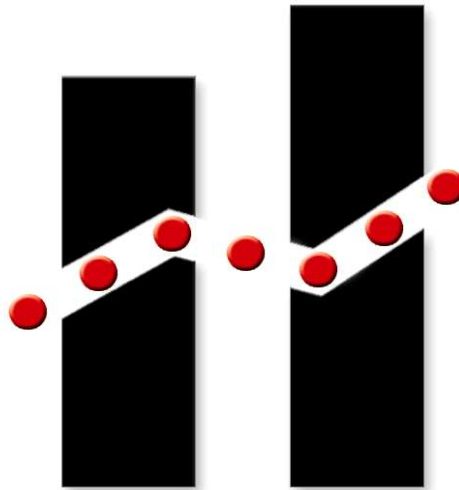


2007
V.2

Oklahoma State Department of Health

Hospital Based Outpatient Surgery Data

SUBMISSION MANUAL



HEALTH CARE INFORMATION

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AT A GLANCE:
**Major changes made to the 2007 version
of the Outpatient Surgery Data Manual**

1. Major changes in the format have occurred in this revision of the manual to coincide with the implementation of the UB-04
2. A 5% error threshold for Patient City, Payer Classification and Total Charges has been added.
3. The preferred method of data submission is through the website, however email and postal mail submissions are also accepted.
4. Street address should be the physical address of the patient. Rural routes and P.O. boxes are not acceptable.
5. National Provider Identifier (NPI) has replaced UPIN for Attending and Procedure Physician.
6. Fields have been defined within existing format for Facility National Provider Identifier, Physician National Provider Identifier and the National Plan Identifier.

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For questions please call: 405-271-6225

Introduction

The Oklahoma Health Care Information System Act, defined in 63 O.S. (Supp. 1994) § 1-115 et seq., established the Division of Health Care Information (“Division”) in the Oklahoma State Department of Health. In accordance with the Act, the Division’s purpose is to develop and operate a system for collecting, processing and disseminating health care data. An integral component of the activities of the Division is the collection of outpatient surgery data. ***All facilities or related institutions that are licensed pursuant to Title 63 Section 1-701 et seq. of the Oklahoma Statutes are required to report information on outpatient surgery encounters.***

This manual defines the data that facilities are required by statute to submit to the Division. It specifies the technical requirements for data submission, defines the data elements to be submitted, and outlines the data editing procedure. In order to ensure the integrity of the database, data must be received in usable formats from all facilities. The Division will provide technical consultation and assistance upon request. This consultation or assistance is limited to activities that specifically enable the facility to submit data that will meet the requirements. The following sections provide a definition of the reporting source, the submission schedule, the preferred transfer method, the format and description of data elements to be transferred, and, finally, information about the editing/validation/error processing of the submitted data.

Data Confidentiality

Outpatient surgery data furnished to the Division are considered confidential under State law and are not public records as defined by the Open Records Act, Title 51 § 24A.1 et seq. Patient identifying information will not be disclosed. It will be used only for the creation and maintenance of anonymous medical case histories for statistical analysis and reports. The Division is prohibited from identifying, either directly or indirectly, any individual in its reports. The Division will not disclose individual patient identities in any manner, except as directed by a court of competent jurisdiction after an application showing good cause.

Selection Criteria for Outpatient Surgery Records

Only those outpatient surgery records defined by an outpatient bill type with a non-zero charge in revenue code categories 36X, 48X, 49X, 75X and 76X are to be submitted to the Division. That is, all outpatient surgery encounters that include records for open procedures, endoscopy procedures, catheterization procedures, pain management procedures, and injection procedures such as myelogram, arthrograms etc.

The CPT codes included are:

10021-69990, 93501-93660, 92502, 92960-92961, 92973-92975, 92980-92998, 93312-93318, 90870 – 90871, 92018, D9999, C1716, C1718, C1719, C1720, G0104, G0105, G0121, G0260, G0289, G0290, 95920 (with any of the following 92585 95822 95860 95861 95867 95868 95900 95904 95925 95926 95927 95930 95933 95934 95936 95937), 96570 and 95671 (with endoscopy and bronchoscopy codes 43228 and 31641). The criteria have been identified as a tool to help you determine what records should be submitted. Other criteria can be used as long as the desired results are met.

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DATA REPORTING SOURCES AND DEFINITIONS

Licensed hospital based and free standing outpatient surgery facilities are the source for outpatient surgery data.

For each single outpatient surgery encounter, a single data record shall be submitted. Each outpatient surgery data record shall consist of billing, medical, and personal information describing a patient, services received by the patient, and charges billed for the patient. The specific fields required are described in detail in the Data Elements Layout and Descriptions sections. Only one outpatient surgery data record should be submitted for each encounter. For a given patient, separate records for each bill generated should not be submitted, unless each bill represents a distinct outpatient encounter.

Outpatient surgery data records should be submitted for persons who had an outpatient surgery encounter. If a patient is admitted as an inpatient after an outpatient encounter then no record should be submitted unless the outpatient record represents a distinct patient encounter separate from the inpatient stay.

A facility may submit outpatient surgery data directly to the Division or designate a submitting intermediary. Please note that each facility is responsible for the quality and completeness of its yearly submission, regardless of the utilization of a submitting intermediary. The Division will contact the institution directly for any necessary corrections or additional information. When an intermediary is designated, the facility must still ensure that correct information is submitted in a timely manner. If a designated intermediary handles only a subset of a facility's encounters, then the facility must make separate arrangements to submit its other records (i.e., those not handled by the intermediary).

For the purpose of communication and problem solving, each facility shall supply the Division with the name, telephone number, and job title of the person responsible for data submission from each facility.

DATA SUBMISSION SCHEDULE

For each calendar year of data collected, the Division must receive all ambulatory surgery data records by March 1st following the close of that calendar year (e.g. calendar year 2007 data must be submitted by March 1, 2008). Facilities may submit on a monthly, quarterly, or semi-annual basis, if they prefer, as long as the Division is notified of their proposed schedule. In all cases, data must be received by March 1st following each calendar year.

The data elements to be submitted are based on encounters occurring in a calendar year. A patient must be discharged within the calendar year to be included in the calendar year data set.

FOLLOW-UP FOR NON-COMPLIANCE

Submitting outpatient surgery data is required and is a condition of the facility's license as defined in Title 63 Section 1-701 et seq. Non-compliance, including incomplete reporting of required fields, will be referred to the Oklahoma State Department of Health Medical Facilities Division for follow-up and will be published as noncompliant in HCI reports.

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DATA TRANSFER MEDIA

Secure Website Data Transfer

The preferred method of data submission is through the Division's secure website. The website is accessible with a login and password.

The URL is: <https://www.phin.state.ok.us/chi-data/>

Instructions for submitting files on the website can be obtained from the Division.

