation</u>
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x x

099X Patient Convenience Items

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Item	PT CONVENIENCE/OTH

<u>Units Required</u>	<u>4 - Digit Detail Required</u>
Units By: C H M B D*	C H M B D
	x x

100X to 209X Reserved for National Assignment

210X Alternative Therapy Services

Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042X, 043X, 044X, 091X, 094X, 095X) or services such as anesthesia or clinic (0374, 0511).

Alternative therapy is intended to enhance and improve standard medical treatment. The following revenue code(s) would be used to report services in a separately designated alternative inpatient/outpatient unit.

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - General Classification	ALTOTHERAPY
1 - Acupuncture	ACUPUNCTURE
2 - Acupressure	ACUPRESSURE
3 - Massage	MASSAGE
4 - Reflexology	REFLEXOLOGY
5 - Biofeedback	BIOFEEDBACK
6 - Hypnosis	HYPNOSIS
9 - Other Alternative Therapy Services	OTHER ALTOTHERAPY

211X to 309X Reserved for National Assignment

EFFECTIVE: APRIL 1, 2003
5/9/02

FORM LOCATOR 42

310X Adult Care

Charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADLs).

<u>Subcategory</u>	<u>Standard Abbreviation</u>
0 - Not Used	
1 - Adult Day Care, Medical and Social - Hourly	ADULT MED/SOC HR
2 - Adult Day Care, Social - Hourly	ADULT SOC HR
3 - Adult Day Care, Medical and Social - Daily	ADULT MED/SOC DAY
4 - Adult Day Care, Social - Daily	ADULT SOC DAY
5 - Adult Foster Care - Daily	ADULT FOSTER DAY
9 - Other Adult Care	OTHER ADULT

311X to 999X Reserved for National Assignment

DATA ELEMENT: Revenue Description

Definition: A narrative description of the related revenue categories included on this bill. Abbreviations may be used.

Procedures:	MEDICARE	Not Required
	MEDICAID	The State Medicaid agency will provide instructions for completion.
	BLUE CROSS	Required
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
23 lines
24 positions
alphanumeric
left-justified

Note: The description and abbreviations should correspond with the revenue codes as defined by the National Uniform Billing Committee.

DATA ELEMENT: HCPCS/Rates/HIPPS Rate Codes

Definition: The accommodation rate for inpatient bills and the HCFA Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient bills. The HIPPS rate code consists of the RUG-III code which is obtained from the MDS Grouper and a two digit modifier to indicate the assessment type attributable to the RUG-III code. (See Form Locator 44 Appendix).

Procedures:

MEDICARE	As required by HIM 10 (See Outpatient note below)
MEDICAID	The state medicaid agency will provide instructions for completion.
BLUE CROSS	Required
COMMERCIAL	Required
CHAMPUS	Required

Field Attributes: 1 field
23 lines
9 positions
numeric (for rates), alphanumeric (for HCPCS)
right-justified (for rates), left-justified (for HCPCS)

Note: **Inpatient Bills**
Accommodations must be entered in revenue code sequence. Dollar values reported in this field must include whole dollars, the decimal, and the cents (NNNNNN.NN).

When multiple rates exist for the same accommodation revenue code (e.g., semi-private room at \$300 and \$310), a separate revenue line should be used to report each rate, and the same revenue code should be reported on each line.

Outpatient Bills
For Medicare, HCPCS codes are almost always required for outpatient bills. (See HIM 10.) For other payers, HCPCS codes may be required for outpatient bills. (See payer manuals.) For CHAMPUS, CPT-4 codes are always required for outpatient bills. Certain approved CHAMPUS providers engaged in special programs are required to provide CHAMPUS-approved Special Purpose Procedural Codes for outpatient bills (a list of these codes is available from CHAMPUS claims processors).

HIPPS Rate Codes

TABLE 1

HIPPS RATE CODES

The HIPPS rate code consists of the RUG-III code which is obtained from the MDS Grouper and a two digit modifier (See Table 2) to indicate the assessment type attributable to the RUG-III code. Both components of the HIPPS rate code must be present for a claim to be paid. There are a total of 45 HIPPS rate codes and a total of 21 modifiers.

AAA (the default code)
BA1, BA2, BB1, BB2
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
RHA, RHB, RHC, RLA, RLB, RMA, RMB, RMC, RUA, RUB, RUC, RVA, RVB, RVC
SE1, SE2, SE3, SSA, SSB, SSC

TABLE 2

HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

The HIPPS modifiers were developed by using the codes contained in Section AA8 in the current version of the Resident Assessment Instrument, Minimum Data Set (MDS) by combining a code from section AA8a. and AA8b., in order to ease the burden of reporting such information for purposes of Medicare reimbursement.

No Assessment Completed	(00)
Admission Assessment - Medicare 5 Day Assessment (Comprehensive)	(11)
Medicare 5 Day Assessment (Full)	(01)
Medicare 14 Day Assessment (Full or Comprehensive)	(07)
Medicare 30 Day Assessment (Full)	(02)
Medicare 60 Day Assessment (Full)	(03)
Medicare 90 Day Assessment (Full)	(04)
Quarterly Review Assessment - Medicare 90 Day Assessment (Full) (54)	
¹ Significant Change in Status Assessment (SCSA)	(38)
² Other Medicare Required Assessment (OMRA)	(08)
³ Significant Correction of Prior Full Assessment/Medicare 5 Day Assessment	(41)
Significant Correction of Prior Full Assessment/Medicare 14 Day Assessment	(47)
Significant Correction of Prior Full Assessment/Medicare 30 Day Assessment	(42)
Significant Correction of Prior Full Assessment/Medicare 60 Day Assessment	(43)
Significant Correction of Prior Full Assessment/Medicare 90 Day Assessment	(44)
Significant Correction of Prior Full Assessment/OMRA or SCSA	(48)
⁴ SCSA or OMRA /Medicare 5 Day Assessment (Replacement)	(31)
SCSA or OMRA/Medicare 14 Day Assessment (Replacement)	(37)
SCSA or OMRA/Medicare 30 Day Assessment (Replacement)	(32)

HIPPS Rate Codes

SCSA or OMRA/Medicare 60 Day Assessment (Replacement) (33)
SCSA or OMRA/Medicare 90 Day Assessment (Replacement) (34)

1. A Significant Change in Status Assessment is completed when triggered by the guidelines on pages 2-8 through 2-11 in the current version of the Resident Assessment Instrument, Minimum Data Set, Version 2.0.
2. An Other Medicare Required Assessment is completed only when a beneficiary discontinues all occupational, physical, and/or speech therapy.
3. A Significant Correction Of Prior Full Assessment (i.e, the Medicare Required Assessment, an OMRA replacement or an SCSA replacement) is completed when the SNF identifies that it 1) made a factual error in Section(s) A, AA, AB, AC or AD of the MDS for a claim that has already been submitted for payment; or 2) submitted an incorrect HIPPS rate code based on an MDS that was either inaccurate or incomplete for a claim that has already been submitted for payment, within 30 days of the assessment reference date. This is not an adjustment bill, payment is not adjusted retroactively. If a different HIPPS rate code is identified, payment is made for up to the number of days (units of service) between the SNF significant correction assessment reference date and the next Medicare required assessment or other off-cycle assessment, whichever comes first.
4. When a Significant Change in Status or Other Medicare Required Assessment is performed during the assessment window of a Medicare required assessment (i.e., 5 day, 14 day, 30 day, 60 day or 90 day) it takes the places of (i.e., replaces) the 5 day, 14 day, 30 day, 60 day, or 90 day Medicare Required Assessment.

HCPCS Modifiers

TABLE 1

Level I - HCPCS Modifiers

Various CPT and HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report the following list of modifiers:

25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. The circumstance may be reported by adding the modifier 25 to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.
50	Bilateral Procedure	Report bilateral procedures performed at the same operative session. Indicate the appropriate five-digit procedure code and add modifier 50 to the procedure code to identify that a second bilateral procedure. The hospital should not submit two lines of items (HCPCS procedure code) to report the bilateral procedure. To report modifier 50 add this to the procedure code on the same line item (xxxxx50) (note x represents the appropriate five digit procedure code).

