

Pennsylvania

Uniform Claims

and

Billing Form

Reporting Manual

for

Inpatient Facilities

UB92 Data Reporting

Pennsylvania Health Care Cost Containment Council

225 Market Street, Suite 400

Harrisburg, PA 17101

(717) 232-8958

www.phc4.org

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Any questions or concerns regarding this manual should be directed to the following:

Data Collection Team
225 Market Street, Suite 400
Harrisburg, PA 17101
(717) 232-8958 (Voice) (717) 772-1401 (Fax)

Detail Record Quick Reference

Data Element Name	Field Number	UB92 Form Locator	Page
Admission Hour	40	18	89
Admit Source	27	20	77
Admit Type	26	19	76
Admitting Diagnosis Code	36	76	85
Attending Physician ID	11	82 (lower line)	42
Certification/SSN/Health Insurance Claim Number	29a-29c	60a,b,c	80
Date of Admission	5	6 (from)	30
Date of Discharge	6	6 (through)	32
Diagnosis Related Group (DRG)	24	2h (lower line)	74
Discharge Hour	41	21	90
Discharge Status	20	22	64
E-Code	37	77	86
Employer Name	32a-32c	65a,b,c	81
Employment Status Code	34a-34c	64a,b,c	82
Estimated Amount Due - Payor and Patient	14g1-14g4	55a,b,c,d	59
Federal Tax ID or Tax Exempt Number	39	5 (lower line)	88
HCPCS/Rates	13a6-13w6	44	53
Non-Covered Charges (By Revenue Category)	13a5-13v5	48	51
Non-Covered Charges (Total)	13w5	48	52
Operating Physician ID	12	83 (lower line)	43
Patient Birth Date	2	14	26
Patient Control Number	23	3	73
Patient Hispanic/Latino Origin or Descent	35a	2i (lower line)	83
Patient Home Zip Code	4	13 (zip code section)	29
Patient Morbidity	21b	2d (lower line)	67
Patient Race	35b	2j (lower line)	84
Patient Severity Upon Admission	21a	2d (lower line)	66
Patient Sex	3	15	28
Patient Uniform Identifier (Social Security Number)	1	2a (upper line)	25
Patient's Relationship to Insured	28a-28c	59a,b,c	79
Payor Group Number	19a-19c	62	63
Payor Type and Identification	14b1-14b3	50a,b,c	55
Principal Diagnosis Code	7a	67	33
Principal Procedure Code	8a	80 (code part)	36
Principal Procedure Date	8b	80 (date part)	38
Prior Payments - Payor and Patient	14f1-14f4	54a,b,c,d	58
Procedure Coding Method Used	25	79	75
Referring Physician ID	38	83 (upper line)	87
Revenue Codes (Numbers 1-22)	13a2-13v2	42	44
Revenue Codes (Number 23 only)	13w2	42	45
Secondary Diagnosis Codes	7b-7i	68-75	35
Secondary Procedure Codes	9a1-9e1	81a-e (code portion)	39
Secondary Procedure Dates	9a2-9e2	81 a-e (date portion)	40
Service Date	13a7-13w7	45	54
Total Charge (By Revenue Code - numbers 1-22)	13a4-13v4	47	46
Total Charge (By Revenue Code - number 23)	13w4	47	47
Type of Bill	22	4	72
Uniform Identifier of Health Care Facility (Medical Assistance ID)	10	2b (upper line)	41
Uniform Identifier of Primary Payor (NAIC Code)	17	2c (upper line)	60
Units of Service (By Revenue Category)	13a3-13v3	46	49
Units of Service (By Revenue Category)	13w3	46	50
Zip Code of Facility	18	1 (zip code section)	62
Unusual Occurrence	21c	2f (lower line)	68
Nosocomial Infection	21d	2g (lower line)	69
Reserved Field	21e	None	71

Header Record

Header Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
1	Data Source Identifier	1	25	X(25)	Left justify. Blank fill right.
2	Data Source Name/Address	26	125	X(100)	Name = Position 26-50 Address 1 = Position 51-75 Address 2 = Position 76-100 City = Position 101-114 State = Position 115-116 Zip Code = Position 117-125
3	Period Covered First Day	126	131	9(6)	MMDDYY
4	Period Covered Last Day	132	137	9(6)	MMDDYY
5	Run Date	138	143	9(6)	MMDDYY. Date tape was created.
7	Inpatient/Outpatient Indicator		144	X(1)	I = Inpatient Claims O = Outpatient Claims
8	Batch/Job/Run Number	145	169	X(25)	For hospital's use in identifying the tape.
6	Filler	170	2298	X(2129)	
9	Submission Type		2299	X(1)	O = Original Submission R = Resubmission of Original Data
10	Record Type		2300	X(1)	H = Header Record

Field 1	Data Source Identifier
Description	The number identifying the provider facility as assigned and used by Medicaid. Use your primary MPI Provider Number to identify your facility.
Procedure	Left justify. Blank fill right.
Field Size & Type	25 characters field; Alphanumeric
Record Location	1 – 25

Field 2	Data Source Name and Address
Description	The name and address of the facility.
Procedure	Left justify. Blank fill right.
	Name = Position 26 - 50
	Address 1 = Position 51 - 75
	Address 2 = Position 76 - 100
	City = Position 101 - 114
	State = Position 115 - 116
	Zip Code = Position 117 - 125
Field Size & Type	100 character field; Alphanumeric
Record Location	26 – 125

Field 3	Period Covered First Day
Description	The first day of the quarter from which the data is provided.
Procedure	Use the format MMDDYY without punctuation.
Field Size & Type	6 character field; Numeric
Record Location	126 - 131

Field 4	Period Covered Last Day
Description	The last day of the quarter from which the data is provided.
Procedure	Use the format MMDDYY without punctuation.
Field Size & Type	6 character field; Numeric
Record Location	132 - 137

Field 5	Run Date
Description	The date the media was produced.
Procedure	Use the format MMDDYY without punctuation.
Field Size & Type	6 character field; Numeric
Record Location	138 - 143

Field 6	Filler
Description	Reserved for future use by the Council.
Procedure	Blank fill.
Field Size & Type	2129 character field; Alphanumeric
Record Location	170 - 2298

Field 7	Inpatient Indicator
Description	The letter indicating claims contained in this file are Inpatient.
Procedure	I = Inpatient
Field Size & Type	1 character field; Alphanumeric
Record Location	144

Field 8	Batch/Job/Run Number
Description	The number for the facility's use in identifying the media.
Procedure	Fill with the number that will identify this media.
Field Size & Type	25 character field; Alphanumeric
Record Location	145 - 169

Field 9	Submission Type
Description	The code indicating whether this submission is an original submission or a resubmission of original data.
Procedure	Coding Structure: O = Original Submission R = Resubmission of Original Media
Field Size & Type	1 character field; Alphanumeric
Record Location	2299

Field 10	Record Type
Description	The code indicating the record is a Header Record.
Procedure	H = Header Record
Field Size & Type	1 character field; Alphanumeric
Record Location	2300

Detail Record

Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
1	Patient Uniform Identifier (Social Security Number)	1	9	X(9)	Right justify. Leave blank if unknown.
2	Patient Birth Date	10	17	9(8)	MMDDYYYY
3	Patient Sex		18	X(1)	F = Female, M = Male, U = Unknown
4	Patient Home Zip Code	19	27	X(9)	XXXXXYYYY. The 9 or 5 character zip code of patient residence. Left justify. If the +4 extension is unknown, leave blank.
5	Date of Admission	28	35	9(8)	MMDDYYYY
6	Date of Discharge	36	43	9(8)	MMDDYYYY
40	Admission Hour	44	45	9(2)	See manual for code definitions.
41	Discharge Hour	46	47	9(2)	See manual for code definitions.
7a	Principal Diagnosis Code	48	53	X(6)	Left justify.
7b	Secondary Diagnosis Code	54	59	X(6)	Left justify.
7c	Secondary Diagnosis Code	60	65	X(6)	Left justify.
7d	Secondary Diagnosis Code	66	71	X(6)	Left justify.
7e	Secondary Diagnosis Code	72	77	X(6)	Left justify.
7f	Secondary Diagnosis Code	78	83	X(6)	Left justify.
7g	Secondary Diagnosis Code	84	89	X(6)	Left justify.
7h	Secondary Diagnosis Code	90	95	X(6)	Left justify.
7i	Secondary Diagnosis Code	96	101	X(6)	Left justify.
36	Admitting Diagnosis Code	102	107	X(6)	Left justify.
37	E-Code	108	113	X(6)	Left justify.
8a	Principal Procedure Code	114	120	X(7)	Left justify.
8b	Principal Procedure Date	121	124	9(4)	MMDD
9a1	Secondary Procedure Code	125	131	X(7)	Left justify.
9a2	Secondary Procedure Date	132	135	9(4)	MMDD
9b1	Secondary Procedure Code	136	142	X(7)	Left justify.
9b2	Secondary Procedure Date	143	146	9(4)	MMDD
9c1	Secondary Procedure Code	147	153	X(7)	Left justify.

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Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
9c2	Secondary Procedure Date	154	157	9(4)	MMDD
9d1	Secondary Procedure Code	158	164	X(7)	Left justify.
9d2	Secondary Procedure Date	165	168	9(4)	MMDD
9e1	Secondary Procedure Code	169	175	X(7)	Left justify.
9e2	Secondary Procedure Date	176	179	9(4)	MMDD
38	Referring Physician ID	180	202	X(23)	Only PA State License Number should be used. Character 180-188 = PA State License Number. Left justify. Blank fill right if name unknown.
11	Attending Physician ID	203	225	X(23)	Only PA State License Number should be used. Character 203-211 = PA State License Number. Left justify. Blank fill right if name unknown.
12	Operating Physician ID	226	248	X(23)	Only PA State License Number should be used. Character 226-234 = PA State License Number. Left justify. Blank fill right if name unknown.
13a2	Revenue Code	249	252	X(4)	Left justify.
13a6	HCPCS/Rate	253	261	X(9)	Blank fill.
13a7	Service Date	262	269	X(8)	Blank fill.
13a3	Units of Service	270	276	9(7)	Right justify. Zero fill left.
13a4	Total Charges	277	286	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13a5	Non-Covered Charges	287	296	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13b2	Revenue Code	297	300	X(4)	Left justify.
13b6	HCPCS/Rate	301	309	X(9)	Blank fill.
13b7	Service Date	310	317	X(8)	Blank fill.
13b3	Units of Service	318	324	9(7)	Right justify. Zero fill left.
13b4	Total Charges	325	334	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13b5	Non-Covered Charges	335	344	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.

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Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
13c2	Revenue Code	345	348	X(4)	Left justify.
13c6	HCPCS/Rate	349	357	X(9)	Blank fill.
13c7	Service Date	358	365	X(8)	Blank fill.
13c3	Units of Service	366	372	9(7)	Right justify. Zero fill left.
13c4	Total Charges	373	382	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13c5	Non-Covered Charges	383	392	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13d2	Revenue Code	393	396	X(4)	Left justify.
13d6	HCPCS/Rates	397	405	X(9)	Blank fill.
13d7	Service Date	406	413	X(8)	Blank fill.
13d3	Units of Service	414	420	9(7)	Right justify. Zero fill left.
13d4	Total Charges	421	430	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13d5	Non-Covered Charges	431	440	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13e2	Revenue Code	441	444	X(4)	Left justify.
13e6	HCPCS/Rates	445	453	X(9)	Blank fill.
13e7	Service Date	454	461	X(8)	Blank fill.
13e3	Units of Service	462	468	9(7)	Right justify. Zero fill left.
13e4	Total Charges	469	478	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13e5	Non-Covered Charges	479	488	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13f2	Revenue Code	489	492	X(4)	Left justify.
13f6	HCPCS/Rates	493	501	X(9)	Blank fill.
13f7	Service Date	502	509	X(8)	Blank fill.
13f3	Units of Service	510	516	9(7)	Right justify. Zero fill left.
13f4	Total Charges	517	526	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13f5	Non-Covered Charges	527	536	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.

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Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
13g2	Revenue Code	537	540	X(4)	Left justify.
13g6	HCPCS/Rates	541	549	X(9)	Blank fill.
13g7	Service Date	550	557	X(8)	Blank fill.
13g3	Units of Service	558	564	9(7)	Right justify. Zero fill left.
13g4	Total Charges	565	574	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13g5	Non-Covered Charges	575	584	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13h2	Revenue Code	585	588	X(4)	Left justify.
13h6	HCPCS/Rates	589	597	X(9)	Blank fill.
13h7	Service Date	598	605	X(8)	Blank fill.
13h3	Units of Service	606	612	9(7)	Right justify. Zero fill left.
13h4	Total Charges	613	622	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13h5	Non-Covered Charges	623	632	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13i2	Revenue Code	633	636	X(4)	Left justify.
13i6	HCPCS/Rates	637	645	X(9)	Blank fill.
13i7	Service Date	646	653	X(8)	Blank fill.
13i3	Units of Service	654	660	9(7)	Right justify. Zero fill left.
13i4	Total Charges	661	670	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13i5	Non-Covered Charges	671	680	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13j2	Revenue Code	681	684	X(4)	Left justify.
13j6	HCPCS/Rates	685	693	X(9)	Blank fill.
13j7	Service Date	694	701	X(8)	Blank fill.
13j3	Units of Service	702	708	9(7)	Right justify. Zero fill left.
13j4	Total Charges	709	718	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.

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Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
13j5	Non-Covered Charges	719	728	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13k2	Revenue Code	729	732	X(4)	Left justify. Zero fill left.
13k6	HCPCS/Rate	733	741	X(9)	Blank fill.
13k7	Service Date	742	749	X(8)	Blank fill.
13k3	Units of Service	750	756	9(7)	Right justify. Zero fill left.
13k4	Total Charges	757	766	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13k5	Non-Covered Charges	767	776	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13l2	Revenue Code	777	780	X(4)	Left justify.
13l6	HCPCS/Rates	781	789	X(9)	Blank fill.
13l7	Service Date	790	797	X(8)	Blank fill.
13l3	Units of Service	798	804	9(7)	Right justify. Zero fill left.
13l4	Total Charges	805	814	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13l5	Non-Covered Charges	815	824	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13m2	Revenue Code	825	828	X(4)	Left justify.
13m6	HCPCS/Rates	829	837	X(9)	Blank fill.
13m7	Service Date	838	845	X(8)	Blank fill.
13m3	Units of Service	846	852	9(7)	Right justify. Zero fill left.
13m4	Total Charges	853	862	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13m5	Non-Covered Charges	863	872	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13n2	Revenue Code	873	876	X(4)	Left justify.
13n6	HCPCS/Rates	877	885	X(9)	Blank fill.
13n7	Service Date	886	893	X(8)	Blank fill.
13n3	Units of Service	894	900	9(7)	Right justify. Zero fill left.
13n4	Total Charges	901	910	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.

