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ELECTRONIC MEDIA CLAIMS (EMC) TECHNICAL LETTER NO. 29E-VI

TO: All Electronic Media Claims Submitters
FROM: William Longenbaker, Bureau Chief
Bureau of Information Systems Support
DATE: December 13, 2005

SUBJECT: REVISED UB-92 EMC FLAT FILE VERSION VI FORMAT SPECIFICATIONS

TECHNICAL LETTER NUMBER (NO) 29E is being issued to notify all submitters of electronic media claims of a revision to the UB-92 EMC Flat File Version VI FORMAT UB-92 for the submission of a Co-payment Status Field Beginning January 1, 2006.

APPLICABLE OHIO ADMINISTRATIVE CODE (OAC) RULES CAN BE VIEWED ON THE ODJFS WEBSITE <http://emanuals.odjfs.state.oh.us/emanuals> OAC RULE 5101:3-1-09 ENTITLED "MEDICAID CO-PAYMENT PROGRAM" CONTAINS GENERAL INFORMATION REGARDING CO-PAYMENTS AND CONSUMER EXCLUSIONS TO CO-PAYMENTS. SPECIFIC CO-PAYMENT AMOUNTS CAN BE FOUND IN EACH PROVIDER'S SPECIFIC OAC RULES REFERENCED IN OAC RULE 5101:3-1-09.

For the UB-92 FFV6 format, the location of the field for the Co-payment Status field is in the 90 record, field location is 17 and this detail line is left justified in position 83-92 for 10 positions. Co-payment exclusions/inclusions should be reported in this data element. When submitting Co-payment claims in conjunction with other claims in the UB-92 claims format, please check the appropriate claim level and form locations. The new specifications are also located at <http://hipaa.oh.gov/odjfs/>. These changes are effective January 1, 2006.

ODJFS encourages you to test this new co-payment status field before submitting these claims to the Production environment. Please send all correspondence, production/test cartridges to the Data Scheduling Unit at the following address:

Ohio Department of Job and Family Services
Bureau of Information Systems Support
Data Scheduling Unit
4200 East Fifth Ave. 1st Fl.
Columbus, Ohio 43219

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES TAPE BILLING INSTRUCTIONS

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Attached are the specifications for the submission of electronic media claim billing tapes for the UB-92 EMC Flat File Version VI to the Ohio Medicaid Program. Please review these instructions and familiarize yourself with the various issues before you attempt to submit a tape.

If you have any questions regarding **billing instructions** or **policies**, please contact:

1st Contact: Ohio Department of Job and Family Services
 Bureau of Plan Operations/Voice Response Unit
 1-800-686-1516
 Hours of Operation:
 24 hours per day 7 days per week

2nd Contact: Ohio Department of Job and Family Services
 Bureau of Plan Operations/Provider Relations Section
 P.O. Box 1461
 Columbus, Ohio 43216-1461
 TELEPHONE: *In-State* 1-800-686-1516
Out-of-State 1-800-686-1516
 FAX: 1-614-728-3264
<http://www.state.oh.us/odjfs/ohp/bpo/>

To obtain a **hardcopy of specific billing instructions**, contact:

Ohio Department of Job and Family Services
 Warehousing Service/Forms Distribution Section
 2098 Integrity Drive, North
 Columbus, Ohio 43209
 FAX: 1-614-728-7724

To **request provider training**:

Ohio Department of Job and Family Services
 Bureau of Plan Operations/Provider Network Management
 Provider Training Unit
 P.O. Box 1461
 Columbus, Ohio 43216-1461
 TELEPHONE: 1-800-686-1516

If you have any **technical** questions regarding tape submission or the specifications, please contact:

7/02 Ohio Department of Job and Family Services
 Bureau of Information Systems Support
 Data Scheduling Unit
 4200 E. Fifth Avenue, 1st Floor E02-01
 Columbus, Ohio 43219
 TELEPHONE: 1-614-387-1212
 Email address: Data_Scheduling_unit@ODJFS.STATE.OH.US

The attached specifications are the **technical specifications**. In order to submit claims on cartridge tape you **must know how to bill on hardcopy**. Hardcopy billing for the UB-92 claim form instructions can be found in **Ohio Medicaid Provider Handbook, Chapter 3352, for Hospital Service and cross-over. Long Term Care Therapy can be found in the Long Term Care Transmittal Letter.**

GENERAL INFORMATION

Authorized providers and electronic media claim submitters can submit inpatient hospital, outpatient hospital, long term care therapy, inpatient hospital Medicare cross-over, outpatient hospital Medicare cross-over, long term care Medicare cross-over claims in machine readable tape format.

Each submission **must be** accompanied by an **ODJFS 06312 Letter of Certification/Batch Recap** form signed by the electronic media claim submitter.

Electronic media claim submitters may submit claims as often as **once per week**, however, these submissions must have a **minimum** count of **250 Claims**. Different types of claim submissions (UB- 92 EMC Flat File Version VI) will be consolidated to reach the 250 submission. There is **no minimum** requirement for **monthly** submissions.

The Medicaid provider is ultimately responsible for the accuracy and validity reporting of all Medicaid claims submitted for payment. A provider using an electronic media claim submitter should ensure through a legal contract that the electronic media claim submitter reports claim information only as directed by the provider. A copy of all contracts between the provider and electronic media claim submitter must be made available to ODJFS upon request. Both the individual provider and the electronic media claim submitter must maintain a record of all Medicaid claims submitted for payment.

The electronic media claim submitter must abide by the provisions of 45 CFR 205.50 which states the requirements for the safeguarding of recipient information. All information pertaining to an individual recipient, supplied by ODJFS or collected internally within the computing and accounting systems for an electronic media claim submitter, can only be used in the accurate billing and accounting of claims or the for purposes of obtaining reimbursement.

Submission must be received by the Data Scheduling Unit no later than **1:00 p.m. every Wednesday**. **The creation date on the file processor data record, record type (01) (processing date) must be the Wednesday the submission is received and any tapes received after the date entered on the file header record will be returned unprocessed.**

The system cannot handle multiple volume files. For multi tape submissions, each file must contain one header record and one trailer record.

Production tapes should be sent to:

7/02 Ohio Department of Job and Family Services
 | Bureau of Information Systems Support
 | Data Scheduling Unit
 4200 E. Fifth Avenue, 1st Floor E02-01
 Columbus, Ohio 43219
 Email address: Data_Scheduling_unit@ODJFS.STATE.OH.US

All claims submitted must be received within **365 days** from the actual date-of-service.

DEFINITIONS RELATED TO ELECTRONIC MEDIA CLAIM SUBMISSION

Provider Any individual or institution licensed or approved for participation in the Medicaid program by ODJFS.

Provider Agreement Is a contract between ODJFS and a provider of MEDICAL ASSISTANCE services in which the provider agrees to comply with the terms of the "Provider Agreement," state statutes and ODJFS administrative code rules, and federal statutes and rules.

Electronic Media Claim Submitter An individual or company who prepares invoices or receives payments on behalf of the provider. A provider who prepares electronic media claim submissions is also considered to be an electronic media claim submitter.

Electronic Media Claims Submission A complete electronic media claims submission consists of tapes prepared as described in the electronic media claim specification publication appropriate to each provider type, and a hard copy of the "Letter of Certification/Batch Recap" signed by the electronic media claim submitters.

Billing Date: Date of invoice preparation.

Service Date: Date service was provided to recipient.

The UB-92 EMC Flat File Version VI Format will accommodate the following providers:

- (1) Inpatient Hospital
- (2) Long Term Care Therapy
- (3) Medicare Cross-Over
 - (a) Long Term Care
 - (b) Inpatient Hospital
 - (c) Outpatient Hospital
- (4) Outpatient Hospital

TECHNICAL TAPE SPECIFICATIONS FOR CARTRIDGE TAPES

Specifications for submission of inpatient hospital, long term care therapy, out patient hospital, inpatient hospital Medicare cross-over, long term care Medicare cross-over, outpatient hospital Medicare cross-over on cartridge tape follow:

- (1) Compatible with IBM 3090 system/3480 or 3490E cartridge.
- (2) Recording Density - 38000 characters per inch.
- (3) Recording Code for Claims - Extended Binary Coded Decimal Interchange Code (EBCDIC 18 track or 36 track).
- (4) File labels - None
- (5) Logical Record Length - 192 characters.
- (6) Physical Record Length - 19200 characters, i.e., a blocking factor of 100
- (7) The outside surface of the tape must be clearly labeled with the **provider's/agent's name, agent's address, agent's ID and the Julian submission day.**
- (8) **DO NOT PAD THE END OF FILE WITH NINES OR BLANKS, INSTEAD, USE A SHORT BLOCK**
- (9) Standard IBM cartridge tape.

ELECTRONIC MEDIA CLAIM TAPE REJECTION CRITERIA

The following errors will cause your **entire tape** submission to be **rejected**. To prevent your submission from being rejected, we recommend that the electronic media claim submitter subject their tape to these edits.

(A) Rejections common to all invoices:

- (1) Agent's number is incorrect.
- (2) Batch number is incorrect or out of sequence.
- (3) File claim count in file trailer record does not match number of claims in file.
- (4) Claim count in any batch trailer record does not match number of claims in batch.
- (5) Provider number is invalid or missing.
- (6) File claim count in file trailer record does not equal the amount stated on the ODJFS 06312 Letter of Certification/Batch Recap form.
- (7) Any violation of the UB-92 EMC Flat File Version VI record ID and/or record ID sequence.
- (8) Line items for a claim exceeds limit of 50.
- (9) File extends over one tape.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

NATIONAL VERSION 006.0

**OHIO MEDICAID
LOCAL VERSION 006.0**

ISSUE DATE - 03/01/1999

IMPLEMENTATION DATE - 08/01/2000

LOCAL ISSUE DATE - 01/01/2001

LOCAL IMPLEMENTATION DATE - 01/01/2001

For HIPPA IMPLEMENTATION - 09/15/03

For HIPPA TRANSITIONS UPDATED - 04/15/2004

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

GENERAL INSTRUCTIONS

The general instructions define the validation requirements for classes of fields.

CONTENTS:

The UB-92 EMC Version-6 Flat File is comprised of scores of record types, both defined and reserved for future consideration. The Ohio Medicaid program uses the data from fourteen of these record types, shown in bold print on the following Record Description Index. Unused record types will not be displayed in this publication. Those that are used are displayed in their entirety.

Not all of the data elements in the used record types are required by the Ohio Medicaid payment system. Those that are necessary are printed in **BOLD type** and are fully elaborated within these pages.

NOTE: To conserve space and processing time, records that do not differ from their initialized state should not be written to the submitted file.

FIELD TYPES:

Field types are shown on the record format pages. The codes depicted are the following:

X = Alphanumeric field (may contain characters or numbers)

N = Numeric field (must contain numbers only)

NS= Numeric signed field (must contain sign in trailing character position) e.g. 9(08)v99s

REQ:

This heading appears on the data field description pages. The heading means "Required" and the codes depicted are the following:

R = Required (the field must be used)

O = Optional (the field may be used if information is available)

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

GENERAL INSTRUCTIONS
(CONTINUED)

MEDICAID NOTES:

BATCH:

Each electronic submission from providers and intermediaries is composed of multiple batches. Each batch is composed of multiple claims.

Our use of the term "batch" for these types of electronic submissions usually relates to the entire file. The individual batch numbers within the file are not used by the Ohio Medicaid payment system but do serve to separate the claims into manageable groups. Therefore, our balancing techniques are file (submission) oriented for providers and intermediaries and use the total number of claims in the entire submission.

MULTIPLE PAYER (THIRD PARTY) SPECIFICATION

The UB-92 and its associated electronic media file allow for up to three payers to be specified. Since Medicaid is by law the payer of last resort, two previous payers may be listed along with their "prior payments".

MEDICARE CROSSOVER CLAIMS

A combination of certain claim types and coinsurance/deductible entries will define a claim as a Medicare Crossover. In such circumstances, include Medicare as the Primary Payer as that will allow the Medicaid payment system to capture some data elements that would otherwise be unavailable. Please note however, that listing Medicaid as a payer will not by itself define a claim as a Crossover.

HOME HEALTH CLAIMS

As of 7/01/98, HOME HEALTH SERVICES were consolidated with other nursing services to form the Ohio Homecare Program. Service dates on or after 7/01/98 are to be submitted using the National Standard Format(NSF). Failure to do so will result in claim denials.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

GENERAL INSTRUCTIONS
(CONTINUED)

04/15/04 MEDICARE HMO (PART C) CLAIMS

Medicare Part C Claims where the HMO has a capitated payment arrangement with the provider are defined in our system by the presence of Value Codes F1, F2, F3 and/or F7. Medicare Part C Claims where the HMO has a non-capitated payment arrangement with the provider are defined in our system by the presence of Value Code E3 with E1, E2 and/or E7.

Medicare Part C claims do not automatically 'cross-over' from Medicare to Medicaid, as do Medicare Part A and Medicare Part B Claims. Medicare Part C claims may be billed only after the provider has received a remittance advice from the Medicare HMO.

CLAIMS NOT TO BE BILLED ELECTRONICALLY

The following types of claims cannot be billed electronically. They must be billed on hardcopy and sent to the Ohio Department of Job and Family Services.

- 1) Abortion, sterilization and hysterectomy claims.
- 2) Service dates over 365 days old.
- 3) Inpatient claims with discharge dates over 365 days old.
- 4) Inpatient interim bills with last date of services over 365 days.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT
 RECORD DESCRIPTIONS INDEX

Record Type	Description	Pages
01	- Processor Data	9-17
02-04	- Reserved for National Assignment	
05-09	- Local Use	
10	- Provider Data	18-27
11-14	- Reserved for National Assignment	
15-19	- Local Use	
20	- Patient Data	28-49
21	- Noninsured Employment Information	
22	- Unassigned State Form Locators	
23-24	- Reserved for National Assignment	
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30	- Third Party Payer Data	50-68
31	- Third Party Payer Data	
32-33	- Reserved for National Assignment	
34	- Authorization	
35-39	- Local Use	
40	- Claim Data TAN-Occurrence	69-85
41	- Claim Data Condition-Value	86-99
42-44	- Reserved for National Assignment	
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51-54	- Reserved for National Assignment	
55-59	- Local Use	
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61	- Outpatient Procedures Data	122-138
62-64	- Reserved for National Assignment	
65-69	- Local Use	
70	- Medical Data	139-150
71	- Plan of Treatment and Patient Information	
72	- Specific Services and Treatments	
73	- Plan of Treatment/Medical Update Narrative	
74-78	- Reserved for National Assignment	
79	- Local Use	

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD DESCRIPTIONS INDEX
(CONTINUED)

Record Type	Description	Page
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82-84	- Reserved for National Assignment	
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95	- Provider Batch Control	169-177
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99	- File Control	178-186

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

FILE LAYOUT

```
-----01 - Processor Data .....Submitter Envelope -----  
  |  
  |-----10 - Provider Data .....Provider Envelope -----  
  | |  
  | |-----20 - Patient Data .....Patient Envelope ----  
  | | |  
  | | |30 - Third Party Payer Data  
  | | |40 - Claim Data TAN-Occurrence  
  | | |41 - Claim Data Condition-Value  
  | | |50 - Inpatient Accommodations Data  
  | | |60 - Inpatient Ancillary Services Data  
  | | |61 - Outpatient Procedures Data  
  | | |70 - Medical Data  
  | | |80 - Physician Data  
  | | |-----90 - Claim Control Screen .....Claim Totals ----  
  | | |-----95 - Provider Batch Control .....Batch Totals -----  
  | | |-----99 - File Control .....File Totals -----
```

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

PROCESSOR DATA

RECORD TYPE: 01

NATIONAL VER. 006.00 - 08/01/2000

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA RECORD TYPE: 01

LEVEL: FILE

PURPOSE: The first record of any file submitted electronically, it contains information pertinent to the submitter of the claim file. A submitter could be a provider of medical services or a billing agency. The information contained in this record will be the determining factor in whether or not the file will be allowed system access.

REQUIREMENTS: A "01" record is required for every submission.

ORDER:	Preceding Record Type	Following Record Type
	----- NONE	----- 10

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

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

It is recommended that you and other billers establish a protocol limiting a file to a single disk, cartridge, or cassette. In the event a file exceeds that limit, the cartridge or disk must end in a batch control (Record Type 95).