Alternate Data Transfer Media

Data can also be submitted by mail on CD-ROM or IBM compatible 3.5" disk or by email to:

**Oklahoma State Department of Health
Health Care Information Division, Room 807
1000 NE 10th Street
Oklahoma City, Oklahoma 73117-1299
chsadmin@health.ok.gov**

All **data submitted** must have a label containing the following information:

- A. Name of the information supplier.
- B. Date of submission as MM / DD / YYYY.
- C. The total number of records contained in the file.
- D. An unduplicated count of the patients contained in the file.
- E. The name and telephone number of an individual to contact if problems arise.
- F. If multiple diskettes are submitted, then a sequence number must indicate the processing order.
- G. The beginning and end dates of the data submitted.

The totals indicated on the label (items C and D) must balance with the detail count obtained when processed.

DATA TRANSFER

The physical characteristics of the transfer media must have the following attributes:

- a. All data fields (numeric and alphanumeric) are to be initialized with blank spaces (character code 32).
- c. The data should be ASCII code.

The Division uses PGP encryption for data security. WinZip version 9.0 can also be used for encryption. If you would like to use another type of data security method, please contact HCI and we will be happy to work with you. Please contact HCI for technical advice on security issues:

Lou Ann Sanders (405) 271-6225.

Files submitted electronically must be HIPAA compliant.

EDITING AND VALIDATION

The Division will perform a variety of edits for quality assurance purposes and compliance with the specifications set forth in this submission manual. Data submissions not meeting a 5% error tolerance level will be rejected.

Rejected submissions will be returned to the facility for resubmission or corrections. Table I gives a list of the data fields and tolerance level for each of the field.

Hospitals are encouraged to review the data records for accuracy and completeness corresponding to these edit criteria prior to submission.

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DATA TRANSFER FORMAT

Table 1 lists the data elements and Table 2 describes the record format. The column headings used in Table 2 are:

Field Name: Data Element names listed in Tables 1 and 2

Type: Field attribute:
A=Alphanumeric
N=Numeric

Length: Field length in bytes

Position: Starting and ending position of the field in the records

Definition: The definition specified for each data element is in general agreement with the definition specified for the field entry in the UB -04 manual. Facilities using data sources other than uniform billing should evaluate definitions and coding systems for agreement with those specified in this manual.

General Comments: Used in a similar manner as the UB-04 manual to provide additional information and guidelines for the reporting of the data element. If a facility is unable to use the codes specified here, the facility must supply the Division with translation tables that read facility codes and output HCI codes.

Edit: The criteria used by the Division to determine acceptability of the information provided.

UB-04 Form: Where applicable, this line is the UB-04 Form Locator

Locator: The number which corresponds to the requested data element.

The data elements for each patient discharge are stored in a single record. No fillers are to be used between data fields.

Oklahoma Law (36 chapter 2 § 6581) has mandated that all hospital outpatient billing and claims submission use the UB-04 form.

Table 1
Outpatient Surgery Discharge Data Elements

DATA ELEMENT NAME	ERROR TOLERANCE LEVEL
<u>Patient Information</u>	
Patient name	5%
Patient street address	-
Patient city	5%
Patient state	5%
Patient address postal code	5%
Patient date of birth	5%
Patient gender	5%
Patient Social Security Number	-
Patient race	-
Patient ethnicity	-
Patient marital status (if available)	-
Patient control number	5%
Patient medical record number	-
<u>Provider Information</u>	
Medicare provider number	-
National Provider Identifier	-
<u>Service Information</u>	
Admission date	5%
Admit hour	-
Discharge date	5%
Discharge hour	-
Source of admission	-
Type of admission	-
Patient discharge status	5%

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Table 1
Outpatient Surgery Discharge Data Elements

DATA ELEMENT NAME	ERROR TOLERANCE LEVEL
<u>Diagnosis and Treatment Information</u>	
External cause of injury codes 1-3	-
Attending physician identifier	-
Facility assigned ambulatory patient classification APC 1-3	-
Principal diagnosis	5%
Other diagnosis codes 1-17	5%
Principal procedure CPT code	5%
Other procedure CPT codes 1-5	5%
Principal procedure physician identifier	-
Other procedure physician identifier 1-5	-
Principal procedure date	-
Other procedure dates 1-5	-
<u>Payer Information</u>	
Primary payer identifier	-
Primary payer name	-
Secondary payer identifier	-
Secondary payer name	-
Primary payer classification	5%

Table 1
Outpatient Surgery Discharge Data Elements

DATA ELEMENT NAME	ERROR TOLERANCE LEVEL
<u>Charge Information</u>	
Total charges for this encounter	5%
Total charges by revenue category	-
Units of service by revenue category	-
<u>Other Information</u>	
Type of bill	5%

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Table 2

Field Name	Type	Length	Position		
Patient name	A	30	1	-	30
Patient street address	A	70	31	-	100
Patient city	A	25	101	-	125
Patient state	A	2	126	-	127
Patient address postal code	A	10	128	-	137
Patient date of birth	N	8	138	-	145
Patient gender	A	1	146	-	146
Blank	A	5	147	-	151
Patient last 4 digits of social security number	N	8	152	-	159
Patient race	N	1	160	-	160
Patient ethnicity	N	1	161	-	161
Patient marital status	A	1	162	-	162
Patient control number	A	17	163	-	179
Patient medical record number	A	17	180	-	196
Medicare provider number	A	6	197	-	202
National provider number	N	10	203	-	212
Admission date	N	8	213	-	220
Admit hour	N	2	221	-	222
Discharge date	N	8	223	-	230
Discharge hour	N	2	231	-	232
Source of admission	A	1	233	-	233
Type of admission	N	1	234	-	234
Patient discharge status	N	2	235	-	236
External cause of injury code (E-code)	A	8	237	-	244
External cause of injury code (E-code)	A	8	245	-	252
External cause of injury code (E-code)	A	8	253	-	260

Table 2

Field Name	Type	Length	Position	
Attending physician identifier	A	11	261	- 271
Facility assigned ambulatory patient classifications (APC) I	A	4	272	- 275
Principal diagnosis	A	7	276	- 282
Other diagnosis code 1	A	7	283	- 289
Other diagnosis code 2	A	7	290	- 296
Other diagnosis code 3	A	7	297	- 303
Other diagnosis code 4	A	7	304	- 310
Other diagnosis code 5	A	7	311	- 317
Other diagnosis code 6	A	7	318	- 324
Other diagnosis code 7	A	7	325	- 331
Other diagnosis code 8	A	7	332	- 338
Other diagnosis code 9	A	7	339	- 345
Other diagnosis code 10	A	7	346	- 352
Other diagnosis code 11	A	7	353	- 359
Other diagnosis code 12	A	7	360	- 366
Other diagnosis code 13	A	7	367	- 373
Other diagnosis code 14	A	7	374	- 380
Other diagnosis code 15	A	7	381	- 387
Principal procedure CPT code	A	13	388	- 400
Other procedure CPT code 1	A	13	401	- 413
Other procedure CPT code 2	A	13	414	- 426
Other procedure CPT code 3	A	13	427	- 439
Other procedure CPT code 4	A	13	440	- 452
Other procedure CPT code 5	A	13	453	- 465