Note: Do not use Modifier 50 for the following situations:

- 1.) Surgical procedures identified by their terminology as bilateral (e.g., 27395 Lengthening of hamstring tendon, multiple, bilateral).
- 2.) Surgical procedure identified as unilateral or bilateral (e.g., 52290 Cystourethroscopy, with meatotomy, unilateral or bilateral)

- 52 Reduced Services Use to identify the service or procedure partially reduced or eliminated at the physician's election. If a surgical procedure is terminated after the patient has been prepared for the surgery (including sedation when provided) and taken to the room where the procedure is to be performed, but before the induction of anesthesia (e.g., local regional, block(s), or general anesthesia), hospitals add modifier 52 to the intended procedure code (single line item). Do not confuse this modifier with modifier 53 for reporting surgical procedures terminated after anesthesia has been induced.
- 53 Discontinued Procedure Use to indicate that a physician elected to terminate a surgical (diagnostic or therapeutic) procedure. The procedure was started but discontinued after the induction of anesthesia (e.g., local, regional block(s), or general anesthesia), or after the procedure was started (incision made, intubation started, scope inserted). Note: this modifier should not be used to report the elective cancellation of a procedure.
- 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure, or the separate five digit modifier 09958 may be used. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

- 59 Distinct Procedural Service Use to identify procedures/services that are not normally reported together, but may be performed under certain circumstances. For instance, this may include a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. Use this modifier to indicate that the procedure or service was distinct or independent from other services performed on the same day.

Example:

Procedures 23030 (incision and drainage, shoulder area; deep abscess or hematoma) and 20103 (exploration of penetrating wound (separate procedure); extremity) are performed on the same patient on the same date of service. If these two codes are billed together without the modifier – 59, then code 20103 would be denied as duplicate billing. (Since the incision and drainage of the shoulder (code 23030) is the definitive procedure, any exploration procedure (code 20103) was conducted on a different part of the same limb, or on a different limb, adding the modifier – 59 to either procedure code 20103, or, code 23030 would explain the circumstance and prevent denial of the service.

- 76 Repeat Procedure by Same Physician Use to indicate that a procedure or service was repeated in a separate operative session on the same day. Report the procedure code once and then follow with the procedure code and modifier – 76. Generally, the number of times the procedure was repeated should be indicated in the units field (FL 46). There are certain exceptions for some types of ASC procedures as indicated in the following exception below.

Exceptions: For certain ASC procedures performed more than once on the same day, hospitals should not use the units field. Instead, hospitals should report the HCPCS procedure code without modifier 76, and then list each repeated procedure code along with modifier 76.

- 77 Repeat Procedure by Another Physician Use to indicate that a basic procedure performed by another physician had to be repeated in a separate operative session on the same day. Report the first procedure code and then on another line report the repeated procedure with modifier –77. If the procedure is repeated more than twice report the number of times it was reported in the units field. There is also an exception for ASC procedures (similar to the exception example above). In this case the modifier 77 will be used instead of 76.

- | | | |
|----|--|--|
| 78 | Return to the Operating Room for a Related Procedure During the Postoperative Period | The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure, or by using the separate five digit modifier 09978. (For repeat procedures on the same day, see modifier 76.) |
| 79 | Unrelated Procedure of Service by the Same Physician During the Postoperative Period | The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79 or by using the separated five digit modifier 09979. (For repeat procedures on the same day, see modifier 76.) |

TABLE 2

Level II – HCPCS Modifiers

There are a series of specific modifiers for certain Level II HCPCS procedure/service codes. Generally, procedures performed on eyelids, fingers, toes, or specific sides of the body require differentiation of the anatomical site or sides of the body.

Eyelids:

- E1 Upper left eyelid
- E2 Lower left eyelid
- E3 Upper right eyelid
- E4 Lower right eyelid

Hands:

- FA Left hand, thumb
- F1 Left hand, second digit
- F2 Left hand, third digit
- F3 Left hand, fourth digit
- F4 Left hand, fifth digit

- F5 Right hand, thumb
- F6 Right hand, second digit
- F7 Right hand, third digit
- F8 Right hand, fourth digit
- F9 Right hand, fifth digit

Feet:

- TA Left Foot, great toe
- T1 Left Foot, second digit
- T2 Left Foot, third digit
- T3 Left Foot, fourth digit
- T4 Left Foot, fifth digit

T5	Right Foot, great toe
T6	Right Foot, second digit
T7	Right Foot, third digit
T8	Right Foot, fourth digit
T9	Right Foot, fifth digit

TABLE 3

Modifiers for Use with Procedure Codes 92980-92982, 92995, and, 92996

LC	Left Circumflex coronary artery
LD	Left Anterior descending coronary artery
RC	Right coronary artery

TABLE 4

Modifiers for Use with Side of the Body Procedures

LT	Left side of the body procedure
RT	Right side of the body procedure

Note: Do not use modifiers LT and RT to report Bilateral surgical procedures (use modifier 50 for reporting Bilateral procedures).

TABLE 5

Ambulance Service

QM	Ambulance Service provided under arrangement by a provider of services
QN	Ambulance Service furnished directly by a provider of services

TABLE 6

Modifiers for ESRD Billing for Adequacy of Hemodialysis

ESRD facilities should report information about the range of urea reduction ratio (URR) values through the use of a “G” modifier attached to the CPT code 90999 in Form Locator 44 of the UB-92. The CPT code and modifier are required for dialysis reported through UB-92 revenue codes 820,821, and 829.

- G1 Most recent URR of less than 60%
- G2 Most recent URR of 60% to 64%
- G3 Most recent URR of 65% to 69.9%
- G4 Most recent URR of 70% to 74.9%
- G5 Most recent URR of 75% or greater

TABLE 7

Laboratory Tests

Some laboratory tests are provided based on physician orders as individual tests or as CPT-recognized panels. The QP modifier cannot be used with automated profile codes 80002-80019, G0058, G0059, and G0060, unless the laboratory has documentation showing that the component tests included under those codes were ordered individually by the physician. In this case, the laboratory bundles the tests into the correct CPT code (i.e., CPT 80002-80019, G0058-G0060) for billing purposes and may report the QP modifier with the automated profile code.

- QP Documentation exists showing that the laboratory test(s) was ordered invidually, or as CPT-recognized panel other than profile codes 80002-800019, G0058,G0059, and G0060.

TABLE 8

Outpatient Rehabilitation Modifiers

Providers are required to report one of the following modifiers to distinguish the type of therapist who performed the outpatient rehabilitation service (not the payment designation) or, if the service was not delivered by a therapist, then the discipline of the Plan of Treatment/Care under which the service is delivered should be reported:

- GN Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology Plan of Care.

GO Service delivered personally by an occupational therapist or under an outpatient occupational therapy Plan of Care.

GP Service delivered personally by a physical therapist or under an outpatient physical therapy Plan of Care.

TABLE 9

Modifier Examples.

-- XXXXX represents the five-digit CPT-4 code

Example Number	Right side?	Left side?	Same operative session?	Same doctor?	Repeat procedure same day?	Code	Service units
1	Y					XXXXXRT	1
2		Y				XXXXXLT	1
3	Y	Y	Y			XXXXX50	1
4	Y	Y	N			XXXXXRT XXXXXLT	1 1
5	Y	Y	Y	Y	Y, right side* only	XXXXX50 XXXXXRT76	1 1
6	Y	Y	Y	N	Y, right side* only	XXXXX50 XXXXXRT77	1 1
7	Y			Y	Y, right side* only	XXXXXRT XXXXX76	1 1
8	Y			N	Y, right side* only	XXXXXRT XXXXX77	1 1

Note that examples 4-8 above reflect very rare circumstances and will not be encountered often. Also, the use of modifier "50" (bilateral) or "RT" and "LT" as described in the grid above only applies to CPT codes where bilateralism is not already inherent in the CPT code description.