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Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
13n5	Non-Covered Charges	911	920	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13o2	Revenue Code	921	924	X(4)	Left justify.
13o6	HCPCS/Rates	925	933	X(9)	Blank fill.
13o7	Service Date	934	941	X(8)	Blank fill.
13o3	Units of Service	942	948	9(7)	Right justify. Zero fill left.
13o4	Total Charges	949	958	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13o5	Non-Covered Charges	959	968	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13p2	Revenue Code	969	972	X(4)	Left justify.
13p6	HCPCS/Rates	973	981	X(9)	Blank fill.
13p7	Service Date	982	989	X(8)	Blank fill.
13p3	Units of Service	990	996	9(7)	Right justify. Zero fill left.
13p4	Total Charges	997	1006	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13p5	Non-Covered Charges	1007	1016	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13q2	Revenue Code	1017	1020	X(4)	Left justify.
13q6	HCPCS/Rates	1021	1029	X(9)	Blank fill.
13q7	Service Date	1030	1037	X(8)	Blank fill.
13q3	Units of Service	1038	1044	9(7)	Right justify. Zero fill left.
13q4	Total Charges	1045	1054	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13q5	Non-Covered Charges	1055	1064	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13r2	Revenue Code	1065	1068	X(4)	Left justify.
13r6	HCPCS/Rates	1069	1077	X(9)	Blank fill.
13r7	Service Date	1078	1085	X(8)	Blank fill.
13r3	Units of Service	1086	1092	9(7)	Right justify. Zero fill left.

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Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
13r4	Total Charges	1093	1102	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13r5	Non-Covered Charges	1103	1112	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13s2	Revenue Code	1113	1116	X(4)	Left justify.
13s6	HCPCS/Rates	1117	1125	X(9)	Blank fill.
13s7	Service Date	1126	1133	X(8)	Blank fill.
13s3	Units of Service	1134	1140	9(7)	Right justify. Zero fill left.
13s4	Total Charges	1141	1150	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13s5	Non-Covered Charges	1151	1160	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13t2	Revenue Code	1161	1164	X(4)	Left justify.
13t6	HCPCS/Rates	1165	1173	X(9)	Blank fill.
13t7	Service Date	1174	1181	X(8)	Blank fill.
13t3	Units of Service	1182	1188	9(7)	Right justify. Zero fill left.
13t4	Total Charges	1189	1198	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13t5	Non-Covered Charges	1199	1208	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13u2	Revenue Code	1209	1212	X(4)	Left justify.
13u6	HCPCS/Rates	1213	1221	X(9)	Blank fill.
13u7	Service Date	1222	1229	X(8)	Blank fill.
13u3	Units of Service	1230	1236	9(7)	Right justify. Zero fill left.
13u4	Total Charges	1237	1246	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13u5	Non-Covered Charges	1247	1256	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13v2	Revenue Code	1257	1260	X(4)	Left justify.
13v6	HCPCS/Rates	1261	1269	X(9)	Blank fill.
13v7	Service Date	1270	1277	X(8)	Blank fill.
13v3	Units of Service	1278	1284	9(7)	Right justify. Zero fill left.

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Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
13v4	Total Charges	1285	1294	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13v5	Non-Covered Charges	1295	1304	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13w2	Revenue Code (number 23 only)	1305	1308	X(4)	Enter 001. Left justify. Blank fill to indicate a continuation record.
13w6	HCPCS/Rates	1309	1317	X(9)	Blank fill.
13w7	Service Date	1318	1325	X(8)	Blank fill.
13w3	Units of Service	1326	1332	9(7)	Right justify. Zero fill left.
13w4	Total Charges	1333	1342	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
13w5	Non-Covered Charges	1343	1352	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
14b1	Payor Type and Identification	1353	1377	X(25)	See manual for code definitions.
14b2	Payor Type and Identification	1378	1402	X(25)	See manual for code definitions.
14b3	Payor Type and Identification	1403	1427	X(25)	See manual for code definitions.
14f1	Prior Payments—Payor and Patient	1428	1437	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
14f2	Prior Payments—Payor and Patient	1438	1447	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
14f3	Prior Payments—Payor and Patient	1448	1457	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
14f4	Prior Payments—Payor and Patient	1458	1467	X(10)	Character 1 = sign, characters 2-8 = whole dollars and characters 9-10 = cents. Right justify. No decimal. Zero fill left.
14g1	Estimated Amount Due	1468	1477	X(10)	At the present time, fill with zeros. The Council will develop a methodology to apply to all facilities.
14g2	Estimated Amount Due	1478	1487	X(10)	At the present time, fill with zeros. The Council will develop a methodology to apply to all facilities.
14g3	Estimated Amount Due	1488	1497	X(10)	At the present time, fill with zeros. The Council will develop a methodology to apply to all facilities.

****Data is required to be submitted in a fixed 2300 character record length, with a carriage return – line feed after each record. Additionally, an end of file marker must follow the line feed of the trailer record.***

Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
14g4	Estimated Amount Due	1498	1507	X(10)	At the present time, fill with zeros. The Council will develop a methodology to apply to all facilities.
17	Uniform Identifier of Primary Payor	1508	1514	X(7)	Left justify. Blank fill right.
18	Zip Code of Facility	1515	1523	X(9)	XXXXXXYYYY. The 9 or 5 character zip code of facility address. Left justify. If the +4 extension is unknown, leave blank.
19a	Payor Group Number	1524	1540	X(17)	Left justify.
19b	Payor Group Number	1541	1557	X(17)	Left justify.
19c	Payor Group Number	1558	1574	X(17)	Left justify.
20	Discharge Status	1575	1576	9(2)	Right justify. See manual for code definitions.
21a	Patient Severity Upon Admission		1577	X(1)	Blank fill.
21b	Patient Morbidity		1578	X(1)	Blank fill.
21c	Unusual Occurrence		1579	X(1)	Blank fill.
21d	Nosocomial Infection	1580	1581	9(2)	See manual for code definitions.
22	Type of Bill	1582	1584	9(3)	Right justify.
23	Patient Control Number	1585	1604	X(20)	Right justify. Zero fill left.
24	Diagnosis Related Group	1605	1607	9(3)	Blank fill.
25	Procedure Coding Method Used		1608	9(1)	See manual for code definitions.
26	Admit Type		1609	X(1)	See manual for code definitions.
27	Admit Source		1610	X(1)	See manual for code definitions.
28a	Patient's Relationship to Insured	1611	1612	9(2)	Right justify.
28b	Patient's Relationship to Insured	1613	1614	9(2)	Right justify.
28c	Patient's Relationship to Insured	1615	1616	9(2)	Right justify.

****Data is required to be submitted in a fixed 2300 character record length, with a carriage return – line feed after each record. Additionally, an end of file marker must follow the line feed of the trailer record.***

Detailed Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
29a	Certification/SSN/Insurance Claim Number	1617	1635	X(19)	Left justify.
29b	Certification/SSN/Health Insurance Claim Number	1636	1654	X(19)	Left justify.
29c	Certification/SSN/Health Insurance Claim Number	1655	1673	X(19)	Left justify.
32a	Employer Name	1674	1697	X(24)	Left justify.
32b	Employer Name	1698	1721	X(24)	Left justify.
32c	Employer Name	1722	1745	X(24)	Left justify.
34a	Employment Status Code		1746	9(1)	See manual for code definitions.
34b	Employment Status Code		1747	9(1)	See manual for code definitions.
34c	Employment Status Code		1748	9(1)	See manual for code definitions.
35a	Patient Hispanic/Latino Origin or Descent		1749	X(1)	See manual for code definitions.
35b	Patient Race		1750	X(1)	See manual for code definitions.
10	Uniform Identifier of Health Care Facility	1751	1758	X(8)	Blank fill.
39	Federal Tax ID or Tax Exempt #	1759	1768	X(10)	Left justify. Include hyphen.
21e	Reserve Field	1769	2300	X(532)	Blank fill.

****Data is required to be submitted in a fixed 2300 character record length, with a carriage return – line feed after each record. Additionally, an end of file marker must follow the line feed of the trailer record.***

Field 2	Patient Birth Date
Description Procedure Field Size & Type Record Location CMS Reference Purpose	The Birth Date of the <u>Patient</u> . Use the format MMDDYYYY, without punctuation. Example: 02191972. If unknown, use your best estimate. 8 character field; Numeric 10 - 17 UB-92, Item 14 To identify readmissions of the same patient, determine the age of the patient, match to the third party severity provider and other databases, and assign the PHC4 DRG.
Field Edit Criteria:	
Error Code: 0002 - 101 Revised: 1998 Q4	Error Report Message: Birth Date Invalid Reason: The patient's Birth Date is blank or not a valid date. User Response: Correct the Birth Date.
Relational Edit Criteria:	
Error Code: 0002 - 300 New: 1998 Q4	Error Report Message: Age greater than 120 Years Reason: The patient's age as calculated by the Birth Date, Admit Date is >120 years. User Response: Correct the Birth Date and/or Admit Date.
Error Code: 0002 - 302 Revised: 1998 Q4	Error Report Message: Age>28 Days, Newborn Diagnosis Reason: The patient's age at admission is >28 days but a Newborn Principal Diagnosis is present. User Response: Correct the Admit Date, Birth Date and/or Principal Diagnosis Code.
Error Code: 0002 - 303 Revised: 1998 Q4	Error Report Message: DOB=Admit Date, No Newborn Diagnosis Reason: The patient's Birth Date equals Admit Date, but a Newborn Principal Diagnosis Code is not present. User Response: Correct the Admit Date, Birth Date and/or Principal Diagnosis Code.
Error Code: 0002 - 304 Revised: 1998 Q4	Error Report Message: DOB After Admit Date Reason: The patient's Birth Date is after the Admit Date. User Response: Correct the Admit Date and/or Birth Date.
Error Code: 0002 - 305a thru 305e, 305p Revised: 1998 Q4	Error Report Message: DOB After Procedure Date Reason: The patient's Birth Date is after one or more of the Procedure Dates. User Response: Correct the Procedure Date and/or Birth Date.

Field 2	Patient Birth Date
<p>Error Code: 0002 - 306a thru 306i</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Age Invalid for Diagnosis</p> <p>Reason: A Diagnosis Code exists on the record that is valid for a specific age range, but the age of the patient is not in that range.</p> <p>User Response: Correct the Admit Date, Birth Date and/or Diagnosis Code.</p>
<p>Error Code: 0002 - 307a thru 307e, 307p</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Age Invalid for Procedure</p> <p>Reason: A Procedure Code exists on the record that is only valid for a specific age range, but the age of the patient is not in that range.</p> <p>User Response: Correct the Admit Date, Birth Date and/or the Procedure Code.</p>

Field 3	Patient Sex
Description Procedure Field Size & Type Record Location CMS Reference Purpose	Patient Sex <i>(as recorded at the time of admission)</i> F = Female M = Male U = Unknown 1 character field; Alphanumeric 18 UB-92, Item 15 To identify readmissions of the same patient, match to other patient-level data and databases, identify sex for population analysis, assign the PHC4 DRG, etc.
Field Edit Criteria:	
Error Code: 0003 - 102 Revised: 1998 Q4	Error Report Message: Sex Code Invalid Reason: The entry is not "F", "M", or "U". User Response: Correct the Sex Code for the patient <i>(as recorded at the time of admission)</i> .
Relational Edit Criteria:	
Error Code: 0003 - 308a thru 0003 - 308i Revised: 1998 Q4	Error Report Message: Sex Invalid for Diagnosis Reason: A Diagnosis Code exists on the record that is not valid for this patient's sex. User Response: Correct the Diagnosis Code(s) and/or Sex Code.
Error Code: 0003 - 309a thru 0003 - 309e, 309p Revised: 1998 Q4	Error Report Message: Sex Invalid for Procedure Reason: A Procedure Code exists on the record that is not valid for this patient's sex. User Response: Correct the Procedure Code(s) and/or Sex Code.
Facility-Level Edit Criteria:	
Error Code: 0003 - 901 New: 1998 Q4	Error Report Message: Number of Unknown Sex Exceeds Acceptable Limits Reason: The number of unknown Sex Codes for your facility exceeds the acceptable limit. This may be caused by a system problem. User Response: Review your data for unknown Sex Codes and resubmit it.

Field 4	Patient Home Zip Code
Description Procedure Field Size & Type Record Location CMS Reference Purpose	<p>The Federal Zip Code for the patient with optional +4 extension. XXXXXYYYY. Left justify without punctuation. Five character Zip Code with the optional four-character extension. Leave the last four digits blank if the +4 extension is not known.</p> <p>For patients from outside of the country enter "OUTCU". For homeless patients enter "HOMELESS". For all other unknown zip codes, enter "UNKNOWN".</p> <p>9 character field; Alphanumeric</p> <p>19 – 27</p> <p>UB-92, Item 13</p> <p>Market Share and population demographic analysis.</p>
Field Edit Criteria:	
Error Code: 0004 - 103 Revised: 1998 Q4	Error Report Message: Patient Zip Code Invalid Reason: The Zip Code listed is not a valid US Zip Code or valid default. User Response: Enter the correct Patient Zip Code or a valid default from the list above.
Facility-Level Edit Criteria:	
Error Code: 0004 - 902 New: 1998 Q4	Error Report Message: Number of Unknown Zip Codes Exceeds Acceptable Limits Reason: The number of "UNKNOWN" Zip Codes for your facility exceeds the acceptable limit. This may be caused by a system problem. User Response: Review your data for "UNKNOWN" Zip Codes and resubmit it.
Error Code: 0004 - 903 New: 1998 Q4	Error Report Message: Number of OUTCU (Foreign) Zip Codes Exceeds Acceptable Limits Reason: The number of "OUTCU" (Foreign) Zip Codes for your facility exceeds the acceptable limit. This may be caused by a system problem. User Response: Review your data for "OUTCU" Zip Codes and resubmit it.
Error Code: 0004 - 904 New: 1998 Q4	Error Report Message: Number of Homeless Zip Codes Exceeds Acceptable Limits Reason: The number of "HOMELESS" Zip Codes for your facility exceeds the acceptable limit. This may be caused by a system problem. User Response: Review your data for "HOMELESS" Zip Codes and resubmit it.

Field 5	Date of Admission
Description Procedure Field Size & Type Record Location CMS Reference Purpose	<p>The date that the patient was admitted to the facility for Inpatient care.</p> <p>Use the format MMDDYYYY without punctuation. Example: 02191999. Use the actual Admit Date. Do not adjust to account for pre-admission procedures.</p> <p>8 characters field; Numeric</p> <p>28 – 35</p> <p>UB-92, Item 6 (<i>Adapted from the “From Date”</i>)</p> <p>Calculations of patient age, length of stay, seasonal admissions analysis, track transfers, match other databases, etc.</p>
Field Edit Criteria:	
Error Code: 0005 - 104 Revised: 1998 Q4	Error Report Message: Admit Date Invalid Reason: The Admit Date is blank or not a valid date. User Response: Correct the Admit Date.
Relational Edit Criteria:	
Error Code: 0005 - 300 New: 1998 Q4	Error Report Message: Age Greater than 120 Years Reason: The patient’s age as calculated by the Birth Date, Admit Date is >120 years. User Response: Correct the Birth Date and/or Admit Date.
Error Code: 0005 - 302 Revised: 19984	Error Report Message: Age>28 Days, Newborn Diagnosis Reason: The patient’s age at admission is >28 days but a Newborn Principal Diagnosis is present. User Response: Correct the Admit Date, Birth Date and/or Principal Diagnosis Code.
Error Code: 0005 - 303 Revised: 1998 Q4	Error Report Message: DOB=Admit Date, No Newborn Diagnosis Reason: The patient’s Birth Date equals Admit Date, but a Newborn Principal Diagnosis Code is not present. User Response: Correct the Admit Date, Birth Date and/or Principal Diagnosis Code.
Error Code: 0005 - 304 Revised: 1998 Q4	Error Report Message: DOB After Admit Date Reason: The patient’s Birth Date is after the Admit Date. User Response: Correct the Admit Date and/or Birth Date.
Error Code: 0005 - 306a thru 306i Revised: 1998 Q4	Error Report Message: Age Invalid for Diagnosis Reason: A Diagnosis Code exists on the record that is valid for a specific age range, but the age of the patient is not in that range. User Response: Correct the Admit Date, Birth Date and/or Diagnosis Code.