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA

RECORD TYPE: 01

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '01'	2	X	1	2
2	SUBMITTER EIN	10	N	3	12
	MULTIPLE PROVIDER				
3	BILLING FILE INDICATOR	1	N	13	13
4	FILLER (NATIONAL USE)	17	X	14	30
5	RECEIVER TYPE CODE	1	X	31	31
6	RECEIVER IDENTIFICATION	5	N	32	36
7	RECEIVER SUB-IDENTIFICATION	4	X	37	40
8	FILLER (NATIONAL USE)	6	N	41	46
9	SUBMITTER NAME	21	X	47	67
10	ADDRESS	18	X	68	85
11	CITY	15	X	86	100
12	STATE	2	X	101	102
13	ZIP CODE	9	N	103	111
14	SUBMITTER FAX NUMBER	10	N	112	121
15	COUNTRY CODE	4	X	122	125
16	SUBMITTER TELEPHONE NUMBER	10	N	126	135
17	FILE SEQUENCE & SERIAL NUMBER	7	X	136	142
18	TEST/PRODUCTION INDICATOR	4	X	143	146
19	DATE OF RECEIPT (CCYYMMDD)	8	N	147	154
	(Intermediary use only)				
20	PROCESSING DATE (CCYYMMDD)	8	N	155	162
21	FILLER (Local Use)	26	X	163	188
21a	TARGET SYSTEM	1	X	189	189
22^	VERSION CODE '060'	3	X	190	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA RECORD/FIELD: 01-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

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

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "01".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA RECORD/FIELD: 01-2

DATA ELEMENT: Submitter EIN

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
2	9(10)	RIGHT	ZEROES	03	12	R

DEFINITION: Field used to identify the direct entry agent.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This is the unique three digit number assigned to each direct entry agent.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA RECORD/FIELD: 01-9

DATA ELEMENT: Submitter Name

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
9	X(21)	LEFT	SPACES	47	67	R

DEFINITION: Identifies the submitter who created the file.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: This is the three position alpha field assigned to each direct entry agent.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA RECORD/FIELD: 01-20

DATA ELEMENT: Processing Date

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
20	9(08)	RIGHT	ZEROES	155	162	R

DEFINITION: Identifies the date the submitter created the the file.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must in the format: CMMDDYY

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES:

Submission must be received by the Data Scheduling Unit no later than 2:00 p.m. every Wednesday. The date must be the Wednesday the submission is received and any tapes received after the date entered on the file header record will be held for the following week.

Production tapes should be sent to:

Ohio Department of Job and Family Services
Bureau of Information Systems Support
Data Scheduling Unit
4200 E. Fifth Ave., 1ST Floor
Columbus, Ohio 43219

Note: The date recorded in the Transaction Control Number of each individual claim in the Medicaid system is the Julian date of receipt, which is assigned by the State.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA RECORD/FIELD: 01-21a

DATA ELEMENT: Target System

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
21a	X(01)	LEFT	SPACES	189	1989	R

DEFINITION: Field used to identify the target system at ODJFS for which the data is intended.

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be blank for Medicaid Fee-for-Service.
Must be 'H' for HMO Encounter data.

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROCESSOR DATA RECORD/FIELD: 01-22

DATA ELEMENT: Version Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
22	X(03)	LEFT	SPACES	190	192	R

DEFINITION: Field used to identify the version of the file format being used.

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "060".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

PROVIDER DATA

RECORD TYPE: 10

NATIONAL VER. 006.00 - 08/01/2000

III-17

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA RECORD TYPE: 10

LEVEL: BATCH

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

REQUIREMENTS: This record is required.
A "10" record is required for every submission.

ORDER:	Preceding Record Type ----- 01 or 95	Following Record Type ----- 20
--------	---	---

NOTES: Only one 10 record is allowed for each batch.

MEDICAID
NOTES: There must be a separate batch for each provider/
type of batch. That is, neither the provider
number or the type of batch can change within a
submitted batch.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA

RECORD TYPE: 10

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '10'	2	X	1	2
2	TYPE OF BATCH	3	X	3	5
3	BATCH NUMBER	2	N	6	7
4	FEDERAL TAX NUMBER OR EIN	10	N	8	17
5	FEDERAL TAX SUB ID	4	X	18	21
6	MEDICARE PROVIDER NUMBER	13	X	22	34
7	MEDICAID PROVIDER NUMBER	13	X	35	47
8	CHAMPUS INSURER PROVIDER NUMBER	13	X	48	60
9	OTHER INSURER PROVIDER NUMBER	13	X	61	73
10	OTHER INSURER PROVIDER NUMBER	13	X	74	86
11	PROVIDER TELEPHONE NUMBER	10	N	87	96
12	PROVIDER NAME	25	X	97	121
13	PROVIDER ADDRESS	25	X	122	146
14	PROVIDER CITY	14	X	147	160
15	PROVIDER STATE	2	X	161	162
16	PROVIDER ZIP CODE	9	N	163	171
17	PROVIDER FAX NUMBER	10	N	172	181
18	COUNTRY CODE	4	X	182	185
19	FILLER (NATIONAL USE)	4	X	186	189
20	FILLER (LOCAL USE)	3	X	190	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA RECORD/FIELD: 10-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

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

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "10".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA RECORD/FIELD: 10-2

DATA ELEMENT: Type of Batch

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
2	X(03)	LEFT	SPACES	03	05	R

DEFINITION: Field used to identify the type of batch being submitted.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: N/A

REMARKS: N/A

**MEDICAID
NOTES:**

This is a constant exclusively defining the type of claims within this batch.

IP = Inpatient Hospital and Inpatient Hospital Crossover

OP = Outpatient Hospital and Outpatient Hospital Crossover

NF = Nursing Facility Therapy Services and Nursing Facility Crossover

There must be a separate batch for each provider/type of batch.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA RECORD/FIELD: 10-3

DATA ELEMENT: Batch Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	9(02)	RIGHT	ZEROES	6	7	R

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

CODE VALUES: Must be equal to 01 through 99.

VALIDATION: Must be entered.

Must be numeric.

First occurrence must be 01.

FORM LOCATION: N/A

REMARKS: N/A

**Medicaid
Notes:**

If you have more than 99 batches, you must re-cycle the batch number.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA RECORD/FIELD: 10-7

DATA ELEMENT: Medicaid Provider Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
7	X(13)	LEFT	SPACES	35	47	R

DEFINITION: The number assigned to the Provider by a Medicaid State Agency for identification purposes.

CODE VALUES: N/A

VALIDATION: If entered:

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

FORM LOCATION: N/A

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

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

MEDICAID

NOTES: This is the 7-digit pay-to Medicaid provider number assigned by ODJFS.

If the Medicaid Provider Number is not entered or entered incorrectly, all Medicaid claims contained within the batch may be deleted from the system or they may cause payment to the wrong provider.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA RECORD/FIELD: 10-7

DATA ELEMENT: Medicaid Provider Number

(CONTINUED)

Billing agencies should validate the digits of the provider number by using the following check digit routine:

The last digit is the "check" digit and is verified by a routine that takes the first six digits of the provider number and calculates a number that is compared to the seventh digit of the provider number.

The check digit is calculated as follows:

- 1) add together the first three odd number digits and multiply the result by 2
- 2) add together the first three even number digits
- 3) add together the results of step 1 and 2, then subtract from 100
- 4) the low order digit from the result of step 3 should be the check digit

For example:

Provider Number 8321597

- 1) $(8 + 2 + 5) \times 2 = 30$
- 2) $3 + 1 + 9 = 13$
- 3) $100 - (30 + 13) = 57$
- 4) 7 should be the check digit

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER DATA RECORD/FIELD: 10-12
 10-13
 10-14
 10-15
 10-16

DATA ELEMENT: Provider Name
 Provider Address
 Provider City
 Provider State
 Provider ZIP Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
12	X(25)	LEFT	SPACES	97	121	O
13	X(25)	LEFT	SPACES	122	146	O
14	X(14)	LEFT	SPACES	147	160	O
15	X(02)	LEFT	SPACES	161	162	O
16	X(09)	LEFT	SPACES	163	171	O

DEFINITION: The Name, Address, City, State and ZIP Code of the individual provider submitting this batch of claims for payment.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered:

This field should contain the Individual Provider's name, address, city, state and zip code as it appears on the Payor's File.

FORM LOCATION: UB-92 FL1, Line 1, 2 and 3

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

PATIENT DATA

RECORD TYPE: 20

NATIONAL VER. 006.00 - 08/01/2000

III-26

NATIONAL VER. 006.00 - 08/01/2000
LOCAL VER. 006.00 - 01/01/2001

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD TYPE: 20

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the patient on this claim.

REQUIREMENTS: This record is required.
A "20" record is required for every submission.

ORDER:	Preceding Record Type ----- 10 or 90	Following Record Type ----- 30
--------	---	---

NOTES: All records following up through Record Type 90 must have the same patient control number.

Record type 20 indicates the start of a new claim. If this is the first claim in a batch, it will follow the Batch Header Record (Record Type 10). Otherwise, it will follow the claim-ending Screen Record (Record Type 90).

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA

RECORD TYPE: 20

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
1	RECORD TYPE '20'	2	X	1	2
2	FILLER (NATIONAL USE)	2	X	3	4
3	PATIENT CONTROL NUMBER	20	X	5	24
4	PATIENT LAST NAME	20	X	25	44
5	PATIENT FIRST NAME	9	X	45	53
6	PATIENT MIDDLE INITIAL	1	X	54	54
7	PATIENT SEX	1	X	55	55
8	PATIENT BIRTHDATE (CCYYMMDD)	8	N	56	63
9	PATIENT MARITAL STATUS	1	X	64	64
10	TYPE OF ADMISSION	1	X	65	65
11	SOURCE OF ADMISSION	1	X	66	66
12	PATIENT ADDRESS - LINE 1	18	X	67	84
13	PATIENT ADDRESS - LINE 2	12	X	85	96
14	PATIENT CITY	15	X	97	111
15	PATIENT STATE	2	X	112	113
16	PATIENT ZIP CODE	9	N	114	122
17	ADMISSION/START OF CARE DATE (CCYYMMDD)	8	N	123	130
18	ADMISSION HOUR	2	X	131	132
19	STATEMENT COVERS PERIOD FROM DATE (CCYYMMDD)	8	N	133	140
20	STATEMENT COVERS PERIOD THRU DATE (CCYYMMDD)	8	N	141	148
21	PATIENT STATUS	2	N	149	150
22	DISCHARGE HOUR	2	X	151	152
23 [^]	PAYMENTS RECEIVED (PATIENT LINE)	10	NS	153	162
24 [^]	ESTIMATED AMOUNT DUE (PATIENT LINE)	10	NS	163	172
25	MEDICAL RECORD NUMBER	17	X	173	189
26	FILLER (NATIONAL USE)	3	X	190	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

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

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "20".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
2	X(20)	LEFT	SPACES	05	24	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

**MEDICAID
NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-4
20-5
20-6

DATA ELEMENT: Patient Last Name
Patient First Name
Patient Middle Initial

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
4	X(20)	LEFT	SPACES	25	44	0
5	X(09)	LEFT	SPACES	45	53	0
6	X(01)	LEFT	SPACES	54	54	0

DEFINITION: The Last Name, First Name and Middle Initial of the patient for whom the claim relates.

CODE VALUES: N/A

VALIDATION: Must be entered if required by payor.

If entered:

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

FORM LOCATION: UB-92 FL12

REMARKS: N/A

MEDICAID

NOTES: Enter the patient's last name, first name and middle initial. The name must correspond to the name on the Medical Assistance I.D. card. No punctuation or abbreviations may be used.

The Ohio Medicaid system limits the last name to 14 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-7

DATA ELEMENT: Patient Sex

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
7	X(01)	LEFT	SPACES	55	55	0

DEFINITION: This is a code denoting the sex of the patient.

CODE VALUES: M = Male
F = Female

VALIDATION: An unknown sex is unacceptable.

FORM LOCATION: UB-92, FL15

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-8

DATA ELEMENT: Patient Birth date

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
8	9(08)	RIGHT	ZEROES	56	63	0

DEFINITION: This is a date denoting the patient's date of birth.

CODE VALUES: N/A

VALIDATION: Must be in CCYYMMDD format.
Was being reported in MMDDYYYY format.
An unknown birth date is unacceptable.

FORM LOCATION: UB-92, FL14

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-10

DATA ELEMENT: Type of Admission

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
10	X(01)	RIGHT	SPACES	65	65	0

DEFINITION: This is a code denoting the reason for the admission.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92, FL19

REMARKS: N/A

**MEDICAID
NOTES:**

For INPATIENT HOSPITAL claims, enter the appropriate one-digit code from the following:

- 1 = Emergency (See Code 1 note)
- 2 = For all admission types excluded from preadmission certification (See Code 2 Note)
- 3 = Elective - Elective inpatient admissions must include a preadmission certification number in form locator 63.
- 4 = Newborn (a baby born within the billing institution). Claims for all newborns must include a birth weight value code 54 in Form Locators 39-41.
- 5 = Pending Medicaid.
- 6 = Medicaid recipient not reviewed until after admission and admission denied by review agency.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-10

DATA ELEMENT: Type of Admission

(CONTINUED)

-
- 7 = An admission for which preadmission certification was obtained but patient was transferred to another hospital.
8 = Rehabilitation Admission

CODE 1 NOTE: should be used for emergency admissions which are defined as any admission to treat a condition requiring medical and/or surgical treatment within the next 48 hours when, in the absence of such treatment, it can reasonable be expected that the patient may suffer unbearable pain, physical impairment, serious bodily injury or death. (THIS ADMISSION IS EXEMPT FROM PRE-CERTIFICATION.) NOTE: All psychiatric admissions, elective and emergency, require pre-certification.

CODE 2 NOTE: should be used for the following admission types EXCLUDED FROM PRE-CERTIFICATION:

- Substance abuse admissions
- Maternity admissions
- Admissions to hospitals in non-contiguous states
- Recipients enrolled in Medicaid HMOs
- Admissions for those elective surgical procedures which are not included on the pre-certification list and standards of medical practice, as described in rule 5101:3-2-40 or the Administrative Code.
- Patients who are jointly eligible for Medicare and Medicaid and who are being admitted under the Medicare Part A benefits
- Transfers from one hospital to another, with the exception of those hospitals identified for intensified review

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-10

DATA ELEMENT: Type of Admission

(CONTINUED)

For OUTPATIENT HOSPITAL claims, this field is
required. Code either 1 (emergency) or 3 (elective).

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-11

DATA ELEMENT: Source of Admission

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
11	X(01)	LEFT	SPACES	66	66	0

DEFINITION: This is a code denoting the authorization of the admission.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92, FL20

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL claims, enter the appropriate one-digit code as follows:

- 1 = Physician Referral
- 2 = Clinic Referral
- 4 = Transfer from an acute care, general hospital subject to prospective payment system. THIS STAY PAID ON A PER-DIEM BASIS.
- 5 = Transfer from a nursing facility (NF).
- 6 = Transfer from another health care facility (other than an acute care hospital subject to prospective payment system or a NF).
- 7 = Emergency Room

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-11

DATA ELEMENT: Source of Admission

(CONTINUED)

Codes for Newborn Admissions (These codes must be used when code No. 4 is used in the Type of Admission):

- 1 = Normal Delivery
- 2 = Premature Delivery
- 3 = Sick Baby
- 4 = Extramural Birth

For OUTPATIENT HOSPITAL, NURSING FACILITY and HOME HEALTH claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-17

DATA ELEMENT: Admission/Start of Care Date

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
17	9(08)	RIGHT	ZEROES	123	130	0

DEFINITION: This is a date identifying the beginning of treatment at the facility.

CODE VALUES: N/A

VALIDATION: Must be in CMMDDYY format.

FORM LOCATION: UB-92, FL17

REMARKS: N/A

MEDICAID

NOTES:

For INPATIENT HOSPITAL claims, enter the date the patient was admitted for care.

04/15/04

For NURSING FACILITY crossover claims (Medicare Part A services) and Medicare Part C claims for the NF per diem, enter the date the patient was admitted for care.

For OUTPATIENT HOSPITAL, NURSING FACILITY THERAPY SERVICES and claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-18

DATA ELEMENT: Admission Hour

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
18	X(02)	LEFT	SPACES	131	132	R

DEFINITION: This is a code denoting the hour of admission.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92, FL18

REMARKS: N/A

MEDICAID

NOTES: Required for INPATIENT and optional for OUTPATIENT HOSPITAL claims, enter the appropriate two-digit code corresponding to the hour of admission:

CODE	TIME: A.M.	CODE	TIME: P.M.
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

For NURSING FACILITY claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-19
20-20

DATA ELEMENT: Statement Covers Period From
Statement Covers Period Thru

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
19	9(08)	RIGHT	ZEROES	133	140	R
20	9(08)	RIGHT	ZEROES	141	148	R

DEFINITION: These fields are the beginning and ending service dates of the period covered by this bill.

CODE VALUES: N/A

VALIDATION: Both dates must be in the format CCMDDYY.

FORM LOCATION: UB-92, FL6

REMARKS: N/A

**MEDICAID
NOTES:**

For INPATIENT HOSPITAL, OUTPATIENT HOSPITAL and NURSING FACILITY THERAPY SERVICES claims, these fields are the beginning and ending service dates of the period covered by this bill.