*Right side is used here for purposes of illustration only. For the left side, the modifier "LT" should be used instead of "RT."

DATA ELEMENT: Service Date

Definition: The date the indicated outpatient service was provided on a series bill.*

This field is also used to report the assessment reference date when billing SNF PPS services (Type of Bill 21X).

Procedures:

MEDICARE	Reported when required for outpatient bills. Required on claims submitted on Type of Bill 21X when FL42 contains revenue code 0022 (SNF PPS) unless FL44 contains HIPPS Rate Code AAA00.
MEDICAID	The State Medicaid Agency will provide instructions for completion.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required only for outpatient series bills. *
CHAMPUS	Required only for outpatient series bills. *

Field Attributes: 1 field
23 lines
6 positions
numeric
right-justified (all positions fully coded)

***Note:** The date of service should only be reported if it is required and it is an outpatient series bill where the From and Through dates in Form Locator 6 are not equal to each other on the form.

Enter: "MMDDYY"

Example: "010192"

DATA ELEMENT: Units of Service

Definition: A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc.*

Procedures:

MEDICARE	Required. Enter the total number of covered accommodation days, ancillary units of service, or visits, where appropriate. Show charges for noncovered services in Form Locator 48.
MEDICAID	The State Medicaid Agency will decide on the necessity of reporting this information. Where required, complete as described in the definition.
BLUE CROSS	Required for accommodation or units of ancillary service charges dependent on Plan needs and specific contract requirements.
COMMERCIAL	Required as indicated in Form Locator 42*
CHAMPUS	Required

Field Attributes: 1 field
23 lines
7 positions
numeric
right-justified

***Note:** Service unit reporting requirements are indicated for each payer under each revenue code in Form Locator 42.

EFFECTIVE: APRIL 1, 1996
11/8/95

FORM LOCATOR 47

DATA ELEMENT: Total Charges (by Revenue Code Category)

Definition: Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and non-covered charges.

Procedures:	MEDICARE	Required
	MEDICAID	Required
	BLUE CROSS	Required
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
23 lines
10 positions (see note)
numeric
right justified, \$,cts

Note: There are 7 positions for dollars, 2 characters for cents, and 1 character to the right of cents to indicate credit. Enter: NNNNNNN.NNS.

The figures in column 47 add up to a total which is reported in this form locator using the revenue code 001.

DATA ELEMENT: Non-Covered Charges

Definition: To reflect non-covered charges for the primary payer pertaining to the related revenue code.

Procedures:

MEDICARE	Required
MEDICAID	The State Medicaid Agency will decide on the necessity for reporting this information. Where required, the State will provide instructions.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required
CHAMPUS	Not Required

Field Attributes: 1 field
23 lines
10 positions (see note)
numeric
right-justified, \$, cts

Notes: There are 7 positions for dollars, 2 characters for cents, and 1 character to the right of cents to indicate credit. Enter: NNNNNNN.NNS.

The figures in column 48 add up to a total which is reported in this form locator using the revenue code 001.

DATA ELEMENT: Payer Identification

Definition: Name and, if required, number identifying each payer organization from which the provider might expect some payment for the bill.

Procedures:

MEDICARE	If Medicare is the payer, enter "Medicare". See note below.
MEDICAID	Enter the designation provided by the State Medicaid Agency.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements. Include assigned Blue Cross Number (oonnn). Blue Cross numbers are attached.
COMMERCIAL	Payer name required on all bills; payer NAIC number and sub-code is optional. NAIC numbers should be requested from the NAIC directly.
CHAMPUS	If CHAMPUS is the <u>only insurer</u> other than Medicaid and CHAMPUS Supplemental Plans, CHAMPUS is the primary payer. Enter the correct CHAMPUS Fiscal Intermediary in line 50A. The NAIC number may be included at the hospital's option. If there are other insurers besides Medicaid, and CHAMPUS supplemental plans, CHAMPUS is not the primary payer. Enter the name of the group(s) or plan(s) in line 50A or 50A and 50B. Enter the correct CHAMPUS FI in line 50B or 50C.

Field Attributes: 1 field
3 lines
25 positions
alphanumeric
left-justified

Notes: A = Primary payer
B = Secondary payer
C = Tertiary payer

Example: If "Medicare" is entered in Form Locator 50A, this indicates that the provider has developed for other insurance and has determined that Medicare is the primary payer.

In UB-92, value codes were developed to indicate various reasons and amounts associated with insurance or other payers that are primary to Medicare (Form Locators 39-41, Codes 12, 13, 14, 15, 16, 41, 42, 43). These value codes are analogous to "Payer Codes" (A, B, D, E, F, H, I, G respectively) reported in EMC v.4 Record Type 30, Field No. 9. When applicable, these value codes should be consistent with the payer codes when an electronic UB-92 is filed (both are required).

**EFFECTIVE: JULY 1, 1998
8/11/98**

FORM LOCATOR 50

**BLUE CROSS AND BLUE SHIELD
PLAN NAMES AND PLAN CODES
(FOR INSTITUTIONAL BILLING ONLY)**

<u>STATE ABBREV</u>	<u>PLAN NAME AND CITY</u>	<u>CODE BC/BS</u>
AL	Blue Cross and Blue Shield of Alabama Birmingham, Alabama	010/510
AZ	Blue Cross and Blue Shield of Arizona Phoenix, Arizona	030/530
AR	Arkansas Blue Cross and Blue Shield Little Rock, Arkansas	020/520
CA	Blue Cross of California Woodland Hills, California	040/
CA	Blue Shield of California San Francisco, California	/542
CO	Blue Cross and Blue Shield of Colorado Denver, Colorado	050/550
CT	Blue Cross and Blue Shield of Connecticut North Haven, Connecticut	060/560
DE	Blue Cross and Blue Shield of Delaware Wilmington, Delaware	070/570
DC	Blue Cross and Blue Shield of the National Capital Area Washington, District of Columbia	080/580
FL	Blue Cross and Blue Shield of Florida Jacksonville, Florida	090/590
GA	Blue Cross and Blue Shield of Georgia Atlanta, Georgia	101/600
HI	Blue Cross and Blue Shield of Hawaii Honolulu, Hawaii	471/971
ID	Blue Cross of Idaho Health Service, Inc. Boise, Idaho	110/610

EFFECTIVE: JULY 1, 1998
8/11/98

FORM LOCATOR 50

ID	Blue Shield of Idaho Lewiston, Idaho	/611
IL	Blue Cross and Blue Shield of Illinois Chicago, Illinois	121/621
IN	Anthem Blue Cross and Blue Shield Indianapolis, Indiana	130/630
IA	Wellmark Blue Cross and Blue Shield of Iowa Des Moines, IA	140/640
KS	Blue Cross and Blue Shield of Kansas, Inc. Topeka, Kansas	150/650
KY	Anthem Blue Cross and Blue Shield of Kentucky Louisville, Kentucky	160/660
LA	Blue Cross and Blue Shield of Louisiana Baton Rouge, Louisiana	170/670
ME	Blue Cross and Blue Shield of Maine South Portland, Maine	180/680
MD	Blue Cross and Blue Shield of Maryland, Inc. Owings Mills, Maryland	190/690
MA	Blue Cross and Blue Shield of Massachusetts, Inc. Boston, Massachusetts	200/700
MI	Blue Cross and Blue Shield of Michigan Detroit, Michigan	210/710
MN	Blue Cross and Blue Shield of Minnesota St. Paul, Minnesota	220/720
MS	Blue Cross and Blue Shield of Mississippi Jackson, Mississippi	230/730
MO	Blue Cross and Blue Shield of Kansas City Kansas City, Missouri	240/740
MO	Alliance Blue Cross and Blue Shield St. Louis, Missouri	241/741
MT	Blue Cross and Blue Shield of Montana, Inc. Helena, Montana	250/751