Field 5	Date of Admission
<p>Error Code: 0005 - 307a thru 307e, 307p</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Age Invalid for Procedure</p> <p>Reason: A Procedure Code exists on the record that is only valid for a specific age range, but the age of the patient is not in that range.</p> <p>User Response: Correct the Admit Date, Birth Date and/or Procedure Code.</p>
<p>Error Code: 0005 - 310</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Admit Date After Discharge Date</p> <p>Reason: The Admit Date or Discharge Date is invalid.</p> <p>User Response: Correct the Admit Date and/or Discharge Date.</p>
<p>Error Code: 0005 - 311a thru 311e, 311p</p> <p>New: 1998 Q4</p>	<p>Error Report Message: Procedure Date is More Than 7 Days Prior to Admit Date</p> <p>Reason: The Procedure Date or the Admit Date is invalid.</p> <p>User Response: Correct the Procedure Date and/or Admit Date.</p>
Facility-Level Edit Criteria:	
<p>Error Code: 0005 - 905</p> <p>New: 1998 Q4</p>	<p>Error Report Message: Number of Admit Date=Discharge Date Exceeds Acceptable Limits</p> <p>Reason: The number of claims with Admit Date = Discharge Date for your facility exceeds the acceptable limit. Claims with Discharge Status of 02, 07, and 20 are excluded from this analysis, along with DRGs 370-376, 380-382, 384, 391.</p> <p>User Response: Review your data for claims that were admitted and discharged on the same day and resubmit it.</p>

Field 6	Date of Discharge
Description Procedure Field Size & Type Record Location CMS Reference Purpose	<p>The final service date of patient care and the date that the patient was discharged from the provider's care.</p> <p>Use the format MMDDYYYY without punctuation. Example: 02231999.</p> <p>8 character field; Numeric</p> <p>36 - 43</p> <p>UB-92, Item 6 (<i>Adapted from the "Through Date"</i>)</p> <p>Calculations of length of stay, seasonal admissions analysis, track transfers, match other databases, assign the PHC4 DRG, etc.</p>
Field Edit Criteria:	
Error Code: 0006 - 105 Revised: 1998 Q4	Error Report Message: Discharge Date Invalid Reason: The Discharge Date is blank or not a valid date. User Response: Correct the Discharge Date.
Relational Edit Criteria:	
Error Code: 0006 - 310 Revised: 1998 Q4	Error Report Message: Admit Date After Discharge Date Reason: The Admit Date or Discharge Date is invalid. User Response: Correct the Admit Date and/or Discharge Date.
Error Code: 0006 - 312 Revised: 1998 Q4	Error Report Message: Discharge Date is Outside Quarter Reason: The record is submitted for the incorrect quarter or the Discharge Date is invalid. User Response: Correct the Discharge Date or submit the record in the proper quarter.
Error Code: 0006 - 313a thru 313e, 313p Revised: 1998 Q4	Error Report Message: Procedure Date After Discharge Date Reason: One or more of the Procedure Dates are after the Discharge Date. User Response: Correct the Procedure Date and/or the Discharge Date.
Facility-Level Edit Criteria:	
Error Code: 0006 - 905 New: 1998 Q4	Error Report Message: Number of Admit Date=Discharge Date Exceeds Acceptable Limits Reason: The number of claims with Admit Date = Discharge Date for your facility exceeds the acceptable limit. Claims with Discharge Status of 02, 07, and 20 are excluded from this analysis, along with DRGs 370-376, 380-382, 384, 391. User Response: Review your data for claims that were admitted and discharged on the same day and resubmit it.

Field 7a	Principal Diagnosis Code
Description Procedure Field Size & Type Record Location CMS Reference Purpose	<p>The code describing the main condition (after study) responsible for causing the hospitalization.</p> <p>Use ICD-9-CM Codes. Left justify. Blank fill right. No decimal. ICD-9-CM E-Codes are not valid as a Principal Diagnosis.</p> <p>6 character field; Alphanumeric</p> <p>48 - 53</p> <p>UB-92, Item 67</p> <p>To identify the principal reason for admission, identify patients with specific diagnoses, assign the PHC4 DRG, etc.</p>
Field Edit Criteria:	
Error Code: 007a - 106 Revised: 1998 Q4	Error Report Message: Principal Diagnosis Invalid Reason: The code is not a valid ICD-9-CM Principal Diagnosis Code, contains an E-Code, decimal is present or the field is blank. User Response: Correct the Principal Diagnosis Code or remove decimals if present.
Relational Edit Criteria:	
Error Code: 007a - 302 Revised: 1998 Q4	Error Report Message: Age > 28 days, Newborn Diagnosis Reason: The patient's age at admission is >28 days but a Newborn Principal Diagnosis is present. User Response: Correct the Admit Date, Birth Date and/or Principal Diagnosis Code.
Error Code: 007a - 303 Revised: 1998 Q4	Error Report Message: DOB=Admit Date, No Newborn Diagnosis Reason: The patient's Birth Date equals Admit Date, but a Newborn Principal Diagnosis Code is not present. User Response: Correct the Admit Date, Birth Date and/or Principal Diagnosis Code.
Error Code: 007a - 306a Revised: 1998 Q4	Error Report Message: Age Invalid for Diagnosis Reason: A Diagnosis Code exists on the record that is valid for a specific age range, but the age of the patient is not in that range. User Response: Correct the Admit Date, Birth Date and/or Diagnosis Code.
Error Code: 007a - 308a Revised: 1998 Q4	Error Report Message: Sex Invalid for Diagnosis Reason: A Diagnosis Code exists on the record that is not valid for this patient's sex. User Response: Correct the Principal Diagnosis Code and/or Sex Code.
Error Code: 007a - 314 Revised: 1998 Q4	Error Report Message: Principal Diagnosis-Admit Type Mismatch for Newborn Reason: If the Principal Diagnosis indicates a newborn then the Admit Type must be "4" or if the Admit Type is "4" then the Principal Diagnosis must indicate a newborn. User Response: Correct the Principal Diagnosis Code and/or Admit Type.

Field 7a	Principal Diagnosis Code
<p>Error Code: 007a - 315</p> <p>New: 1998 Q4</p>	<p>Error Report Message: Duplicate Diagnosis Codes <i>(When a duplicate diagnosis is encountered, all submitted Diagnosis Codes are shown on the Error Correction Report for your information)</i></p> <p>Reason: Duplicate Diagnosis Code.</p> <p>User Response: Correct or delete the duplicate(s) <i>(a Principal Diagnosis Code is required)</i></p>
<p>Error code: 007a - 316</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Principal Diagnosis Requires E-Code</p> <p>Reason: The Principal Diagnosis Code requires an entry in the E-Code field (Field 37).</p> <p>User Response: Correct the Principal Diagnosis Code or include an E-Code.</p>
<p>Error Code: 007a - 327</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Admit Source Invalid for Newborn</p> <p>Reason: If the Admit Type is 4, then the Admit Source must be 1, 2, 3 or 4.</p> <p>User Response: Correct the Principal Diagnosis Code, Admit Source and/or Admit Type.</p>

Field 7b-7i	Secondary Diagnosis Codes
Description Procedure Field size & type Record location CMS reference Purpose	<p>The diagnosis codes describing additional conditions related to this hospitalization.</p> <p>Use ICD-9-CM Codes. Left justify. Blank fill right. No decimal. Leave the remaining fields blank if less than eight Secondary Diagnoses were used.</p> <p>8 fields with 6 characters each; Alphanumeric</p> <p>7b : 54 - 59 7f : 78 - 83 7c : 60 - 65 7g : 84 - 89 7d : 66 - 71 7h : 90 - 95 7e : 72 - 77 7i : 96 - 101</p> <p>UB-92, Items 68 – 75</p> <p>To identify patients with specific diagnoses and assign the PHC4 DRG, etc.</p>
Field Edit Criteria:	
Error Code: 007b - 107b thru 007i - 107i Revised: 1998 Q4	Error report message: Secondary Diagnosis Invalid Reason: The code is not a valid ICD-9-CM Diagnosis Code or is in an incorrect format. User Response: Correct the Diagnosis Code, delete the Diagnosis Code, or remove decimal if present.
Relational Edit Criteria:	
Error Code: 007b – 306b thru 007i – 306i New: 1998 Q4	Error report message: Age Invalid for Diagnosis Reason: A Diagnosis Code exists on the record that is valid for a specific age range, but the age of the patient is not in that range. User Response: Correct the Admit Date, Birth Date and/or Diagnosis Code.
Error Code: 007b – 308b thru 007i – 308i Revised: 1998 Q4	Error report message: Sex Invalid for Diagnosis Reason: A Diagnosis Code exists on the record that is not valid for the patient's sex. User Response: Correct the Diagnosis Code(s) and/or Sex Code.
Error Code: 007b – 315 thru 007i – 315 Revised: 1998 Q4	Error report message: Duplicate Diagnosis Codes <i>(When a duplicate diagnosis code is encountered, all submitted Diagnosis Codes are shown on the Error Correction Report for your information)</i> Reason: Duplicate Diagnosis Code. User Response: Correct or delete the duplicate(s) <i>(a Principle Diagnosis Code is required)</i> .

Field 8a	Principal Procedure Code
Description Procedure Field Size & Type Record Location CMS Reference Purpose	The code that identifies the Principal Procedure performed during the hospitalization. Use ICD-9-CM Codes. Left justify. Blank fill right. No decimal. 7 character field; Alphanumeric 114 - 120 UB-92, Item 80 (Procedure Code Portion) To identify the Principal Procedure performed, to identify patients with specific procedures, assign the PHC4 DRG, etc.
Field Edit Criteria:	
Error Code: 008a - 110 Revised: 1998 Q4	Error Report Message: Principal Procedure Code Invalid Reason: The code is not a valid ICD-9-CM Procedure Code or is not in the correct format. User Response: Correct the Principal Procedure Code or remove decimal if present.
Relational Edit Criteria:	
Error Code: 008a - 307p Revised: 1998 Q4	Error Report Message: Age Invalid for Procedure Reason: A Procedure Code exists on the record that is valid for a specific age range, but the age of the patient is not in that range. User Response: Correct the Admit Date, Birth Date and/or Principal Procedure Code.
Error Code: 008a - 309p Revised: 1998 Q4	Error Report Message: Sex Invalid for Procedure Reason: A Procedure Code exists on the record that is not valid for this patient's sex. User Response: Correct the Principal Procedure Code and/or Sex Code.
Error Code: 008a - 317 Revised: 1998 Q4	Error Report Message: Principal Procedure Code Blank, Secondary Procedure Codes Present Reason: Coding rules do not allow for a Secondary Procedure Code if a Principal Procedure Code is not present. User Response: Provide a Principal Procedure Code and/or remove the Secondary Procedure Code(s).
Error Code: 008a - 319 New: 1998 Q4	Error Report Message: Principal Procedure Code and Operating Physician ID Mismatch Reason: The Operating Physician field is filled but the Principal Procedure Code field is blank, or the Principal Procedure Code field contains a procedure code that requires an Operating Physician and the Operating Physician field is blank. User Response: Correct the record so that it has both a Principal Procedure Code and an Operating Physician, or does not contain either value.

Field 8a	Principal Procedure Code
<p>Error Code: 008a - 320</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Principal Procedure Code and Principal Procedure Date Mismatch</p> <p>Reason: There is either a missing Principal Procedure Code or a missing Principal Procedure Date.</p> <p>User Response: Correct the record so that it has both a Principal Procedure Code and a Principal Procedure Date, or does not contain either value.</p>

Field 8b	Principal Procedure Date
Description Procedure Field size & type Record location CMS reference Purpose	<p>The date on which the Principal Procedure was performed.</p> <p>Use the format MMDD without punctuation. Example: 0219. Use the true Procedure Date, even if it is before the actual Admit Date.</p> <p>4 character field; Numeric</p> <p>121 - 124</p> <p>UB-92, Item 80 (Date Portion)</p> <p>To identify the date of the principal procedure, calculate post-procedure stay, etc.</p>
Field Edit Criteria:	
Error Code: 008b - 111 Revised: 1998 Q4	Error Report Message: Principal Procedure Date Invalid Reason: The field entry must be a valid date or blank if there is not a Principal Procedure Code. User Response: Enter the correct date or blank fill if there is not a Principal Procedure.
Relational Edit Criteria:	
Error Code: 008b - 305p Revised: 1998 Q4	Error Report Message: DOB After Principal Procedure Date Reason: The patient's Birth Date is after the Principal Procedure Date. User Response: Correct the Principal Procedure Date and/or Birth Date.
Error Code: 008b - 311p New: 1998 Q4	Error Report Message: Procedure Date is More Than 7 Days Prior to Admit Date Reason: The Principal Procedure Date or the Admit Date is invalid. User Response: Correct the Principal Procedure Date and/or Admit Date.
Error Code: 008b - 313p Revised: 1998 Q4	Error Report Message: Procedure Date After Discharge Date Reason: The Principal Procedure Date is after the Discharge Date. User Response: Correct the Procedure Date and/or the Discharge Date.
Error Code: 008b - 320 Revised: 1998 Q4	Error Report Message: Principal Procedure Code and Principal Procedure Date Mismatch Reason: There is either a missing Principal Procedure Code or a missing Principal Procedure Date. User Response: Correct the record so that it has both a Principal Procedure Code and a Principal Procedure Date, or does not contain either value.