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Table 2

Field Name	Type	Length	Position	
Principle procedure physician identifier	A	11	466	- 476
Other procedure physician identifier 1	A	11	477	- 487
Other procedure physician identifier 2	A	11	488	- 498
Other procedure physician identifier 3	A	11	499	- 509
Other procedure physician identifier 4	A	11	510	- 520
Other procedure physician identifier 5	A	11	521	- 531
Principal procedure date	N	8	532	- 539
Other procedure date 1	N	8	540	- 547
Other procedure date 2	N	8	548	- 555
Other procedure date 3	N	8	556	- 563
Other procedure date 4	N	8	564	- 571
Other procedure date 5	N	8	572	- 579
Primary payer identifier	N	15	580	- 594
Primary payer name	A	25	595	- 619
Secondary payer identifier	N	15	620	- 634
Secondary payer name	A	25	635	- 659
Payer classification	A	1	660	- 660
Total charges	N	7	661	- 667
Total charges-rev. code 010x	N	6	668	- 673
Total charges-rev. code 011x	N	6	674	- 679
Total charges-rev. code 012x	N	6	680	- 685
Total charges-rev. code 013x	N	6	686	- 691
Total charges-rev. code 014x	N	6	692	- 697

Table 2

Field Name	Type	Length	Position
Total charges-rev. code 015x	N	6	698 - 703
Total charges-rev. code 016x	N	6	704 - 709
Total charges-rev. code 017x	N	6	710 - 715
Total charges-rev. code 018x	N	6	716 - 721
Total charges-rev. code 019x	N	6	722 - 727
Total charges-rev. code 020x	N	6	728 - 733
Total charges-rev. code 021x	N	6	734 - 739
Total charges-rev. code 022x	N	6	740 - 745
Total charges-rev. code 023x	N	6	746 - 751
Total charges-rev. code 024x	N	6	752 - 757
Total charges-rev. code 025x	N	6	758 - 763
Total charges-rev. code 026x	N	6	764 - 769
Total charges-rev. code 027x	N	6	770 - 775
Total charges-rev. code 028x	N	6	776 - 781
Total charges-rev. code 029x	N	6	782 - 787
Total charges-rev. code 030x	N	6	788 - 793
Total charges-rev. code 031x	N	6	794 - 799
Total charges-rev. code 032x	N	6	800 - 805
Total charges-rev. code 033x	N	6	806 - 811
Total charges-rev. code 034x	N	6	812 - 817
Total charges-rev. code 035x	N	6	818 - 823
Total charges-rev. code 036x	N	6	824 - 829
Total charges-rev. code 037x	N	6	830 - 835
Total charges-rev. code 038x	N	6	836 - 841

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Table 2

Field Name	Type	Length	Position
Total charges-rev. code 039x	N	6	842 - 847
Total charges-rev. code 040x	N	6	848 - 853
Total charges-rev. code 041x	N	6	854 - 859
Total charges-rev. code 042x	N	6	860 - 865
Total charges-rev. code 043x	N	6	866 - 871
Total charges-rev. code 044x	N	6	872 - 877
Total charges-rev. code 045x	N	6	878 - 883
Total charges-rev. code 046x	N	6	884 - 889
Total charges-rev. code 047x	N	6	890 - 895
Total charges-rev. code 048x	N	6	896 - 901
Total charges-rev. code 049x	N	6	902 - 907
Total charges-rev. code 050x	N	6	908 - 913
Total charges-rev. code 051x	N	6	914 - 919
Total charges-rev. code 052x	N	6	920 - 925
Total charges-rev. code 053x	N	6	926 - 931
Total charges-rev. code 054x	N	6	932 - 937
Total charges-rev. code 055x	N	6	938 - 943
Total charges-rev. code 056x	N	6	944 - 949
Total charges-rev. code 057x	N	6	950 - 955
Total charges-rev. code 058x	N	6	956 - 961
Total charges-rev. code 059x	N	6	962 - 967
Total charges-rev. code 060x	N	6	968 - 973
Total charges-rev. code 061x	N	6	974 - 979
Total charges-rev. code 062x	N	6	980 - 985

Table 2

Field Name	Type	Length	Position
Total charges-rev. code 063x	N	6	986 - 991
Total charges-rev. code 064x	N	6	992 - 997
Total charges-rev. code 065x	N	6	998 - 1003
Total charges-rev. code 066x	N	6	1004 - 1009
Total charges-rev. code 067x	N	6	1010 - 1015
Total charges-rev. code 068x	N	6	1016 - 1021
Total charges-rev. code 069x	N	6	1022 - 1027
Total charges-rev. code 070x	N	6	1028 - 1033
Total charges-rev. code 071x	N	6	1034 - 1039
Total charges-rev. code 072x	N	6	1040 - 1045
Total charges-rev. code 073x	N	6	1046 - 1051
Total charges-rev. code 074x	N	6	1052 - 1057
Total charges-rev. code 075x	N	6	1058 - 1063
Total charges-rev. code 076x	N	6	1064 - 1069
Total charges-rev. code 077x	N	6	1070 - 1075
Total charges-rev. code 078x	N	6	1076 - 1081
Total charges-rev. code 079x	N	6	1082 - 1087
Total charges-rev. code 080x	N	6	1088 - 1093
Total charges-rev. code 081x	N	6	1094 - 1099
Total charges-rev. code 082x	N	6	1100 - 1105
Total charges-rev. code 083x	N	6	1106 - 1111
Total charges-rev. code 084x	N	6	1112 - 1117
Total charges-rev. code 085x	N	6	1118 - 1123
Total charges-rev. code 086x	N	6	1124 - 1129

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Table 2

Field Name	Type	Length	Position
Total charges-rev. code 087x	N	6	1130 - 1135
Total charges-rev. code 088x	N	6	1136 - 1141
Total charges-rev. code 089x	N	6	1142 - 1147
Total charges-rev. code 090x	N	6	1148 - 1153
Total charges-rev. code 091x	N	6	1154 - 1159
Total charges-rev. code 092x	N	6	1160 - 1165
Total charges-rev. code 093x	N	6	1166 - 1171
Total charges-rev. code 094x	N	6	1172 - 1177
Total charges-rev. code 095x	N	6	1178 - 1183
Total charges-rev. code 096x	N	6	1184 - 1189
Total charges-rev. code 097x	N	6	1190 - 1195
Total charges-rev. code 098x	N	6	1196 - 1201
Total charges-rev. code 099x	N	6	1202 - 1207
Total charges-rev. code 100x	N	6	1208 - 1213
Total charges-rev. code 101x-209x	N	6	1214 - 1219
Total charges-rev. code 210x	N	6	1220 - 1225
Total charges-rev. code 211x-309x	N	6	1226 - 1231
Total charges-rev. code 310x	N	6	1232 - 1237
Total charges-rev. code 311x-999x	N	6	1238 - 1243
Units of service-rev. code 010x	N	7	1244 - 1250
Units of service-rev. code 011x	N	7	1251 - 1257
Units of service-rev. code 012x	N	7	1258 - 1264
Units of service-rev. code 013x	N	7	1265 - 1271
Units of service-rev. code 014x	N	7	1272 - 1278

