Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1796 **Date: APRIL 2000**

CHANGE REQUEST 1151

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Addendum A (Cont.) -	A-19 - A-20 (2 pp.)	A-19 - A-20 (2 pp.)
Addendum A (Cont.)	A-31 - A-32 (2 pp.)	A-31 - A-32 (2 pp.)
	A-43 - A-48 (6 pp.)	A-43 - A-48 (6 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2000*
IMPLEMENTATION DATE: July 1, 2000

Addendum A, Provider Electronic Billing File and Record Formats, is being revised to update the Coordination of Benefits Records (C0B) to accommodate line item expansion that is required under the Balance Budget Action of 1997. Transmittal 1788 issued in January 2000 updated the non COB UB-92 records to accommodate line item expansion but did not include the COB records. The version number is 6.0 for COB Record Types 51, 52, 62, and 63. This is the same version number that was issued in Transmittal 1788 for the non COB UB-92 records. RT's 90 and 91, although not COB specific, contain COB data and were also revised. RT 60 is being reissued because of a typographical error.

No changes are necessary for ANSI 837 vs. 3051.3A.01, since this system will accommodate as many line items as needed.

HCFA WILL STOP SUPPORTING EARLIER VERSIONS OF THE UB-92 FLAT FILE FOR BOTH REGULAR INCOMING AND COB CLAIMS AFTER DECEMBER 31, 2000. ALL COB CLAIMS SHOULD BE IN VERSION 6.0 AS 0F DECEMBER 31, 2000, INCLUDING THOSE THAT HAD TRADING PARTNER AGREEMENTS BEFORE JUNE 1996.

YOU SHOULD ALSO INFORM YOUR PROVIDERS THAT IF THEY HAVE MORE THAN 297 LINES TO SUBMIT ON A CLAIM, THEY WILL HAVE TO SUBMIT VERSION 6.0 OF THE UB-92. EARLIER VERSIONS OF THE UB-92 WILL NOT SUPPORT THE NEW FUNCTIONALITY.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

RECORD TYPE 60 - IP Ancillary Services Data

- o May be preceded by RT 40, 41, 50 - 5n, or 60.
- o May be followed by RT 60 or 70.
- o The sequence number for record type 60 can go from 001 to 999 with each such physical record containing three inpatient ancillary service codes, thus making provision for reporting up to 2997 services although only 450 items will be accepted on a single claim.
- o Write all sequences of RT 60.

PAYER AND RELATED INFORMATION REVENUE CODES: CODES 0010 - 0099.

THESE CODES MAY BE REPORTED IN RT 60, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RTS 90 AND 91.

INPATIENT ANCILLARY SERVICES REVENUE CODES: CODES 0220 - 099X.

INPATIENT ANCILLARY CODES MUST BE IN CODE NUMBER SEQUENCE.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record type '60'	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Patient Control Number	X(20)	L	6	25
4	Filler (National Use)	X(2)		26	27
	Inpatient Ancillaries (occurs 3 times)				
	Inpatient Ancillaries - 1	X(55)		28	82
5	Inpatient Ancillary Revenue Code	9(4)	R	28	31
	If Revenue Code is 624, then also use RT 34.				
	When Revenue Code is 002X then field 6 contains a HIPPS Rate Code				
6	HCPCS Procedure Code/HIPPS	X(5)	L	32	36
7	Modifier 1 (HCPCS & CPT-4)	X(2)	L	37	38
8	Modifier 2 (HCPCS & CPT-4)	X(2)	L	39	40
9	Inpatient Ancillary Units of Service	9(7)	R	41	47
10	Inpatient Ancillary Total Charges	9(8)V99S	R	48	57
11	Inpatient Ancillary Noncovered Charges	9(8)V99S	R	58	67
12	Form Locator 49	X(4)	L	68	71
* 13	Assessment Date (CCYYMMDD)	X(8)	L	72	79
14	Filler (National Use)	X(3)		80	82
15	Inpatient Ancillaries - 2	X(55)		83	137
16	Inpatient Ancillaries - 3	X(55)		138	192

* Field 13 must only be completed when Revenue Code 002X is used, otherwise leave blank. See footnote C-13 for benefit coordination.

RECORD TYPE 61 - OUTPATIENT PROCEDURES

- o May be preceded by RT 40, 41, or 61.
- o May be followed by RT 61 - 6n, 70, or 80.
- o The sequence number for record type 61 can go from 001 to 999, each such physical record containing three procedure codes, thus making provision for reporting up to 2997 services although only 450 items will be accepted on a single claim.

PAYER AND RELATED INFORMATION REVENUE CODES: CODES 0010 -0099.