Field 9a1 - 9e1	Secondary Procedure Codes
Description	The codes that identify all significant procedures other than the Principal Procedure performed during the hospitalization.
Procedure	Use ICD-9-CM Codes. Left justify. Blank fill right. No decimal. Leave the remaining fields blank if fewer than five Secondary Procedures were performed.
Field Size & Type	5 fields with 7 characters each; Alphanumeric
Record Location	9a1: 125 - 131 9c1: 147 - 153 9e1: 169 – 175 9b1: 136 - 142 9d1: 158 - 164
CMS Reference	UB-92, Item 81 a-e (Procedure Code Portion)
Purpose	To identify additional procedures performed during the hospitalization.
Field Edit Criteria:	
Error Code: 09a1 - 112a thru 09e1 - 112e Revised: 1998 Q4	Error Report Message: Procedure Code Invalid Reason: The code is not a valid ICD-9-CM Procedure Code. User Response: Correct the Procedure Code and/or remove decimal if present.
Relational Edit Criteria:	
Error Code: 09a1 - 307a thru 09e1 - 307e Revised: 1998 Q4	Error Report Message: Age Invalid for Procedure Reason: A Procedure Code exists on the record that is only valid for a specific age range, but the age of the patient is not in that range. User Response: Correct the Admit Date, Birth Date and/or Procedure Code.
Error Code: 09a1 - 309a thru 09e1 - 309e Revised: 1998 Q4	Error Report Message: Sex Invalid for Procedure Reason: A Procedure Code exists on the record that is not valid for this patient's sex. User Response: Correct the Procedure Code(s) and/or Sex Code.
Error Code: 09a1 - 317 Revised: 1998 Q4	Error Report Message: Principal Procedure Code Blank, Secondary Procedure Codes Present Reason: Coding rules do not allow for a Secondary Procedure Code if a Principal Procedure Code is not present. User Response: Provide a Principal Procedure Code and/or remove the Secondary Procedure Code(s).
Error Code: 09a1 - 322a thru 09e1 - 322e Revised: 1998 Q4	Error Report Message: Secondary Procedure Code and Secondary Procedure Date Mismatch Reason: There is either a missing Secondary Procedure Code or a missing Secondary Procedure Date. User Response: Correct the record so that it has both a Secondary Procedure Code and a Secondary Procedure Date, or does not contain either value.

Field 9a2 – 9e2	Secondary Procedure Dates
Description Procedure Field Size & Type Record Location CMS Reference Purpose	<p>The date on which the corresponding Secondary Procedure was performed.</p> <p>Use the format MMDD without punctuation. Example: 0219. Use the true Procedure Date, even if it is before the actual Admit Date.</p> <p>4 character field; Numeric</p> <p>9a2: 132 - 135 9c2: 154 - 157 9e2: 176 - 179 9b2: 143 - 146 9d2: 165 - 168</p> <p>UB-92, Item 81 a-e (Date Portion)</p> <p>To identify the date of the procedure, to calculate post-procedure stay, etc.</p>
Field Edit Criteria:	
Error Code: 09a2 - 113a thru 09e2 - 113e Revised: 1998 Q4	Error Report Message: Secondary Procedure Date Invalid Reason: The field entry must be a valid date or blank if there is not a corresponding Secondary Procedure. User Response: Enter the correct date or blank fill if there is not a corresponding Secondary Procedure.
Relational Edit Criteria:	
Error Code: 09a2 - 305a thru 305e Revised: 1998 Q4	Error Report Message: DOB After Procedure Date Reason: The patient's Birth Date is after one or more of the Procedure Dates. User Response: Correct the Procedure Date and/or Birth Date.
Error Code: 09a2 - 311a thru 09e2 - 311e New: 1998 Q4	Error Report Message: Procedure Date is More Than 7 Days Prior to Admit Date Reason: The Procedure Date or the Admit Date is invalid. User Response: Correct the Procedure Date and/or Admit Date.
Error Code: 09a2 - 313a thru 09e2 - 313e Revised: 1998 Q4	Error Report Message: Procedure Date After Discharge Date Reason: One or more of the Procedure Dates are after the discharge date. User Response: Correct the Procedure Date and/or Discharge Date.
Error Code: 09a2 - 322a thru 09e2 - 322e Revised: 1998 Q4	Error Report Message: Secondary Procedure Code and Secondary Procedure Date Mismatch Reason: There is either a missing Secondary Procedure Code or a missing Secondary Procedure Date. User Response: Correct the record so that it has both a Secondary Procedure Code and a Secondary Procedure Date or does not contain either value.

Field 10	Uniform Identifier of Health Care Facility
Description	The number identifying the provider facility.
Procedure	Blank fill
Field Size & Type	8 character field; Alphanumeric.
Record Location	1751 - 1758
CMS Reference	UB-92, Item 2b (positions 10-17 of 29 character field, upper line)

Field 11	Attending Physician ID
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>The Pennsylvania State License Number and name of the physician that was responsible for the patient's care.</p> <p>Left justify. Blank fill right if name unknown.</p> <p>203 - 211 Enter the license number</p> <p>212 - 223 Enter the last name of the physician</p> <p>224 - 225 Enter the first and middle initial</p> <p>Do not place "PA" in the PA state license number.</p> <p>Do not use UPIN numbers in place of the PA license numbers.</p> <p>Example: MD123456LDOE JA</p> <p>23 character field; Alphanumeric</p> <p>203 - 225</p> <p>UB-92, Item 82 lower line</p> <p>To identify Inpatient services that were under the care of a specific physician.</p>
Field Edit Criteria:	
<p>Error Code: 0011 - 115</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Attending Physician ID Invalid</p> <p>Reason: The Attending Physician ID is invalid or blank.</p> <p>User Response: Correct the Attending Physician ID Number. If the number is correct, please contact the Data Collection Team. We will contact the Department of State Bureau of Professional and Occupational Affairs to verify this number and add it to our Database of Physician ID Numbers.</p>

Field 12	Operating Physician ID
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>The Pennsylvania State License Number and name of the physician that performed the Principal Procedure.</p> <p>Left justify. Blank fill right if name unknown.</p> <p>226 - 234 Enter the license number</p> <p>235 - 246 Enter the last name of the physician</p> <p>247 - 248 Enter the first and middle initial</p> <p>Do not place "PA" in the PA State License Number.</p> <p>Do not use UPIN Numbers in place of the PA State License Numbers.</p> <p>Example: MD123456LDOE JA</p> <p>23 character field; Alphanumeric</p> <p>226 – 248</p> <p>UB-92, Item 83, lower line</p> <p>To identify Inpatient services performed by a specific physician.</p>
Field Edit Criteria:	
<p>Error Code: 0012 - 116</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Operating Physician ID Invalid</p> <p>Reason: The Operating Physician ID is invalid or blank.</p> <p>User Response: Correct the Operating Physician ID Number. If the number is correct, please contact the Data Collection Team. We will contact the Department of State Bureau of Professional and Occupational Affairs to verify this number and add it to our Database of Physician ID Numbers.</p>
Relational Edit Criteria:	
<p>Error Code: 0012 - 319</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Principal Procedure Code and Operating Physician ID Mismatch</p> <p>Reason: The Operating Physician field is filled but the Principal Procedure Code field is blank, or the Principal Procedure Code field contains a Procedure Code that requires an Operating Physician and the Operating Physician field is blank.</p> <p>User Response: Correct the record so that it has both a Principal Procedure Code and an Operating Physician or does not contain either value.</p>

Field 13a2-13v2	Revenue Codes (numbers 1 through 22)																								
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>The codes which identify specific accommodations, ancillary services, and billing calculations for the entire length of stay.</p> <p>See CMS guidelines for more information. Left justify. Blank fill right. See <i>Appendix A</i> for instructions regarding multiple record bills.</p> <p>22 fields with 4 characters each; Alphanumeric</p> <table border="0"> <tr> <td>13a2: 249 - 252</td> <td>13i2: 633 - 636</td> <td>13q2: 1017 - 1020</td> </tr> <tr> <td>13b2: 297 - 300</td> <td>13j2: 681 - 684</td> <td>13r2: 1065 - 1068</td> </tr> <tr> <td>13c2: 345 - 348</td> <td>13k2: 729 - 732</td> <td>13s2: 1113 - 1116</td> </tr> <tr> <td>13d2: 393 - 396</td> <td>13l2: 777 - 780</td> <td>13t2: 1161 - 1164</td> </tr> <tr> <td>13e2: 441 - 444</td> <td>13m2: 825 - 828</td> <td>13u2: 1209 - 1212</td> </tr> <tr> <td>13f2: 489 - 492</td> <td>13n2: 873 - 876</td> <td>13v2: 1257 - 1260</td> </tr> <tr> <td>13g2: 537 - 540</td> <td>13o2: 921 - 924</td> <td></td> </tr> <tr> <td>13h2: 585 - 588</td> <td>13p2: 969 - 972</td> <td></td> </tr> </table> <p>UB-92, Item 42</p> <p>To identify the billing item behind the charge and separate charges into reportable categories (room and board, equipment, professional, etc).</p>	13a2: 249 - 252	13i2: 633 - 636	13q2: 1017 - 1020	13b2: 297 - 300	13j2: 681 - 684	13r2: 1065 - 1068	13c2: 345 - 348	13k2: 729 - 732	13s2: 1113 - 1116	13d2: 393 - 396	13l2: 777 - 780	13t2: 1161 - 1164	13e2: 441 - 444	13m2: 825 - 828	13u2: 1209 - 1212	13f2: 489 - 492	13n2: 873 - 876	13v2: 1257 - 1260	13g2: 537 - 540	13o2: 921 - 924		13h2: 585 - 588	13p2: 969 - 972	
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13b2: 297 - 300	13j2: 681 - 684	13r2: 1065 - 1068																							
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13d2: 393 - 396	13l2: 777 - 780	13t2: 1161 - 1164																							
13e2: 441 - 444	13m2: 825 - 828	13u2: 1209 - 1212																							
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13g2: 537 - 540	13o2: 921 - 924																								
13h2: 585 - 588	13p2: 969 - 972																								
Field Edit Criteria:																									
<p>Error Code: 13a2 -117a thru 13v2 - 117v</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Revenue Code Invalid</p> <p>Reason: The Revenue Code used is not a valid CMS Revenue Code.</p> <p>User Response: Correct the Revenue Code or leave blank if appropriate (<i>use CMS Revenue Codes</i>).</p>																								
<p>Error Code: 13a2 -118</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: No Revenue Information Present (<i>This will appear on the detail Revenue Code Report</i>)</p> <p>Reason: The Revenue Code in Field 13a2 is blank. Each record needs to have at least one Revenue Code and Charge.</p> <p>User Response: Either add the additional Revenue information for this record or remove the extraneous continuation record.</p>																								
Relational Edit Criteria:																									
<p>Error Code: 13a2 - 323a thru 13v2 - 323v</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Revenue Code and Charges Mismatch (<i>This will appear on the detail Revenue Code Report</i>)</p> <p>Reason: There is either a missing Revenue Code or a missing Charge.</p> <p>User Response: Correct the record so that each charge has a Revenue Code.</p>																								
<p>Error Code: 13a2 - 324 thru 13v2 - 324</p> <p>New: 1998 Q4</p>	<p>Error Report Message: Room and Board Charges Not Present (<i>This will appear on the detail Revenue Code Report</i>)</p> <p>Reason: All Inpatient discharges require a room and board charge and this discharge does not have a room and board charge.</p> <p>User Response: Review all charges and make the appropriate corrections.</p>																								

Field 13w2	Revenue Code (number 23 only)
Description Procedure Field Size & Type Record Location CMS Reference Purpose	<p>The code that indicates the total charges or a continuation record.</p> <p>Enter 001. Left justify to indicate the last record in the bill. Blank fill to indicate that a continuation record follows.</p> <p>See <i>Appendix A</i> for instructions regarding multiple record bills.</p> <p>4 character field; Alphanumeric</p> <p>13w2: 1305 - 1308</p> <p>UB-92, Item 42</p> <p>To assure that the individual charges are complete for the entire length of stay.</p>
Field Edit Criteria:	
Error Code: 13w2 - 119 Revised: 1998 Q4	Error Report Message: 23rd Revenue Code is not 001 or Spaces Reason: The only valid Revenue Code for the 23rd position in the record is 001, which indicates the Total Charges for the last record (<i>spaces indicate that there is a continuation record following</i>). User Response: Enter 001 or blanks as appropriate.
Error Code: 13w2 - 120 Revised: 1998 Q4	Error Report Message: 001 Revenue Code Missing on the Final Record for the Claim Reason: The 23rd Revenue Code in the last record of the claim must be 001 to indicate Total Charges. User Response: Enter 001 in the 23rd Revenue Code position for the last record of the claim or add additional continuation records as appropriate.
Relational Edit Criteria:	
Error Code: 13w2 - 323w Revised: 1998 Q4	Error Report Message: Revenue Code and Charges Mismatch (<i>This will appear on the detail Revenue Code Report</i>) Reason: There is either a missing Revenue Code or a missing Charge. User Response: Correct the record so that each charge has a Revenue Code.

Field 13a4-13v4	Total Charges (By Revenue Code – numbers 1 through 22)																								
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>The Total Charges pertaining to the related Revenue Code for the entire length of stay.</p> <p>Right justify. Zero fill left. No decimal. See <i>Appendix A</i> for instructions regarding multiple record bills.</p> <p>22 fields with 10 characters each; Alphanumeric Character 1: Either positive (+), negative (-) or blank [equals positive]. Characters 2-8: whole dollars Characters 9-10: cents</p> <table border="0"> <tr> <td>13a4: 277 - 286</td> <td>13i4: 661 - 670</td> <td>13q4: 1045 - 1054</td> </tr> <tr> <td>13b4: 325 - 334</td> <td>13j4: 709 - 718</td> <td>13r4: 1093 - 1102</td> </tr> <tr> <td>13c4: 373 - 382</td> <td>13k4: 757 - 766</td> <td>13s4: 1141 - 1150</td> </tr> <tr> <td>13d4: 421 - 430</td> <td>13l4: 805 - 814</td> <td>13t4: 1189 - 1198</td> </tr> <tr> <td>13e4: 469 - 478</td> <td>13m4: 853 - 862</td> <td>13u4: 1237 - 1246</td> </tr> <tr> <td>13f4: 517 - 526</td> <td>13n4: 901 - 910</td> <td>13v4: 1285 - 1294</td> </tr> <tr> <td>13g4: 565 - 574</td> <td>13o4: 949 - 958</td> <td></td> </tr> <tr> <td>13h4: 613 - 622</td> <td>13p4: 997 - 1006</td> <td></td> </tr> </table> <p>UB-92, Item 47</p> <p>To measure the amount charged for services by individual charge category.</p>	13a4: 277 - 286	13i4: 661 - 670	13q4: 1045 - 1054	13b4: 325 - 334	13j4: 709 - 718	13r4: 1093 - 1102	13c4: 373 - 382	13k4: 757 - 766	13s4: 1141 - 1150	13d4: 421 - 430	13l4: 805 - 814	13t4: 1189 - 1198	13e4: 469 - 478	13m4: 853 - 862	13u4: 1237 - 1246	13f4: 517 - 526	13n4: 901 - 910	13v4: 1285 - 1294	13g4: 565 - 574	13o4: 949 - 958		13h4: 613 - 622	13p4: 997 - 1006	
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13g4: 565 - 574	13o4: 949 - 958																								
13h4: 613 - 622	13p4: 997 - 1006																								
Field Edit Criteria:																									
<p>Error Code: 13a4 - 121a thru 13v4 - 121v</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Individual Charges Invalid</p> <p>Reason: Total Charges must be positive (+), negative (-) or blank [equals positive] in the first character; characters 2 through 10 must be numeric.</p> <p>User Response: Use only numeric charges.</p>																								
Relational Edit Criteria:																									
<p>Error Code: 13a4 - 323a thru 13v4 - 323v</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Revenue Code and Charges Mismatch (<i>This will appear on the detail Revenue Code Report</i>)</p> <p>Reason: There is either a missing Revenue Code or a missing Charge.</p> <p>User Response: Correct the record so that each charge has a Revenue Code.</p>																								
<p>Error Code: 13a4 - 325 thru 13v4 - 325</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Sum of Line Items Not Equal to Total Charge (<i>This will appear on the detail Revenue Code Report</i>)</p> <p>Reason: When the sum of the individual charges does not equal the Total Charges.</p> <p>User Response: Correct the Total Charges (in 13w4) and/or individual charges.</p>																								