Table 2

Field Name	Type	Length	Position
Units of service-rev. code 015x	N	7	1279 - 1285
Units of service-rev. code 016x	N	7	1286 - 1292
Units of service-rev. code 017x	N	7	1293 - 1299
Units of service-rev. code 018x	N	7	1300 - 1306
Units of service-rev. code 019x	N	7	1307 - 1313
Units of service-rev. code 020x	N	7	1314 - 1320
Units of service-rev. code 021x	N	7	1321 - 1327
Units of service-rev. code 022x	N	7	1328 - 1334
Units of service-rev. code 023x	N	7	1335 - 1341
Units of service-rev. code 024x	N	7	1342 - 1348
Units of service-rev. code 025x	N	7	1349 - 1355
Units of service-rev. code 026x	N	7	1356 - 1362
Units of service-rev. code 027x	N	7	1363 - 1369
Units of service-rev. code 028x	N	7	1370 - 1376
Units of service-rev. code 029x	N	7	1377 - 1383
Units of service-rev. code 030x	N	7	1384 - 1390
Units of service-rev. code 031x	N	7	1391 - 1397
Units of service-rev. code 032x	N	7	1398 - 1404
Units of service-rev. code 033x	N	7	1405 - 1411
Units of service-rev. code 034x	N	7	1412 - 1418
Units of service-rev. code 035x	N	7	1419 - 1425
Units of service-rev. code 036x	N	7	1426 - 1432
Units of service-rev. code 037x	N	7	1433 - 1439
Units of service-rev. code 038x	N	7	1440 - 1446

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Table 2

Field Name	Type	Length	Position
Units of service-rev. code 039x	N	7	1447 - 1453
Units of service-rev. code 040x	N	7	1454 - 1460
Units of service-rev. code 041x	N	7	1461 - 1467
Units of service-rev. code 042x	N	7	1468 - 1474
Units of service-rev. code 043x	N	7	1475 - 1481
Units of service-rev. code 044x	N	7	1482 - 1488
Units of service-rev. code 045x	N	7	1489 - 1495
Units of service-rev. code 046x	N	7	1496 - 1502
Units of service-rev. code 047x	N	7	1503 - 1509
Units of service-rev. code 048x	N	7	1510 - 1516
Units of service-rev. code 049x	N	7	1517 - 1523
Units of service-rev. code 050x	N	7	1524 - 1530
Units of service-rev. code 051x	N	7	1531 - 1537
Units of service-rev. code 052x	N	7	1538 - 1544
Units of service-rev. code 053x	N	7	1545 - 1551
Units of service-rev. code 054x	N	7	1552 - 1558
Units of service-rev. code 055x	N	7	1559 - 1565
Units of service-rev. code 056x	N	7	1566 - 1572
Units of service-rev. code 057x	N	7	1573 - 1579
Units of service-rev. code 058x	N	7	1580 - 1586
Units of service-rev. code 059x	N	7	1587 - 1593
Units of service-rev. code 060x	N	7	1594 - 1600
Units of service-rev. code 061x	N	7	1601 - 1607
Units of service-rev. code 062x	N	7	1608 - 1614

Table 2

Field Name	Type	Length	Position
Units of service-rev. code 063x	N	7	1615 - 1621
Units of service-rev. code 064x	N	7	1622 - 1628
Units of service-rev. code 065x	N	7	1629 - 1635
Units of service-rev. code 066x	N	7	1636 - 1642
Units of service-rev. code 067x	N	7	1643 - 1649
Units of service-rev. code 068x	N	7	1650 - 1656
Units of service-rev. code 069x	N	7	1657 - 1663
Units of service-rev. code 070x	N	7	1664 - 1670
Units of service-rev. code 071x	N	7	1671 - 1677
Units of service-rev. code 072x	N	7	1678 - 1684
Units of service-rev. code 073x	N	7	1685 - 1691
Units of service-rev. code 074x	N	7	1692 - 1698
Units of service-rev. code 075x	N	7	1699 - 1705
Units of service-rev. code 076x	N	7	1706 - 1712
Units of service-rev. code 077x	N	7	1713 - 1719
Units of service-rev. code 078x	N	7	1720 - 1726
Units of service-rev. code 079x	N	7	1727 - 1733
Units of service-rev. code 080x	N	7	1734 - 1740
Units of service-rev. code 081x	N	7	1741 - 1747
Units of service-rev. code 082x	N	7	1748 - 1754
Units of service-rev. code 083x	N	7	1755 - 1761
Units of service-rev. code 084x	N	7	1762 - 1768
Units of service-rev. code 085x	N	7	1769 - 1775
Units of service-rev. code 086x	N	7	1776 - 1782
Units of service-rev. code 087x	N	7	1783 - 1789

For questions please call: 405-271-6225

Table 2

Field Name	Type	Length	Position
Units of service-rev. code 088x	N	7	1790 - 1796
Units of service-rev. code 089x	N	7	1797 - 1803
Units of service-rev. code 090x	N	7	1804 - 1810
Units of service-rev. code 091x	N	7	1811 - 1817
Units of service-rev. code 092x	N	7	1818 - 1824
Units of service-rev. code 093x	N	7	1825 - 1831
Units of service-rev. code 094x	N	7	1832 - 1838
Units of service-rev. code 095x	N	7	1839 - 1845
Units of service-rev. code 096x	N	7	1846 - 1852
Units of service-rev. code 097x	N	7	1853 - 1859
Units of service-rev. code 098x	N	7	1860 - 1866
Units of service-rev. code 099x	N	7	1867 - 1873
Units of service-rev. code 100x	N	7	1874 - 1880
Units of service-rev. code 101x-209x	N	7	1881 - 1887
Units of service-rev. code 210x	N	7	1888 - 1894
Units of service-rev. code 211x-309x	N	7	1895 - 1901
Units of service-rev. code 310x	N	7	1902 - 1908
Units of service-rev. code 311x-999x	N	7	1909 - 1915
Type of Bill	N	4	1916 - 1919
Facility assigned ambulatory patient classifications (APC) 2	A	4	1920 - 1923
Facility assigned ambulatory patient classifications (APC) 3	A	4	1924 - 1927

Description of Data Elements

Field Name: Patient Name

Type: A

Position: 1-30

Length: 30

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

Comments: Use a comma and one space to separate last and first names. No space should be left between a prefix and a name (e.g. McCauley, DeClair, or VonFeldt). Titles such as Sir, Msgr., and Dr. should not be recorded. No special characters (e.g. (), *, **, /) should be included in the name. Record hyphenated names with the hyphen (e.g. Smith-Jones, Rebecca). To record a suffix of a name, write the last name, leave a space, and then write the suffix. Follow the suffix with a comma and a first name. For example: Jones II, Robert or Adams Jr., Fred. The middle initial should include only one character. Comments such as 'deceased' should not be included.

Edit: Name must have a comma and space separating the last name from the first.

UB-04 FL 8

Field Name: Patient Street Address

Type: A

Position: 31-100

Length: 70

Definition: The street address of the patients residence. P.O. Boxes and Rural Routes are not acceptable.