THESE CODES MAY BE REPORTED IN RT 61, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RTS 90 AND 91.

OUTPATIENT ANCILLARY CODES MUST BE IN CODE NUMBER SEQUENCE.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record type '61'	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Patient Control Number	X(20)	L	6	25
4	Filler (National Use)	XX		26	27
	Revenue Center (occurs 3 times)				
	Revenue Code - 1	X(55)		28	82
5	Revenue Code If Revenue Code is 624, then also use RT 34.	9(4)	R	28	31
6	HCPCS Procedure Code	X(5)	L	32	36
7	Modifier 1 (HCPCS & CPT-4)	X(2)	L	37	38
8	Modifier 2 (HCPCS & CPT-4)	X(2)	L	39	40
9	Units of Service	9(7)	R	41	47
10	Form Locator 49	X(6)	L	48	53
11	Outpatient Total Charges	9(8)V99S	R	54	63
12	Outpatient Noncovered Charges	9(8)V99S	R	64	73
13	Date of Service (CCYYMMDD)	9(8)	R	74	81
14	Filler (National Use)	X		82	82
* 15	Revenue Code - 2	X(55)		83	137
* 16	Revenue Code - 3	X(55)		138	192

* Revenue Codes 2 and 3 have the same format as fields 5-14 in Revenue Center 1.

See footnote C-14 for benefit coordination.

RECORD TYPE 90 - CLAIM CONTROL SCREEN

- o May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80 - 8N.
- o Must be followed by RT 20, 74, 91, or 95.
- o If more than 105 characters are required for Form Locator 84, use RT 91 to report the additional characters and code a "1" in field 12 of RT 90. A "0" indicates that no RT 91 follows.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record Type '90'	XX	L	1	2
2	Filler (National Use)	XX		3	4
3	Patient Control Number	X(20)	L	5	24
4	Physical Record Count (Excluding RT 90 + 91)	9(4)	R	25	28
	Record Type nn Count (Fields 5-11)				
5	Record Type 2n Count	99	R	29	30
6	Record Type 3n Count	99	R	31	32
7	Record Type 4n Count	99	R	33	34
8	Record Type 5n Count	9(3)	R	35	37
9	Record Type 6n Count	9(3)	R	38	40
10	Record Type 7n Count	99	R	41	42
11	Record Type 8n Count	99	R	43	44
12	Record Type 91 Qualifier	9		45	45
13	Total Accommodation Charges Revenue Centers	9(8)V99S	R	46	55
14	Noncovered Accommodation Charges - Revenue Centers	9(8)V99S	R	56	65
15	Total Ancillary Charges Revenue Centers	9(8)V99S	R	66	75
16	Noncovered Ancillary Charges - Revenue Centers	9(8)V99S	R	76	85
17	Filler (National Use)	X(2)		86	87
18	Remarks	X(105)	L	88	192

See footnote C-25 for benefit coordination.

RECORD TYPE 91 - REMARKS

- Must be preceded by RT 90.
- Must be followed by RT 20, 74, or 95.
- The first 105 characters from Form Locator 84, Remarks, that are required to provide additional information on the claim must be entered on RT 90. If more than 105 characters are required, use field 4 of RT 91 to report them.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record Type '91'	XX	L	1	2
2	Filler (National Use)	XX		3	4
3	Patient Control Number	X(20)	L	5	24
4	Remarks (Additional)	X(87)	L	25	111
5	Filler (National Use)	X(81)		112	192

See footnote C-26 for benefit coordination.

CLAIM CHANGE REASON CODE (cont.)

RECORD TYPE 42

*******OPTIONAL RECORD*******

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
24	MIA/MOA Remark Code-1	X(5)	L	131	135
25	MIA/MOA Remark Code-2	X(5)	L	136	140
26	MIA/MOA Remark Code-3	X(5)	L	141	145
27	MIA/MOA Remark Code-4	X(5)	L	146	150
28	MIA/MOA Remark Code-5	X(5)	L	151	155
29	Filler (National Use)	X(37)		156	192

Comment: This is a payer generated Record Type and is not created by the provider.

NOTE: Mandatory for Medicare if ASC X12N 835 Remittance Reason Codes used in claims processing. Reason code values and amounts should be the same as those applied to the ANSI ASC X12N 835 Remittance.