Field 13w4	Total Charge (By Revenue Code – number 23 only)
Description Procedure Field Size & Type Record Location CMS Reference Purpose	<p>The Total Charges for the entire length of stay.</p> <p>Right justify. Zero fill left. No decimal. See <i>Appendix A</i> for instructions regarding multiple record bills. The only valid value for this field is the total charges for this claim, or zeros (with a leading space or plus) to indicate that there is a continuation record to follow.</p> <p>10 character field; Alphanumeric Character 1: Either positive (+), negative (-) or blank [equals positive]. Characters 2-8: whole dollars Characters 9-10: cents</p> <p>13w4: 1333 - 1342</p> <p>UB-92, Item 47.</p> <p>To assure that the individual charges are complete for the entire length of stay.</p>
Field Edit Criteria:	
Error Code: 13w4 -121w Revised: 1998 Q4	Error Report Message: Individual Charges Invalid Reason: Total charges must be positive (+) or blank [equals positive]. Field 13w4 cannot contain a negative (-) in the first character and characters 2 through 10 must be numeric. User Response: Use only numeric charges. Investigate and correct negative charges if they exist.
Relational Edit Criteria:	
Error Code: 13w4 - 323w Revised: 1998 Q4	Error Report Message: Revenue Code and Charges Mismatch (<i>This will appear on the detail Revenue Code Report</i>) Reason: There is either a missing Revenue Code or a missing Charge. User Response: Correct the record so that each charge has a Revenue Code.
Error Code: 13w4 - 325 Revised: 1998 Q4	Error Report Message: Sum of Line Items Not Equal to Total Charge (<i>This will appear on the detail Revenue Code Report</i>) Reason: When the sum of the individual charges does not equal the Total Charge. User Response: Correct the Total Charge (in 13w4) and/or individual charges.
Facility-Level Edit Criteria:	
Error Code: 13w4 - 907 New: 1998 Q4	Error Report Message: Zero Charges Exceeds Acceptable Limits Reason: The number of claims without a charge exceeds expected limits (Excluding newborns – MDC 15). User Response: Review the data that has zero charges and resubmit it.

Field 13w4	Total Charge (By Revenue Code – number 23 only)
<p>Error Code: 13w4 - 908</p> <p>New: 1998 Q4</p>	<p>Error Report Message: Average Charges Are Uncharacteristic for Your Facility</p> <p>Reason: Your average charges are not within the expected range for your facility. This may be caused by a system problem.</p> <p>User Response: Review the data for the records that have unusually high or low Total Charges, then resubmit the data, or if your facility has had a change in status that would explain this error please return the report with an explanation.</p>

Field 13a3-13v3	Units of Service (By Revenue Category)																								
Description	A quantitative measure of services rendered by revenue category to or for the patient including items such as the number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc. according to Medicare definitions.																								
Procedure	Right justify. Zero fill left. See <i>Appendix A</i> for instructions regarding multiple record bills.																								
Field Size & Type	22 fields with 7 characters each; Numeric																								
Record Location	<table border="0"> <tr> <td>13a3: 270 - 276</td> <td>13i3: 654 - 660</td> <td>13q3: 1038 - 1044</td> </tr> <tr> <td>13b3: 318 - 324</td> <td>13j3: 702 - 708</td> <td>13r3: 1086 - 1092</td> </tr> <tr> <td>13c3: 366 - 372</td> <td>13k3: 750 - 756</td> <td>13s3: 1134 - 1140</td> </tr> <tr> <td>13d3: 414 - 420</td> <td>13l3: 798 - 804</td> <td>13t3: 1182 - 1188</td> </tr> <tr> <td>13e3: 462 - 468</td> <td>13m3: 846 - 852</td> <td>13u3: 1230 - 1236</td> </tr> <tr> <td>13f3: 510 - 516</td> <td>13n3: 894 - 900</td> <td>13v3: 1278 - 1284</td> </tr> <tr> <td>13g3: 558 - 564</td> <td>13o3: 942 - 948</td> <td></td> </tr> <tr> <td>13h3: 606 - 612</td> <td>13p3: 990 - 996</td> <td></td> </tr> </table>	13a3: 270 - 276	13i3: 654 - 660	13q3: 1038 - 1044	13b3: 318 - 324	13j3: 702 - 708	13r3: 1086 - 1092	13c3: 366 - 372	13k3: 750 - 756	13s3: 1134 - 1140	13d3: 414 - 420	13l3: 798 - 804	13t3: 1182 - 1188	13e3: 462 - 468	13m3: 846 - 852	13u3: 1230 - 1236	13f3: 510 - 516	13n3: 894 - 900	13v3: 1278 - 1284	13g3: 558 - 564	13o3: 942 - 948		13h3: 606 - 612	13p3: 990 - 996	
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13g3: 558 - 564	13o3: 942 - 948																								
13h3: 606 - 612	13p3: 990 - 996																								
CMS Reference	UB-92, Item 46																								

Field 13w3	Units of Service (By Revenue Category)
Description	A quantitative measure of services rendered by revenue category to or for the patient including items such as the number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc. according to Medicare definitions.
Procedure	Right justify. Zero fill left. See <i>Appendix A</i> for instructions regarding multiple record bills.
Field Size & Type	7 character field; Numeric
Record Location	1326 - 1332
CMS Reference	UB-92, Item 46

Field 13a5-13v5	Non-Covered Charges (By Revenue Category)																								
Description Procedure	<p>The charges relating to the revenue code that are not covered by a Payor.</p> <p>Right justify. Zero fill left. No decimal.</p> <p>See <i>Appendix A</i> for instructions regarding multiple record bills</p> <p>Character 1: Either positive (+), negative (-) or blank [equals positive].</p> <p>Characters 2-8: whole dollars</p> <p>Characters 9-10: cents</p>																								
Field Size & Type	22 fields with 10 characters each; Alphanumeric																								
Record Location	<table border="0"> <tr> <td>13a5: 287 - 296</td> <td>13l5: 671 - 680</td> <td>13q5: 1055 - 1064</td> </tr> <tr> <td>13b5: 335 - 344</td> <td>13j5: 719 - 728</td> <td>13r5: 1103 - 1112</td> </tr> <tr> <td>13c5: 383 - 392</td> <td>13k5: 767 - 776</td> <td>13s5: 1151 - 1160</td> </tr> <tr> <td>13d5: 431 - 440</td> <td>13i5: 815 - 824</td> <td>13t5: 1199 - 1208</td> </tr> <tr> <td>13e5: 479 - 488</td> <td>13m5: 863 - 872</td> <td>13u5: 1247 - 1256</td> </tr> <tr> <td>13f5: 527 - 536</td> <td>13n5: 911 - 920</td> <td>13v5: 1295 - 1304</td> </tr> <tr> <td>13g5: 575 - 584</td> <td>13o5: 959 - 968</td> <td></td> </tr> <tr> <td>13h5: 623 - 632</td> <td>13p5: 1007 - 1016</td> <td></td> </tr> </table>	13a5: 287 - 296	13l5: 671 - 680	13q5: 1055 - 1064	13b5: 335 - 344	13j5: 719 - 728	13r5: 1103 - 1112	13c5: 383 - 392	13k5: 767 - 776	13s5: 1151 - 1160	13d5: 431 - 440	13i5: 815 - 824	13t5: 1199 - 1208	13e5: 479 - 488	13m5: 863 - 872	13u5: 1247 - 1256	13f5: 527 - 536	13n5: 911 - 920	13v5: 1295 - 1304	13g5: 575 - 584	13o5: 959 - 968		13h5: 623 - 632	13p5: 1007 - 1016	
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13f5: 527 - 536	13n5: 911 - 920	13v5: 1295 - 1304																							
13g5: 575 - 584	13o5: 959 - 968																								
13h5: 623 - 632	13p5: 1007 - 1016																								
CMS Reference	UB-92, Item 48																								

Field 13w5	Non-Covered Charges (Total)
Description Procedure Field Size & Type Record Location CMS Reference	<p>The total charges that are not covered by a Payor.</p> <p>Right justify. Zero fill left. No decimal.</p> <p>See <i>Appendix A</i> for instructions regarding multiple record bills.</p> <p>Character 1: positive (+) or blank [equals positive] for credit, negative (-) for debit, or zero (0) if the entire amount is equal to zero.</p> <p>Characters 2 - 8: whole dollars</p> <p>Characters 9 - 10: cents</p> <p>10 character field; Alphanumeric</p> <p>1343 - 1352</p> <p>UB-92, Item 48</p>

Field 13a6-13w6	HCPCS/Rates
Description	Ambulatory/Outpatient Reporting Only
Procedure	Blank fill.
Field size & type	23 fields, 9 characters each
CMS reference	UB-92, Item 44

Field 13a7-13w7	Service Date
Description	Ambulatory/Outpatient Reporting Only
Procedure	Blank fill.
Field size & type	23 fields, 8 characters each
CMS reference	UB-92, Item 45

Field 14b1-14b3	Payor Type and Identification																		
<p>Description</p> <p>Procedure</p>	<p>Code identifying Payor and Product Type as well as the actual name of the Payor from which the facility expects payment for the bill.</p> <p>Place the Primary Payor in Field 14b1, the Secondary Payor in Field 14b2 and the Tertiary Payor in Field 14b3. If there is not a Secondary or Tertiary Payor, then Fields 14b2 and 14b3 should be blank.</p> <p>Each Payor entry must consist of a two-digit identification code and an alphanumeric listing of the Payor's Name. Both components of the Payor entry (Two-digit ID Code and Payor Name) must be filled.</p> <p>Identification Code:</p> <p>The first digit of the code is used to identify the type of Payor administering health care benefits for the patient. The second digit identifies the type of product used to provide those benefits. Example: HealthCentral, Inc. POS should contain the two-digit ID Code 43 as well as the Payor Name HealthCentral, Inc.(e.g. 43HealthCentral)</p> <p>Use the following values to assign a two-digit code:</p> <table border="0"> <thead> <tr> <th>First Digit (Type of Payor)</th> <th>Second Digit (Type of Product)</th> </tr> </thead> <tbody> <tr> <td>Uninsured</td> <td>0 Self Pay or Charity/Indigent Care</td> </tr> <tr> <td>Medicare</td> <td>1 Preferred Provider Organization (PPO)</td> </tr> <tr> <td>Medicaid</td> <td>2 Point of Service (POS)</td> </tr> <tr> <td>Blue Cross</td> <td>3 Fee for Service</td> </tr> <tr> <td>Commercial Insurer</td> <td>4 Health Maintenance Organization (HMO)</td> </tr> <tr> <td>Other Government</td> <td>8 Workers' Compensation</td> </tr> <tr> <td>Unknown/Not Listed</td> <td>9 Automobile</td> </tr> <tr> <td></td> <td>Unknown/Not Listed</td> </tr> </tbody> </table> <p><i>(Unknown/Not Listed codes will be monitored for excessive use)</i></p> <p>Code Unknown Payors as 99.</p> <p>Code Self-Pay or Charity/Indigent Care as 00.</p> <p>Code companies providing coverage under an Automobile Policy as 48.</p> <p>Code companies providing coverage under Workers' Compensation as 47.</p> <p>Code patients receiving care at a State Psychiatric Facility as 89.</p> <p>Code all Federal/State/County-Funded Programs except TriCare such as Black Lung, Postal Workers, Inmates, Veterans, etc. as 89.</p> <p>Employer-Funded Plans should use the code of the insurance company administering the plan.</p>	First Digit (Type of Payor)	Second Digit (Type of Product)	Uninsured	0 Self Pay or Charity/Indigent Care	Medicare	1 Preferred Provider Organization (PPO)	Medicaid	2 Point of Service (POS)	Blue Cross	3 Fee for Service	Commercial Insurer	4 Health Maintenance Organization (HMO)	Other Government	8 Workers' Compensation	Unknown/Not Listed	9 Automobile		Unknown/Not Listed
First Digit (Type of Payor)	Second Digit (Type of Product)																		
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Medicaid	2 Point of Service (POS)																		
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Commercial Insurer	4 Health Maintenance Organization (HMO)																		
Other Government	8 Workers' Compensation																		
Unknown/Not Listed	9 Automobile																		
	Unknown/Not Listed																		

Field 14b1-14b3	Payor Type and Identification		
	Valid Codes: The following are the only valid combinations of the two-digit ID code. Any other entries will generate an error for an invalid Payor Code:		
	<u>Type of Payor (First Digit)</u>	<u>Type of Product (Second Digit)</u>	<u>ID Code</u>
	Uninsured	Self Pay or Charity/Indigent Care	00
	Medicare	PPO	12
	Medicare	POS	13
	Medicare Part A & B	Fee for Service	14
	Medicare	HMO	15
	Medicaid	PPO	22
	Medicaid	Fee for Service	24
	Medicaid	HMO	25
	Blue Cross	PPO	32
	Blue Cross	POS	33
	Blue Cross	Fee for Service	34
	Blue Cross	HMO	35
	Blue Cross	Unknown/Not Listed	39 *
	Commercial	PPO	42
	Commercial	POS	43
	Commercial	Fee for Service	44
	Commercial	HMO	45
	Commercial	Workers' Compensation	47
	Commercial	Automobile	48
	Commercial	Unknown/Not Listed	49
	Government	PPO	82
	Government	Fee for Service	84
	Government	HMO	85
	Government	Unknown/Not Listed	89
	Unknown/Not Listed	Unknown/Not Listed	99

* This code is only valid for Out-of-State Blue Cross plans (please see Appendix C).