EFFECTIVE: JULY 1, 1998
8/11/98

FORM LOCATOR 50

NE	Blue Cross and Blue Shield of Nebraska Omaha, Nebraska	260/760
NV	Blue Cross and Blue Shield of Nevada Reno, Nevada	265/765
NH	Blue Cross and Blue Shield of New Hampshire Manchester, New Hampshire	270/770
NJ	Blue Cross and Blue Shield of New Jersey, Inc. Newark, New Jersey	280/780
NM	Blue Cross and Blue Shield of New Mexico Albuquerque, New Mexico	290/790
NY	Blue Cross and Blue Shield of Western New York Buffalo, New York	301/801
NY	Empire Blue Cross and Blue Shield New York, New York	303/803
NY	The Fingerlakes Companies, Inc. Rochester, New York	304/804
NY	Blue Cross and Blue Shield of Central New York Syracuse, New York	305/805
NY	Blue Cross and Blue Shield of Utica-Watertown, Inc. Utica, New York	306/806
NC	Blue Cross and Blue Shield of North Carolina Durham, North Carolina	310/810
ND	Blue Cross and Blue Shield of North Dakota Fargo, North Dakota	320/820
OH	Anthem Blue Cross and Blue Shield - Ohio Cincinnati, Ohio	332/834
OK	Blue Cross and Blue Shield of Oklahoma Tulsa, Oklahoma	340/840

EFFECTIVE: JULY 1, 1998
8/11/98

FORM LOCATOR 50

OR	Blue Cross and Blue Shield of Oregon Portland, Oregon	350/851
OR	The Benchmark Group Portland, Oregon	351/850
PA	Highmark Camp Hill Camp Hill, Pennsylvania	865/
PA	Capital Blue Cross Harrisburg, Pennsylvania	361/
PA	Independence Blue Cross Philadelphia, Pennsylvania	362/
PA	Highmark Blue Cross and Blue Shield Pittsburgh, Pennsylvania	363/
PA	Blue Cross of Northeastern Pennsylvania Wilkes-Barre, Pennsylvania	364/
PR	La Cruz Azul de Puerto Rico San Juan, Puerto Rico	470/
PR	Triple-S San Juan, Puerto Rico	/973
RI	Blue Cross and Blue Shield of Rhode Island Providence, Rhode Island	370/870
SC	Blue Cross and Blue Shield of South Carolina Columbia, South Carolina	380/880
SD	Wellmark Blue Cross and Blue Shield of South Dakota Sioux Falls, South Dakota	/141
TN	Blue Cross and Blue Shield of Tennessee Chattanooga, Tennessee	390/890
TN	Blue Cross and Blue Shield of Memphis Memphis, Tennessee	392/892
TX	Blue Cross and Blue Shield of Texas, Inc. Dallas, Texas	400/900
UT	Regence Blue Cross and Blue Shield of Utah Salt Lake City, Utah	410/910

**EFFECTIVE: JULY 1, 1998
8/11/98**

FORM LOCATOR 50

VT	Blue Cross and Blue Shield of Vermont Montpelier, Vermont	415/915
VA	Trigon Blue Cross Blue Shield Richmond, Virginia	423/923
WA	Blue Cross of Washington and Alaska Blue Shield in Central Washington Seattle, Washington	430/934
WA	Regence Washington Health Seattle, Washington	/932
WA	Northwest Medical Bureau Bellingham, Washington	/938
WA	Medical Service Corporation of Eastern Washington Spokane, Washington	/936
WA	Regence Blue Shield Tacoma, Washington	/937
WV	Mountain State Blue Cross and Blue Shield, Inc. Parkersburg, West Virginia	443/943
WI	Blue Cross and Blue Shield United of Wisconsin Milwaukee, Wisconsin	450/950
WY	Blue Cross and Blue Shield of Wyoming Cheyenne, Wyoming	460/960

EFFECTIVE: OCTOBER 1, 1993
1/8/93

FORM LOCATOR 51

DATA ELEMENT: Provider Number

Definition: The number assigned to the provider by the payer indicated in FL50 A, B, C.

Procedures:	MEDICARE	Required
	MEDICAID	Required
	BLUE CROSS	Required
	COMMERCIAL	Desirable
	CHAMPUS	Required as assigned by the CHAMPUS claims processor.

Field Attributes: 1 field
3 lines
13 positions
alphanumeric
left-justified

Note: A = Primary payer
B = Secondary payer
C = Tertiary payer

DATA ELEMENT: Release of Information Certification Indicator

Definition: A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

Procedures:

MEDICARE	Required
MEDICAID	The State Medicaid Agency will decide on the necessity of reporting this information.
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required for each third party payer.
CHAMPUS	Indicate that a release has been obtained (code Y - Release).

Field Attributes: 1 field
3 lines
1 position
alphanumeric
left-justified

Note: A = Primary
B = Secondary
C = Tertiary

Code Structure:

Y	Yes	The hospital has signed written authority to release medical/billing information for purposes of claiming insurance benefits.
R	Restricted or Modified Release	The hospital has limited or restricted authority to release some medical/billing information for purposes of claiming insurance benefits.
N	No Release	The hospital does not have permission to release any medical/billing information.

DATA ELEMENT: Assignment of Benefits Certification Indicator

Definition: A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

Procedures:	MEDICARE	Not Required
	MEDICAID	Not Required
	BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
3 lines
1 position
alpha-numeric
left justified

Notes: The presence of an assignment does not permit release of medical information about a patient.

CHAMPUS:

When participation in CHAMPUS/CHAMPVA is mandated by law, required in a provider agreement, or when the provider accepts the assignment of benefits (indicated by using code Y in this form locator), the provider is agreeing to accept the charge determination of the CHAMPUS fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, effective January 1, 1987, Medicare participating hospitals are required to also participate in CHAMPUS/CHAMPVA and accept patients from those programs.

Code Structure:	Y	Yes	Benefits assigned
	N	No	Benefits not assigned

DATA ELEMENT: Prior Payments - Payers and Patient

Definition: The amount the provider has received toward payment of this bill prior to the billing date by the indicated payer.

Procedures:

MEDICARE	Required on outpatient bills. Enter any amount received from the patient under Form Locator 54 (Due From Patient).
MEDICAID	Required
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required
CHAMPUS	Required. Enter the actual payment amount paid by the other health insurance.

Field Attributes: 1 field
4 lines
10 positions (see note)
numeric
right justified, \$, cts

Notes: There are 7 positions for dollars, 2 characters for cents, and 1 character to the right of the cents to indicate credit.

Enter: "NNNNNNN.NNS"

A = Primary
B = Secondary
C = Tertiary
P = Due From Patient

DATA ELEMENT: Estimated Amount Due

Definition: The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).

Procedures:

MEDICARE	Not Required
MEDICAID	Not Required
BLUE CROSS	Not Required
COMMERCIAL	Desirable
CHAMPUS	Not Required

Field Attributes: 1 field
4 lines
10 positions (see note)
numeric
right-justified, \$, cts

Notes: There are 7 positions for dollars, 2 characters for cents, and 1 character to the right of the cents to indicate credit.

Enter: "NNNNNNN.NNS"

A = Primary
B = Secondary
C = Tertiary
P = Due From Patient

DATA ELEMENT: Insured's Name

Definition: The name of the individual in whose name the insurance is carried, as qualified below by the payer organization.

Procedures: MEDICARE Enter the following patient information: last name, first name, and middle initial, if any. Name must be the same as on the patient's Health Insurance Card or other Medicare notice. Medicare requires the insured's name for the primary payer on the primary payer line where Medicare is secondary.

MEDICAID Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the Medicaid ID card. If the patient is covered by insurance other than Medicaid, complete as described above in the definition.

BLUE CROSS Enter the full given name as required by local plan needs.

COMMERCIAL Required. Enter as recorded on the ID card, if available.