For NURSING FACILITY crossover claims, these fields are the beginning and ending date series included on the Medicare claim. Dates must match those on the Medicare remittance advice.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-21

DATA ELEMENT: Patient Status

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
21	9(02)	RIGHT	ZEROES	149	150	R

DEFINITION: This field is a code representing the status of the patient.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92, FL22

REMARKS: N/A

MEDICAID

NOTES: Patient Status Code 05 is not acceptable for Medicaid.

For INPATIENT HOSPITAL claims, enter the appropriate two-digit code as follows:

- 01 = Discharged to home or self care (routine discharge)
- 02 = Discharged/transferred to another acute care general hospital, subject to prospective payment system. THIS STAY PAID ON A PER DIEM BASIS.
- 03 = Discharged/transferred to a nursing facility (NF)
- 04 = Discharged/transferred to an intermediate care facility (ICF). (This code is appropriate for use when a discharge/transfer is made to a freestanding rehabilitation hospital.)

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-21

DATA ELEMENT: Patient Status

(CONTINUED)

-
- 06 = Discharged/transferred to home under care of home health service organization
 - 07 = Left against medical advice
 - 10 = Discharged/transferred to or from a distinct part psychiatric unit within the same hospital. If your hospital is not recognized as a Medicare approved distinct part psychiatric unit, do not use this code.
 - 20 = Expired
 - 30 = Still patient (Must only be used on bill types 112, 113, 122, and 123)

For OUTPATIENT HOSPITAL claims, this field is required. Enter the appropriate two-digit code as follows:

- 01 = Discharged to home or self care (routine discharge)
- 02 = Discharged/transferred to another acute care general hospital, subject to prospective payment system.
- 03 = Discharged/transferred to a skilled nursing facility (NF)
- 04 = Discharged/transferred to an intermediate care facility (ICF). (This code is appropriate for use when a discharge/transfer is made to a freestanding rehabilitation hospital.)
- 06 = Discharged/transferred to home under care of home health service organization
- 07 = Left against medical advice
- 10 = Discharged/transferred to or from a distinct part psychiatric unit within the same hospital. If your hospital is not recognized as a Medicare approved distinct part psychiatric unit, do not use this code.
- 20 = Expired
- 30 = Still patient

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-21

DATA ELEMENT: Patient Status (CONTINUED)

For NURSING FACILITY claims, this field is required.
Enter the appropriate two-digit code as follows:

- 01 = Discharged to home or self care (routine discharge)
- 20 = Expired
- 30 = Still patient

For HOME HEALTH* claims, this field is required.
Enter the appropriate two-digit code for patient status as of the through date on Form Locator 6:

- 01 = Discharged to home or self care (routine discharge)
- 02 = Discharged to a short-term general hospital for inpatient care
- 03 = Discharged to a skilled nursing facility (SNF).
- 04 = Discharged to an intermediate care facility (ICF).
- 06 = Discharged/transferred to another home health service organization.
- 07 = Left against medical advice.
- 20 = Expired
- 30 = Still patient

*SEE 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-22

DATA ELEMENT: Discharge Hour

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
22	X(02)	LEFT	SPACES	151	152	0

DEFINITION: This field is a code representing the hour of the day that the patient was discharged from the facility.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92, FL21

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL claims, enter the appropriate two-digit code corresponding to the hour of discharge:

CODE	TIME: A.M.	CODE	TIME: P.M.
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	18	07:00-07:59
08	08:00-08:59	29	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

For OUTPATIENT HOSPITAL HOME HEALTH* and NURSING FACILITY claims, this field is not required.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PATIENT DATA RECORD/FIELD: 20-25

DATA ELEMENT: Medical Record Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
25	X(17)	LEFT	SPACES	173	189	0

DEFINITION: This field is the unique identifier assigned by the facility to the patient's medical records.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92, FL23

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL, OUTPATIENT HOSPITAL, HOME HEALTH and NURSING FACILITY claims, this field is required. Enter the unique alphanumeric number assigned to the patient's medical record by the hospital, home health agency or facility. Up to 9 characters may be entered.

NOTE: The medical record number will appear on the Remittance Advice for an adjudicated claim.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

THIRD PARTY PAYER DATA

RECORD TYPE: 30

NATIONAL VER. 006.00 - 08/01/2000

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD TYPE: 30

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding a payer on this claim.

REQUIREMENTS: This record is required for each "payer" identified in Form Locator 50.

A maximum of three Third Party Payer Records are allowed per claim, one record for each payer.

ORDER:	Preceding Record Type ----- 20 or 30	Following Record Type ----- 30 or 40
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MEDICAID

NOTES:

If there is no coordination of benefits, then there will be a single Record Type 30 for Medicaid.

If other payers are involved in the payment of the claim, they will each have a specific Record Type 30 sequenced relative to their position in Field Locator 50 (Payers). Note that Medicaid will be the final entry.

Based on the particular payer, different data elements may be required on the record.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA

RECORD TYPE: 30

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
1	RECORD TYPE '30'	2	X	1	2
2	SEQUENCE NUMBER	2	N	3	4
3	PATIENT CONTROL NUMBER	20	X	5	24
4	SOURCE OF PAYMENT CODE	1	X	25	25
5	PAYER IDENTIFICATION	5	N	26	30
6	PAYER SUB-IDENTIFICATION	4	X	31	34
7	CERTIFICATE/SOC SEC NUMBER/ HEALTH INSURANCE CLAIM/ IDENTIFICATION NUMBER	19	X	35	53
8a	PAYER IDENTIFICATION INDICATOR	2	X	54	55
8b	PAYER NAME	23	X	56	78
9	PRIMARY PAYER CODE	1	X	79	79
10	INSURANCE GROUP NUMBER	17	X	80	96
11	INSURED GROUP NAME	14	X	97	110
12	INSURED'S LAST NAME	20	X	111	130
13	INSURED'S FIRST NAME	9	X	131	139
14	INSURED'S MIDDLE INITIAL	1	X	140	140
15	INSURED'S SEX	1	X	141	141
16	RELEASE OF INFORMATION CERTIFICATION INDICATOR	1	X	142	142
17	ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR	1	X	143	143
18	PATIENT'S RELATIONSHIP TO INSURED	2	N	144	145
19	EMPLOYMENT STATUS CODE	1	N	146	146
20	COVERED DAYS	3	N	147	149
21	NONCOVERED DAYS	4	N	150	153
22	COINSURANCE DAYS	3	N	154	156
23	LIFETIME RESERVE DAYS	3	N	157	159
24	PROVIDER IDENTIFICATION NUMBER	13	X	160	172
25 [^]	PAYMENTS RECEIVED	10	NS	173	182
26 [^]	ESTIMATED AMOUNT DUE	10	NS	183	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Third Party Payer Data Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "30".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-2

DATA ELEMENT: Sequence Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
2	9(02)	RIGHT	ZEROES	03	04	R

DEFINITION: A numeric value from 01 through 03 used to sequence the "30" records.

CODE VALUES: 01 - Identifies the primary payer record.
02 - Identifies the secondary payer record.
03 - Identifies the tertiary payer record.

VALIDATION: Must be entered.

Must be a valid code from the above list.

A claim must have at least one "30" record and may have up to three. All "30" records must be sequenced by this number.

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

FORM LOCATION: N/A

REMARKS: Multiple '30' records should be sequenced according to national and state coordination of benefits rules. The primary payor should always be first regardless of whether or not payment is being requested in this transmission.

The order of the records should always be PRIMARY followed by SECONDARY insurance (if applicable) and then TERTIARY insurance (if applicable).

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	05	24	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-5

DATA ELEMENT: Payer Identification

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	9(05)	RIGHT	ZEROES	26	30	R

DEFINITION: This field identifies the payer to which the information on the record pertains.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL50 A, B and C

REMARKS: N/A

MEDICAID

NOTES: Enter the payer codes and names from the following list:

- 100 = Medicaid
- 200 = Private Insurance Carrier (enter only if prior payment collected)
- 300 = Blue Cross/Blue Shield (enter only if prior payment collected)
- 400 = Employer/Union (enter only if prior payment collected)
- 500 = Medicare
- 900 = Other (enter only if prior payment collected)

There can be no duplicate payer identification on a claim.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-5

DATA ELEMENT: Payer Identification

(CONTINUED)

NOTE: THE MEDICAID PROGRAM CAN MAKE PAYMENT FOR COVERED SERVICES ONLY AFTER ANY AVAILABLE THIRD PARTY BENEFITS ARE EXHAUSTED. Benefits available under the Medicaid program must be reduced to the extent that they are payable by any third party resource. The Bureau for Children with Medical Handicaps (BCMh/BCCS) and the Ohio Rehabilitation Services Commission (ORSC) are the only exception to this policy. When there is only BCMh and Medicaid coverage, or only ORSC and Medicaid coverage, Medicaid is the primary payer. All documentation must be retained for at least six years.

Providers who have attempted to collect from another payer without success must use occurrence codes available in Form Locators 32-35, to report to the department insurance denials or no carrier response. The provider must retain in the patient's record appropriate documentation to justify use of denial or no response codes.

NOTE: A = Primary Payer
B = Secondary Payer
C = Tertiary Payer

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-7

DATA ELEMENT: Certificate/Soc Sec Number/Health Insurance
Claim/Identification Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
7	X(19)	LEFT	SPACES	35	53	R

DEFINITION: This field identifies the patient to the payer.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL 60 A, B and C

REMARKS: N/A

MEDICAID

NOTES: For Payer Identification 100 (Medicaid), this is a required field and is an unique number assigned to each recipient.

This is the 12 digit billing number which is found in the column marked "Billing Number" on the Ohio Medical card (Medicaid, Disability Assistance).

The tenth digit of the number is the "check" digit and is verified by a routine that takes the first nine digits of the Billing Number and calculates a number that is compared to the tenth digit of the Billing Number. If digits 11 and 12 are equal to 80, the routine is ignored.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-7

DATA ELEMENT: Certificate/Soc Sec Number/Health Insurance
 Claim/Identification Number

(CONTINUED)

The check digit is calculated as follows:

- 1) take the first five odd number digits and treat it as a single number
- 2) multiply the result of step 1 by 2
- 3) add together each digit of the result of step 2 with the first four even number digits
- 4) subtract the result of step 3 from 100
- 5) the low order digit from the result of step 4 should be the check digit

For example:

Billing Number 736285914701

- 1) (76894) X 2 = 153788
- 2) (1+5+3+7+8+8) + (3+2+5+1) = 43
- 3) 100 - (43) = 57
- 4) 7 should be the check digit

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-18

DATA ELEMENT: Patient's Relationship to Insured

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
18	9(02)	RIGHT	ZEROES	144	145	0

DEFINITION: This field identifies the relationship of the patient to the insured.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL59 A, B, C

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL claims, the selected code must be keyed from the Form Locator 59 A, B or C entry corresponding to Payer Identification 100 (Medicaid):

- 11 = Organ Donor
- 12 = Cadaver Donor

For OUTPATIENT HOSPITAL and NURSING FACILITY claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-20

DATA ELEMENT: Covered Days

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
20	9(03)	RIGHT	ZEROES	147	149	0

DEFINITION: This field identifies the number of days covered by the payer.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL7

REMARKS: N/A

MEDICAID

NOTES: This item is required only for Payer Identification 100 (Medicaid).

The number of covered days in this item must also equal the number of accommodation units in Form Locator 46. Note: that the day of discharge is not Counted as a covered day.)

04/15/04 For Nursing Facility Part C claims, the number of days is required.

04/15/04 For OUTPATIENT HOSPITAL, NURSING FACILITY PART A Claims and Nursing Facility Therapy Claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-21

DATA ELEMENT: Non-covered Days

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
21	9(04)	RIGHT	ZEROES	150	153	0

DEFINITION: This field identifies the number of days not covered by the payer.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL8

REMARKS: N/A

MEDICAID

NOTES: This item is required only for Payer Identification 100 (Medicaid).

04/15/04 For INPATIENT HOSPITAL claims and Nursing Facility Part C claims, enter the total number of non-covered days and days denied by PRO/UR. The number of days in Form Locators 7 and 8 must equal the number of days in the date span of Form Locator 6.

04/15/04 For OUTPATIENT HOSPITAL, NURSING FACILITY PART A CROSSOVER CLAIMS, AND NURSING FACILITY THERAPY CLAIMS. this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-22

DATA ELEMENT: Coinsurance Days

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
22	9(03)	RIGHT	ZEROES	154	156	0

DEFINITION: This field identifies the number of days involving coinsurance by another payer.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL9

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL crossover and NURSING FACILITY crossover claims, this item is required.

04/15/04 WHEN APPLICABLE, For INPATIENT HOSPITAL MEDICARE HMO (PART C) claims, this item is required. Enter the number of inpatient days occurring after the 60th day and before the 91st day. The value in this item may not exceed 30.

04/15/04 WHEN APPLICABLE, For NURSING FACILITY PART C Claims, this item is covered. Enter the number of Nursing Facility inpatient days, included in the claim span that occurs after the 20th day and before the 101st day. The value in this item cannot exceed 80.

For OUTPATIENT HOSPITAL, HOME HEALTH* and NURSING FACILITY THERAPY SERVICES claims, this field is not required.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-23

DATA ELEMENT: Lifetime Reserve Days

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
23	9(03)	RIGHT	ZEROES	157	159	0

DEFINITION: This field identifies the number of lifetime reserve days.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL10

REMARKS: N/A

**MEDICAID
NOTES:**

04/15/04 For INPATIENT HOSPITAL crossover claims, this item is required.

04/15/04 WHEN APPLICABLE, For INPATIENT HOSPITAL MEDICARE HMO PART C claims, this item is required.

For OUTPATIENT HOSPITAL, NURSING FACILITY THERAPY SERVICES and HOME HEALTH* claims, this field is not required.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-24

DATA ELEMENT: Provider Identification Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
24	X(13)	LEFT	SPACES	160	172	R

DEFINITION: This field is the provider's identification number as assigned by the payer.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL51 A, B, C

REMARKS: N/A

MEDICAID

NOTES: This field is required for Payer Identification 100 (Medicaid).

Please note that for Payer Identification 100 (Medicaid), this is the 7 digit Ohio Medicaid Provider Number. It must match that of the Batch (Provider) Header Record Type 10.

If the Medicaid Provider Number is not entered or entered incorrectly, all Medicaid claims contained within the batch may be deleted from the system or they may cause payment to the wrong provider.

Billing agencies should validate the digits of the provider number by using the following check digit routine:

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-24

DATA ELEMENT: Provider Identification Number (CONTINUED)

MEDICAID PROVIDER NUMBER CHECK DIGIT CALCULATION

The last digit is the "check" digit and is verified by a routine that takes the first six digits of the provider number and calculates a number that is compared to the seventh digit of the provider number.

The check digit is calculated as follows:

- 1) add together the first three odd number digits and multiply the result by 2
- 2) add together the first three even number digits
- 3) add together the results of step 1 and 2, then subtract from 100
- 4) the low order digit from the result of step 3 should be the check digit

For example:

Provider Number 8321597

- 1) $(8 + 2 + 5) \times 2 = 30$
- 2) $3 + 1 + 9 = 13$
- 3) $100 - (30 + 13) = 57$
- 4) 7 should be the check digit

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-25

DATA ELEMENT: Payments Received

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
25	9(08)V99S	RIGHT	ZEROES	173	182	R

DEFINITION: This field denotes the amount of payments already received from other payers.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL54 A, B, C

REMARKS: N/A

MEDICAID

NOTES:

04/15/04 For INPATIENT and OUTPATIENT HOSPITAL claims, enter the amount the hospital is obligated to accept or has received, whichever is greater, toward payment of the bill from sources other than Medicare prior to billing Ohio Medicaid. For Medicare Part C claims, record actual payment received from Medicare HMO Part C Plan as it appears on the Medicare HMO remittance advice. Third party payments received must be indicated in this item and should appear on the line item corresponding to the appropriate payer code in Form Locator 50 A, B, and C. **NON-PAYMENT MUST BE REPORTED USING THE OCCURRENCE CODES AVAILABLE IN FORM LOCATORS 32-35.**

04/15/04 For NURSING FACILITY claims, enter the amount the facility has received toward payment of the bill from sources other than Medicare prior to billing Ohio Medicaid. For Medicare HMO claims, record actual payment received from the Medicare HMO Plan as it appears on the Medicare HMO remittance advice. Third party payments received must be indicated in this item and should appear on the line item corresponding to the appropriate payer code in Form

RECORD NAME: THIRD PARTY PAYER DATA RECORD/FIELD: 30-25

DATA ELEMENT: Payments Received

(CONTINUED)

Locator 50 A, B, and C. NON-PAYMENT MUST BE REPORTED
USING THE OCCURRENCE CODES AVAILABLE IN FORM LOCATORS
32-35.