Field 14f1 – 14f4	Prior Payments - Payor and Patient
Description	The amount the facility has received from the indicated Payor toward payment of this bill prior to the billing date.
Procedure	Right justify. Zero fill. No decimal. Place the amount paid by the patient in Field 14f4. Character 1: Either positive (+), negative (-) or blank [equals positive]. Characters 2-8: whole dollars (<i>zero fill left</i>) Characters 9-10: cents (<i>zero fill left</i>) 14f1 = Primary Payor Prior Payments 14f2 = Secondary Payor Prior Payments 14f3 = Tertiary Payor Prior Payments 14f4 = Prior Payments From Patient
Field Size & Type	4 fields with 10 characters each; Alphanumeric
Record Location	14f1 : 1428 – 1437 14f2 : 1438 – 1447 14f3 : 1448 – 1457 14f4 : 1458 – 1467
CMS Reference	UB-92, Item 54 a, b, c, d

Field 14g1 – 14g4	Estimated Amount Due - Payor and Patient
Description	The amount estimated by the facility to be due from the indicated Payor (<i>estimated responsibility less prior payments</i>)
Procedure	<p>At the present time fill with zeros. The Council will develop a methodology to apply to all facilities.</p> <p>14g1 = Primary Payor Prior Payments 14g2 = Secondary Payor Prior Payments 14g3 = Tertiary Payor Prior Payments 14g4 = Prior Payments From Patient</p>
Field Size & Type	4 fields with 10 characters each; Alphanumeric
Record Location	14g1 : 1468 - 1477 14g2 : 1478 - 1487 14g3 : 1488 - 1497 14g4 : 1498 - 1507
CMS Reference	UB-92, Item 55 a, b, c, d

Field 17	Uniform Identifier of Primary Payor (NAIC Code)																
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p>	<p>A number that provides a unique identification of individual insurance carriers.</p> <p>Enter the five-digit NAIC Code for the Primary Payor in this field. Please refer to <i>Appendix C</i> for a list of the <u>most common</u> Primary Payors and corresponding NAIC Codes.</p> <p>Blank fill this field if the Primary Payor is not listed in <i>Appendix C</i> and you do not know the correct NAIC Code. Please note that valid NAIC Codes, not found in <i>Appendix C</i>, from licensed insurance carriers in both Pennsylvania as well as the surrounding states will be accepted.</p> <p>When an insurer is providing contractual Medicare or Medicaid managed care services use the NAIC Code for that specific company.</p> <p>The following seven-digit codes should be used to identify the unique Primary Payors listed below:</p> <table border="0"> <tr> <td>Self Pay or Charity/Indigent Care:</td> <td>1111111</td> <td>Federal/State/County funded programs except Medicare and Medicaid</td> <td>6666666</td> </tr> <tr> <td>Behavioral Health Care</td> <td>2222222</td> <td>Third Party Administrators</td> <td>7777777</td> </tr> <tr> <td>Automobile Insurance</td> <td>3333333</td> <td>Medicaid Fee for Service</td> <td>8888888</td> </tr> <tr> <td>Workers' Compensation</td> <td>4444444</td> <td>Medicare Fee for Service:</td> <td>9999999</td> </tr> </table> <p>State Psychiatric Facility Care: 5555555</p> <p>Left justify. Blank fill right.</p> <p>1 field with 7 characters; Alphanumeric</p> <p>1508 - 1514</p> <p>UB-92, Item 2c (positions 18-24 of 29 character field, upper line)</p>	Self Pay or Charity/Indigent Care:	1111111	Federal/State/County funded programs except Medicare and Medicaid	6666666	Behavioral Health Care	2222222	Third Party Administrators	7777777	Automobile Insurance	3333333	Medicaid Fee for Service	8888888	Workers' Compensation	4444444	Medicare Fee for Service:	9999999
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Behavioral Health Care	2222222	Third Party Administrators	7777777														
Automobile Insurance	3333333	Medicaid Fee for Service	8888888														
Workers' Compensation	4444444	Medicare Fee for Service:	9999999														
Field Edit Criteria:																	
<p>Error Code: 0017 - 135</p> <p>Revised: 2000 Q1</p>	<p>Error Report Message: Uniform Identifier of Primary Payor Invalid</p> <p>Reason: The Uniform Identifier of Primary Payor (NAIC Code) is invalid.</p> <p>User Response: See <i>Appendix C</i> for a list of the <u>most common</u> Uniform Identifier of Primary Payors (NAIC Codes) and/or correct the two-digit Payor Code.</p>																
Relational Edit Criteria:																	
<p>Error Code: 0017 - 334</p> <p>Revised: 2000 Q1</p>	<p>Error Report Message: Payor ID Code and Uniform Identifier of Primary Payor Mismatch</p> <p>Reason: The two-digit Payor ID Code (Field 14b1) and the Uniform Identifier of Primary Payor (NAIC Code) are mismatched.</p> <p>User Response: Correct the two-digit Payor ID Code and/or Uniform Identifier of Primary Payor (NAIC Code). Please refer to <i>Appendix C</i>.</p>																

Field 17	Uniform Identifier of Primary Payor (NAIC Code)
Facility-Level Edit Criteria:	
<p>Error Code: 0017 - 912</p> <p>Revised: 2000 Q1</p>	<p>Error Report Message: Number of Blank NAIC Codes Exceeds Acceptable Limit</p> <p>Reason: The number of blank Uniform Identifier of Primary Payor (NAIC Code) for your facility exceeds the acceptable limit.</p> <p>User Response: Review all records containing a blank Uniform Identifier of Primary Payor (NAIC Code), identify the correct code and resubmit your data.</p>
<p>Error Code: 0017 – 914</p> <p>Revised: 2000 Q2</p>	<p>Error Report Message: Number of Blank NAIC Codes Approaching Unacceptable Limit.</p> <p>Reason: The number of blank Uniform Identifier of Primary Payor (NAIC Code) for your facility approaching unacceptable limit.</p> <p>User Response: Review all records containing blank Uniform Identifier of Primary Payor (NAIC Code), identify the correct code and resubmit your data.</p>

Field 18	Zip Code of Facility
Description	The Federal Zip Code for the facility with optional +4 extension.
Procedure	XXXXXXYYY. Left justify without punctuation. Five character Zip Code with the optional four-character extension. If the +4 extension is not known, then leave the last four digits blank.
Field Size & Type	9 character field; Alphanumeric
Record Location	1515 - 1523
CMS Reference	UB-92, Item 1 (Zip Code section)
Purpose	Market Share analysis and population demographic analysis.

Field 19a-19c	Payor Group Number
Description	The identification number or code assigned by the carrier or plan administrator to identify the group under which the individual is covered. The group or policy number is derived from the insurance card as presented by the party responsible for the payment of this bill.
Procedure	<p>Left justify.</p> <p>19a = Primary Payor Group Number</p> <p>19b = Secondary Payor Group Number</p> <p>19c = Tertiary Payor Group Number</p> <p>If the corresponding 14b field is 99 (unknown), then place the word "UNKNOWN" in this field.</p> <p>State owned psychiatric facilities, place the word "STATE" in this field.</p> <p>If the claim is a federally paid claim, place the word "FEDERAL" in this field.</p> <p>If the claim is a self-pay claim, place the word "SELF" in this field.</p>
Field Size & Type	3 fields with 17 characters each; Alphanumeric
Record Location	<p>19a: 1524 - 1540</p> <p>19b: 1541 - 1557</p> <p>19c: 1558 - 1574</p>
CMS Reference	UB-92, Item 62

Field 20	Discharge Status
Description Procedure	<p>Code indicating the patient status at the time of Discharge.</p> <p>Right justify.</p> <p>The coding for this field is defined by CMS. The following is a list of valid entries:</p> <p>01 = Discharged to home or self care</p> <p>02 = Discharged / transferred to a short term general hospital for inpatient care</p> <p>03 = Discharged / transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care</p> <p>04 = Discharged / transferred to an intermediate care facility (ICF)</p> <p>05 = Discharged / transferred another type of institution not defined elsewhere in this code list</p> <p>06 = Discharged / transferred to home under care of organized Home Health Service Organization in anticipation of covered skilled care</p> <p>07 = Left against medical advice (AMA) or discontinued care</p> <p>20 = Expired</p> <p>43 = Discharged / transferred to a Federal health care facility</p> <p>50 = Hospice – home</p> <p>51 = Hospice – medical facility</p> <p>61 = Discharged / transferred to hospital-based Medicare approved swing bed</p> <p>62 = Discharged / transferred to an inpatient rehabilitation facility including rehabilitation distinct part units of a hospital</p> <p>63 = Discharged / transferred to a Medicare certified long term care hospital (LTCH)</p> <p>64 = Discharged / transferred to a nursing facility certified under Medicaid but not certified under Medicare</p> <p>65 = Discharged / transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital</p> <p>66 = Discharged / transferred to a Critical Access Hospital (CAH)</p> <p>Note: PHC4 does not accept interim bills.</p>
Field Size & Type	2 character field; Numeric
Record Location	1575 – 1576
CMS Reference	UB-92, Item 22
Purpose	To identify the disposition and destination of the patient upon discharge from Inpatient care.

Field 20	Discharge Status
Field Edit Criteria:	
Error Code: 0020 -122 Revised: 1998 Q4	Error Report Message: Discharge Status Invalid Reason: The Discharge Status is blank or does not contain one of the values listed above. User Response: Correct the Discharge Status.

Field 21b	Patient Morbidity
Description	A score reflecting the morbidity of illness upon admission.
Procedure	As defined by the current third-party severity provider.
Field Size & Type	1 character field; Alphanumeric
Record Location	1578
CMS Reference	UB-92 Item 2d (position 1 of 30-character field, lower line)
Purpose	We currently use the Patient Morbidity that is submitted by the third-party severity provider on the hospitals' behalf.

Field 21c	Unusual Occurrence
Description	Unusual Occurrence
Procedure	Blank fill.
Field Size & Type	1 character field; Alphanumeric
Record Location	1579
CMS Reference	UB-92 Item 2-f (position 3 of 30 character field, lower line)

Field 21d	Nosocomial Infection
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p>	<p>The Centers for Disease Control and Prevention (CDC) defines a nosocomial infection as a localized or systemic condition 1) that results from adverse reaction to the presence of an infectious agent(s) or its toxin(s) and 2) that was not present or incubating at the time of admission to the hospital.</p> <p>The CDC nosocomial infection surveillance system known as the National Nosocomial Infections Surveillance System (NNIS) developed 13 major body site categories that will be used by PHC4 to define the nosocomial infection location. <i>Please contact Data Collection for the Nosocomial Infection Collection Guide, which provides additional guidance on the identification and collection of nosocomial infections.</i></p> <p>Valid Codes:</p> <p><i>01 = Indwelling Urinary Catheter Associated Urinary Tract Infection</i></p> <p><i>02 = Surgical Site Infection</i></p> <p><i>03 = Ventilator Associated Pneumonia</i></p> <p><i>04 = Central Line Associated Bloodstream Infection</i></p> <p><i>05 = Bone and Joint Infection</i></p> <p><i>06 = Central Nervous System Infection</i></p> <p><i>07 = Cardiovascular System Infection</i></p> <p><i>08 = Eye, Ear, Nose, Throat, or Mouth Infection, including Upper Respiratory Infection</i></p> <p><i>09 = Gastrointestinal System Infection</i></p> <p><i>10 = Lower Respiratory Tract Infection, Other Than Pneumonia</i></p> <p><i>11 = Reproductive Tract Infection</i></p> <p><i>12 = Skin and Soft Tissue Infection</i></p> <p><i>13 = Systemic Infection</i></p> <p><i>14 = Multiple Infections</i></p> <p><i>21 = Urinary Tract Infection (not device related)</i></p> <p><i>23 = Pneumonia (not device related)</i></p> <p><i>24 = Bloodstream Infection (not device related)</i></p> <p><i>99 = No nosocomial infection present</i></p> <p>2 character field; Alphanumeric</p> <p>1580 - 1581</p> <p>UB-92, Item 2g (Position 4 - 5 of 30 character field, lower line)</p>
Field Edit Criteria:	
<p>Error Code: 021d-136</p> <p>Revised: 2004 Q1</p>	<p>Error Report Message: Nosocomial Infection Code Invalid</p> <p>Reason: The two-digit Nosocomial Infection Code is blank or does not contain one of the valid codes listed above.</p> <p>User Response: Correct the two-digit Nosocomial Infection Code.</p>

Field 21d	Nosocomial Infection
Facility-Level Edit Criteria:	
<p>Error Code: 021d-919</p> <p>Revised: 2004 Q1</p>	<p>Error Report Message: No Nosocomial Infection Present, every record contains a 99 code.</p> <p>Reason: Every record contains a No Nosocomial Infection Present (99) Code.</p> <p>User Response: Review all records containing No Nosocomial Infection Present (99) Code, identify the correct codes, and resubmit your data.</p>

Field 21e	Reserved Field
Description	To be reserved for future use by the Council.
Procedure	Blank fill. Reserved for future use by the Council.
Field Size & Type	532 character field; Alphanumeric
Record Location	1769 - 2300

Field 22	Type of Bill
Description Procedure Field Size & Type Record Location CMS Reference	A code indicating the specific type of bill (inpatient, adjustments, voids, etc.) This three-digit code requires 1 digit each for: 1. Type of facility (1,4, or 6) 2. Bill Classification (1 or 2) 3. Frequency (1, 4, 5, 6, 7, or 8) See CMS guidelines for more detailed information. 3 character field; Numeric 1582 - 1584 UB-92, Item 4

Field 23	Patient Control Number
Description Procedure Field Size & Type Record Location CMS Reference Purpose	A unique code that is used to identify a <u>Patient's</u> bill Use the patient's account billing number. Right justify. Zero fill left. This field needs to match the account number used for the third-party severity provider to identify the patient. 20 character field; Alphanumeric 1585 - 1604 UB-92, Item 3 To identify the claim and perform matches with other data sources such as the third-party severity provider.
Field Edit Criteria:	
Error Code: 0023 - 123 Revised: 1998 Q4	Error Report Message: Patient Control Number Invalid Reason: The Control Number is either all zeros or contains spaces. User Response: Enter the correct Patient Control Number. Right justify and zero fill left if the Patient Control Number is less than 20 characters long.

Field 24	Diagnosis Related Group (DRG)
Description	The condition established, after study, to be chiefly responsible for this hospitalization. The classification of payment group based on diagnosis, age, treatment procedure, patient sex, and discharge status.
Procedure	Right justify with leading zeros. Use the Medicare grouper in effect for each reporting period associated for DRG classification.
Field Size & Type	3 character field; Numeric
Record Location	1605 -1607
CMS Reference	UB-92, Item 2h (position 6-8 of 30 character field, lower line).
Purpose	To provide a comparison between the hospital and PHC4 DRGs.
Field Edit Criteria:	
Error Code: 0024 - 124 Revised: 1998 Q4	Error Report Message: Record is Ungroupable (DRG 470) (<i>This will appear on a separate DRG report</i>) Reason: Could be caused by invalid or missing grouper input parameters. User Response: Check the patient Birth Date, Admit Date, Diagnosis and Procedure Codes, Patient Sex and Discharge Status. Make sure that you are using the correct Medicare grouper.
Relational Edit Criteria:	
Error Code: 0024 - 326 Revised: 1998 Q4	Error Report Message: Hospital DRG Does not Match PHC4 DRG (<i>This will appear on a separate DRG report</i>) Reason: The DRG supplied by the hospital does not match the DRG assigned by PHC4. User Response: Check the patient Birth Date, Admit Date, Diagnosis and Procedure Codes, Patient Sex and Discharge Status. Make sure that you are using the correct Medicare grouper.

Field 25	Procedure Coding Method Used
Description	A Code that identifies the method used for procedure coding on this bill.
Procedure	9 = ICD-9-CM coding method for Inpatient
	❖ Note: All Inpatient records are required to use ICD-9-CM Coding guidelines.
Field Size & Type	1 character field; Numeric
Record Location	1608
CMS Reference	UB-92, Item 79
Purpose	To identify the type of coding method used for the Principal Procedure Code.