Comments: Left justified with spaces to the right to complete the field. The order of the street address should be:

- Street number
- Street direction e.g. N, NW, SW, SE etc. (where applicable)
- Street name
- Street type e.g. Avenue, St, Rd, Road, Ct etc. (where applicable). Refer to the link for commonly use street suffixes.
- http://www.usps.com/ncsc/lookups/abbr_suffix.txt
- Apartment number ((where applicable)

Edit: Street address must be present.

UB-04 FL9a**Field Name: Patient City**

Type: A

Position: 101-125

Length: 25

Definition: The city of the patient's street address.

Edit: Valid city must be present.

UB-04 FL 9b

Field Name: Patient State

Type: A
Position: 126-127
Length: 2
Definition: The state of the patient's address.
Comments: Use standard Post Office state abbreviations (e.g. OK for Oklahoma, TX for Texas).
Edit: State abbreviation must be present and valid.

UB-04 FL 9c

Field Name: Patient Address Postal Code

Type: A
Position: 128-137
Length: 10
Definition: The zip code of the patient's address.
Comments: Left justified with spaces to the right to complete the field. Nine-digit zip codes are encouraged in the form XXXXX-YYYY or XXXXXYYYY.
Edit: Postal zip code must be present and valid.

UB-04 FL 9d

Field Name: Patient Date of Birth

Type: N

Position: 138-145

Length: 8

Definition: The date of birth of the patient.

Comments: Use the eight-digit format MMDDYYYY where:

- MM is the month in two digits ranging from 01 to 12
- DD is the day in two digits ranging from 01 to 31
- YYYY is the year of birth in four digits.
- right justified. (all positions fully coded).

Edit: Date of birth must be:

- Present
- A valid date- not occurring after admit or discharge date
- Equal to admit date for hospital newborns (Principal diagnosis V30-V39)
- Consistent with diagnosis
- Age calculated from date of birth and discharge and must be less than 125 years

UB-04 FL 10

Field Name: Patient Gender

Type: A

Position: 146-146

Length: 1

Definition: Patient gender as recorded at date of admission or start of care.

Comments: This is a one-character code:

M = Male

F = Female

U = Unknown

Edit: Code must be valid and consistent with diagnosis and procedure codes.

UB-04 FL 11

Field Name: Blank

Type: A

Position: 147-151

Length: 5

Definition: Previously Patient first 5 digits of Social Security Number

Field Name: Patient Social Security Number

Type: N

Position: 152-159

Length: 8

Definition: The last 4 digits of the Social Security Number of the patient receiving care.

Comments: Left justify with spaces to the right to complete the field. Do not use hyphens. If a patient does not have a Social Security Number, use the following codes:

- 200 for a patient who has no SSN
- 300 for a patient who chooses not to provide his/her SSN.

Edit: Entry must be a valid SSN, or 200 or 300.

Currently not a UB-04 field.

Field Name: Patient Race

Type: N

Position: 160-160

Length: 1

Definition: This item gives the race of the patient. The information is based on self-identification, and is to be obtained from the patient, a relative, or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Comments: If the patient chooses not to answer, the facility should enter the code for unknown. If the facility fails to request the information, the hospital should enter the code for unknown.

1 = American Indian or Alaskan Native

Definition: A person having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.

2 = Asian or Pacific Islander

Definition: A person having origins in any of the original oriental peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.

3 = Black

Definition: A person having origins in any of the black racial groups of Africa.

4 = White

Definition: A person having origins in any of the original Caucasian peoples of Europe, North Africa or the Middle East.

5 = Other

Definition: Any possible options not covered in the above categories.

6 = Unknown

Definition: A person who chooses not to answer the question or the hospital fails to request the information.

Edit: Code must be valid.

Currently not a UB-04 field

For questions please call: 405-271-6225

Field Name: Patient Ethnicity

Type: N

Position: 161-161

Length: 1

Definition: This item gives the Patients answer to the question “Are you Hispanic?”. The information is based on self-identification and is to be obtained from the patient, a relative or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Comments: If the patient chooses not to answer, the facility should enter the code for unknown. If the facility fails to request the information, the hospital should enter the code for unknown.

1 = Hispanic origin

Definition: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultural origin, regardless of race.

2 = Not of Hispanic origin

Definition: A person who is not classified in 1.

6 = Unknown

Definition: A person who chooses not to respond to the inquiry.

Edit: Code must be valid.

Currently not a UB-04 field.

Field Name: Patient Marital Status

Type: A

Position: 162-162

Length: 1

Definition: The marital status of the patient at date of admission.

Comments: One-character code, where:

S = Single

M= Married

P = Life Partner

X= Legally separated

D= Divorced

W= Widowed

U= Unknown

Edit: Code, if present, must be valid.

Currently not a UB-04 field.

Field Name: Patient Control Number

Type: A

Position: 163-179

Length: 17

Definition: A code assigned by the facility uniquely identifying individual discharge events.

Comments: This code will be used for reference in correspondence, problem solving, edit corrections and return of grouped data.

The PCN identifies a single facility visit for a patient and maybe called or defined as an account number.

The PCN is different from the medical record number which identifies an individual patient remaining the same through multiple facility visits.

Edit: PCN code must be present and should be unique within a facility.

UB-04 FL3a

Field Name: Patient Medical Record Number

Position: 180-196

Length: 17

Definition: A unique identifier assigned by the facility to the patient's medical/health record at the first admission and used for all subsequent admissions.

Edit: MRN code must be present.

UB-04 FL 3b

Field Name: Medicare Provider Number

Type: A

Position: 197-202

Length: 6

Definition: The six-digit number assigned to the facility by Center for Medicare and Medicaid Services.

Edit: Number must be valid.

Currently not a UB-04 field.

Field Name: National Provider Number

Type: N

Position: 203-212

Length: 10

Definition: The ten-digit number assigned to the ASC facility as a result of HIPAA's National Provider Identifier (NPI) regulations.

Edit: Number must be valid and match the CMS national provider list.

Currently not a UB-04 field.

Field Name: Admission Date

Type: N

Position: 213-220

Length: 8

Definition: The date the patient was admitted to the facility for outpatient care.

Comments: Admission date has a 8 digit format MMDDYYYY where:

- MM is the month in two digits ranging from 01 to 12
- DD is the day in two digits ranging from 01 to 31
- YYYY is the year in four digits (e.g. 2007)

Each of the three components must be right justified (all positions fully coded).

Edit: Admission date must be:

- Present and valid
- No earlier than the date of birth
- No later than discharge date.

UB-04 FL 12

Field Name: Admit Hour

Type: N

Position: 221-222

Length: 2

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

Comments: Admit hour is a 2-digit format with the following structure:

Code	Time – AM	Code	Time - PM
00	12:00 – 12:59 Midnight	12	12:00–12:59 Noon
01	01:00 – 01:59	13	01:00 – 01:59
02	02:00 – 02:59	14	02:00 – 02:59
03	03:00 – 03:59	15	03:00 – 03:59
04	04:00 – 04:59	16	04:00 – 04:59
05	05:00 – 05:59	17	05:00 – 05:59
06	06:00 – 06:59	18	06:00 – 06:59
07	07:00 – 07:59	19	07:00 – 07:59
08	08:00 – 08:59	20	08:00 – 08:59
09	09:00 – 09:59	21	09:00 – 09:59
10	10:00 – 10:59	22	10:00 – 10:59
11	11:00 – 11:59	23	11:00 – 11:59
99	Hour Unknown		

Edits: Valid hour must be present.