For HOME HEALTH*, enter the amount the home health
agency has received toward payment of the bill
prior to billing Ohio Medicaid. Third party
payments received must be indicated in this item
and should appear on the line item corresponding
to the appropriate payer code in Form Locator 50
A, B, and C. NON-PAYMENT MUST BE REPORTED USING
THE OCCURRENCE CODES AVAILABLE IN FORM LOCATORS 32-35.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

CLAIM DATA - TAN-OCCURRENCE

RECORD TYPE: 40

NATIONAL VER. 006.00 - 08/01/2000

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD TYPE: 40

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding Treatment Authorization Numbers and Occurrence Codes and Dates relative to a claim.

REQUIREMENTS: This record is required.

Record Type 40 must follow a Third Party Payer Record (record 30). There must be one record type 40 per Patient Record (record 20).

ORDER:	Preceding Record Type	Following Record Type
	-----	-----
	30	41 or 50

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE

RECORD TYPE: 40

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '40'	2	X	1	2
2	SEQUENCE NUMBER	2	N	3	4
3	PATIENT CONTROL NUMBER	20	X	5	24
4	TYPE OF BILL	3	N	25	27
5	TREATMENT AUTHORIZATION CODE-A	18	X	28	45
6	TREATMENT AUTHORIZATION CODE-B	18	X	46	63
7	TREATMENT AUTHORIZATION CODE-C	18	X	64	81
8	OCCURRENCE CODE - 1	2	X	82	83
9	OCCURRENCE DATE - 1 (CCYYMMDD)	8	N	84	91
10	OCCURRENCE CODE - 2	2	X	92	93
11	OCCURRENCE DATE - 2 (CCYYMMDD)	8	N	94	101
12	OCCURRENCE CODE - 3	2	X	102	103
13	OCCURRENCE DATE - 3 (CCYYMMDD)	8	N	104	111
14	OCCURRENCE CODE - 4	2	X	112	113
15	OCCURRENCE DATE - 4 (CCYYMMDD)	8	N	114	121
16	OCCURRENCE CODE - 5	2	X	122	123
17	OCCURRENCE DATE - 5 (CCYYMMDD)	8	N	124	131
18	OCCURRENCE CODE - 6	2	X	132	133
19	OCCURRENCE DATE - 6 (CCYYMMDD)	8	N	134	141
20	OCCURRENCE CODE - 7	2	X	142	143
21	OCCURRENCE DATE - 7 (CCYYMMDD)	8	N	144	151
22	OCCURRENCE SPAN CODE - 1	2	X	152	153
23	OCCURRENCE SPAN FROM DATE - 1 (CCYYMMDD)	8	N	154	161
24	OCCURRENCE SPAN THRU DATE - 1	8	N	162	169
25	OCCURRENCE SPAN CODE - 2	2	X	170	171
26	OCCURRENCE SPAN FROM DATE - 2 (CCYYMMDD)	8	N	172	179
27	OCCURRENCE SPAN THRU DATE - 2 (CCYYMMDD)	8	N	180	187
28	FILLER (NATIONAL USE)	5	X	188	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Claim Data - TAN-Occurrence Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "40".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	05	24	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-4

DATA ELEMENT: Type of Bill

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
4	9(03)	LEFT	SPACES	25	27	R

DEFINITION: This field is a code that represents the type of bill being submitted.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL4

REMARKS: N/A

MEDICAID

NOTES:

The following bill types are consolidated into groups defined by the Type of Batch which occurs on Record Type 10, Provider (Batch) header.

For INPATIENT HOSPITAL claims, the following bill types are allowed for hospital paid under the prospective payment system (DRG):

- 110 = Zero Pay Bill (used by DRG hospitals reporting late charges - not reimbursable)
- 111 = Hospital inpatient admit through discharge (including Inpatient Medicare HMO PART C claims)
- 112 = Hospital inpatient 1st interim bill (see Form Locator 4: Note A)
- 113 = Hospital inpatient continuing interim bill (see Form Locator 4: Note A)
- 121 = Hospital inpatient admit through discharge (patient has Medicare Part B only - Billing Medicaid for Part A)

04/15/04

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-4
DATA ELEMENT: Type of Bill

(CONTINUED)

-
- 122 = Hospital inpatient 1st interim bill (patient has Medicare Part B only - Billing Medicaid for Part A)
 - 123 = Hospital inpatient continuing interim bill (patient has Medicare Part B only - Billing Medicaid for Part A)

The following bill types are allowable for INPATIENT claims in DRG EXEMPT HOSPITALS. (Certain types of hospitals are not subject to the prospective payment system and are referred to as DRG-exempt hospitals. Generally, DRG-exempt hospitals include freestanding rehabilitation and long-term hospitals and Ohio hospitals which are owned and operated by health maintenance organizations.)

- 04/15/04 111 = Hospital inpatient admit through discharge (including Inpatient Medicare HMO Part C claims)
- 112 = Hospital inpatient 1st interim bill (see Form Locator 4: Note A)
- 113 = Hospital inpatient continuing interim bill (see Form Locator 4: Note A)
- 114 = Hospital inpatient last interim bill
- 115 = Hospital inpatient late charges
- 121 = Hospital inpatient (patient has Medicare Part B only - Billing Medicaid for Part A) admit through discharge
- 122 = Hospital inpatient 1st interim bill (patient has Medicare Part B only - Billing Medicaid for Part A)
- 123 = Hospital inpatient continuing interim bill (patient has Medicare Part B only - Billing Medicaid for Part A)
- 124 = Hospital inpatient last interim bill (patient has Medicare Part B only - Billing Medicaid for Part A)
- 125 = Hospital inpatient late charges (patient has Medicare Part B only - Billing Medicaid for Part A)

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-4

NOTE A:

For discharges beginning on September 3, 1991, claims qualify for advance interim payment on the 30th day of a consecutive inpatient stay and at 30-day intervals thereafter. Hospitals will be paid at a percentage of the billed charges using the hospital specific cost-to-charge ratio.

Hospitals subject to DRG payment may use bill types 112 and 113 or 122 and 123, as appropriate, when submitting these bills electronically to the department. However, the final bill must be a complete admit through discharge bill utilizing bill types 111 or 121 as appropriate.

Hospitals exempt from DRG payment must bill their final interim bill through normal claims processing channels, using bill types 114 or 124.

For OUTPATIENT HOSPITAL claims, the following codes are allowed:

04/15/04

- 131 = Outpatient admit through discharge (including Outpatient Medicare HMO PART C claims)
- 135 = Outpatient late charge. Only two late charge bills may be submitted per provider, per recipient, per date of service only for laboratory, clinic, emergency room, pregnancy services and radiology services. Late charges will not be accepted for any other services. Any other adjustments must be submitted to the Claims Adjustment Unit.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-4

DATA ELEMENT: Type of Bill

(CONTINUED)

For HOME HEALTH* claims, the following codes are allowed:

- 331 = Admit through discharge. Used for a bill which is expected to be the only bill the payer will receive for a course of treatment.
- 332 = Interim - First Claim. Used for the first of a series of bills for the same course of treatment.
- 333 = Interim - Continuing Claim. Used when a bill for the same course of treatment has already been submitted and it is expected that further billings for the same course of treatment will be submitted.
- 334 = Interim - Last Claim. Used for the last of a series of bills for the same course of treatment.
- 335 = Late Charge(s) Only Claim. Used for submitting charges which were received by the provider after the admit through discharge or the last interim claim has been submitted.

For NURSING FACILITY THERAPY SERVICES claims, bill type 231 must always be used.

04/15/04

For NURSING FACILITY PART A crossover claims, the bill type must be copied from the Medicare Remittance Advice.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-4

DATA ELEMENT: Type of Bill

(CONTINUED)

04/15/04

For NURSING FACILITY PART C claims, the bill type must be copied from the Medicare HMO remittance advice. The following codes are allowed:

- 211 = Nursing facility admit thru discharge
- 212 = Nursing facility interim - first claim
- 213 = Nursing facility interim - continuing claim
- 214 = Nursing facility interim - last claim

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-5
 40-6
 40-7

DATA ELEMENT: Treatment Authorization Code - A
 Treatment Authorization Code - B
 Treatment Authorization Code - C

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----	-----	-----	-----	-----	-----	---
5	X(18)	LEFT	SPACES	28	45	0
6	X(18)	LEFT	SPACES	46	63	0
7	X(18)	LEFT	SPACES	64	81	0

DEFINITION: This field is an authorization number for treatment.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL63 A, B, C

REMARKS: N/A

MEDICAID

NOTES: Medicaid will only use the Treatment Authorization Code A, B or C which corresponds to the Payer Identification 100 (Medicaid).

For INPATIENT HOSPITAL claims, elective inpatient admissions not exempt from pre-certification require the appropriate six-digit pre-certification as issued by ODJFS or its review agency.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-5

DATA ELEMENT: Treatment Authorization Codes

(CONTINUED)

For services which require prior authorization, enter the six-digit prior authorization control number as found on the approved ODJFS Prior Authorization Form (ODJFS 3142).

For OUTPATIENT HOSPITAL claims, services which require prior authorization from the Ohio Department of Job and Family Services should use the six-digit prior authorization control number as found on the approved ODJFS #3142.

For NURSING FACILITY THERAPY SERVICES claims, services which require prior authorization from the Ohio Department of Human Services should use the six-digit prior authorization control number as found on the approved ODJFS 3142.

For NURSING FACILITY and HOME HEALTH* crossover claims, this field is not required.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-8
 THRU 40-21

DATA ELEMENT: Occurrence Code - 1 Occurrence Code - 5
 Occurrence Date - 1 Occurrence Date - 5
 Occurrence Code - 2 Occurrence Code - 6
 Occurrence Date - 2 Occurrence Date - 6
 Occurrence Code - 3 Occurrence Code - 7
 Occurrence Date - 3 Occurrence Date - 7
 Occurrence Code - 4
 Occurrence Date - 4
 Occurrence Code - 5
 Occurrence Date - 5

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
8	X(02)	LEFT	SPACES	82	83	0
9	9(08)	RIGHT	ZEROES	84	91	0
10	X(02)	LEFT	SPACES	92	93	0
11	9(08)	RIGHT	ZEROES	94	101	0
12	X(02)	LEFT	SPACES	102	103	0
13	9(08)	RIGHT	ZEROES	104	111	0
14	X(02)	LEFT	SPACES	112	113	0
15	9(08)	RIGHT	ZEROES	114	121	0
16	X(02)	LEFT	SPACES	122	123	0
17	9(08)	RIGHT	ZEROES	124	131	0
18	X(02)	LEFT	SPACES	132	133	0
19	9(08)	RIGHT	ZEROES	134	141	0
20	X(02)	LEFT	SPACES	142	151	0
21	9(08)	RIGHT	ZEROES	152	153	0

DEFINITION: These fields are codes and dates describing what events occurred or conditions exists and when they happened or the institution was notified.

CODE VALUES: N/A

VALIDATION: The dates must be in the CMMDDYY format.

FORM LOCATION: UB-92 FL32A, FL33A, FL34A, FL35A, FL32B

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-8
THRU
40-21

DATA ELEMENT: Occurrence Codes and Dates

(CONTINUED)

MEDICAID

NOTES:

- NOTE A:** Fields 32a through 35a must be completed before the "b" fields
- NOTE B:** The Medicaid payment system will only use the first five (5) occurrence codes entered on the UB-92.

For INPATIENT HOSPITAL claims, enter when appropriate the two-digit codes and dates from the following list. Refer to the Ohio UB-92 Manual for instructions on what date to enter.

- 01 = Auto Accident
- 02 = Auto Accident/No Fault Insurance Involved
- 03 = Accident/Tort Liability
- 04 = Accident/Employment Related
- 05 = Other Accident
- 06 = Crime Victim
- 10 = Last menstrual period. The date of the last menstrual period. Applicable when the patient is being treated for a maternity related condition. Not required.
- 24 = Date Insurance Denied
- 25 = Date Benefits Terminated by Primary Payer
- 42 = Date of Discharge when "Through" date in Item 6 is not the actual discharge date and frequency code in Item 4 is that of final bill
- 50 = Medicaid Benefits Exhaust Date. Applicable when limits are placed on Medicaid coverage.
- 51 = No response from carrier for 90 days following first service date. DO NOT BILL THIS CLAIM UNTIL THE 91st DAY FROM THE FIRST SERVICE DATE ON THE CLAIM.
- 52 = No coverage for this Medicaid Recipient ID
- 53 = Non-covered service
- 54 = Disputed or contested liability

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-8
THRU
40-21

DATA ELEMENT: Occurrence Codes and Dates

(CONTINUED)

-
- 55 = Recipient denies coverage for all Medicaid Recipient Numbers
 - 56 = Non-cooperative recipient
 - A3 = Benefits Exhausted - Payer A
 - B3 = Benefits Exhausted - Payer B
 - C3 = Benefits Exhausted - Payer C
- For INPATIENT HOSPITAL crossover claims:
- 57 = Date of Medicare Primary Payment. Date of Medicare Primary Payment on a Medicare/Medicaid Crossover claim. This date must match the pay date on the Medicare remittance advice.
- 04/15/04 For INPATIENT HOSPITAL MEDICARE HMO PART C claims:
- 57 = Date of Medicare HMO Plan primary payment. This date must match the pay date on the Medicare HMO plan remittance advice. For providers who are subject to a capitation arrangement with the Medicare HMO, use Code 57 and the Date of submission to Medicaid. The Date of submission to Medicaid must not be more than 365 days from the date of service.
- For OUTPATIENT HOSPITAL claims, enter when appropriate the two-digit codes and dates from the following list. Refer to the Ohio UB-92 Manual for instructions on what date to enter.
- 01 = Auto Accident
 - 02 = Auto Accident/No Fault Insurance Involved
 - 03 = Accident/Tort Liability
 - 04 = Accident/Employment Related
 - 05 = Other Accident
 - 06 = Crime Victim
 - 10 = Last menstrual period. The date of the last menstrual period. Applicable when the patient is being treated for a maternity related condition. Not required.
 - 24 = Date Insurance Denied
 - 25 = Date Benefits Terminated/Exhausted by Primary Payer

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-8
THRU
40-21

DATA ELEMENT: Occurrence Codes and Dates

(CONTINUED)

-
- 43 = Outpatient Operating Room Prepared - Surgery Cancelled. NOTE: ONE OF THE TWO LOCAL LEVEL CANCELLED SURGERY CODES MUST BE BILLED ON A CLAIM ALSO CARRYING THIS OCCURRENCE CODE
 - 50 = Medicaid Benefits Exhaust Date. Applicable when limits are placed on Medicaid coverage.
 - 51 = No response from carrier for 90 days following first service date. DO NOT BILL THIS CLAIM UNTIL THE 91st DAY FROM THE FIRST SERVICE DATE ON THE CLAIM.
 - 52 = No coverage for this Medicaid Recipient ID
 - 53 = Non-covered service
 - 54 = Disputed or contested liability
 - 55 = Recipient denies coverage for all case identification numbers
 - 56 = Non-cooperative recipient
 - A3 = Benefits Exhausted - Payer A
 - B3 = Benefits Exhausted - Payer B
 - C3 = Benefits Exhausted - Payer C

For OUTPATIENT HOSPITAL crossover claims:

- 57 = Date of Medicare Primary Payment. Date of Medicare Primary Payment on a Medicare/Medicaid Crossover claim. This date must match the pay date on the Medicare remittance advice.

04/15/04

For OUTPATIENT HOSPITAL MEDICARE HMO PART C claims:

- 57 = Date of Medicare HMO Part C primary payment. This date must match the pay date on the Medicare HMO plan remittance advice. For providers who are subject to a capitation arrangement with the Medicare HMO, use Code 57 and the Date of submission to Medicaid. The Date of submission to Medicaid must not be more than 365 days from the date of service.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-8
THRU
40-21

DATA ELEMENT: Occurrence Codes and Dates

(CONTINUED)

For NURSING FACILITY THERAPY SERVICES claims,
enter the appropriate two-digit codes and date
from the following list. Refer to the Ohio UB-92
Manual for instructions on what date to enter.

- 01 = Auto Accident
- 02 = Auto Accident/No Fault Insurance Involved
- 03 = Accident/Tort Liability
- 04 = Accident/Employment Related
- 05 = Other Accident
- 06 = Crime Victim`
- 23 = Medicare benefits exhausted
- 24 = Date Insurance Denied
- 25 = Date Benefits Terminated/Exhausted by Primary
Payer
- 35 = Date treatment started for skilled physical
therapy
- 44 = Date treatment started for skilled occupational
therapy
- 45 = Date treatment started for skilled speech
therapy/audiology
- 51 = No response from carrier for 60-90 days
following first service date. DO NOT BILL THIS
CLAIM UNTIL THE 91st DAY FROM THE FIRST SERVICE
DATE ON THE CLAIM.
- 52 = No coverage for this Medicaid number
- 53 = Non-covered service
- 54 = Disputed or contested liability
- 55 = Recipient denies coverage for all case
identification numbers
- 56 = Non-cooperative recipient

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-8
THRU
40-21

DATA ELEMENT: Occurrence Codes and Dates

(CONTINUED)

For NURSING FACILITY crossover claims:

- 24 = Date Insurance Denied
- 25 = Date Benefits Terminated/Exhausted by Primary Payer
- 35 = Date treatment started for skilled physical therapy
- 44 = Date treatment started for skilled occupational therapy
- 45 = Date treatment started for skilled speech therapy/audiology
- 51 = No response from carrier for 60-90 days following first service date. DO NOT BILL THIS CLAIM UNTIL THE 91st DAY FROM THE FIRST SERVICE DATE ON THE CLAIM.
- 52 = No coverage for this Medicaid number
- 53 = Non-covered service
- 54 = Disputed or contested liability
- 55 = Recipient denies coverage for all case identification numbers
- 56 = Non-cooperative recipient
- 57 = Date of Medicare Primary Payment. Date of Medicare Primary Payment on a Medicare/Medicaid Crossover claim. This date must match the pay date on the Medicare remittance advice.