CHAMPUS Required. If the primary payer(s) is other than CHAMPUS, enter the name of person(s) carrying other insurance in 58A or 58A and 58B. Enter the sponsor's name in line 58B or 58C if CHAMPUS patient; or Veteran's name in line 58B or 58C if CHAMPVA patient, as recorded on ID card. (Not required if patient and sponsor or veteran are the same.)

If CHAMPUS or CHAMPVA is primary, enter the sponsor's name as recorded on the ID card, in line 58A. (Not required if the patient and sponsor or veteran are the same.)

Field Attributes: 1 field
3 lines
25 positions
alphanumeric
left-justified

Note: A = Primary payer
B = Secondary payer
C = Tertiary payer

Notes: (continued)

Use a comma or space to separate last and first names. Enter last name first.

No space should be left between a prefix and a name as in MacBeth, VonSchmidt, McEnroe.

Titles (such as Sir, Msgr, Dr.) should not be recorded in this date element.

Record hyphenated names with the hyphen as in Smith-Jones, Rebecca.

To record suffix of a name, write the last name, leave a space and write the suffix, then write the first name as in Snyder III, Harold, or Addams Jr., Glen.

DATA ELEMENT: Patient's Relationship to Insured

Definition: A code indicating the relationship of the patient to the identified insured.

Procedures:

MEDICARE	Medicare requires the primary payer information on the primary payer line when Medicare is secondary.
MEDICAID	The State Medicaid Agency will decide on the necessity for reporting this information. Where required, complete as described in the definition.
BLUE CROSS	Required
COMMERCIAL	Required
CHAMPUS	Required. If primary payer(s) is <u>other</u> than CHAMPUS, enter the patient's relationship code to the person(s) carrying other insurance in line 59A or 59A and 59B. Enter the patient's relationship code to the sponsor in line 59B or 59C if CHAMPUS patient; or patient's relationship code to veteran in line 59B or 59C if CHAMPVA patient. If CHAMPUS or CHAMPVA is primary, enter the patient's relationship code to the sponsor or to the veteran in line 59A.

Field Attributes: 1 field
3 lines
2 positions
alphanumeric
left-justified

Note: A = Primary payer
B = Secondary payer
C = Tertiary payer

See Code Structure on the following page.

Code Structure:

I. Effective Until October 16, 2003

<u>Code</u>	<u>Title</u>	<u>Description</u>	<u>Map to List II</u>
01	Patient Is Insured	Self-explanatory	18
02	Spouse	Self-explanatory	01
03	Natural Child/Insured Financial Responsibility	Self-explanatory	19
04	Natural Child/Insured Does not Have Financial Responsibility	Self-explanatory	43
05	Step Child	Self-explanatory	17
06	Foster Child	Self-explanatory	10
07	Ward of the Court	Patient is ward of the insured as a result of a court order.	15
08	Employee	Patient is employed by the insured.	20
09	Unknown	Patient's relationship to the insured is unknown.	None
10	Handicapped Dependent	Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage.	22
11	Organ Donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.	39
12	Cadaver Donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.	40
13	Grandchild	Self-explanatory	05
14	Niece/Nephew	Self-explanatory	07
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.	41
16	Sponsored Dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.	23
17	Minor Dependent of a Minor Dependent	Code is used where patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured.	24

**EFFECTIVE: OCTOBER 16, 2003
8/7/02**

FORM LOCATOR 59

18	Parent	Self-explanatory	None
19	Grandparent	Self-explanatory	04
20	Life Partner	Patient is covered under insurance policy of his/her life partner (or similar designation, e.g., domestic partner, significant other)	29*, 53*
21-99		Reserved for national assignment.	None

II. Effective October 16, 2003

<u>Code</u>	<u>Title</u>	<u>Description</u>	<u>Map to List I</u>
01	Spouse		02
04	Grandfather or Grandmother		19
05	Grandson or Granddaughter		13
07	Nephew or Niece		14
10	Foster Child		06
15	Ward	Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order.	07
17	Stepson or Stepdaughter		05
18	Self		01
19	Child		03
20	Employee		08
21	Unknown		09
22	Handicapped Dependent		10
23	Sponsored Dependent		16
24	Dependent of a Minor Dependent		17
29	Significant Other		None*
32	Mother		None
33	Father		None
36	Emancipated Minor		None
39	Organ Donor		11
40	Cadaver Donor		12
41	Injured Plaintiff		15
43	Child Where Insured Has No Financial Responsibility		04
53	Life Partner		None*
G8	Other Relationship		None

* No 1:1 map for Significant Other and Life Partner.

**DATA ELEMENT: Certificate/Social Security Number/Health Insurance Claim/
Identification Number**

Definition: Insured's unique identification number assigned by the payer organization.

Procedures:

MEDICARE	Enter the patient's Medicare HIC number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office. Medicare requires the primary payer information on the primary payer line when Medicare is secondary.
MEDICAID	Enter the Medicaid Identification number of the insured or case head Medicaid number shown on the Medicaid Identification card.
BLUE CROSS	Enter information depending on Plan information needs and specific contract requirements.
COMMERCIAL	Required. If group, use insured ID number from claim form or ID card. If not available, use insured SSN. If an individual insurance contract is involved, use policy number.
CHAMPUS	If primary payer(s) is <u>other</u> than CHAMPUS, enter the unique ID number assigned by the primary payer to the person(s) carrying other insurance in line 60A or 60A and 60B. Enter the sponsor's social security number in line 60B or 60C if CHAMPUS patient; or Veteran's ID Card number, VA number or VA file Number in line 60B or 60C if CHAMPVA patient; or enter the NATO in line 60B or 60C if a NATO beneficiary.

Field Attributes: 1 field
3 lines
19 positions
alphanumeric
left-justified

Note: A = Primary payer
B = Secondary payer
C = Tertiary payer

DATA ELEMENT: Insured Group Name

Definition: Name of the group or plan through which the insurance is provided to the insured.

Procedures:

MEDICARE	Medicare requires the primary payer information on the primary payer line when Medicare is secondary.
MEDICAID	The State Medicaid Agency will decide the necessity for reporting this information. Where required, the state will provide instructions for completion.
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required on group coverage claims. Do not enter on individual claims.
CHAMPUS	Required. If primary payer(s) is <u>other</u> than CHAMPUS, enter the name of the group(s) or plan(s) other insurance in line 61A or 61A and 61B.

Field Attributes: 1 field
3 lines
14 positions
alphanumeric
left-justified

Note: A = Primary
B = Secondary
C = Tertiary

DATA ELEMENT: Insurance Group Number

Definition:	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	
Procedures:	MEDICARE	Medicare requires the primary payer information on the primary payer line when Medicare is secondary.
	MEDICAID	The State Medicaid agency will decide on the necessity for reporting this information. If so, the state will provide instructions.
	BLUE CROSS	Enter information depending on Plan information needs and specific contract requirements.
	COMMERCIAL	If group policy, enter the number assigned by the insurer to identify the group policy number. Do not enter if individual insurance contract is involved.
	CHAMPUS	Required. If the primary payer(s) is other than CHAMPUS, enter the ID number, control number or carrier code of the groups(s) or plan(s) other insurance in line 62A or 62A and 62B.
Field Attributes:	1 field 3 lines 17 positions alphanumeric left-justified	
Note:	A = Primary payer B = Secondary payer C = Tertiary payer	

DATA ELEMENT: Treatment Authorization Code

Definition: A number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.

Procedures:

MEDICARE	Required. Whenever the PRO review has been performed on a preadmission or preprocedure basis the authorization number is required for all approved admissions or services.
MEDICAID	If required for services on this bill, enter the prior approval number.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required, if applicable
CHAMPUS	Enter only when the course of treatment has been specifically authorized for the patient.

Field Attributes: 1 field
3 lines
18 positions
alphanumeric
left-justified

Note: A = Primary payer
B = Secondary payer
C = Tertiary payer

DATA ELEMENT: Employment Status Code of the Insured

Definition: A code used to define the employment status of the insured individual identified in Form Locator 58.