UB-04 FL 13

Field Name: Discharge Date

Type: N

Position: 223-230

Length: 8

Definition: The date the patient was discharged from the facility.

Comments: Discharge date is in an eight digit format MMDDYYYY where:

- MM is the month in two digits ranging from 01 to 12
- DD is the day in two digits ranging from 01 to 31
- YYYY is the year of discharge (e.g. 2007)

Each of the three components must be right justified (all positions fully coded).

Edit: Discharge date must be:

- Present
- Valid
- No earlier than admission date
- No earlier than date of birth

UB-04 FL 6

Field Name: Discharge Hour

Type: N

Position: 231-232

Length: 2

Definition: The hour during which the patient was discharged from outpatient care .

Comments: Discharge hour is a 2-digit format with the following structure:

Code	Time – AM	Code	Time - PM
00	12:00 – 12:59 Midnight	12	12:00–12:59 Noon
01	01:00 – 01:59	13	01:00 – 01:59
02	02:00 – 02:59	14	02:00 – 02:59
03	03:00 – 03:59	15	03:00 – 03:59
04	04:00 – 04:59	16	04:00 – 04:59
05	05:00 – 05:59	17	05:00 – 05:59
06	06:00 – 06:59	18	06:00 – 06:59
07	07:00 – 07:59	19	07:00 – 07:59
08	08:00 – 08:59	20	08:00 – 08:59
09	09:00 – 09:59	21	09:00 – 09:59
10	10:00 – 10:59	22	10:00 – 10:59
11	11:00 – 11:59	23	11:00 – 11:59
99	Hour Unknown		

Edits: Valid hour must be present.

UB-04 FL 16

Field Name: Source of Admission

Type: A

Position: 233-233

Length: 1

Definition: A code indicating the source of the referral for this encounter.

Comments: This single digit code depends on the code entered for Type of Admission. If Type of Admission is 1 (emergency), 2 (urgent) or 3 (elective), source of admission codes have different meanings than when Type of Admission is 4, (newborn).

Source of Admission codes for Type of Admission=Emergency (1), Urgent (2), or Elective (3):

1 = Physician referral

Definition: The patient was referred to this facility by his or her personal physician. (See code 3 if the physician has an HMO affiliation.)

2 = Clinic Referral

Definition: The patient was referred to this facility by the facility's clinic physician or other outpatient department physician.

3 = HMO referral

Definition: The patient was referred to this facility by a health maintenance organization physician.

4 = Transfer from a hospital

Definition: The patient was referred to this facility for outpatient services by (a physician of) a different acute care facility.

5 = Transfer from a skilled nursing facility

Definition: The patient was referred to this facility by (a physician of) the skilled nursing facility where he or she is a resident.

6 = Transfer from another health care facility

Definition: The patient was referred to this facility by (a physician of) another health care facility where he or she is an inpatient.

7 = Emergency room

Definition: The patient received services in this facility's emergency department.

8 = Court/Law enforcement

Definition: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.

9 = Information not available

Definition: The means by which the patient was admitted to this facility is not known. For Medicare outpatient bills this is not a valid code.

A = Transfer from a critical access hospital

Definition: The patient was referred to this facility by (a physician of) a Critical Access Hospital where he or she was an inpatient.

D= Transfer from Hospital Inpatient in the Same Facility resulting in a separate Claim to the Payer

Definition: The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

Source of Admission codes for Type of Admission=Newborn (4)

1 = Normal delivery

Definition: A baby delivered without complications.

2 = Premature delivery

Definition: A baby delivered with time or weight factors qualifying it for premature status.

3 = Sick baby

Definition: A baby delivered with medical complications, other than those relating to premature status.

4 = Extramural birth

Definition: A baby born in a non-sterile environment.

Edit: The code must be present, valid, and in agreement with the Type of Admission code:
When Type of Admission code = 1, 2, or 3, valid Source of Admission codes = 1 to 9 or A to D.
When Type of Admission code = 4, valid Source of Admission codes = 1 to 4.

Field Name: Type of Admission
Type: N
Position: 234-234
Length: 1
Definition: A code indicating the priority of the admission/visit.
Comments: This code is a one-digit code between 1 and 4, or 9

1= Emergency

Definition: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions.

2= Urgent

Definition: The patient requires immediate attention for the care and treatment of a physical or mental disorder.

3= Elective

Definition: The patient condition permits adequate time to schedule the services.

4= Newborn

Definition: The use of this code necessitates the use of special Source of Admission Codes (Form Locator 15).

5= Trauma center

Definition: This code is for a visit to a trauma center/hospital as licensed or designated by the state or local government authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

9= Information is not available

Edit: The field must be:

- present and valid
- between 1 and 5, or 9

If Type of Admission = 4 (newborn):

- Source of Admission codes must be 1 to 4, or 9
- Date of Birth must equal date of admission
- Diagnosis must be consistent with newborn

UB-04 FL 14

Field Name: Patient Discharge Status

Type: N

Position: 235-236

Length: 2

Definition: A code indicating patient status at the time of discharge.

Comments: Codes for this two-digit field are:

- 01= Discharged to home or self-care (routine discharge)
- 02= Discharged/transferred to a short-term general hospital for inpatient care
- 03= Discharged/transferred to skilled nursing facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care
- 04= Discharged/transferred to an intermediate care facility (ICF)
- 05= Discharged/transferred to another type of health care institution not defined elsewhere in this code list.

Effective through 09/30/07. For discharges 10/01/07 and after use code 70.

Definition Effective 10/01/07: Discharged/Transferred to a Designated Cancer Center or Children's Hospital

- 06= Discharged/transferred to home under care of organized home health service organization
- 07= Left against medical advice or discontinued care
- 20= Expired
- 43= Discharged/transferred to a federal health care facility.
Effective 10/01/2003
- 50= Hospice—home
- 51= Hospice—medical facility
- 61= Discharged/transferred to a hospital-based Medicare approved swing bed. *Effective 05/2002*
- 62= Discharged/transferred to an inpatient rehabilitation facility (IRF) including distinct part units of a hospital. *Effective 05/2002*
- 63= Discharged/transferred to a long term care hospital (LTCH).
Effective 05/2002
- 64= Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. *Effective 05/2002*
- 65= Discharged/transferred to a Psychiatric hospital or Psychiatric Distinct Part Unit of a Hospital.
- 66= Discharged/transferred to a Critical Access Hospital (CAH)
- 70= Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this Code List. **Effective 10/01/07. For discharges prior to 10/01/07 use code 05.**

Edit: Discharge status code must be present and valid.