Field 26	Admit Type
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>A code indicating the priority of this admission.</p> <p>Coding Structure:</p> <p>1 = Emergency The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.</p> <p>2 = Urgent The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.</p> <p>3 = Elective The patient's condition permits adequate time to schedule the availability of a suitable accommodation.</p> <p>4 = Newborn Use of this code necessitates the use of special Source of Admission Codes. (See Field 27)</p> <p>5 = Trauma Center Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons <u>and</u> involving a trauma activation.</p> <p>1 character field; Numeric</p> <p>1609</p> <p>UB-92, Item 19</p> <p>To identify the urgency and type of admission.</p>
Field Edit Criteria:	
<p>Error Code: 0026 - 126</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Admit Type Invalid</p> <p>Reason: The value in this field is not 1, 2, 3, or 4.</p> <p>User Response: Correct the value.</p>
Relational Edit Criteria:	
<p>Error Code: 0026 - 314</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Principal Diagnosis-Admit Type Mismatch for Newborn</p> <p>Reason: If the Principal Diagnosis indicates a newborn then the Admit Type must be "4" or if the Admit Type is "4" then the Principal Diagnosis must indicate a newborn.</p> <p>User Response: Correct the Principal Diagnosis Code and/or Admit Type.</p>
<p>Error Code: 0026 - 327</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Admit Source Invalid for Newborn</p> <p>Reason: If the Admit Type is 4, then the Admit Source must be 1, 2, 3, or 4.</p> <p>User Response: Correct the Principal Diagnosis Code, Admit Source and/or Admit Type.</p>

Field 27	Admit Source
Description Procedure	<p>A code indicating the source prior to admission.</p> <p>Coding Structure for Emergency, Elective, or Other Type of Admission (1, 2, or 3).</p> <p>1 = Physician Referral The patient was referred and/or admitted to this facility upon the recommendation of his or her personal physician.</p> <p>2 = Clinic Referral The patient was referred and/or admitted to this facility upon the recommendation of the facility's clinic physician.</p> <p>3 = HMO Referral The patient was referred and/or admitted to this facility upon the recommendation of a Health Maintenance Organization physician.</p> <p>4 = Transfer from a Hospital (Different Facility*) The patient was referred and/or admitted to this facility as a transfer from a different acute care facility where he or she was an inpatient. (Effective April 2006)</p> <p>*For Transfers from Hospital Inpatient in the Same Facility. See Code D.</p> <p>5 = Transfer from a Skilled Nursing Facility The patient was referred and/or admitted to this facility as a transfer from a skilled nursing facility.</p> <p>6 = Transfer from another Health Care Facility The patient was referred and/or admitted to this facility as a transfer from a health care facility other than an acute care facility, or a skilled nursing facility.</p> <p>7 = Emergency Room The patient was referred and/or admitted to this facility upon the recommendation of this facility's emergency room physician.</p> <p>8 = Court / Law Enforcement The patient was referred and/or admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.</p> <p>A = Transfer from a Critical Access Hospital The patient was admitted to this facility as a transfer from a critical access hospital where he or she was an inpatient.</p>

Field 27	Admit Source	
<p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>D = Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer</p> <p>The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer. (Effective April 2006)</p> <p>Coding Structure for Newborn Admit Type (4) Field 26.</p> <p>1= Normal Delivery A baby delivered without complications</p> <p>2 = Premature Delivery A baby delivered with time and/or weight factors qualifying it for premature status</p> <p>3 = Sick Baby A baby delivered with medical complications other than those relating to premature status</p> <p>4 = Extramural A newborn delivered in a non-sterile environment</p> <p>1 character field; Alphanumeric</p> <p>1610</p> <p>UB-92, Item 20</p> <p>To identify the urgency and source of admission.</p>	
Field Edit Criteria:		
<p>Error Code: 0027 - 127</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Admit Source Invalid</p> <p>Reason: The value in this field is not 0 through 8 or A.</p> <p>User Response: Correct the value.</p>	
Relational Edit Criteria:		
<p>Error Code: 0027 - 327</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Admit Source Invalid for Newborn</p> <p>Reason: If the Admit Type is 4, then the Admit Source must be 1, 2, 3, or 4.</p> <p>User Response: Correct the Principal Diagnosis Code, Admit Source and/or Admit Type.</p>	

Field 28a-28c	Patient's Relationship to Insured
Description	A code indicating the relationship of the <u>Patient</u> to the insured.
Procedure	28a = Primary Payor Relationship to Insured 28b = Secondary Payor Relationship to Insured 28c = Tertiary Payor Relationship to Insured Right justify. See CMS guidelines for code values and more detailed information.
Field Size & Type	3 fields with 2 characters each; Numeric
Record Location	28a : 1611 - 1612 28b : 1613 - 1614 28c : 1615 - 1616
CMS Reference	UB-92, Item 59 a, b, c

Field 29a-29c	Certification/SSN/Health Insurance Claim Number
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p>	<p>Insurer's unique identification number as assigned by the Payor Organization.</p> <p>29a = Primary Payor Claim Number 29b = Secondary Payor Claim Number 29c = Tertiary Payor Claim Number</p> <p>Left justify.</p> <p>If the corresponding field 14b is 99 (unknown), place the word "UNKNOWN" in this field. If the claim is a self-pay, place the word "SELF" in this field.</p> <p>3 fields with 19 characters each; Alphanumeric</p> <p>29a : 1617 - 1635 29b : 1636 - 1654 29c : 1655 - 1673</p> <p>UB-92, Item 60 a, b, c</p>

Field 32a-32c	Employer Name
Description	The name of the employer that provides health care coverage for the individual who is responsible for the payment of the bill.
Procedure	32a = Primary Payor Employer Name 32b = Secondary Payor Employer Name 32c = Tertiary Payor Employer Name Left justify. If the name of the employer is unknown, place the word "UNKNOWN" in this field.
Field Size & Type	3 fields with 24 characters each; Alphanumeric
Record Location	32a : 1674 - 1697 32b : 1698 - 1721 32c : 1722 - 1745
CMS Reference	UB-92, Item 65 a, b, c

Field 34a-34c	Employment Status Code
Description	A code used to define the employment status of the individual who is responsible for the payment of the bill.
Procedure	34a = Primary Payor Employment Status Code 34b = Secondary Payor Employment Status Code 34c = Tertiary Payor Employment Status Code Coding Structure: 1 = Employed full-time 2 = Employed part-time 3 = Not employed 4 = Self-employed 5 = Retired 6 = On active military duty 9 = Unknown
Field Size & Type	3 fields with 1 character each; Numeric
Record Location	34a: 1746 34b: 1747 34c: 1748
CMS Reference	UB-92, Item 64 a, b, c

Field 35a	Patient Hispanic/Latino Origin or Descent
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>Hispanic/Latino origin refers to people whose origins are from Spain, Mexico, or the Spanish speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality lineage, or country in which the person or his/her ancestors were born before their arrival in the United States.</p> <p>1 = Yes, the patient is of Hispanic origin or descent. 2 = No, the patient is not of Hispanic origin or descent.</p> <p>1 character field; Numeric</p> <p>1749</p> <p>UB-92, Item 2i (position 9 of 30 character field, lower line)</p> <p>To identify whether the patient is of Hispanic or Latino origin.</p>
Relational Edit Criteria:	
<p>Error Code: 035a - 328</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Origin/Race Mismatch</p> <p>Reason: When the patient Hispanic/Latino Origin or Descent is 1 (yes), then Race must be either W (white), B (black), N (other), or U (unknown).</p> <p>User Response: Correct the Patient Race and/or Hispanic/Latino Origin or Descent.</p>
<p>Error Code: 035a - 333</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Origin or Patient Race is Invalid</p> <p>Reason: 35a and/or 35b are not valid identifier(s).</p> <p>User Response: Correct the Patient Race and/or Hispanic/Latino Origin or Descent.</p>
Facility-Level Edit Criteria:	
<p>Error Code: 035a -916</p> <p>New: 2002 Q3</p>	<p>Error Report Message: Number of Hispanic Records for Your Facility is Unusually High or Low</p> <p>Reason: The submission contains considerably more (or fewer) Hispanic records than expected according to the 2000 Census Data.</p> <p>User Response: Verify the number of Hispanic records submitted. If the record count is correct notify the PHC4 Data Collection Team. If the record count is incorrect resubmit the data.</p>

Field 35b	Patient Race
Description Procedure Field Size & Type Record Location CMS Reference Purpose	The <u>Patient's</u> racial background. Coding Structure: W = White B = Black A = Asian or Pacific Island I = Native American or Eskimo N = Other U = Unknown 1 character field; Alphanumeric 1750 UB-92, Item 2j (position 10 of 30 character field, lower line) To identify the race of the patient.
Relational Edit Criteria:	
Error Code: 035b - 328 Revised: 1998 Q4	Error Report Message: Origin/Race Mismatch Reason: When the patient Hispanic/Latino Origin or Descent is 1 (yes), then Race must be either W (white), B (black), N (other), or U (unknown). User Response: Correct the Patient Race and/or Hispanic/Latino Origin or Descent.
Error Code: 035b - 333 Revised: 1998 Q4	Error Report Message: Origin or Patient Race is Invalid Reason: 35a and/or 35b are not valid identifier(s). User Response: Correct the Patient Race and/or Hispanic/Latino Origin or Descent.
Facility-Level Edit Criteria:	
Error Code: 035b - 915 New: 2002 Q3	Error Report Message: Number of Unknown Race Codes Exceeds Acceptable Limit Reason: The number of unknown Race Codes for your facility exceeds the acceptable limit. User Response: Review all records containing an unknown race code, identify the correct code and resubmit your data.

Field 36	Admitting Diagnosis Code
Description	The ICD-9-CM Diagnosis Code provided at the time of admission by the Attending Physician.
Procedure	<p>The ICD-9-CM Diagnosis Code describing the Admitting Diagnosis as a significant finding representing patient distress, an abnormal finding on examination, a possible diagnosis based on significant findings, a diagnosis established from a previous encounter, an admission, an injury, a poisoning, a reason, or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one Admitting Diagnosis. This condition shall be determined based on the ICD-9-CM coding directives in Volumes 1 and II of the ICD-9-CM coding manuals and the official coding guidelines.</p> <p>The reporting of the decimal between the third and fourth digits is eliminated because it is implied.</p> <p>Left justify. Blank fill right.</p>
Field Size & Type	6 character field; Alphanumeric
Record Location	102-107
CMS Reference	UB-92, Item 76

Field 37	E-Code
<p>Description</p> <p>Procedure</p> <p>Field Size & Type</p> <p>Record Location</p> <p>CMS Reference</p> <p>Purpose</p>	<p>The ICD-9-CM code for the external cause of injury, poisoning or adverse effect.</p> <p>If there is an E-Code associated with the Principal Diagnosis Code, enter it in this field. Otherwise, enter the most important E-Code present on the record.</p> <p>This field is required when a Principal Diagnosis Code of 800-904; 910-994; 9950-9955; 9958 or 99657 is used.</p> <p>The data contained in this field can also appear in the Diagnosis Code fields (7b-7i)</p> <p>Left justify. Blank fill right. No decimal.</p> <p>6 character field; Alphanumeric</p> <p>108-113</p> <p>UB-92, Item 77</p> <p>To identify external causes of injury for individual claims.</p>
Field Edit Criteria:	
<p>Error Code: 0037 - 130</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: E-Code Invalid</p> <p>Reason: The value in Field 37 is not a valid ICD-9-CM E-Code. All E-Codes must include a leading "E". For example, E1234.</p> <p>User Response: Correct the E-Code or delete if one is not required.</p>
Relational Edit Criteria:	
<p>Error Code: 0037 - 316</p> <p>Revised: 1998 Q4</p>	<p>Error Report Message: Principal Diagnosis Requires E-Code</p> <p>Reason: The Principal Diagnosis Code requires an entry in the E-Code Field (Field 37).</p> <p>User Response: Correct the Principal Diagnosis Code or include an E-Code.</p>
Facility-Level Edit Criteria:	
<p>Error Code: 0037 - 920</p> <p>New: 2004 Q1</p>	<p>Error Report Message: Number of Unspecified E-codes Exceeds Acceptable Limit</p> <p>Reason: The number of unspecified E-codes for your facility exceeds the acceptable limit.</p> <p>User Response: Review all records containing E8889 or E9289, (the unspecified E-codes), identify the correct codes and resubmit your data.</p>

Field 38	Referring Physician ID
Description	The PA State License Number of the physician who referred the patient to the Attending Physician for care and/or treatment.
Procedure	Character 180 - 188 = PA State License Number Character 189 - 200 = Last Name Character 201 - 202 = First & Middle Initial Do not place the "PA" in the PA State License Number in this field. Format as follows: MD123456LDOE JA If field 26 (Admit Type) is equal to 4 (Newborn), then Field 38 can be blank. Left justify. Blank fill right if the name is unknown.
Field Size & Type	23 character field; Alphanumeric
Record Location	180-202
CMS Reference	UB-92, Item 83 (upper line)

Field 39	Federal Tax ID or Tax Exempt #
Description	The number assigned to the provider by the Federal Government for tax reporting purposes. Also known as a Tax Identification Number (TIN) or Employer Identification Number (EIN).
Procedure	Format: NN-NNNNNNN Left justify. Include hyphen.
Field Size & Type	10 character field; Alphanumeric
Record Location	1759 - 1768
CMS Reference	UB-92, Item 5 (lower line)

Field 40	Admission Hour																																																												
Description	The hour during which the patient was admitted to the provider for Inpatient care.																																																												
Procedure	<p>Coding Structure:</p> <table border="0"> <thead> <tr> <th colspan="2">Code Time</th> <th colspan="2">Code Time</th> </tr> <tr> <th colspan="2">AM</th> <th colspan="2">PM</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00 - 12:59</td> <td>Midnight</td> <td>12 12:00 - 12:59</td> </tr> <tr> <td>01</td> <td>01:00 - 01:59</td> <td></td> <td>13 01:00 - 01:59</td> </tr> <tr> <td>02</td> <td>02:00 - 02:59</td> <td></td> <td>14 02:00 - 02:59</td> </tr> <tr> <td>03</td> <td>03:00 - 03:59</td> <td></td> <td>15 03:00 - 03:59</td> </tr> <tr> <td>04</td> <td>04:00 - 04:59</td> <td></td> <td>16 04:00 - 04:59</td> </tr> <tr> <td>05</td> <td>05:00 - 05:59</td> <td></td> <td>17 05:00 - 05:59</td> </tr> <tr> <td>06</td> <td>06:00 - 06:59</td> <td></td> <td>18 06:00 - 06:59</td> </tr> <tr> <td>07</td> <td>07:00 - 07:59</td> <td></td> <td>19 07:00 - 07:59</td> </tr> <tr> <td>08</td> <td>08:00 - 08:59</td> <td></td> <td>20 08:00 - 08:59</td> </tr> <tr> <td>09</td> <td>09:00 - 09:59</td> <td></td> <td>21 09:00 - 09:59</td> </tr> <tr> <td>10</td> <td>10:00 - 10:59</td> <td></td> <td>22 10:00 - 10:59</td> </tr> <tr> <td>11</td> <td>11:00 - 11:59</td> <td></td> <td>23 11:00 - 11:59</td> </tr> <tr> <td>99</td> <td>Hour</td> <td>Unknown</td> <td></td> </tr> </tbody> </table> <p>Right justify. <i>(All positions fully coded)</i></p>	Code Time		Code Time		AM		PM		00	12:00 - 12:59	Midnight	12 12:00 - 12:59	01	01:00 - 01:59		13 01:00 - 01:59	02	02:00 - 02:59		14 02:00 - 02:59	03	03:00 - 03:59		15 03:00 - 03:59	04	04:00 - 04:59		16 04:00 - 04:59	05	05:00 - 05:59		17 05:00 - 05:59	06	06:00 - 06:59		18 06:00 - 06:59	07	07:00 - 07:59		19 07:00 - 07:59	08	08:00 - 08:59		20 08:00 - 08:59	09	09:00 - 09:59		21 09:00 - 09:59	10	10:00 - 10:59		22 10:00 - 10:59	11	11:00 - 11:59		23 11:00 - 11:59	99	Hour	Unknown	
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Field Size & Type	2 character field; Numeric																																																												
Record Location	44 - 45																																																												
CMS Reference	UB-92, Item 18																																																												

Edits Not Associated with Specific Fields

Facility-Level

Error Code: 909

Error Report Message: Number of Claims for Your Facility is Unusually High or Low

Reason: The submission contains considerably more (or fewer) records than the facility usually submits. A system problem or a media failure may cause this to occur.