Procedures:

MEDICARE	Medicare requires the primary payer information on the primary payer line where Medicare is secondary and the provider has requested conditional payment.
MEDICAID	To be completed at the option of the State Medicaid agency.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required. Enter the code (See Code Structure) which describes the employment status of the insured individual identified in Form Locator 58.
CHAMPUS	Required. Enter the code (See Code Structure) which describes the employment status of the insured individual identified in Form Locator 58.

Field Attributes: 1 field
3 lines
1 position
numeric
right-justified

Note: A = Primary
B = Secondary
C = Tertiary

(See Code Structure on next page)

Code Structure:

<u>Code</u>	<u>Code Title</u>	<u>Definition</u>
1	Employed Full Time	Individual states that he or she is employed full time.
2	Employed Part Time	Individual states that he or she is employed part time.
3	Not Employed	Individual states that he or she is not employed full time or part time.
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory
7-8		Reserved for national assignment
9	Unknown	Individual's employment status is unknown.

EFFECTIVE: OCTOBER 1, 1993
8/23/93

FORM LOCATOR 65

DATA ELEMENT: Employer Name of the Insured

Definition: The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

Procedures:

MEDICARE	Medicare requires the primary payer information on the primary payer line where Medicare is secondary.
MEDICAID	To be completed at the option of the state Medicaid agency.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Enter the name of the employer of the insured identified in Form Locator 58.
CHAMPUS	Enter the name of the employer of the insured identified in Form Locator 58.

Field Attributes: 1 field
3 lines
24 positions
alphanumeric
left-justified

Note: A = Primary
B = Secondary
C = Tertiary

DATA ELEMENT: Employer Location of the Insured

Definition: The specific location of the employer of the insured individual identified in Form Locator 58.

Procedures:

MEDICARE	Medicare requires the primary payer information on the primary payer line where Medicare is secondary.
MEDICAID	To be completed at the option of the State Medicaid agency.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required. Enter the specific location of the employer of the insured identified in Form Locator 58.
CHAMPUS	Required. Enter the specific location of the employer of the insured identified in Form Locator 58.

Field Attributes: 1 field
3 lines
35 positions
alphanumeric
left-justified

Note: A = Primary payer
B = Secondary payer
C = Tertiary payer

A specific location is the city, plant, etc. in which the employer is located.

DATA ELEMENT: Principal Diagnosis Code

Definition: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

Procedures: MEDICARE Inpatient: Required. Enter the full ICD-9-CM code for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

Outpatient: Required. Enter the full ICD-9-CM code for the diagnosis shown in the provider records to be chiefly responsible for the outpatient services performed during this visit. A working diagnosis is acceptable in the absence of a confirmed diagnosis. Where only testing is done and the physician requesting the test does not furnish the diagnosis, use an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination. (See ICD-9-CM codes V70-V82.)

MEDICAID Required. Enter the ICD-9-CM code for the principal diagnosis. Enter the codes for diagnoses other than the principal diagnosis in Form Locators 68-75. The State Medicaid Agency will provide instructions for completion.

BLUE CROSS Required

COMMERCIAL Required

CHAMPUS Inpatient Required.

Outpatient: CHAMPUS cannot accept a vague diagnosis (V70-V82) for outpatient testing. Please submit the referring physician's working diagnosis if a diagnosis has not been confirmed. CHAMPUS can accept V222 for routine maternity testing.

EFFECTIVE: OCTOBER 1, 1993
3/31/92-2

FORM LOCATOR 67

Field Attributes: 1 field
1 line
6 positions
alphanumeric
left-justified

Notes: The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

The principal diagnosis code will include the use of "V" codes.

DATA ELEMENT: Other Diagnoses Codes

Definition: The ICD-9-CM diagnoses codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

For additional information, refer to The Official ICD-9-CM Guidelines for Coding and Reporting.

Procedures:

MEDICARE	<u>Inpatient</u> : Required. Enter the full ICD-9-CM codes for other diagnoses that co-exist at the time of admission or develop subsequently.
	<u>Outpatient</u> : Required. Enter the full ICD-9-CM codes for other diagnosis that co-exist in addition to the diagnosis reported in Form Locator 67.
MEDICAID	See Form Locator 67 for instructions.
BLUE CROSS	Required
COMMERCIAL	Required
CHAMPUS	Required

Field Attributes: 8 fields
1 line
6 positions
alpha-numeric
left justified

Notes: The reporting of the decimal between the third and fourth digits is unnecessary because it is implied.

Other diagnoses codes will permit the use of ICD-9-CM “V” and “E” codes where appropriate.

DATA ELEMENT: Admitting Diagnosis/Patient's Reason for Visit

Definition: The ICD-9-CM diagnosis code describing the patient's diagnosis or reason for visit at the time of admission or outpatient registration.

Procedures:

MEDICARE	<u>Inpatient</u> -- Admitting diagnosis required for inpatient bills.
	<u>Outpatient</u> -- Patient's reason for visit required for outpatient bills.
MEDICAID	The state Medicaid Agency will decide on the necessity of reporting this information. Where required, complete as described in the definition.
BLUE CROSS	Enter information depending on Plan information needs and specific contract requirements.
COMMERCIAL	Required for both inpatient and outpatient bills.
CHAMPUS	Required for both inpatient and outpatient bills.

Field Attributes: 1 field
1 line
6 positions
alphanumeric
left-justified

Notes: **Inpatient Bills**
The ICD-9-CM diagnosis code describing the admitting diagnosis as a significant finding representing patient distress, an abnormal finding on examination, a possible diagnosis based on significant findings, a diagnosis established from a previous encounter or admission, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one admitting diagnosis. This condition shall be determined based on the ICD-9-CM coding directives in Volumes I and II of the ICD-9-CM coding manuals (ICD-9-CM codes 001 - V82.9). The reporting of the decimal between the third and fourth digits is unnecessary because it is implied.

Outpatient Bills

The ICD-9-CM diagnosis code describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one diagnosis code describing the patients' primary reason for seeking care. This condition shall be determined based on the ICD-9-CM directives in Volumes I and II of the ICD-9-CM coding manuals (ICD-9-CM codes 001 - V82.9). The reporting of the decimal between the third and fourth digits is unnecessary because it is implied.

Revenue Code Requirement (Form Locator 42)

The patient's reason for visit information should be reported for all unscheduled outpatient visits when revenue codes 45X, 516 or 526 are present.

ASC X12N 837

For reporting in the Institutional 837 Health Care Claim transaction (Release 4010), use admitting diagnosis qualifier "ZZ" in the HI segment until further notice. New qualifier code "PR" has been suggested, but not finalized, as a replacement at a later date.

DATA ELEMENT: External Cause of Injury Code (E-code)

Definition: The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

Procedures:	MEDICARE	Not required
	MEDICAID	Not required
	BLUE CROSS	Not required
	COMMERCIAL	Not required
	CHAMPUS	Not required

Field Attributes: 1 field
1 line
6 positions
alpha-numeric
left justified

Notes: Health care facilities are encouraged to complete Form Locator 77 whenever there is a diagnosis of an injury, poisoning, or adverse effect. The completion of this field is voluntary in states where E-coding is not required.

The priorities for recording an E-code in Form Locator 77 are:

- 1) Principal diagnosis of an injury or poisoning
- 2) Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis
- 3) Other diagnosis with an external cause

DATA ELEMENT: Procedure Coding Method Used

Definition: An indicator that identifies the coding method used for procedure coding on the bill.