UB-04 FL 17

For questions please call: 405-271-6225

Field Name: External Cause of Injury Code (3 E-codes)

Type: A

Position: 237-260

Length: 24 (3 fields, 8 positions each)

Definition: The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

Comments: Required whenever there is any diagnosis (primary or secondary) of an injury, poisoning, or adverse effect (ICD-9-CM codes 800-999) and it is the initial treatment for that condition.

The priorities for recording an E-code are:

- Initial treatment of the injury or poisoning.
- Principal diagnosis of an injury or poisoning.
- Other diagnosis of an injury, poisoning or adverse effect directly related to the principal diagnosis.
- Other diagnosis with an external cause.
- Place of occurrence is not required.

Entries:

- Are left justified
- Are without a decimal. If a decimal is included, the fifth digit is lost, which will result in an inaccurate E-code.
- Start with an uppercase E

Edit: If any diagnosis is ICD-9-CM code from 800 through 999, there must be a valid E-Code, between E800 to E999.

UB-04 FL 72a-c

Field Name: Attending Physician Identifier

Type: A

Position: 261-271

Length: 11

Definition: The ten-digit National Provider Identifier Number (NPI) of the physician who has overall responsibility for the patient's medical care and treatment.

Comments: Left justify with spaces to the right to complete the field.

Edit: Entry must be a valid NPI number.

UB-04 FL 76**Field Name: Facility Assigned Ambulatory Patient Classification APC I**

Type: A

Position: 272-275

Length: 4

Definition: The Ambulatory Patient Classification(s) assigned to the outpatient record by the facility.

Comments: The APC field must be:

- Four digits in length
- Left justified with spaces to the right to complete the field length

Edit: The APC field must be:

- Present and valid
- Consistent with age and sex

Currently not a UB-04 field.

For questions please call: 405-271-6225

Field Name: Principal Diagnosis

Type: A

Position: 276-282

Length: 7

Definition: The ICD-9-CM code describing the condition or problem that is the reason for the encounter as shown in the provider records to be chiefly responsible for the outpatient services performed during this visit.

Comments: To code the principal diagnosis:

- Use an ICD-9-CM code without a decimal point in the first 7 positions.
- Enter all three, four, and five digits or to the highest level of specificity.
- Enter the “V” prefix as appropriate
- **Left justify with spaces to the right to complete the field length.**

Edit: A principal diagnosis must be:

- Present
- Valid
- Consistent with sex and age
- An E-code should not be entered as the principal diagnosis.

UB-04 FL 67

Field Name: Other Diagnosis Code (1 - 15)

Type: A

Position: 283-387

Length: 105 (15 fields, 7 positions each)

Definition: ICD-9-CM codes describing other diagnoses corresponding to additional conditions that co-exist at the time of the encounter or develop subsequently, and which have an effect on the treatment received or the length of stay.

Comments: Up to 15 secondary diagnoses may be recorded.

- Use an ICD-9-CM code
- Enter all three, four, and five digits
- Enter the E-code as appropriate
- Left justify with spaces to the right to complete the field length

Edit: A secondary diagnosis must be:

- Valid
- Consistent with sex and age

UB-04 FL 67a-o

Field Name: Principal Procedure CPT Code and Modifiers

Type: A

Position: 388-400

Length: 13

Definition: The Principal Current Procedural Terminology (CPT) procedure code identifies the principal outpatient procedure performed during the outpatient encounter. The principal procedure is that procedure most related to the principal diagnosis.

A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

Comments: Code entry should be in the first five positions in the field and include all digits and should be left justified. The remaining eight positions are for all qualifying modifiers.

Edit: Principal Procedure CPT code field must be:

- Present unless one of the secondary diagnosis codes is V64.
- Valid
- Consistent with patient's sex and age
- HCPCS codes are not valid as a principal procedure except for D9999, G0104, G0105, G0121, G0260, G0289, G0290, C1716, C1718, C1719, C1720, 0020T or as required by Medicare or Medicaid.

CPT Modifiers must be:

- Valid, if present
- Two digits in length

UB-04 FL 44

**Field Name: Other Procedure CPT Codes and Modifiers
(1 - 5)**

- Type: A
- Position: 401-465
- Length: 65 (5 fields, 13 positions each)
- Definition: The Current Procedural Terminology (CPT) procedure code(s) identifies all significant secondary procedure(s) performed during the outpatient encounter and any applicable modifiers.
- A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.
- Comments: Up to 5 secondary procedure CPT codes and modifiers may be recorded. See comments for the principal procedure CPT code. Code entry should be in the first five positions in the field and include all digits and should be left justified. The remaining eight positions are for all qualifying modifiers.
- Edit: Other Procedure CPT Codes 1 – 5 field must be:
- Present only if a principal procedure CPT code is present
 - Valid
 - Consistent with patient's sex and age
- CPT Modifiers must be:
- Valid, if present
 - Two digits in length

UB-04 FL 44

For questions please call: 405-271-6225

Field Name: Principal Procedure—Physician Identifier

Type: A

Position: 466-476

Length: 11

Definition: The ten-digit National Provider Identifier (NPI) of the physician performing the principal procedure.

Comments: Left justify with spaces to the right to complete the field.

Edit: Field must contain a valid NPI.

UB-04 FL 77

Field Name: Other Procedure—Physician Identifier (1-5)

Type: A

Position: 477-531

Length: 55 (5 fields, 11 positions each)

Definition: The 10 digit National Provider Identifier (NPI) of the physician performing other or secondary procedure.

Comments: Left justify with spaces to the right to complete the field.

Edit: Field must contain a valid NPI.

UB-04 FL 78 and 79

Field Name: Principal Procedure Date

Type: N

Position: 532-539

Length: 8

Definition: The date the principal procedure was performed.

Comments: Principal procedure date has a eight digit format **MMDDYYYY** where:

- **MM** is the month in two digits ranging from 01 to 12
- **DD** is the day in two digits ranging from 01 to 31
- **YYYY** is the four-digit year the procedure was performed

Each of the three components must be right justified (all positions fully coded).

Edit: Principal Procedure date must be:

- Present
- Valid
- No earlier than date of encounter
- No later than discharge date
- No earlier than date of birth

UB-04 FL-74

Field Name: Other Procedure Dates (I-5)

Type: N

Position: 540-579

Length: 40 (5 fields, 8 positions each)

Definition: The date(s) that all significant other procedure(s) were performed other than the principal procedure..

Comments: Other procedure dates has an eight digit format **MMDDYYYY** where:

- **MM** is the month in two digits ranging from 01 to 12
- **DD** is the day in two digits ranging from 01 to 31
- **YYYY** is the four-digit year the procedure was performed

Each of the three components must be right justified (all positions fully coded).

Edit: Other Procedure date must be:

- Valid
- No earlier than date of encounter
- No later than discharge date
- No earlier than date of birth

UB-04 FL-74a-e

Field Name: Primary Payer Identifier

Type: A
Position: 580-594
Length: 15
Definition: National Health Plan Identifier identifying the primary payer for this bill.
Comments: This field is to contain the National Health Plan Identifier of the primary payer organization.
Edit: The identifier must be that of a licensed health insurer or self-pay.