User Response: Verify the number of claims submitted. If the record count is correct notify the PHC4 Data Collection Team. If the record count is incorrect resubmit the data. If your facility has had a change in status that would explain this error please return the report with an explanation.

New: 1998 Q4

Trailer Record

Trailer Record Format

Data Element	Data Element Description	Position		Picture	Format
		From	To		
1	Total Records	1	10	9(10)	Total number of records.
2	Total Claims	11	20	9(10)	Total number of patients.
3	Total Dollars	21	32	9(12)	Total dollars. Characters 1-10 = whole dollars, characters 11-12 = cents. Right justify. No decimal. Zero fill left.
4	Filler	33	2299	X(2267)	
5	Record Type		2300	X(1)	T = Trailer

Field 1	Total Records
Description	The total number of records contained on the media, not including the Header and Trailer Records.
Procedure	Right justify. ❖ Note: Each record of a continuation record must be counted.
Field Size & Type	10 character field; Numeric
Record Location	1 – 10

Field 2	Total Claims
Description	The total number of claims contained on the media.
Procedure	Right justify. ❖ Note: Each continuation record must be counted as one claim.
Field Size & Type	10 character field; Numeric
Record Location	11 – 20

Field 3	Total Dollars
Description	The total dollars submitted on the media.
Procedure	Right justify. Zero fill left. No decimal.
	Characters 1 - 10 = Dollars
	Characters 11 - 12 = Cents
Field Size & Type	12 character field; Numeric
Record Location	21 – 32

Field 4	Filler
Description	Reserved for future use by the Council.
Procedure	Blank fill.
Field Size & Type	2267 character field; Alphanumeric
Record Location	33 - 2299

Field 5	Record Type
Description	The code indicating the record is a Trailer Record.
Procedure	T = Trailer
Field Size & Type	1 character field; Alphanumeric
Record Location	2300

Appendix A

Format for Continuation Records

If the number of revenue category lines (13s-w2-5) exceeds 23, the claim will have to be continued on subsequent records. If you encounter this scenario follow the instructions listed below:

Instructions for the first record of a claim

- ◆ Fill all fields on the first record of the claim **except** for the fields listed below; follow the specific instruction for each field.

13w2, Revenue Code, position 1305-1308, blank fill;
13w6, HCPCS/Rates, position 1309, blank fill and position 1310-1317, zero fill;
13w7, Service Date, position 1318-1325, zero fill;
13w3, Units of Service, position 1326-1332, zero fill;
13w4, Total Charges, position 1333, blank fill and position 1334-1342, zero fill;
13w5, Non-Covered Charge, position 1343, blank fill and position 1344-1352, zero fill.

Instructions for the subsequent records of a claim

- ◆ Fill Field 1, position 1 of the subsequent records with a slash (/ or \).
- ◆ You are **required** to fill the following fields where applicable on the subsequent records:

005 Admit Date, positions 28-35
006 Discharge Date, positions 36-43
023 Patient Control Number, positions 1585-1604
13a2 - 13w2 Revenue Code, positions 249-1308
13a3 - 13w3 Units of Service, positions 270-1332
13a4 - 13w4 Total Charges, positions 277-1342
13a5 - 13w5 Non-Covered Charges positions 287-1352
13a6 - 13w6 HCPCS Rates, positions 253-1317
13a7 - 13w7 Service Date, positions 262-1325

- ◆ The final record of the claim, will have a slash (/ or \) in the first position and will contain the 001 in the Revenue Code position on line 23 and will contain dollar amounts equal to a Total Charge for the bill.

NOTE: ALL CHARGES FROM ALL RECORDS NEED TO BE ADDED TOGETHER AND INCLUDED ON THE LAST RECORD OF THE CLAIM.

Appendix B

Revenue Sequence and Payor Sequence Columns

Two columns have been added to the Error Correction Report to facilitate your identification of errors in these categories.

Rev Seq

- ◆ The number 6 appears in the column: *This indicates that an error has been identified in the 6th Revenue Code Field of the record.*

In the event of a continuation record, the following examples apply:

- ◆ The number 24 appears in the column: *This indicates that an error has been identified in the 1st Revenue Code Field of the second record. (A 25 indicates the 2nd Revenue Code Field of the second record, 26 indicates the 3rd Revenue Code Field of the second record, etc.)*
- ◆ The number 47 appears in the column: *This indicates that an error has been identified in the 1st Revenue Code Field of the third record. (A 48 indicates the second record, 49 indicates the 3rd Revenue Code Field of the second record, etc.)*

Pay Seq

- ◆ This column represents the field in which the error has occurred. Examples are as follows:

The number 1 appears in the column: *This indicates that an error has been identified in field 14b1, the Primary Payor Field.*

The number 2 appears in the column: *This indicates that an error has been identified in field 14b2, the Secondary Payor Field.*

The number 3 appears in the column: *This indicates that an error has been identified in field 14b3, the Tertiary Payor Field.*

NOTE: *THIS COLUMN WOULD ALSO BE USED WHEN ERRORS OCCUR IN FIELDS 14F1, 14G, 19, 28, 29, 32, AND 34.*

Appendix C

Most Common Health Plan ID Numbers (NAIC Codes)

Full Name of Payor/Insurer	Product Type	Payor Type Code	NAIC Code	Product Names/(Notes)
Aetna Health, Inc.	HMO	45	95109	
Aetna Health, Inc.	Medicare HMO	15	95109	Golden Medicare
Aetna Health, Inc.	Medicare PPO	12	95109	Golden Choice
Aetna Life Insurance Company	Fee for Service	44	60054	TraditionalChoice
Aetna Life Insurance Company	PPO	42	60054	
American Progressive	Fee for Service	44	80624	
Americhoice	Medicaid HMO	25	95033	
AmeriHealth	HMO	45	95044	
AmeriHealth	Medicaid HMO	25	95044	AmeriHealth Mercy
AmeriHealth	Medicare HMO	15	95044	AmeriHealth 65
AmeriHealth	PPO	42	95044	
Capital Blue Cross (Central PA & Lehigh Valley)	Fee for Service	34	54720	BasicBlue
Capital Blue Cross (Central PA & Lehigh Valley)	Medicare PPO	12	54720	Senior Blue PPO
Capital Blue Cross (Central PA & Lehigh Valley)	PPO	32	54720	CustomBlue
CIGNA	Fee for Service	44	22667	(Also known as CT General)
CIGNA Healthcare of PA	HMO	45	95121	
CIGNA Healthcare of PA	POS	43	95121	
CIGNA Healthcare of PA	PPO	42	95121	
Coventry Health	Fee for Service	44	81973	
Coventry Health	PPO	42	81973	
Educators Mutual Life Insurance Company	Fee for Service	44	62804	
Educators Mutual Life Insurance Company	PPO	42	62804	
Elder Health	Medicare HMO	15	11524	Elder Health Personal Care Plus
First Priority Life Insurance Company	Fee for Service	34	60147	
First Priority Life Insurance Company	PPO	32	60147	Blue Care PPO
Gateway Health Plan, Inc.	Medicaid HMO	25	96938	
Gateway Health Plan, Inc.	Medicare HMO	15	96938	Medicare Assured
Geisinger Health Plan	Fee for Service	44	10244	
Geisinger Health Plan	HMO	45	95923	HMO Solutions

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Most Common Health Plan ID Numbers (NAIC Codes)

Full Name of Payor/Insurer	Product Type	Payor Type Code	NAIC Code	Product Names/(Notes)
Geisinger Health Plan	Medicare HMO	15	95923	Gold Classic, Gold Select
Geisinger Health Plan	Medicare PPO	12	95923	Gold Preferred PPO
Geisinger Health Plan	POS	43	95923	
Geisinger Health Plan	PPO	42	95923	Selectus Coordinated Care, Selectus Direct Access
Health Partners of Philadelphia, Inc.	Medicaid HMO	25	95066	(Also known as Partnership Health Plan)
Health Partners of Philadelphia, Inc.	Medicare HMO	15	95066	Senior Partners (Also known as Partnership Health Plan)
HealthAmerica (Central and Pittsburgh)	HMO	45	95060	HealthAmerica HMO, Advantra HMO
HealthAmerica (Central and Pittsburgh)	Medicare HMO	15	95060	Advantra HMO
HealthAssurance Pennsylvania, Inc.	Medicare HMO	15	11102	Advantra PPO
HealthAssurance Pennsylvania, Inc.	POS	43	11102	HealthAssurance Coordinate Care PPO
HealthAssurance Pennsylvania, Inc.	PPO	42	11102	HealthAssurance PPO
HealthGuard of Lancaster HMO	HMO	35	95443	
HealthGuard of Lancaster HMO	POS	33	95443	
HealthGuard of Lancaster HMO	PPO	32	95443	
Highmark Blue Shield (Central PA)	Fee for Service	34	54771	Highmark ClassicBlue
Highmark Blue Shield (Central PA)	Medicare PPO	12	54771	FreedomBlue
Highmark Blue Shield (Central PA)	POS	33	54771	SelectBlue POS
Highmark Blue Shield (Central PA)	PPO	32	54771	DirectBlue, PPO Blue
Highmark, Inc. (Western PA)	Fee for Service	34	54771	ClassicBlue
Highmark, Inc. (Western PA)	Medicare PPO	12	54771	FreedomBlue
Highmark, Inc. (Western PA)	POS	33	54771	SelectBlue or CommunityBlue
Highmark, Inc. (Western PA)	PPO	32	54771	PreferredBlue or DirectBlue
HMO of Northeastern Pennsylvania	HMO	35	96601	Blue Care HMO
HMO of Northeastern Pennsylvania	POS	33	96601	Blue Care POS
Horizon Healthcare PA	HMO	45	95359	(Formally known as Medigroup)
Horizon Healthcare PA	POS	43	95359	
Hospital Service Association of Northeastern PA	Fee for Service	34	54747	
Hospital Service Association of Northeastern PA	PPO	32	54747	Access Care II (Also know as Blue Cross of Northeast PA)
Humana Insurance Company	Fee for Service	44	73288	
Humana Insurance Company	Medicare HMO	15	73288	Gold Plus

Appendix C

Most Common Health Plan ID Numbers (NAIC Codes)

Full Name of Payor/Insurer	Product Type	Payor Type Code	NAIC Code	Product Names/(Notes)
Humana Insurance Company	Medicare PPO	12	73288	Humana Choice PPO
Independence Blue Cross (Eastern PA)	Fee for Service	34	54704	
Keystone Health Plan Central, Inc.	HMO	35	95199	
Keystone Health Plan Central, Inc.	Medicare HMO	15	95199	Senior Blue
Keystone Health Plan East, Inc.	HMO	35	95056	Keystone HMO
Keystone Health Plan East, Inc.	Medicare HMO	15	95056	Keystone 65 Choice
Keystone Health Plan East, Inc.	POS	33	95056	Keystone Select
Keystone Health Plan West, Inc.	HMO	35	95048	KeystoneBlue or Community Blue HMO
Keystone Health Plan West, Inc.	Medicare HMO	15	95048	SecurityBlue
Keystone Mercy Health Plan	Medicaid HMO	25	96660	Offered through Vista Health Plan d/b/a KeystoneFIRST
Optimum Choice, Inc. of PA	HMO	45	95225	(Also known as OCI-PA)
Prudential Companies	Fee for Service	44	68241	(Code is for Prudential Insurance Company of America)
QCC Insurance Company	Medicare HMO	15	93688	Personal Choice 65
QCC Insurance Company	PPO	32	93688	Personal Choice
Sterling Medicare	Fee for Service	44	77399	
Unison Health Plan	Medicaid HMO	25	95220	MedPLUS (formally Three Rivers Health Plans, Inc.)
Unison Health Plan	Medicare HMO	15	95220	Unison Advantage
United Healthcare	Medicare HMO	15	79413	Evercare
United Healthcare	POS	43	79413	
United Healthcare	PPO	42	79413	
UPMC Health Network	Medicare PPO	12	11994	For Life, Premier, Premier Plus
UPMC Health Network	POS	43	11994	
UPMC Health Network	PPO	42	11994	
UPMC Health Plan, Inc.	HMO	45	95216	
UPMC Health Plan, Inc.	Medicaid HMO	25	11995	UPMC For You
UPMC Health Plan, Inc.	Medicare HMO	15	95216	For Life, Classics, Classics Plus, Prime
UPMC Health Plan, Inc.	POS	43	95216	
Out-of-State Blue Cross	PPO	32	1000000	

Appendix C

Most Common Health Plan ID Numbers (NAIC Codes)

Full Name of Payor/Insurer	Product Type	Payor Type Code	NAIC Code	Product Names/(Notes)
Out-of-State Blue Cross	POS	33	1000000	
Out-of-State Blue Cross	Fee for Service	34	1000000	
Out-of-State Blue Cross	HMO	35	1000000	
Out-of-State Blue Cross	Unknown/Not Listed	39	1000000	
Uninsured	Self Pay or Charity/Indigent Care	00	1111111	
Behavioral Health Coverage	Unknown/Not Listed	49	2222222	
All Automobile Insurers	Automobile	48	3333333	
Workers' Compensation Insurers	Workers' Compensation	47	4444444	
State-Hospital Funded Psychiatric Care	Unknown/Not Listed	89	5555555	
Black Lung	Unknown/Not Listed	89	6666666	
TriCare	HMO	85	6666666	(Formally known as CHAMPUS)
Other Federal/State/County Funded Programs	Unknown/Not Listed	89	6666666	Including Postal Workers, Inmates, Veterans, etc.
Government	PPO	82	6666666	
Government	Fee for Service	84	6666666	
Third Party Administrators	Unknown/Not Listed	49	7777777	TPA
Medical Assistance (Medicaid)	Medicaid	24	8888888	Use ONLY for Fee for Service Medicaid, Not Managed Care
Medicare Part A & B	Medicare	14	9999999	Use ONLY for Fee for Service Medicare, Not Managed Care