04/15/04

For Nursing Facility Part C claims, enter occurrence code 57 and the date payment was made by the Medicare HMO Plan. This date must match the pay date on the Medicare HMO remittance advice. For providers who are subject to a capitation arrangement with the Medicare HMO, use Code 57 and the Date of submission to Medicaid. The Date of submission to Medicaid must not be more than 365 days from the date of service.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-5 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - TAN-OCCURRENCE RECORD/FIELD: 40-8
THRU
40-21

DATA ELEMENT: Occurrence Codes and Dates

(CONTINUED)

For HOME HEALTH* claims, enter the code and associated date defining a significant event relating to this bill. Code 27 is a required entry.

- 25 = Date Benefits Terminated/Exhausted by Primary Payer. The date on which coverage is no longer available to the patient.
- 27 = Date Home Health Plan established or last reviewed.
- 51 = No response from carrier for 90 days following first service date. DO NOT BILL THIS CLAIM UNTIL THE 91st DAY FROM THE FIRST SERVICE DATE ON THE CLAIM.
- 52 = No coverage for this Medicaid Recipient ID. There is insurance coverage in the case but not for this patient.
- 53 = Non-covered service. Home Health services are not covered under other third party insurance policy.
- 54 = Disputed or contested liability. The health insurance carrier is uncooperative in clarifying their legal liability.
- 55 = Recipient denies coverage for all case identification numbers
- 56 = Non-cooperative recipient. The recipient refuses to provide information necessary to bill third party.
- A3 = Benefits Exhausted - Payer A. The last date for which benefits are available, and after which no payment can be made by the payer listed in Item 50A.
- B3 = Benefits Exhausted - Payer B. The last date for which benefits are available, and after which no payment can be made by the payer listed in Item 50B.
- C3 = Benefits Exhausted - Payer C. The last date for which benefits are available, and after which no payment can be made by the payer listed in Item 50C.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

CLAIM DATA - CONDITION-VALUE

RECORD TYPE: 41

NATIONAL VER. 006.00 - 08/01/2000

III-85

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD TYPE: 41

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding treatment events on a claim.

REQUIREMENTS: This record is optional.

ORDER:	Preceding Record Type	Following Record Type
	-----	-----
	40	40 or 50

MEDICAID
NOTES: Only one 41 record will be processed per claim.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD TYPE: 41

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '41'	2	X	1	2
2	SEQUENCE NUMBER	2	N	3	4
3	PATIENT CONTROL NUMBER	20	X	5	24
4	CONDITION CODE - 1	2	X	25	26
5	CONDITION CODE - 2	2	X	27	28
6	CONDITION CODE - 3	2	X	29	30
7	CONDITION CODE - 4	2	X	31	32
8	CONDITION CODE - 5	2	X	33	34
9	CONDITION CODE - 6	2	X	35	36
10	CONDITION CODE - 7	2	X	37	38
11	CONDITION CODE - 8	2	X	39	40
12	CONDITION CODE - 9	2	X	41	42
13	CONDITION CODE - 10	2	X	43	44
14	FORM LOCATOR 31 (UPPER)	5	X	45	49
15	FORM LOCATOR 31 (LOWER)	6	X	50	55
16	VALUE CODE - 1	2	X	56	57
17^	VALUE AMOUNT - 1	9	NS	58	66
18	VALUE CODE - 2	2	X	67	68
19^	VALUE AMOUNT - 2	9	NS	69	77
20	VALUE CODE - 3	2	X	78	79
21^	VALUE AMOUNT - 3	9	NS	80	88
22	VALUE CODE - 4	2	X	89	90
23^	VALUE AMOUNT - 4	9	NS	91	99
24	VALUE CODE - 5	2	X	100	101
25^	VALUE AMOUNT - 5	9	NS	102	110
26	VALUE CODE - 6	2	X	111	112
27^	VALUE AMOUNT - 6	9	NS	113	121
28	VALUE CODE - 7	2	X	122	123
29^	VALUE AMOUNT - 7	9	NS	124	132
30	VALUE CODE - 8	2	X	133	134
31^	VALUE AMOUNT - 8	9	NS	135	143
32	VALUE CODE - 9	2	X	144	145
33^	VALUE AMOUNT - 9	9	NS	146	154
34	VALUE CODE - 10	2	X	155	156
35^	VALUE AMOUNT - 10	9	NS	157	165

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD TYPE: 41
(CONTINUED)

36	VALUE CODE - 11	2	X	166	167
37^	VALUE AMOUNT - 11	9	NS	168	176
38	VALUE CODE - 12	2	X	177	178
39^	VALUE AMOUNT - 12	9	NS	179	187
40	FILLER (NATIONAL USE)	5	X	188	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Claim Data - Condition-Value Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "41".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	05	24	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

**MEDICAID
NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-4
THRU
41-13

DATA ELEMENT: Condition Code - 1 Condition Code - 6
Condition Code - 2 Condition Code - 7
Condition Code - 3 Condition Code - 8
Condition Code - 4 Condition Code - 9
Condition Code - 5 Condition Code - 10

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
4	X(02)	LEFT	SPACES	25	26	0
5	X(02)	LEFT	SPACES	27	28	0
6	X(02)	LEFT	SPACES	29	30	0
7	X(02)	LEFT	SPACES	31	32	0
8	X(02)	LEFT	SPACES	33	34	0
9	X(02)	LEFT	SPACES	33	34	0
10	X(02)	LEFT	SPACES	33	34	0
11	X(02)	LEFT	SPACES	33	34	0
12	X(02)	LEFT	SPACES	33	34	0
13	X(02)	LEFT	SPACES	33	34	0

DEFINITION: These fields are a series of codes describing the patient's condition.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL24-30

REMARKS: N/A

MEDICAID

NOTES: The Medicaid payment system will only use the first five (5) condition codes entered on the UB-92.

For INPATIENT HOSPITAL claims, enter when appropriate the two-digit codes from the following:
02 = Condition is employment related
03 = Patient covered by insurance not reflected here
39 = Private room medically necessary

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-4
THRU
41-13

DATA ELEMENT: Condition Codes

(CONTINUED)

71 = Full care in dialysis unit
72 = Self-care in dialysis unit
73 = Self-care training
74 = Home dialysis
75 = Home - 100% reimbursement - Home dialysis using
a machine purchased by Medicare under the 100%
program
76 = Back-up in-facility dialysis (for home dialysis
patients)
A1 = HEALTHCHEK/(EPSDT)
A2 = Bureau of Children With Medical Handicaps/(BCCS)
A4 = Family Planning
AA = Abortion Due to Rape
AB = Abortion Performed Due to Incest
AD = Abortion Performed Due to a Life Endangering
Physical Condition Caused by, Arising from, or
Exacerbated by the Pregnancy Itself
AI = Sterilization

Note: Condition codes 81, 85-96, 98, A7, X0, and X1 were eliminated under
HIPAA, effective for services provided on or after 10/16/03.
\$For replacement of condition code 81, see value code 31.
\$For replacement of condition codes 88-96, see value code 54.
\$Condition code A7 was replaced with condition code AD.
\$Condition codes X0 and X1 were replaced with condition code A1.
\$Condition codes 85 and 98 were not replaced.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-4
THRU
41-13

DATA ELEMENT: Condition Codes

(CONTINUED)

For OUTPATIENT HOSPITAL claims, enter the
appropriate two-digit codes from the following:

- 02 = Condition is employment related
- 03 = Patient covered by insurance not reflected here
- 71 = Full care in unit
- 72 = Self-care in unit
- 73 = Self-care training
- A1 = HEALTHCHEK/(EPSDT)
- A2 = Bureau of Children With Medical Handicaps/(BCCS)
- A4 = Family Planning
- AA = Abortion Due to Rape
- AB = Abortion Performed Due to Incest
- AD = Abortion Performed Due to a Life Endangering
Physical Condition Caused by, Arising from, or
Exacerbated by the Pregnancy Itself
- AI = Sterilization
- C3 = Partial Approval (This code should only be used
when billing on the outpatient basis for an admission
that upon retrospective review, the location of
service was determined by the medical review entity
to not be medically necessary, but the services
rendered were medically necessary).

Note: Condition codes 81, 85-96, 98, A7, X0, and X1 were eliminated under
HIPAA, effective for services provided on or after 10/16/03.

\$Condition code A7 was replaced with condition code AD.

\$Condition codes X0 and X1 were replaced with condition code A1.

\$Condition code 86 was replaced by condition code C3.

\$Condition code 87 was replaced by adding modifier A-22" to the emergency
room procedure code, see rule 5101:3-2-21 of the OAC.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-4
THRU
41-13

(CONTINUED)

For NURSING FACILITY claims, these fields are not required.

For HOME HEALTH* claims, when applicable, enter the following condition code to indicate that the recipient is on Medicare, but not homebound.

83 = Home Health Patient is not Homebound. Services rendered are outside of the Medicare scope of coverage.

NOTE: A Medicare denial is not required. However, documentation supporting this condition must be kept in the patient's file at the home health agency for a period of six years.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT
 RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-16
 THRU
 41-39

DATA ELEMENT: Value Code - 1 Value Code - 7
 Value Amount - 1 Value Amount - 7
 Value Code - 2 Value Code - 8
 Value Amount - 2 Value Amount - 8
 Value Code - 3 Value Code - 9
 Value Amount - 3 Value Amount - 10
 Value Code - 4 Value Code - 11
 Value Amount - 4 Value Amount - 11
 Value Code - 5 Value Code - 12
 Value Amount - 5 Value Amount - 12
 Value Code - 6
 Value Amount - 6

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
16	X(02)	LEFT	SPACES	56	57	0
17	9(07)V99S	RIGHT	ZEROES	58	66	0
18	X(02)	LEFT	SPACES	67	68	0
19	9(07)V99S	RIGHT	ZEROES	69	77	0
20	X(02)	LEFT	SPACES	78	79	0
21	9(07)V99S	RIGHT	ZEROES	80	88	0
22	X(02)	LEFT	SPACES	89	90	0
23	9(07)V99S	RIGHT	ZEROES	91	99	0
24	X(02)	LEFT	SPACES	100	101	0
25	9(07)V99S	RIGHT	ZEROES	102	110	0
26	X(02)	LEFT	SPACES	111	112	0
27	9(07)V99S	RIGHT	ZEROES	113	121	0
28	X(02)	LEFT	SPACES	122	123	0
29	9(07)V99S	RIGHT	ZEROES	124	132	0
30	X(02)	LEFT	SPACES	133	134	0
31	9(07)V99S	RIGHT	ZEROES	135	143	0
32	X(02)	LEFT	SPACES	144	145	0
33	9(07)V99S	RIGHT	ZEROES	146	154	0
34	X(02)	LEFT	SPACES	155	156	0
35	9(07)V99S	RIGHT	ZEROES	157	165	0
36	X(02)	LEFT	SPACES	166	167	0
37	9(07)V99S	RIGHT	ZEROES	168	176	0
38	X(02)	LEFT	SPACES	177	178	0
39	9(07)V99S	RIGHT	ZEROES	179	187	0

DEFINITION: These fields are a series of codes and amounts
 which describe the finance or frequency of treatment visits.
 CODE VALUES: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-16
THRU
41-39

DATA ELEMENT: Value Codes and Amounts

(CONTINUED)

VALIDATION: N/A

FORM LOCATION: UB-92 FL39 A-D, 40 A-D, 41 A-D

REMARKS: N/A

MEDICAID

NOTES:

NOTE A: Value code 05 is not an acceptable code for Medicaid. Use of this code will cause claim to reject.

NOTE B: Value codes must be entered into 39a, 40a, and 41a before 39b, 40b, 41b; and so on.

NOTE C: The Medicaid payment system will only use the first eight (8) value codes entered on the UB-92.

For INPATIENT HOSPITAL claims, enter, when appropriate, the following two-digit code and associated dollar amount:

- 02 = Hospital has no semi-private rooms (do not list any dollar amounts)
- 23 = Recurring monthly income (Medicaid spend-down amount received by the hospital from the patient)
- 31 = Patient Liability Amount (Required when a patient chooses a private room and agrees to pay the room differential. Differential must also be reported as non-covered charges for revenue code 011X).
- 54 = Newborn birth weight in grams (Required for all newborns as well as any neonates that group to DRG 385)

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-16
THRU
41-39

DATA ELEMENT: Value Codes and Amounts

(CONTINUED)

04/15/04

For INPATIENT HOSPITAL MEDICARE HMO PART C claims:

- E1 = Medicare HMO deductible, non-capitated
- E2 = Medicare HMO coinsurance, non-capitated
- E3 = Medicare HMO allowed amount, non-capitated
(always required)
- E7 = Medicare HMO co-payment, non-capitated
- F1 = Medicare HMO deductible, capitated
- F2 = Medicare HMO coinsurance, capitated
- F3 = Medicare HMO allowed amount, capitated
(always required)
- F7 = Medicare HMO co-payment, capitated

For INPATIENT HOSPITAL crossover claims:

- 02 = Hospital has no semi-private rooms (do not list dollar amounts)
- 06 = Medicare Part A Blood Deductible
- 23 = Recurring monthly income (Medicare spend-down amount received by the hospital from the patient)
- A1 = Deductible, Payer A.
- B1 = Deductible, Payer B.
- C1 = Deductible, Payer C.
- A2 = Coinsurance, Payer A.
- B2 = Coinsurance, Payer B.
- C2 = Coinsurance, Payer C.
- 31 = Patient Liability Amount (Required when a patient chooses a private room and agrees to pay the room differential. Differential must also be reported as non-covered charges for revenue code 011X).
- 54 = Newborn birth weight in grams (Required for all newborns as well as any neonates that group to DRG 385)

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-16
THRU
41-39

DATA ELEMENT: Value Codes and Amounts

(CONTINUED)

For OUTPATIENT HOSPITAL claims, enter, when appropriate, the following two-digit code and associated dollar amount:

23 = Recurring monthly income (Medicaid spend-down amount received by the hospital from the patient)

For OUTPATIENT HOSPITAL crossover claims:

23 = Recurring monthly income (Medicaid spend-down amount received by the hospital from the patient)

A1 = Deductible, Payer A.
B1 = Deductible, Payer B.
C1 = Deductible, Payer C.
A2 = Coinsurance, Payer A.
B2 = Coinsurance, Payer B.
C2 = Coinsurance, Payer C.

04/15/04

For OUTPATIENT HOSPITAL MEDICARE HMO PART C claims:

E1 = Medicare HMO deductible, non-capitated
E2 = Medicare HMO coinsurance, non-capitated
E3 = Medicare HMO allowed amount, non-capitated
(always required)
E7 = Medicare HMO co-payment, non-capitated
F1 = Medicare HMO deductible, capitated
F2 = Medicare HMO co-insurance, capitated
F3 = Medicare HMO allowed amount, capitated
F7 = Medicare HMO co-payment, capitated

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-16
THRU
41-39

DATA ELEMENT: Value Codes and Amounts

(CONTINUED)

For HOME HEALTH claims, these fields are not required.

For NURSING FACILITY THERAPY SERVICES claims, this field is required. Enter the following two-digit code and associated number of days of the appropriate therapy or therapies in the "amount" section of the field, right justified to the left of the dollar/cents delimiter.

50 = Physical therapy visit. Indicates the number of days on which skilled physical therapy services were provided in this billing period.

51 = Occupational therapy visits. Indicates the number of days on which skilled occupational therapy services were provided in this billing period.

52 = Speech therapy or audiology visits. Indicates the number of days on which skilled speech/audiology therapy services were provided in this billing period.

A2 = Coinsurance, Payer A.

B2 = Coinsurance, Payer B.

C2 = Coinsurance, Payer C.

04/15/04

For NURSING FACILITY PART A crossover claims:

23 = Patient resources. Patient resources applied to deductible or coinsurance

A1 = Deductible, Payer A.

B1 = Deductible, Payer B.