Procedures:	MEDICARE	Not Required
	MEDICAID	Enter the appropriate code.
	BLUE CROSS	Enter information depending on Plan information needs and specific contract requirements.
	COMMERCIAL	Required
	CHAMPUS	Required

Field Attributes: 1 field
1 line
1 position
numeric
right justified

Code Structure:	1-3	Reserved for State Assignment.
	4	CPT-4
	5	HCPCS (HCFA Common Procedure Coding System)
	6-8	Reserved for National Assignment
	9	ICD-9-CM

DATA ELEMENT: Principal Procedure Code and Date

Definition: The code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

Procedures:

MEDICARE	Required for inpatient and Home IV therapy, if surgery was performed during the inpatient stay from which the course of therapy was initiated. Enter the full ICD-9-CM code and date for the principal procedure.
MEDICAID	Enter the code identifying the principal surgical or obstetrical procedure. The State Medicaid Agency will provide instructions for completion. Date is required, if applicable.
BLUE CROSS	Code and date are required, if applicable. ICD-9-CM coding method should be utilized.
COMMERCIAL	Code and date are required, if applicable. Indicate in Form Locator 79 if ICD-9-CM or CPT-4 is being used.
CHAMPUS	Code and date are required, if applicable. ICD-9-CM coding method should be utilized.

Field Attributes:

1 field (code)	1 field (date)
1 line	1 line
7 positions	6 positions
alphanumeric	numeric
left-justified	right-justified (all positions fully coded)

Notes: The code structure must be consistent with the information provided in Form Locator 79.

The reporting of the decimal between the second and third digits is unnecessary because it is implied.
Enter date as month, day, and year (MMDDYY).

Example: "010192"

DATA ELEMENT: Other Procedure Codes and Dates

Definition: The codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Procedures:

MEDICARE	Required for inpatient and Home IV therapy, if surgery was performed during the inpatient stay from which the course of therapy was initiated. Enter the full ICD-9-CM codes and dates.
MEDICAID	Various states require this information, others do not. The State Medicaid Agency will provide instructions for completion.
BLUE CROSS	Code and date are required, if applicable. ICD-9-CM coding method should be utilized.
COMMERCIAL	Code and date are required.
CHAMPUS	Required. Enter the full ICD-9-CM codes and dates.

Field Attributes:

5 fields (codes)	5 fields (dates)
1 line	1 line
7 positions	6 positions
alphanumeric	numeric
left-justified	right-justified (all positions fully coded)

Notes: The code structure must be consistent with the coding method indicated in Form Locator 79.

Enter codes in descending order of importance.

The reporting of the decimal between the second and third digits is unnecessary because it is implied.

Enter date as month, day, and year (MMDDYY).

Example: "010192"

DATA ELEMENT: Attending Physician ID

Definition: The name and/or number 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.

Procedures: MEDICARE:

For the Medicare program enter the unique physician identification number (UPIN) and name of the attending physician for inpatient bills or the physician that requested the outpatient services.

Inpatient Part A -- Enter the UPIN and name of the clinician who is primarily and largely responsible for the care of the patient from the beginning of the provider episode. Enter the UPIN in the first six positions, followed by two spaces, the last name, one space, the first name, one space, and middle initial.

Outpatient and Other Part B -- Enter the UPIN of the physician that requested the surgery, therapy, diagnostic tests or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

If the patient was self referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a physician name.

Claims Not Requiring UPINs

Enter the following codes in the indicated circumstances:

- INT000 for each intern
- RES000 for each resident
- PHS000 for Public Health Service physicians
- VAD000 for Veterans Administration physicians
- BIA000 for Bureau of Indian Affairs
- SLF000 for providers to report that the patient is self referred. (not accepted for services requiring physician referral).
- OTH000 For other situations where no UPIN is assigned.

Claims Requiring UPINs

All other Medicare claims require UPINs, e.g., including cases where there is a private primary insurer involved. UPINs may be obtained by physicians not participating in the Medicare program. Additionally, for outpatient and other Part B. if there is more than one referring physician, enter the UPIN of the physician requesting the service with the highest charge.

MEDICAID	<p><u>Inpatient</u> -- Enter the number assigned by Medicaid for the physician attending an inpatient. This is the physician primarily responsible for the care of the patient from the beginning of this hospitalization. The state may require the physician's name. If so, the state will provide instructions for completion.</p> <p><u>Outpatient</u> -- Enter the number assigned by Medicaid for the physician referring the patient to the hospital.</p>
BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
COMMERCIAL	Required. Enter physician last name, first name and middle initial.
CHAMPUS	Required. Enter physician last name, first name and middle initial only.

Field Attributes: 1 field
upper line (optional - see note)
23 positions
alphanumeric
left-justified

lower line
32 positions
alphanumeric
left-justified

Notes: Recommended format: physician number entered first, then name.

The upper line can be used to capture other state physician ID numbers in cases involving Medicare claims crossed over to the Medicaid program since the Medicare program requires UPINS and the Medicaid program may require state license numbers.

DATA ELEMENT: Other Physician ID

Definition: The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.

Procedures: MEDICARE Inpatient Part A -- Enter the UPIN and name of the physician who performed the principal procedure. If no principal procedure is performed, leave blank. See Form Locator 82 (inpatient) for specifications and details concerning claims not requiring UPINS.

Outpatient and Other Part B -- Enter the UPIN and name of the physician who performed the principal procedure. If there is no principal procedure enter the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. Use the format for inpatient.

Other Bills -- Not required.

MEDICAID Enter the number assigned by Medicaid for the physician who performed the principal procedure. The state may require the physician's name. If so, the state will provide instructions for completion.

BLUE CROSS Enter information depending on Plan needs and specific contract requirements.

COMMERCIAL Desirable - physician last name, first name, and middle initial.

CHAMPUS Required for inpatient bills only - physician last name, first name, and middle initial for the physician who performed the principal procedure.

Field Attributes: 2 fields
upper line (optional - see note)
25 positions
alphanumeric
left-justified

lower line
32 positions
alphanumeric
left-justified

EFFECTIVE: JANUARY 1, 1992
7/15/91

FORM LOCATOR 83

Notes:

Recommended format: physician number entered first, then name

The upper line can be used to capture other state physician ID numbers in cases involving medicare claims crossed over to the Medicaid program since medicare requires UPINS and the Medicaid program may require state license numbers.

DATA ELEMENT: Remarks

Definition: Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements.

Procedures:

MEDICARE	Enter information when applicable.
MEDICAID	The State Medicaid Agency will decide on the necessity for reporting information in this area and will provide specific instructions on its completion.
BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
COMMERCIAL	Enter information when applicable.
CHAMPUS	Enter information when applicable.

Field Attributes:

- 1 field
- 1 line
- 43 positions
- 3 lines
- 48 positions
- alphanumeric
- left-justified

Note: See the following page concerning "Recommended Format of Standard Entries Into Remarks."

**RECOMMENDED FORMAT OF STANDARD
ENTRIES INTO REMARKS**

GENERAL: Print the following fields in each category across the single line with a single space separating each field.

1. To report the address of an insured when it is not the same as that of the patient.
 - a. Code "ADDR-X" where X is either A, B, or C based upon the insurance reference.
 - b. Street Address (24 characters)
 - c. City and State (18 characters)
 - d. Zip Code (5 characters)
2. To report overflow information (e.g., condition code, value code, occurrence code and occurrence span code).
 - a. Code "FL_" to indicate form locator number.
 - b. Provide appropriate code number.
 - c. Provide appropriate date(s) or value(s).
 - d. Separate multiple entries with a semicolon ";".
 - e. FORMAT:
 - occurrence span code: FL36: 72, 100491/110391
 - value code: FL39: 09, 76.00; 11, 89.00
3. To report treatment codes (i.e., data from the HCFA-485 and HCFA-486) for home health agency paper bills.
 - a. Place after all other information in the Remarks area (FL84).
 - b. The prefix "HHA" must precede the reported treatment codes.
 - c. Separate multiple entries with a semicolon ";".
 - d. The list of treatment codes is included as an addendum to Remarks (FL84)
 - e. If insufficient space is available in Remarks (FL84) the HCFA-485 and HCFA-486 must be completed.

Note: For electronic claims HCFA/UB-92 Record Type 72 should be used to report from the HCFA-485 and HCFA-486.