IP ACCOMMODATIONS LINE ITEM REMARKS CODES

RECORD TYPE 51

*******MANDATORY IF LINE LEVEL REMARKS CODES ARE PRESENT*******

- o May follow RT 50 or RT 51.
- o May be followed by RT 50, RT 51, RT 52, RT 60, or RT 70.
- o RT 51 should directly correspond to the previous RT 50.
- o The sequence number for RT 51 can go from 001 to 999.
- o The payer sequence ‘01' would represent the Primary Payer, payer sequence ‘02' would represent the Secondary Payer, and payer sequence ‘03' would represent the Tertiary Payer.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '51'	XX	L	1	2
2	Sequence Number	(9)3	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Accommodation Revenue Code	9(4)	R	28	31
6	Remarks Code 1	X(4)	L	32	35
7	Remarks Code 2	X(4)	L	36	39
8	Remarks Code 3	X(4)	L	40	43
9	Remarks Code 4	X(4)	L	44	47
10	Remarks Code 5	X(4)	L	48	51
11	Remarks Code 6	X(4)	L	52	55
12	Remarks Code 7	X(4)	L	56	59
13	Remarks Code 8	X(4)	L	60	63
14	Remarks Code 9	X(4)	L	64	67
15	Remarks Code 10	X(4)	L	68	71
16	Filler (National Use)	X(121)		72	192

NOTE: All RT 51 records for the Primary Payer should be followed by all RT 51 for the Secondary Payer, followed by all RT 51 for the Tertiary Payer. All RT 51 for each payer should be in numerical sequence.

INPATIENT ACCOMMODATION REASON CODES

RECORD TYPE 52

*******MANDATORY IF LINE LEVEL REASON CODES ARE PRESENT*******

- o May follow RT 50, RT 51, or RT 52.
- o May be followed by RT 50, RT 52, RT 60, or RT 70.
- o Use RT 52 for IP accommodations
- o RT 52 should directly correspond to the previous RT 50.
- o The sequence number for RT 52 can go from 001 to 999.
- o The payer sequence '01' would represent the Primary Payer, payer Sequence '02' would represent the Secondary Payer, and payer sequence '03' would represent the Tertiary Payer.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type 52	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Accommodation Revenue Code	9(4)	L	28	31
6	Group Code	X(2)	L	32	33
7	Reason Code 1	X(3)	L	34	36
8	Adjustment Amount 1	9(7)V99S	R	37	45
9	Adjustment Quantity 1	9(5)S	R	46	50
10	Reason Code 2	X(3)	L	51	53
11	Adjustment Amount 2	9(7)V99S	R	54	62
12	Adjustment Quantity 2	9(5)S	R	63	67
13	Reason Code 3	X(3)	L	68	70
14	Adjustment Amount 3	9(7)V99S	R	71	79
15	Adjustment Quantity 3	9(5)S	R	80	84
16	Reason Code 4	X(3)	L	85	87
17	Adjustment Amount 4	9(7)V99S	R	88	96
18	Adjustment Quantity 4	9(5)S	R	97	101
19	Reason Code 5	X(3)	L	102	104
20	Adjustment Amount 5	9(7)V99S	R	105	113
21	Adjustment Quantity 5	9(5)S	R	114	118
22	Reason Code 6	X(3)	L	119	121
23	Adjustment Amount 6	9(7)V99S	R	122	130
24	Adjustment Quantity 6	9(5)S	R	131	135
29	Filler (National Use)	X(57)		136	192

NOTE: All RT 52 records for the Primary Payer should be followed by all RT 52 for the Secondary payer, followed by all RT 52 for the Tertiary Payer. All RT 52 for each payer should be organized in group sequence.

ANCILLARY OR OP ITEM REMARKS CODES

RECORD TYPE 62

- o May follow RT 60, RT 61, or RT 62.
- o May be followed by RT 60, RT 61, RT 62, RT 63, or RT 70.
- o RT 62 should directly correspond to the previous RT 60 or RT 61.
- o The sequence number for RT 62 can go from 001 to 999.
- o The payer sequence '01' would represent the Primary Payer, payer sequence '02' would represent the Secondary Payer, and payer sequence '03' would represent the Tertiary Payer.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '62'	XX	L	1	2
2	Sequence Number	(9)3	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Accommodation Revenue Code	9(4)	R	28	31
6	Remarks Code 1	X(4)	L	32	35
7	Remarks Code 2	X(4)	L	36	39
8	Remarks Code 3	X(4)	L	40	43
9	Remarks Code 4	X(4)	L	44	47
10	Remarks Code 5	X(4)	L	48	51
11	Remarks Code 6	X(4)	L	52	55
12	Remarks Code 7	X(4)	L	56	59
13	Remarks Code 8	X(4)	L	60	63
14	Remarks Code 9	X(4)	L	64	67
15	Remarks Code 10	X(4)	L	68	71
16	Filler (National Use)	X(121)		72	192

NOTE: All RT 62 records for the Primary Payer should be followed by all RT 62 for the Secondary Payer, followed by all RT 62 for the Tertiary Payer. All RT 62 for each payer should be in numerical sequence.