C1 = Deductible, Payer C.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM DATA - CONDITION-VALUE RECORD/FIELD: 41-16
THRU
41-39

DATA ELEMENT: Value Codes and Amounts

(CONTINUED)

04/15/04 For NURSING FACILITY PART C claims:

- E1 = Medicare HMO deductible when the provider is reimbursed by the Medicare HMO pursuant to a non-capitated arrangement.
- E2 = Medicare HMO co-insurance when the provider is reimbursed by the Medicare HMO pursuant to a non-capitated arrangement.
- E3 = Medicare HMO allowed amount when the provider is reimbursed by the Medicare HMO pursuant to a non-capitated arrangement. (IF THIS INFORMATION IS NOT PRESENT ON THE CLAIM, THE CLAIM WILL BE DENIED.)
- E7 = Medicare HMO co-payment when the provider is reimbursed by the Medicare HMO pursuant to a non-capitated arrangement.
- F1 = Medicare HMO deductible when the provider is reimbursed by the Medicare HMO pursuant to a capitated arrangement.
- F2 = Medicare HMO co-insurance when the provider is reimbursed by the Medicare HMO pursuant to a capitated arrangement.
- F3 = Medicare HMO allowed amount when the provider is reimbursed by the Medicare HMO pursuant to a capitated arrangement. (IF AN ALLOWED AMOUNT IS REPORTED BY THE MEDICARE HMO ON THE REMITTANCE ADVICE, THE ALLOWED AMOUNT MUST BE REPORTED ON THE MEDICAID CLAIM)
- F7 = Medicare HMO co-payment when the provider is reimbursed by the Medicare HMO pursuant to a capitated arrangement.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

INPATIENT ACCOMODATIONS DATA

RECORD TYPE: 50

NATIONAL VER. 006.00 - 08/01/2000

III-101

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMODATIONS DATA RECORD TYPE: 50

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the accommodations provided for a patient in an **Inpatient setting.**

REQUIREMENTS: This record type must be greater than or equal to the previous record type processed. There must be at least one IP Accommodation Record or an Ancillary Record (record type 60) per Patient Record.

Accommodations must be entered in numeric sequence.

ORDER:	Preceding Record Type ----- 40, 41 or 50	Following Record Type ----- 50, 60 or 70
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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS RECORD RECORD TYPE: 50

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '50'	2	X	1	2
2	SEQUENCE NUMBER	3	N	3	5
3	PATIENT CONTROL NUMBER	20	X	6	26
4 [^]	FILLER (NATIONAL USE)	3	X	27	28
	ACCOMMODATIONS - Repeats 4 times				
[^]	ACCOMMODATIONS - 1	41		29	69
5 [^]	ACCOMMODATIONS REVENUE CODE	4	N	29	32
6 [^]	ACCOMMODATIONS RATE	9	NS	33	41
7 [^]	ACCOMMODATIONS DAYS	4	N	42	45
8 [^]	ACCOMMODATIONS TOTAL CHARGES	10	NS	46	55
9 [^]	ACCOMMODATIONS NONCOVERED CHARGES	10	NS	56	65
10 [^]	FORM LOCATOR 49	4	X	66	69
11 [^]	ACCOMMODATIONS - 2	41		70	110
12 [^]	ACCOMMODATIONS - 3	41		111	151
13 [^]	ACCOMMODATIONS - 4	41		152	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Inpatient Accommodations Data Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "50".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-2

DATA ELEMENT: Sequence Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
2	9(03)	RIGHT	ZEROES	03	05	R

DEFINITION: Field used to sequence multiple records of this type.

CODE VALUES: N/A

VALIDATION: The sequence number for record type 50 can go from 01 to 999, each such physical record containing four accommodations, thus making provision for reporting up to 3996 accommodations on a single claim.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: The Ohio Medicaid payment system limits the number of "line items" to 50 per claim.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	06	25	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

MEDICAID

NOTES: This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-5

DATA ELEMENT: Accommodations Revenue Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	9(04)	RIGHT	ZEROES	29	32	0

DEFINITION: This field is a code describing the type of room provided for the patient.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL42

REMARKS: N/A

MEDICAID

NOTES:

For INPATIENT HOSPITAL claims, enter the appropriate three-digit revenue center code from the coding table in Section III of the Hospital Handbook.

04/15/04

For NURSING FACILITY PART A Crossover claims and Medicare Part C claims, enter the same three-digit revenue center code(s) as on the Medicare bill.

NOTE: Enter revenue center code 001 as the last revenue center code. Charges should be totaled and entered adjacent to revenue center code 001 in Form Locators 47 and 48. Total claim charges must not exceed eight (8) digits.

A revenue description is not required. However, if the revenue center code in Form Locator 42 indicates room and board charges, enter the daily rate in Form Locator 44 and the number of days in Form Locator 46.

NATIONAL VER. 006.00 - 08/01/2000
LOCAL VER. 006.00 - 01/01/2001

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-5

DATA ELEMENT: Accommodations Revenue Code

(CONTINUED)

For revenue center codes 200-210 and 720-729, if used for room and board, room rates and units of service are required in order for the code to be counted as an accommodations day. If revenue center codes 200-219, 720-729 are not used for room and board charges, DO NOT include any rates in Form Locator 44. Merely reflect revenue center charges in Form Locator 47.

NOTE: Any units of service accompanied by a rate in revenue center codes 100-179, 200-219 or 720-729 will be counted as accommodation days. Total accommodation days must be equal to covered days as reflected in Form Locator 7. Any claim with accommodation units (Form Locator 46) which do not equal covered days (Form Locator 7) will be denied.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-6

DATA ELEMENT: Accommodations Rate

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
6	9(07)V99S	RIGHT	ZEROES	33	41	R

DEFINITION: This field is the daily room rate.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL44

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL claims, this field is required. Enter the daily room rate for Revenue Center Codes 200-219 and 720-729.

For NURSING FACILITY crossover claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-6

DATA ELEMENT: Accommodations Days

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
9	9(04)	RIGHT	ZEROES	42	45	R

DEFINITION: This field is the number of days the patient occupied the room.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL46

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL claims, this field is required for inpatient room and board codes. Enter the number of days. The number of accommodation units entered here must equal the number of days in Form Locator 7.

For NURSING FACILITIES crossover claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-7

DATA ELEMENT: Accommodations Total Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
8	9(08)V99S	RIGHT	ZEROES	46	55	R

DEFINITION: This field is the total charges for the particular revenue center code.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL47

REMARKS: N/A

MEDICAID

NOTES: This field is by revenue center code category. Enter the line charge for each revenue center code shown. This entry cannot exceed seven digits. If the charge for a single line exceeds seven digits, make two line entries.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ACCOMMODATIONS DATA RECORD/FIELD: 50-8

DATA ELEMENT: Accommodations Non-covered Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
9	9(08)V99S	RIGHT	ZEROES	56	65	R

DEFINITION: This field is the non-covered charges for the particular revenue center code.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL48

REMARKS: N/A

MEDICAID

NOTES: Enter the line charges for services not covered by Medicaid or any third party payer on the line corresponding to the revenue center code for the service.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

INPATIENT ANCILLARY SERVICES DATA

RECORD TYPE: 60

NATIONAL VER. 006.00 - 08/01/2000

III-113

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA RECORD TYPE: 60

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the services provided for the patient in an **Inpatient setting.**

REQUIREMENTS: This record type must be greater than or equal to the previous record type processed. It must follow the Claim Data - TAN Occurrence record(s) (record 40 and 41) or an IP Accommodation Record (record 50) or an Ancillary Record (record 60). There must be at least one IP Accommodation Record (record 50) or one Ancillary Record for each Inpatient claim.

Inpatient and Outpatient line item record types are not to be mixed.

ORDER:	Preceding Record Type -----	Following Record Type -----
	50 or 60	60 or 70

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA RECORD TYPE: 60

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '60'	2	X	1	2
2^	SEQUENCE NUMBER	3	N	3	5
3	PATIENT CONTROL NUMBER	20	X	6	25
4^	FILLER	2	X	26	27
	INPATIENT ANCILLARIES				
	Repeats 3 times				
	INPATIENT ANCILLARIES - 1	55		28	82
5^	INPATIENT ANCILLARY REVENUE CODE	4	N	28	31
6^	HCPCS PROCEDURE CODE	5	X	32	36
7^	MODIFIER 1 (HCPCS & CPT-4)	2	X	37	38
8^	MODIFIER 2 (HCPCS & CPT-4)	2	X	39	40
9^	INPATIENT ANCILLARY UNITS OF SERVICE	7	N	41	47
10^	INPATIENT ANCILLARY TOTAL CHARGES	10	NS	48	57
11^	INPATIENT ANCILLARY NONCOVERED CHARGES	10	NS	58	67
12^	FORM LOCATOR 49	4	X	68	71
13^	ASSESSMENT DATE (CCYYMMDD)	8	X	72	79
14^	FILLER (NATIONAL USE)	3	X	80	82
15^	INPATIENT ANCILLARIES - 2	55		83	137
16^	INPATIENT ANCILLARIES - 3	55		138	192

NATIONAL VER. 006.00 - 08/01/2000
LOCAL VER. 006.00 - 01/01/2001

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA
RECORD/FIELD: 60-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Inpatient Ancillary Services Data Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "60".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA
RECORD/FIELD: 60-2

DATA ELEMENT: Sequence Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
2	9(03)	RIGHT	ZEROES	03	05	R

DEFINITION: Field used to sequence multiple records of this type.

CODE VALUES: N/A

VALIDATION: The sequence number for record type 60 can go from 001 to 999, each such physical record containing three inpatient ancillary service codes, thus making provision for reporting up to 2997 inpatient ancillary services on a single claim.

FORM LOCATION: N/A

REMARKS: N/A

**MEDICAID
NOTES:**

The Ohio Medicaid payment system limits the number of "line items" to 50 per claim.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA
RECORD/FIELD: 60-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	06	25	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

**MEDICAID
NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA
RECORD/FIELD: 60-5

DATA ELEMENT: Inpatient Ancillary Revenue Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	9(04)	RIGHT	ZEROES	28	31	0

DEFINITION: This field is a code describing services provided for the patient, excluding room and board.

CODE VALUES: N/A

VALIDATION: Inpatient Ancillary Codes must be in code number sequence.

FORM LOCATION: UB-92 FL42

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL claims, enter the appropriate three-digit revenue center code from the coding table in Section III of the Hospital Handbook.

For NURSING FACILITY crossover claims, enter the same three-digit revenue center code as on the Medicare bill.

NOTE: Enter revenue center code 001 as the last revenue center code. Charges should be totaled and entered adjacent to revenue center code 001 in Column 47 and 48. Total claim charges must not exceed eight (8) digits.

A revenue description is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA
RECORD/FIELD: 60-6

DATA ELEMENT: HCPCS Procedure Code/HIPPS

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
6	9(05)	RIGHT	ZEROES	32	36	0

DEFINITION: This field is a code describing services provided for the patient, excluding room and board.

CODE VALUES: N/A

VALIDATION: Inpatient Ancillary Codes must be in code number sequence.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID NOTES: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA
RECORD/FIELD: 60-10

DATA ELEMENT: Inpatient Ancillary Total Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
10	9(08)V99S	RIGHT	ZEROES	48	57	R

DEFINITION: This field is the total charges for the particular revenue center code.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL47

REMARKS: N/A

MEDICAID

NOTES: This field is by revenue center code category. Enter the line charge for each revenue center code shown. This entry cannot exceed seven digits. If the charge for a single line exceeds seven digits, make two line entries.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: INPATIENT ANCILLARY SERVICES DATA
RECORD/FIELD: 60-11

DATA ELEMENT: Inpatient Ancillary Non-covered Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
11	9(08)V99S	RIGHT	ZEROES	58	67	0

DEFINITION: This field is the non-covered charges for the particular revenue center code.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL48

REMARKS: N/A

MEDICAID

NOTES: Enter the line charges for services not covered by Medicaid or any third party payer on the line corresponding to the revenue center code for the service.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

OUTPATIENT PROCEDURES DATA

RECORD TYPE: 61

NATIONAL VER. 006.00 - 08/01/2000

III-123

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD TYPE: 61

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the services provided for the patient in an outpatient setting.

REQUIREMENTS: This record type must be greater than or equal to the previous record type processed.

This record type must not be mixed on a given claim with any record type 50 or 60 (Inpatient procedures).

ORDER:	Preceding Record Type ----- 40, 41, or 61	Following Record Type ----- 61 or 70
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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD TYPE: 61

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '61'	2	X	1	2
2 [^]	SEQUENCE NUMBER	3	N	3	5
3 [^]	PATIENT CONTROL NUMBER	20	X	6	25
4 [^]	FILLER (NATIONAL USE)	2	X	26	27
	REVENUE CENTER - Repeats 3 times				
	REVENUE CENTER -1	55		28	82
5 [^]	REVENUE CENTER CODE	4	N	28	31
6 [^]	HCPCS PROCEDURE CODE	5	X	32	36
7 [^]	MODIFIER 1 (HCPCS & CPT-4)	2	X	37	38
8 [^]	MODIFIER 2 (HCPCS & CPT-4)	2	X	39	40
9 [^]	UNITS OF SERVICE	7	N	41	47
10 [^]	FORM LOCATOR 49	6	X	8	53
11 [^]	OUTPATIENT TOTAL CHARGES	10	NS	54	63
12 [^]	OUTPATIENT NONCOVERED CHARGES	10	NS	64	73
13 [^]	DATE OF SERVICE (CCYYMMDD)	8	N	74	81
14 [^]	FILLER (NATIONAL USE)	1	X	82	82
15 [^]	REVENUE CENTER - 2	55		83	137
16 [^]	REVENUE CENTER - 3	55		138	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Outpatient Procedures Data Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "61".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-2

DATA ELEMENT: Sequence Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
2	9(03)	RIGHT	ZEROES	03	05	R

DEFINITION: Field used to sequence multiple records of this type.

CODE VALUES: N/A

VALIDATION: The sequence number for record type 61 can go from 001 to 999, each such physical record containing three procedures codes, thus making provision for reporting up to 2997 procedures on a single claim.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: The Ohio Medicaid payment system limits the total number of "line items" to 50 per claim.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	06	25	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

**MEDICAID
NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-5

DATA ELEMENT: Revenue Center Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	9(04)	RIGHT	ZEROES	28	31	0

DEFINITION: This field is a code describing services provided for the patient.

CODE VALUES: N/A

VALIDATION: Revenue Center Codes must be in code number sequence.

FORM LOCATION: UB-92 FL42

REMARKS: N/A

**MEDICAID
NOTES:**

NOTE: Enter revenue center code 001 as the last revenue center code. Charges should be totaled and entered adjacent to revenue center code 001 in Form Locator columns 47 and 48. Total claim charges must not exceed eight (8) digits.

For OUTPATIENT HOSPITAL claims, enter the appropriate three-digit revenue center code from the coding table of the Hospital Handbook.

04/15/04

For NURSING FACILITY PART A crossover AND PART C claims, enter the same three-digit revenue center code as on the Medicare bill.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-5

DATA ELEMENT: Revenue Center Code

(CONTINUED)

For NURSING FACILITY THERAPY SERVICES, enter the appropriate three-digit revenue center code from the coding table below:

		<u>SUBCATEGORY</u>	<u>STANDARD ABBREVIATION</u>
42X	Physical Therapy	2-Hourly Charge 4-Evaluation or Reevaluation	PHYS THERP/HOUR PHYS THERP/EVAL
43X	Occupational Therapy	2-Hourly Charge 4-Evaluation or Reevaluation	OCCUP THERP/HOUR OCCUP THERP/EVAL
44X	Speech-Language Pathology/ Audiology	2-Hourly Charge 4-Evaluation or Reevaluation	SPEECH PATH/HOUR SPEECH PATH/EVAL

For HOME HEALTH* claims, enter the appropriate revenue center code from the list below that corresponds with the descriptions listed in Form Locator 43. Medical Supplies and equipment, pregnancy-related services, private duty nursing, and home and community-based waiver services are not billable on the UB-92.

421 = Physical Therapy Visit
431 = Occupational Therapy Visit
441 = Speech Pathology/Therapy visit
551 = Skilled Nursing Visit
571 = Home Health Aide Visit
589 = Other Nursing visit

*see 'General Instructions' regarding HOME HEALTH claim submission.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-6

DATA ELEMENT: HCPCS Procedure Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
6	X(05)	LEFT	SPACES	32	36	0

DEFINITION: This field is the HCPCS Procedure Code describing those services performed to the patient.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL44

REMARKS: N/A

**MEDICAID
NOTES:**

For OUTPATIENT HOSPITAL claims, most outpatient services require a CPT code. Services requiring CPT coding are detailed in the Hospital Handbook. Claims containing line items which are missing required CPT coding will be rejected.

For NURSING FACILITY THERAPY SERVICES, a CPT code must be reported. Claims containing line items which are missing required CPT coding will be rejected.