**ADDENDUM TO REMARKS (FL84)
TREATMENT CODES FOR HOME HEALTH SERVICES
(Electronic HCFA/UB-92 Record Type 72)**

TREATMENT CODES FOR PROFESSIONAL SERVICES REQUIRED

Skilled Nursing

A1	Skilled Observation and Assessment (Inc. V.S., Response to Med.,etc.)
A2	Foley Insertion
A3	Bladder Instillation
A4	Wound Care/Dressing
A5	Decubitus Care
A6	Venipuncture
A7	Restorative Nursing
A8	Post Cataract Care
A9	Bowel/Bladder Training
A10	Chest Physio (Inc. Postural Drainage)
A11	Adm. of Vitamin B/12
A12	Prep./Adm. Insulin
A13	Adm. Other IM/Subq.
A14	Adm. IV's/Clysis
A15	Teach. Ostomy or Ileo conduit care
A16	Teach. Nasogastric Feeding
A18	Teach. Gastrostomy Feeding
A19	Teach. Parenteral Nutrition
A20	Teach. Care of Trach
A21	Adm. Care of Trach
A22	Teach. Inhalation Rx
A23	Adm. Inhalation Rx
A24	Teach. Adm. of Injection
A25	Teach. Diabetic Care
A26	Disimpaction/Follow-Up Enema
A27	Other (Spec. under Orders)
A28	Wound Care/Dressing-Closed Incision/Suture Line
A29	Decubitus Care (Other than A5)
A30	Teaching Care of Any Indwelling Catheter
A31	Management and Evaluation of a Patient Care Plan
A32	Teaching and Training (Other) (spec. under order)
A33-A60	Reserved for National Assignment

Physical Therapy

B1	Evaluation
B2	Therapeutic Exercise
B3	Transfer Training
B4	Home Program
B5	Gait Training
B6	Pulmonary Physical Therapy
B7	Ultrasound
B8	Electrotherapy
B9	Prosthetic Training
B10	Fabrication Temporary Devices
B11	Muscle Reeducation
B12	Management and Evaluation of a Patient Care Plan
B13-14	Reserved for National Assignment
B15	Other (Specify Under Orders)
B16-B39	Reserved for National Assignment

Speech Therapy

C1	Evaluation
C2	Voice Disorders Treatments
C3	Speech Articulation Disorders Treatments
C4	Dysphagia Treatments
C5	Language Disorders Treatments
C6	Aural Rehabilitation
C7	Reserved
C8	Nonoral Communications
C9	Other (Specify Under Orders)
C10-C24	Reserved for National Assignment

Occupational Therapy

D1	Evaluation
D2	Independent Living/Daily Living Skills (ADL Training)
D3	Muscle Re-education
D4	Reserved
D5	Perceptual Motor Training
D6	Fine Motor Coordination
D7	Neurodevelopment Treatment
D8	Sensory Treatment
D9	Orthotics/Splinting
D10	Adaptive Equipment (Fabrication and Training)
D11	Other
D12 -D25	Reserved for National Assignment

Medical Social Services

E1	Assessment of Social and Emotional Factors
E2	Counseling for Long-Range Planning and Decision Making
E3	Community Resource Planning
E4	Short Term Therapy
E5	Reserved
E6	Other (Specify Under Orders)
E7-E20	Reserved for National Assignment

Home Health Aide

F1	Tub/Shower Bath
F2	Partial/Complete Bed Bath
F3	Reserved
F4	Personal Care
F5	Reserved
F6	Catheter Care
F7	Reserved
F8	Assist with Ambulation
F9	Reserved
F10	Exercises
F11	Prepare Meal
F12	Grocery Shop
F13	Wash Clothes
F14	Housekeeping
F15	Other (Specify Under Orders)
F16-F30	Reserved for National Assignment

DATA ELEMENT: Provider Representative Signature

Definition: An authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of this bill.

Procedures:	MEDICARE	When a certification or recertification is required, a provider representative should make sure that the physician's certification and recertification are in the provider records. No signature is required for a general hospital stay unless a physician's certification or recertification was required during the course of the stay. A stamped signature is acceptable.
	MEDICAID	The State will decide what signature requirements are necessary to satisfy state or federal law or regulation.
	BLUE CROSS	Enter the information depending on Plan needs and specific contract requirements.
	COMMERCIAL	Required - facsimile signature acceptable.
	CHAMPUS	Required

Field Attributes: 1 field
1 line
22 positions
alpha-numeric
left justified

Note: Use of a facsimile signature must be approved by the individual payer organization.

DATA ELEMENT: Date Bill Submitted

Definition: The date on which the bill is submitted to the payer, as defined by the payer organization procedures given below.

Procedures:	MEDICARE	Not Required
	MEDICAID	Enter the date on which the bill was signed, or sent to the payer for payment.
	BLUE CROSS	Enter information depending on Plan needs and specific contract requirements.
	COMMERCIAL	Required
	CHAMPUS	Desirable

Field Attributes: 1 field
1 line
10 positions (See note)
numeric
right-justified

Note: Ten positions were allowed to facilitate hand entry on the paper form. However, only 6 positions are actually needed to enter the date. Enter month, day, and year (“MMDDYY”).

Example: “010192”

APRIL 15, 1993
(Current as of 5/12/94)

ZZ1

**UB-92 Form - Print Specifications as Developed
by the NUBC - January 8, 1993**

Paper Weight:

1st part is 20 CB - OCR Bond*
2nd part is 14 CFB*
(if not last part)
Last part is 15 CF*

*CB = Coated Back (Carbonless blackprint)
CFB = Coated Front and Back (Carbonless blackprint)
CF = Coated Front (Carbonless blackprint)

Ink:

All parts of the form set are to be printed as follows:

Front - Ink is to be PMS no. 192 (OCR-Red) (For Example, Flint J6983, formerly known as Sinclair Valentine). There is to be no contamination with "Black" ink or pigment. Printed product must meet specifications established as ANSI Standard X-3.86. Printer must maintain proper ink reflectance limits of the OCR reader specified by the purchaser.

Back - Ink is to be PMS no. 421 (Grey).

Titles:

Placement will be indicated on negative:

The top copy is to be labeled "OCR/Original".
The remaining copies are to be labeled copy 1, copy 2, copy 3.

Note: Users may determine the number of parts that are applicable to their needs. Up to four total parts are feasible on some printers; some other printers may limit the readability of multiple plies.

Color of the above titles are to be in the same ink as the form (see above).

Form Name:

"UB-92 HCFA 1450"

OMB approval is: "APPROVED OMB NO. 0938-0279"

APRIL 15, 1993
(Current as of 12/11/97)

ZZ1

Printing “Negatives”:

Negatives for total accuracy in form printing detail for UB-92 (one required for front and one required for back printing) can be obtained by any party from Standard Register Co. by calling 800-755-6405. The cost will be \$50 per negative, \$100 for a set of front and back printing negatives. Negatives are presently available.

Software Program Change Formatting Aid:

One of the costs of changing software and print programs to create UB-92 is “Test Forms”. It was suggested that a “transparency” of the UB-92 design (with a character spacing grid added) could be used with computer stock paper for greater efficiency and economy. Standard Register Co. will provide these “transparencies” to any party at a cost of \$35 each. Telephone 800-755-6405. (“Transparencies” are presently available.)

VENDORS AND PURCHASERS OF FORMS ARE ADVISED TO EXERCISE CAUTION IN THE QUANTITIES OF UB-92 FORMS ORDERED, ESPECIALLY DURING THE EARLY PERIOD AS THE UB-92 MOVES FROM DEVELOPMENT TO IMPLEMENTATION. (EVERY EFFORT HAS BEEN MADE TO VERIFY PROPER FORM LAYOUT, HOWEVER, IT IS POSSIBLE FOR THE FORM TO CHANGE WITHOUT ADVANCE NOTICE IF UNDETECTED ERRORS NECESSITATE REVISION.)