ANCILLARY OR OP REASON CODES

RECORD TYPE 63

*******MANDATORY RECORD IF LINE LEVEL REASON CODES ARE PRESENT*****

o May follow RT 60, RT 61, RT 62 or RT 63.

o Use RT 63 for IP ancillary or OP line level reason codes.

o RT 63 should directly correspond to the previous RT 60 or 61.

o The sequence number for RT 63 can go from 001 to 999.

o The payer sequence '01' would represent the Primary payer, payer sequence '02' would represent the Secondary payer, and payer sequence '03' would represent the Tertiary Payer.

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type 63	XX	L	1	2
2	Sequence Number	9(3)	R	3	5
3	Payer Sequence	99	R	6	7
4	Patient Control Number	X(20)	L	8	27
5	Revenue Code	9(4)	R	28	31
6	Group Code	X(2)	L	32	33
7	Reason Code 1	X(3)	L	34	36
8	Adjustment Amount 1	9(7)V99S	R	37	45
9	Adjustment Quantity 1	9(5)S	R	46	50
10	Reason Code 2	X(3)	L	51	53
11	Adjustment Amount 2	9(7)V99S	R	54	62
12	Adjustment Quantity 2	9(5)S	R	63	67
13	Reason Code 3	X(3)	L	68	70
14	Adjustment Amount 3	9(7)V99S	R	71	79
15	Adjustment Quantity 3	9(5)S	R	80	84
16	Reason Code 4	X(3)	L	85	87
17	Adjustment Amount 4	9(7)V99S	R	88	96
18	Adjustment Quantity 4	9(5)S	R	97	101
19	Reason Code 5	X(3)	L	102	104
20	Adjustment Amount 5	9(7)V99S	R	105	113
21	Adjustment Quantity 5	9(5)S	R	114	118
22	Reason Code 6	X(3)	L	119	121
23	Adjustment Amount 6	9(7)V99S	R	122	130
24	Adjustment Quantity 6	9(5)S	R	131	135
29	Filler (National Use)	X(57)		136	192

NOTE: All RT 63 records for the Primary Payer should be followed by all RT 63 for the Secondary payer, followed by all RT 63 for the Tertiary Payer. All RT 63 for each payer should be organized in numerical sequence.

CLAIM CONTROL TOTALS

RECORD TYPE 92

*** MANDATORY RECORD ***

- o May follow RT 90, RT 91 or RT 92.
- o May be followed by RT 20, 92, 93 or RT 95
- o This Record Type is used ONLY for OUT Bound COB Bills
- o If there is an Inpatient DRG bill, RT 51 and 61 will not be present because the DRG amount paid is at a claim level, rather than at an individual revenue code level.
- o Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

	FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
	1	Record Type '92'	XX	L	1	2
	2	Sequence Number	99	R	3	4
	3	Patient Control Number	X(20)	L	5	24
N1	4	Current DCN/ICN	X(23)	L	25	47
	5	Filler - (National Use)	X(6)		48	53
N2	6	Total Submitted Charges	9(8)V99S	R	54	63
N3	7	Total Non-covered Charges	9(8)V99S	R	64	73
	8	Total Charges Allowed	9(8)V99S	R	74	83
	9	Total Medicare Reimbursement	9(8)V99S	R	84	93
	10	Total Amount Medicare Paid Provider	9(8)V99S	R	94	103
	11	Total Amount Paid Beneficiary	9(8)V99S	R	104	113
N4	12	Total Medicare Days Utilized	9(4)	R	114	117
	13	DRG/APC Assigned via Grouper	999	R	118	120
	14	DRG/APC Amount Applied via Pricer	9(8)V99S	R	121	130
	15	DRG Outlier Amount	9(8)V99S	R	131	140
	16	Total Denied Charges	9(8)V99S	R	141	150
	17	Cost Report Days	999S	R	151	153
	18	Lifetime Psychiatric Days	999S	R	154	156
N5	19	Claim Status	XX	L	157	158
	20	Reimbursement Rate (%)	9(4)V999	R	159	165
	21	Claim Paid Date (CCYYMMDD)	9(8)	R	166	173
	22	Filler (National Use)	X(19)		174	192

N1 NOTE: This is the claim ICN/DCN currently being processed.

N2 NOTE: Sum of RT 90 FL 13/15

N3 NOTE: Sum of RT 90 FL 14/16

N4 NOTE: Same as RT 30 FL 20-covered days

N5 NOTE: Claim Status Codes-Refer to ANSI X12 codes.