For NURSING FACILITY and HOME HEALTH crossover claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-7

DATA ELEMENT: HCPCS Procedure Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
7	X(02)	LEFT	SPACES	37	38	0

DEFINITION: This field is the HCPCS Procedure Code Modifier which assists in describing those services performed to the patient.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL44

REMARKS: N/A

MEDICAID

NOTES:

For OUTPATIENT HOSPITAL claims, emergency room trauma services, counseling and education services, cancelled surgeries and pregnancy services require the use of modifiers in certain circumstances. Please consult HHTL 3352-03-5 for additional information regarding the use of modifiers when billing for these outpatient hospital services rendered on or after October 16, 2003.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-9

DATA ELEMENT: Units of Service

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
9	9(07)	RIGHT	ZEROES	41	47	0

DEFINITION: This field represents the number of units for a particular service or product provided.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL46

REMARKS: N/A

MEDICAID

NOTES:

For OUTPATIENT HOSPITAL claims, units can only be used in payment calculation when billed in conjunction with laboratory, radiology, physical therapy CPT codes, occupational therapy local level codes, and local level code X7100 - Observation for Admission Determination. A total of 9 units per laboratory, radiology, occupational therapy or physical therapy line items is allowable whereas a total of 11 units per X7100 is allowable. Claims which carry more than the number of allowable units will be denied.

For NURSING FACILITY THERAPY SERVICES claims, units are required. A total of 9 units per therapy line item is allowable. Claims which carry more than the number of allowable units will be denied.

NATIONAL VER. 006.00 - 08/01/2000
LOCAL VER. 006.00 - 01/01/2001

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-9

DATA ELEMENT: Units of Service

(CONTINUED)

For HOME HEALTH* claims, units are required. Enter the number of visits for the corresponding Revenue Center Code and revenue description in Form Locator columns 42 and 43. Enter total visits adjacent to revenue center code 001.

For NURSING FACILITY crossover claims, this field is not required.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-11

DATA ELEMENT: Outpatient Total Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
11	9(08)V99S	RIGHT	ZEROES	54	63	R

DEFINITION: This field is the total charges for the particular revenue center code.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL47

REMARKS: N/A

MEDICAID

NOTES: For OUTPATIENT HOSPITAL and NURSING FACILITY claims, this field is by revenue center code category. Enter the line charge for each revenue center code shown. Enter total charges adjacent to revenue center code 001. This entry cannot exceed seven digits. If the charge for a single line exceeds seven digits, make two line entries.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-12

DATA ELEMENT: Outpatient Non-covered Charges

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
12	9(08)V99S	RIGHT	ZEROES	64	73	0

DEFINITION: This field is the non-covered charges for the particular revenue center code.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL48

REMARKS: N/A

MEDICAID

NOTES:

For OUTPATIENT HOSPITAL claims, enter the line charges for services not covered by Medicaid or any third party payer on the line corresponding to the revenue center code for the service.

For NURSING FACILITY claims, this field is not required.

For HOME HEALTH* claims, enter the line charges for services not covered by Medicaid or any third party payer on the line corresponding to the revenue center code for the service.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: OUTPATIENT PROCEDURES DATA RECORD/FIELD: 61-13

DATA ELEMENT: Date of Service

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
13	9(08)	RIGHT	ZEROES	74	81	0

DEFINITION: This field represents the date on which the particular service or product was provided.

CODE VALUES: N/A

VALIDATION: This date must be in the format of CMMDDYY.

FORM LOCATION: UB-92 FL45

REMARKS: N/A

MEDICAID

NOTES:

- | For OUTPATIENT HOSPITAL and HOME HEALTH* claims, this field is required. For each line item on an outpatient bill the corresponding eight-digit date of service must be reported. Invoices without a date of service on every line item will be rejected.
- | For NURSING FACILITY THERAPY SERVICES claims, this field is required. For each line item on an outpatient bill the corresponding eight-digit date of service must be reported. Invoices without a date of service on every line item will be rejected.
- | For NURSING FACILITY crossover claims, this field is not required.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

MEDICAL DATA

RECORD TYPE: 70

NATIONAL VER. 006.00 - 08/01/2000

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD TYPE: 70

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the medical condition and procedures.

REQUIREMENTS: This record type must be greater than the previous record type processed. It must follow an IP Accommodation Record (Record Type 50), an Ancillary Record (Record Type 60), or an Outpatient Procedures Record (Record Type 61). There is a limit of one Medical Record per claim.

ORDER:	Preceding Record Type ----- 50, 60 or 61	Following Record Type ----- 80
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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA

RECORD TYPE: 70

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS	
				FROM	THRU
1	RECORD TYPE '70'	2	X	1	2
2	SEQUENCE NUMBER	2	N	3	4
3	PATIENT CONTROL NUMBER	20	X	5	24
4	PRINCIPAL DIAGNOSIS CODE	6	X	25	30
5	OTHER DIAGNOSIS CODE - 1	6	X	31	36
6	OTHER DIAGNOSIS CODE - 2	6	X	37	42
7	OTHER DIAGNOSIS CODE - 3	6	X	43	48
8	OTHER DIAGNOSIS CODE - 4	6	X	49	54
9 [^]	OTHER DIAGNOSIS CODE - 5	6	X	55	60
10 [^]	OTHER DIAGNOSIS CODE - 6	6	X	61	66
11 [^]	OTHER DIAGNOSIS CODE - 7	6	X	67	72
12 [^]	OTHER DIAGNOSIS CODE - 8	6	X	73	78
13	PRINCIPAL PROCEDURE CODE	7	X	79	85
14	PRINCIPAL PROCEDURE DATE (CCYMMDD)	8	N	86	93
15	OTHER PROCEDURE CODE - 1	7	X	94	100
16	OTHER PROCEDURE DATE - 1 (CCYMMDD)	8	N	101	108
17	OTHER PROCEDURE CODE - 2	7	X	109	115
18	OTHER PROCEDURE DATE - 2 (CCYMMDD)	8	N	116	123
19 [^]	OTHER PROCEDURE CODE - 3	7	X	124	130
20 [^]	OTHER PROCEDURE DATE - 3 (CCYMMDD)	8	N	131	138
21 [^]	OTHER PROCEDURE CODE - 4	7	X	139	145
22 [^]	OTHER PROCEDURE DATE - 4 (CCYMMDD)	8	N	146	153
23 [^]	OTHER PROCEDURE CODE - 5	7	X	154	160
24 [^]	OTHER PROCEDURE DATE - 5 (CCUUMDD)	8	N	161	168
25	ADMITTING DIAGNOSIS CODE	6	X	169	174
26	EXTERNAL CAUSE OF INJURY (E-CODE)	6	X	175	180
27	PROCEDURE CODING METHOD USED	1	X	181	181
28	FILLER (NATIONAL USE)	11	X	182	192

[^][^]As of version 6.0, Medicaid will accept eight 'other diagnosis' codes.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

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

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "70".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	05	24	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

**MEDICAID
NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-4

DATA ELEMENT: Principal Diagnosis Code

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
4	X(06)	LEFT	SPACES	25	30	R

DEFINITION: This field is the ICD-9 Code describing the primary diagnosis.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL67

REMARKS: N/A

**MEDICAID
NOTES:**

For INPATIENT HOSPITAL claims, enter the ICD-9-CM code for the principal diagnosis. Hospitals must code to the last available digit of the ICD-9-CM code structure. The principal diagnosis is the condition established after study (discharge diagnosis) to be chiefly responsible for causing the hospitalization. Diagnosis codes are found in ICD-9-CM, Volumes One and Two. Do not use decimal points.

NOTE: DO NOT use "E" codes as a principal diagnosis or the claim will be rejected. DO NOT use "unspecified" diagnosis codes as a principal diagnosis (e.g., 5909-Kidney infection, unspecified) or the claim will be rejected.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-4

DATA ELEMENT: Principal Diagnosis Code

(CONTINUED)

For OUTPATIENT HOSPITAL claims, this field is required on all invoices. Hospitals should code to the last available digit of the ICD-9-CM code structure. Diagnosis codes are found in ICD-9-CM 9th Revision, Volumes One and Two. In the case of cycle bills, this diagnosis code must be associated with all claims on the invoice. Do not use decimal points.

For NURSING FACILITY THERAPY SERVICES claims, this field is required on all invoices. Facilities should code to the last available digit of the ICD-9-CM code structure. Diagnosis codes are found in ICD-9-CM 9th Revision, Volumes One and Two. The principal diagnosis is the condition established to be chiefly responsible for causing the need for skilled therapy services. Do not use decimal points.

04/15/04

For NURSING FACILITY PART A crossover AND PART C claims, facilities should code to the last available digit of the ICD-9-CM code structure. Diagnosis codes are found in ICD-9-CM 9th Revision, Volumes One and Two. The principal diagnosis is the condition established to be chiefly responsible for causing the need for skilled services. Do not use decimal points.

For HOME HEALTH* claims, this field is required on all invoices. Hospitals should code to the last available digit of the ICD-9-CM code structure. Diagnosis codes are found in ICD-9-CM 9th Revision, Volumes One and Two. In the case of cycle bills, this diagnosis code must be associated with all claims on the invoice. Do not use decimal points. "E" codes are not acceptable as a primary diagnosis.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-5
 THRU
 70-12

DATA ELEMENT: Other Diagnosis Code - 1 through 8

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	X(06)	LEFT	SPACES	31	36	0
6	X(06)	LEFT	SPACES	37	42	0
7	X(06)	LEFT	SPACES	43	48	0
8	X(06)	LEFT	SPACES	49	54	0
9	X(06)	LEFT	SPACES	31	36	0
10	X(06)	LEFT	SPACES	37	42	0
11	X(06)	LEFT	SPACES	43	48	0
12	X(06)	LEFT	SPACES	49	54	0

DEFINITION: This field is used for other diagnosis codes.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL68-75

REMARKS: N/A

MEDICAID

NOTES: NOTE: The Medicaid payment system will use a total of FIVE (5) DIAGNOSIS CODES entered on the UB-92. (This includes the Principal and four "Other" Diagnosis Codes.)

For INPATIENT HOSPITAL claims, hospitals must code to the last available digit of the ICD-9-CM code structure for secondary diagnoses for cases which require supplementary medical treatment. When services are rendered as a result of an accident (see Form Locators 32-35), appropriate accident ICD-9-CM coding may be used. Do not use decimal points.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-5
THRU
70-12

DATA ELEMENT: Other Diagnosis Codes

(CONTINUED)

For OUTPATIENT HOSPITAL claims, hospitals must code to the last available digit of the ICD-9-CM code structure for secondary diagnoses for cases which require supplementary medical treatment. When services are rendered as a result of an accident (see Form Locators 32-35), appropriate accident ICD-9-CM coding may be used. Do not use decimal points.

For NURSING FACILITY THERAPY SERVICES claims, facilities must code to the last available digit of the ICD-9-CM code structure for secondary diagnoses for cases which require multiple therapies. Do not use decimal points.

04/15/04

For NURSING FACILITY PART A crossover AND PART C claims, facilities must code to the last available digit of the ICD-9-CM code structure for secondary diagnoses. Do not use decimal points.

For HOME HEALTH* claims, home health agencies must code to the last available digit of the ICD-9-CM code structure for secondary diagnoses for cases which require supplementary medical treatment. When services are rendered as a result of an accident, appropriate accident ICD-9-CM coding may be used. Do not use decimal points.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-13
70-14

DATA ELEMENT: Principal Procedure Code
Principal Procedure Date

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
13	X(07)	LEFT	SPACES	79	85	0
14	9(08)	RIGHT	ZEROES	86	93	0

DEFINITION: These fields are used for the primary procedure code and date.

CODE VALUES: N/A

VALIDATION: The date must be in the format of CCMMDDYY.

FORM LOCATION: UB-92 FL80

REMARKS: N/A

**MEDICAID
NOTES:**

For INPATIENT HOSPITAL claims, only ICD-9-CM coding is acceptable. Enter the ICD-9-CM code identifying the principal surgical, obstetrical or medical procedure. Hospitals must code to the last available digit of the ICD-9-CM code structure. Procedure codes are found in ICD-9-CM Volume Three.

Enter the date the procedure was performed.

If the Principal Procedure is completed, Form Locator 83 (the Operating Physician) must also be completed.

For OUTPATIENT HOSPITAL and NURSING FACILITY claims, these fields are not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: MEDICAL DATA RECORD/FIELD: 70-15
 THRU
 70-24

DATA ELEMENT: Other Procedure Code - 1 through 5
 Other Procedure Date - 1 through 5

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
15	X(07)	LEFT	SPACES	94	100	0
16	9(08)	RIGHT	ZEROES	101	108	0
17	X(07)	LEFT	SPACES	109	115	0
18	9(08)	RIGHT	ZEROES	116	123	0
19^	X(07)	LEFT	SPACES	124	130	0
20^	9(08)	RIGHT	ZEROES	131	138	0
21^	X(07)	LEFT	SPACES	139	145	0
22^	9(08)	RIGHT	ZEROES	146	153	0
23^	X(07)	LEFT	SPACES	139	145	0
24^	9(08)	RIGHT	ZEROES	146	153	0

DEFINITION: These fields are used for secondary procedure codes and dates.

CODE VALUES: N/A

VALIDATION: The dates must be in the format of CCMDDYY.

FORM LOCATION: UB-92 FL81 A-E

REMARKS: N/A

MEDICAID

NOTES: **NOTE: The Medicaid payment system will use a total of THREE (3) PROCEDURE CODES entered on the UB-92. (This includes the Principal and two "Other" Procedure Codes and Dates.)**

For INPATIENT HOSPITAL claims, if applicable, enter the ICD-9-CM codes of other procedures and the dates performed. Hospitals must code to the last available digit of the ICD-9-CM code structure.

For OUTPATIENT HOSPITAL and NURSING FACILITY claims, these fields are not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

PHYSICIAN DATA

RECORD TYPE: 80

NATIONAL VER. 006.00 - 08/01/2000

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PHYSICIAN DATA RECORD TYPE: 80

LEVEL: CLAIM

PURPOSE: To identify and provide information regarding the physician or physicians.

REQUIREMENTS: This record type must follow the Medical Record (record 70). There is a limit of one Physician Record per claim.

ORDER:	Preceding Record Type	Following Record Type
	----- 70	----- 90

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PHYSICIAN DATA

RECORD TYPE: 80

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '80'	2	X	1	2
2	SEQUENCE NUMBER	2	N	3	4
3	PATIENT CONTROL NUMBER	20	X	5	24
4	PHYSICIAN NUMBER QUALIFYING CODES	2	X	25	26
5	ATTENDING PHYSICIAN NUMBER	16	X	27	42
6	OPERATING PHYSICIAN NUMBER	16	X	43	58
7	OTHER PHYSICIAN NUMBER	16	X	59	74
8	OTHER PHYSICIAN NUMBER	16	X	75	90
9	ATTENDING PHYSICIAN NAME	25	X	91	115
10	OPERATING PHYSICIAN NAME	25	X	116	140
11	OTHER PHYSICIAN NAME	25	X	141	165
12	OTHER PHYSICIAN NAME	25	X	166	190
13	FILLER (NATIONAL USE)	2	X	191	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PHYSICIAN DATA RECORD/FIELD: 80-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

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

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "80".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PHYSICIAN DATA RECORD/FIELD: 80-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	05	24	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

**MEDICAID
NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PHYSICIAN DATA RECORD/FIELD: 80-5

DATA ELEMENT: Attending Physician Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	X(16)	LEFT	SPACES	27	42	R

DEFINITION: This field is a number assigned by the payer to describe the attending physician.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL82 a & b

REMARKS: N/A

MEDICAID

NOTES: For INPATIENT HOSPITAL, OUTPATIENT HOSPITAL and NURSING FACILITY and HOME HEALTH* claims, enter the seven-digit OHIO Medicaid provider number beginning on the "b" line. If the attending physician does not have an OHIO Medicaid provider number, enter "9111115" on the "b" line and the physician's last name on the "a" line.

*see 'General Instructions' regarding HOME HEALTH claim submissions

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PHYSICIAN DATA RECORD/FIELD: 80-6

DATA ELEMENT: Operating Physician Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
6	X(16)	LEFT	SPACES	43	58	0

DEFINITION: This field is a number assigned by the payer to describe the operating physician.

CODE VALUES: N/A

VALIDATION: N/A

FORM LOCATION: UB-92 FL83 a & b

REMARKS: N/A

MEDICAID

NOTES:

For INPATIENT and OUTPATIENT HOSPITAL claims, enter the seven-digit OHIO Medicaid provider number of the physician performing the principal surgical, obstetrical, or medical procedure, in Form Locator 80 beginning on the "b" line. Only if the physician does not have an OHIO Medicaid provider number, enter "9111115" on the "b" line and the physician's last name on the "a" line. The physician performing the principal procedure may also be the attending physician noted in Form Locator 82.

For NURSING FACILITY claims, this field is not required.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

CLAIM CONTROL SCREEN

RECORD TYPE: 90

NATIONAL VER. 006.00 - 08/01/2000

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD TYPE: 90

LEVEL: CLAIM

PURPOSE: To provide control over the number of records and over the total number of charges submitted on a claim.

REQUIREMENTS: This record type must follow the Physician Record (record 80). There is a limit of one Screen Record per claim.

ORDER:	Preceding Record Type -----	Following Record Type -----
	80	20 or 95

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN

RECORD TYPE: 90

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '90'	2	X	1	2
2	FILLER (NATIONAL USE)	2	N	3	4
3	PATIENT CONTROL NUMBER	20	X	5	24
4 [^]	PHYSICAL RECORD COUNT (Excluding RT 90 & 91) RECORD TYPE COUNTS Fields 5-11	4	N	25	28
5 [^]	RECORD TYPE 2n COUNT	2	N	29	30
6 [^]	RECORD TYPE 3n COUNT	2	N	31	32
7 [^]	RECORD TYPE 4n COUNT	2	N	33	34
8 [^]	RECORD TYPE 5n COUNT	3	N	35	37
9 [^]	RECORD TYPE 6n COUNT	3	N	38	40
10 [^]	RECORD TYPE 7n COUNT	2	N	41	42
11 [^]	RECORD TYPE 8n COUNT	2	N	43	44
12 [^]	RECORD TYPE 91 QUALIFIER	1	N	45	45
13 [^]	TOTAL ACCOMMODATION CHARGES - REVENUE CENTERS	10	NS	46	55
14 [^]	NONCOVERED ACCOMMODATION CHARGES - REVENUE CENTERS	10	NS	56	65
15 [^]	TOTAL ANCILLARY CHARGES - REVENUE CENTERS	10	NS	66	75
16 [^]	NONCOVERED ANCILLARY CHARGES - REVENUE CENTERS	10	NS	76	85
17 [^]	CO-PAYMENT REMARKS	10	X	86	95
18 [^]	REMARKS	97	X	96	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Claim Control Screen Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "90".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-3

DATA ELEMENT: Patient Control Number

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
3	X(20)	LEFT	SPACES	05	24	R

DEFINITION: This field is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual case records at the hospital or facility.

CODE VALUES: N/A

VALIDATION: Must be entered.

FORM LOCATION: UB-92 FL3

REMARKS: N/A

**MEDICAID
NOTES:**

This field is used to link all records for a single claim. The entire claim will be denied without this information. It will not appear on the remittance advice.

The Ohio Medicaid system limits this field to 17 characters.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-4

DATA ELEMENT: Physical Record Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
4	9(04)	RIGHT	ZEROES	25	28	R

DEFINITION: This field denotes the number of records used to describe the claim. It is used for balancing purposes.

CODE VALUES: N/A

VALIDATION: This field is required.

This must be equal to the number of records submitted for the claim excluding record type 90.

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-5
 THRU
 90-11

DATA ELEMENT: Record Type 2n Count
 Record Type 3n Count
 Record Type 4n Count
 Record Type 5n Count
 Record Type 6n Count
 Record Type 7n Count
 Record Type 8n Count

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	9(02)	RIGHT	ZEROES	29	30	R
6	9(02)	RIGHT	ZEROES	31	32	R
7	9(02)	RIGHT	ZEROES	33	34	R
8	9(03)	RIGHT	ZEROES	35	37	R
9	9(03)	RIGHT	ZEROES	38	40	R
10	9(02)	RIGHT	ZEROES	41	42	R
11	9(02)	RIGHT	ZEROES	43	44	R

DEFINITION: These fields denote the number of records for a particular sequence of record type that were submitted to describe the claim. They are used for balancing purposes.

CODE VALUES: N/A

VALIDATION: These fields are required.

They must be equal to the number of records submitted for the claim for that particular record type sequence. For example, the field "Record Type 4n Count" must be equal to the number of records for Record Types 40 and 41.

FORM LOCATION: N/A

REMARKS: N/A

NATIONAL VER. 006.00 - 08/01/2000
LOCAL VER. 006.00 - 01/01/2001

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-13

DATA ELEMENT: Total Accommodation Charges - Revenue Centers

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
13	9(08)V99S	RIGHT	ZEROES	46	55	R

DEFINITION: This field denotes the total amount of charges submitted on the claim for accommodations.

CODE VALUES: N/A

VALIDATION: This field is required.

The field must be equal to the total amount of the "Accommodations Total Charges" fields found on the Inpatient Accommodations Data Records (Record Type 50).

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-14

DATA ELEMENT: Non-covered Accommodation Charges - Revenue Centers

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
14	9(08)V99S	RIGHT	ZEROES	56	65	R

DEFINITION: This field denotes the total amount of charges submitted on the claim for non-covered accommodations.

CODE VALUES: N/A

VALIDATION: This field is required.

The field must be equal to the total amount of the "Accommodations Non-covered Charges" fields found on the Inpatient Accommodations Data Records (Record Type 50).

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-15

DATA ELEMENT: Total Ancillary Charges - Revenue Centers

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
15	9(08)V99S	RIGHT	ZEROES	66	75	R

DEFINITION: This field denotes the total amount of charges submitted on the claim for inpatient/outpatient services.

CODE VALUES: N/A

VALIDATION: This field is required.

The claim is either for Inpatient or Outpatient services, making the two types of charges mutually exclusive.

Therefore, the field must be equal to the total amount of either the "Inpatient Ancillary Total Charges" fields found on the Inpatient Ancillary Services Data Records (Record Type 60) or the "Outpatient Total Charges" fields found on the Outpatient Procedures Records (Record Type 61).

FORM LOCATION: N/A

REMARKS: N/A

NATIONAL VER. 006.00 - 08/01/2000
LOCAL VER. 006.00 - 01/01/2001

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: CLAIM CONTROL SCREEN RECORD/FIELD: 90-16

DATA ELEMENT: Non-covered Ancillary Charges - Revenue Centers

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
16	9(08)V99S	RIGHT	ZEROES	76	85	R

DEFINITION: This field denotes the total amount of non-covered charges submitted on the claim for inpatient/outpatient services.

CODE VALUES: N/A

VALIDATION: This field is required.

The claim is either for Inpatient or Outpatient services, making the two types of charges mutually exclusive.

Therefore, the field must be equal to the total amount of either the "Inpatient Ancillary Non-covered Charges" fields found on the Inpatient Ancillary Services Data Records (Record Type 60) or the "Outpatient Non-covered Charges" fields found on the Outpatient Procedures Records (Record Type 61).

FORM LOCATION: N/A

REMARKS: N/A

RECORD NAME: CLAIM CONTROL SCREEN

RECORD/FIELD: 90-17

DATA ELEMENT: COPAYMENT REMARKS

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
17	X(10)	RIGHT	S	86	95	R

DEFINITION: This field is used to denote a co-payment applies.

Follow the information in the table below to indicate that a co-payment applies.

Note: If the consumer is receiving a non-emergency emergency department service, but is exempt from co-payment because they fall into an exclusion category, leave the Co-payment Remarks field blank and no co-payment will be taken. Exclusions on co-payments include consumers: under the age of 21, receiving hospice services, receiving emergency services, women who are pregnant, consumers that reside in a nursing facility or ICF-MR, or consumers that are receiving services for family planning.

Inclusion Description	Inclusion Code - Denotes a Co-payment Should Be Taken
All non-emergency emergency services received in an emergency department.	COPAY NEMR ^ Important: this caret denotes a space between the qualifier copay and the inclusion code nemr.

VALIDATION: This field is required.

FORM LOCATION: N/A

REMARKS: If COPAY is not found in the first five bytes of this field, the rest of the field will be bypassed.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

PROVIDER BATCH CONTROL

RECORD TYPE: 95

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL RECORD TYPE: 95

LEVEL: BATCH

PURPOSE: To provide control over the number of claims and over the total number of charges submitted in a batch.

REQUIREMENTS: This record type must be the last record in a batch. It must follow the Claim Control Screen (record 90). The batch record contains the number of documents in the batch. There is a limit of one batch record per batch.

ORDER:	Preceding Record Type -----	Following Record Type -----
	90	10 or 99

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL

RECORD TYPE: 95

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '95'	2	X	1	2
2	FEDERAL TAX NUMBER (EIN)	10	N	3	12
3	RECEIVER IDENTIFICATION	5	N	13	17
4	RECEIVER SUB-IDENTIFICATION	4	X	18	21
5	TYPE OF BATCH	3	X	22	24
6	NUMBER OF CLAIMS	6	N	25	30
7	FILLER (NATIONAL USE)	6	X	31	36
8^	ACCOMMODATIONS TOTAL CHARGES FOR THE BATCH	12	NS	37	48
9^	ACCOMMODATIONS NONCOVERED CHARGES FOR THE BATCH	12	NS	49	60
10^	ANCILLARY TOTAL CHARGES FOR THE BATCH	12	NS	61	72
11^	ANCILLARY NONCOVERED CHARGES FOR THE BATCH	12	NS	73	84
12-13	FILLER (COB ONLY)	24	X	85	108
14^	Reserve for Future Use	12	X	109	120
15^	FILLER (NATIONAL USE)	54	X	121	138
16^	FILLER (NATIONAL USE)	54	X	139	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL RECORD/FIELD: 95-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "Provider Batch Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.
Must be "95".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL RECORD/FIELD: 95-6

DATA ELEMENT: Number of Claims

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
6	9(06)	RIGHT	ZEROES	25	30	R

DEFINITION: This field denotes the number of claims submitted in the batch.

CODE VALUES: N/A

VALIDATION: This field is required.
This must be equal to the number of claims in the batch.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID
NOTES: An incorrect total in this field would reject the entire submission.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL RECORD/FIELD: 95-8

DATA ELEMENT: Accommodation Total Charges for the Batch

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
8	9(10)V99S	RIGHT	ZEROES	37	48	R

DEFINITION: This field denotes the total amount of charges submitted in the batch for accommodations.

CODE VALUES: N/A

VALIDATION: This field is required.

The field must be equal to the total amount of the "Accommodations Total Charges" fields found on the Inpatient Accommodations Data Records (Record Type 50) within the batch.

FORM LOCATION: N/A

REMARKS: N/A

MEDICAID

NOTES: An incorrect total in this field would not reject the entire submission.

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL RECORD/FIELD: 95-9

DATA ELEMENT: Accommodations Non-covered Charges for the Batch

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
9	9(10)V99S	RIGHT	ZEROES	49	60	R

DEFINITION: This field denotes the total amount of charges submitted in the batch for non-covered accommodations.

CODE VALUES: N/A

VALIDATION: This field is required.

The field must be equal to the total amount of the "Accommodations Non-covered Charges" fields found on the Inpatient Accommodations Data Records (Record Type 50) within the batch.

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL RECORD/FIELD: 95-10

DATA ELEMENT: Ancillary Total Charges for the Batch

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
10	9(10)V99S	RIGHT	ZEROES	61	72	R

DEFINITION: This field denotes the total amount of charges submitted in the batch for inpatient/outpatient services.

CODE VALUES: N/A

VALIDATION: This field is required.

The claims are either for Inpatient or Outpatient services, making the two types of charges mutually exclusive.

Therefore, the field must be equal to the total amount of either the "Inpatient Ancillary Total Charges" fields found on the Inpatient Ancillary Services Data Records (Record Type 60) or the "Outpatient Total Charges" fields found on the Outpatient Procedures Records (Record Type 61) within the batch.

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: PROVIDER BATCH CONTROL RECORD/FIELD: 95-11

DATA ELEMENT: Ancillary Non-covered Charges for the Batch

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
11	9(10)V99S	RIGHT	ZEROES	73	84	R

DEFINITION: This field denotes the total amount of non-covered charges submitted in the batch for inpatient/outpatient services.

CODE VALUES: N/A

VALIDATION: This field is required.

The claims are either for Inpatient or Outpatient services, making the two types of charges mutually exclusive.

Therefore, the field must be equal to the total amount of either the "Inpatient Ancillary Non-covered Charges" fields found on the Inpatient Ancillary Services Data Records (Record Type 60) or the "Outpatient Non-covered Charges" fields found on the Outpatient Procedures Records (Record Type 61) within the batch.

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

FILE CONTROL

RECORD TYPE: 99

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-5 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL RECORD TYPE: 99

LEVEL: FILE

PURPOSE: To provide control over the number of batches and over the total number of charges submitted in a file.

REQUIREMENTS: This record type must be the last record on the tape. It must follow the Provider Batch Control (record 95). The Tape control Record indicates that there is no more data to be processed. There is a limit of one Tape Control Record per tape.

ORDER:	Preceding Record Type -----	Following Record Type -----
	95	none: last record on file

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL

RECORD TYPE: 99

FIELD NO.	FIELD NAME	FIELD LENGTH	TYPE	POSITIONS FROM	THRU
1	RECORD TYPE '99'	2	X	1	2
2	SUBMITTER EIN	10	N	3	12
3	RECEIVER IDENTIFICATION	5	N	13	17
4	RECEIVER SUB-IDENTIFICATION	4	X	18	21
5	NUMBER OF BATCHES BILLED THIS FILE	4	N	22	25
6^	ACCOMMODATIONS TOTAL CHARGES FOR THE FILE	13	NS	26	38
7^	ACCOMMODATIONS NONCOVERED CHARGES FOR THE FILE	13	NS	39	51
8^	ANCILLARY TOTAL CHARGES FOR THE FILE	13	NS	52	64
9^	ANCILLARY NONCOVERED CHARGES FOR THE FILE	13	NS	65	77
10	FILLER (NATIONAL USE)	58	X	78	135
11	FILLER (LOCAL USE)	54	X	136	192

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL RECORD/FIELD: 99-1

DATA ELEMENT: Record Type

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
1	X(02)	LEFT	SPACES	01	02	R

DEFINITION: Field used to identify the "File Control Record".

CODE VALUES: N/A

VALIDATION: Must be entered.

Must be "99".

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL RECORD/FIELD: 99-5

DATA ELEMENT: Number of Batches Billed This File

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
5	9(04)	RIGHT	ZEROES	22	25	R

DEFINITION: This field denotes the number of batches submitted in the file.

CODE VALUES: N/A

VALIDATION: This field is required.
This must be equal to the number of batches in the file.

FORM LOCATION: N/A

REMARKS: N/A

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL RECORD/FIELD: 99-6

DATA ELEMENT: Accommodation Total Charges for the File

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
6	9(11)V99S	RIGHT	ZEROES	26	38	R

DEFINITION: This field denotes the total amount of charges submitted in the file for accommodations.

CODE VALUES: N/A

VALIDATION: This field is required.

The field must be equal to the total amount of the "Accommodations Total Charges" fields found on the Inpatient Accommodations Data Records (Record Type 50) within the file.

FORM LOCATION: N/A

REMARKS: N/A

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL RECORD/FIELD: 99-7

DATA ELEMENT: Accommodations Non-covered Charges for the File

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----	-----	-----	-----	-----	-----	---
7	9(11)V99S	RIGHT	ZEROES	39	51	R

DEFINITION: This field denotes the total amount of charges submitted in the file for non-covered accommodations.

CODE VALUES: N/A

VALIDATION: This field is required.
 The field must be equal to the total amount of the "Accommodations Non-covered Charges" fields found on the Inpatient Accommodations Data Records (Record Type 50) within the file.

FORM LOCATION: N/A

REMARKS: N/A

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LOCAL VER. 006.00 - 01/01/2001

UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL RECORD/FIELD: 99-8

DATA ELEMENT: Ancillary Total Charges for the File

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----	-----	-----	-----	-----	-----	---
8	9(11)V99S	RIGHT	ZEROES	52	64	R

DEFINITION: This field denotes the total amount of charges submitted in the file for inpatient/outpatient services.

CODE VALUES: N/A

VALIDATION: This field is required.

The claims are either for Inpatient or Outpatient services.

Therefore, the field must be equal to the total amount of either the "Inpatient Ancillary Total Charges" fields found on the Inpatient Ancillary Services Data Records (Record Type 60) and the "Outpatient Total Charges" fields found on the Outpatient Procedures Records (Record Type 61) within the file.

FORM LOCATION: N/A

REMARKS: N/A

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UB-92 ELECTRONIC MEDIA CLAIMS VERSION-6 FLAT FILE FORMAT

RECORD NAME: FILE CONTROL RECORD/FIELD: 99-9

DATA ELEMENT: Ancillary Non-covered Charges for the File

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
----	-----	-----	-----	-----	-----	---
9	9(11)V99S	RIGHT	ZEROES	65	77	R

DEFINITION: This field denotes the total amount of non-covered charges submitted in the file for inpatient/outpatient services.

CODE VALUES: N/A

VALIDATION: This field is required.
 The claims are either for Inpatient or Outpatient services.

Therefore, the field must be equal to the total amount of either the "Inpatient Ancillary Non-covered Charges" fields found on the Inpatient Ancillary Services Data Records (Record Type 60) and the "Outpatient Non-covered Charges" fields found on the Outpatient Procedures Records (Record Type 61) within the file.

FORM LOCATION: N/A

REMARKS: N/A