UB-04 FL 51a

Field Name: Primary Payer Name

Type: A
Position: 595-619
Length: 25
Definition: Name and payer number (if available) identifying the primary payer for this bill.
Comments: This field is to contain the name of the primary payer, spelled out as completely as space allows. If a name has more than 25 characters, use abbreviations that can be used to uniquely identify the payer. If the patient paid for or was responsible for the hospital stay, primary payer should indicate self-pay.
Edit: The name must be present and that of a licensed health insurer or self-pay

UB-04 FL 50a

For questions please call: 405-271-6225

Field Name: Secondary Payer Identifier

Type: A

Position: 620-634

Length: 15

Definition: National Health Plan Identifier identifying the secondary payer for this bill.

Comments: This field is to contain the National Health Plan Identifier of the primary payer organization.

Edit: The identifier must be that of a licensed health insurer or self-pay.

UB-04 FL 51b

Field Name: Secondary Payer Name

Type: A

Position: 635-659

Length: 25

Definition: Payer name identifying the secondary payer for this bill.

Comments: This field is to contain the name of the secondary payer, spelled out as completely as space allows. If a name has more than 25 characters, use abbreviations that can be used to uniquely identify the payer. If the patient paid for or was responsible for part of the hospital stay, secondary payer should indicate self-pay.

Edit: The name must be that of a licensed health insurer or self-pay.

UB-04 FL 50b

Field Name: Payer Classification

Type: A

Position: 660-660

Length: 1

Definition: This field indicates the payer group for the primary payer.

Comments: The payer group should be classified as:

1. **Commercial** - Includes HMO, PPO, POS, Indemnity, BCBS, Aetna, HealthChoice etc.
2. **Medicare** - Including HMO and insurance Managed Medicare
3. **Medicaid** - Including Medicaid pending
4. **Veterans affairs / Military** - Includes Champus, ChampVA and Tricare.
5. **Workers Compensation**
6. **Uninsured/ Self –pay**
7. **Others** - Payers not in any of the above groups and including charity, Indian Health, auto-liability, DOC inmate.

Left justified with spaces to the right to complete the field length.

Edit: The code must be present and valid.

Currently not a UB-04 field.

Field Name: Total Charges

Type: N

Position: 661-667

Length: 7

Definition: The total charges associated with the patient's encounter.

Comments: This entry is:

- Rounded to nearest whole dollar
- A maximum of seven digits
- Right justified within the field.

Edit: This field must be present and valid. The field should equal the sum of subtotals of charges by revenue code fields.

UB-04 FL 47

Field Name: Total Charges (by Revenue Category) 0001-0990

Type: N

Position: 668-1243

Length:: 576 (96 fields, 6 positions each)

Definition: Dollars charged, subtotaled for each revenue service category.

All valid revenue categories are defined in:

- Table 3-Revenue Codes and Units of Service

The revenue category for this charge subtotal is determined by the position of this item within the computer record specified in:

- Table 2-Data Elements Layout and Description

The four-digit revenue code:

- Identifies a specific accommodation, ancillary service or billing calculation
- Indicates a major category (the only level reported) with the first three digits
- Has "0" for its fourth digit of the four-digits, indicating the general classification for the major category.

Comments: The total allows for a six-digit dollar amount (no cents or decimal point). All entries are right justified. The charge should be rounded to the nearest whole dollar.

Edit: The sum of all charge subtotals should equal the total charges.

UB-04 FL 42

Field Name: Units of Service (by Revenue Category)
0001-0990

Type: N

Position: 1244-1915

Length: 672 (96 fields, 7 positions each)

Definition: The number of units of service rendered for each revenue category.

Comments: Like subtotal of charges, the revenue category which this unit of service describes, is determined by the position of this item within the computer record specified in:

- Table 2 – Data Elements Layout and Description

Units of service for each revenue code are defined in:

- Table 3 – Revenue Codes and Units of Service

Edit: The units of service must be present:

- If the revenue category requires a unit, and the total charges for the revenue code are greater than zero (0).

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Field Name: Type of Bill
Type: A
Position: 1916-1919
Length: 4
Definition: A code indicating the specific type of bill. The first digit is a leading zero and the fourth digit defines the frequency of the bill.
Comments: The leading zero is not included on electronic claims. The field is left justified. Even though all bill types are included in the table below only outpatient bill types should be reported for outpatient data.

<u>Type of bill</u>	<u>Description</u>	<u>IP/OP</u>
0000-010x	Reserved for Assignment by NUBC	
011x	Hospital Inpatient including Medicare Part A	IP
012x	Hospital Inpatient Medicare Part B only	OP
013x	Hospital outpatient	OP
014x	Hospital – Laboratory Services Provided to Non-patients	OP
015x-017x	Reserved for Assignment by NUBC	
018x	Hospital – Swing Beds	IP
019x-020x	Reserved for Assignment by NUBC	
021x	Skilled Nursing – Inpatient including Medicare Part A	IP
022x	Skilled Nursing – Inpatient including Medicare Part B	OP
023x	Skilled Nursing – Outpatient	OP
024x-027x	Reserved for Assignment by NUBC	
028x	Skilled Nursing – Swing Beds	IP
029x-031x	Reserved for Assignment by NUBC	
032x	Home Health – Inpatient Medicare Part B only	OP
033x	Home Health – Outpatient Medicare Part A including DME under Part A	OP
034x	Home Health – Other	OP
035x-040x	Reserved for Assignment by NUBC	
041x	Religious Non-Medical Health Care Institutions	IP
042x	Reserved for Assignment by NUBC	
043x	Religious Non-Medical Health Care Institutions – Outpatient Services	OP
044x-064x	Reserved for Assignment by NUBC	
065x	Intermediate Care – Level I	IP

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<u>Type of bill</u>	<u>Description</u>	<u>IP/OP</u>
066x	Intermediate Care – Level II	IP
067x-070x	Reserved for Assignment by NUBC	
071x	Clinic – Rural Health	OP
072x	Clinic – Hospital Based or Independent Renal Dialysis Center	OP
073x	Clinic – Freestanding	OP
074x	Clinic – Outpatient Rehabilitation Facility (ORF)	OP
075x	Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF)	OP
076x	Clinic – Community Mental Health Center	OP
077x-078x	Reserved for Assignment by NUBC	
079x	Clinic – Other	OP
080x	Reserved for Assignment by NUBC	
081x	Special Facility – Hospice (non-hospital based)	OP
082x	Special Facility – Hospice (hospital based)	OP
083x	Special Facility – Ambulatory Surgery Center	OP
084x	Special Facility – Free Standing Birthing Center	IP
085x	Special Facility – Critical Access Hospital	OP
086x	Special Facility – Residential Facility	IP
087x-088x	Reserved for Assignment by NUBC	
089x	Special Facility – Other	IP
090x-9999	Reserved for Assignment by NUBC	

Frequency – 3rd Digit

- 0 = Non-payment / zero claim
- 1 = Admit thru discharge claim
- 2 = Interim – 1st claim
- 3 = Interim – Continuing Claim
- 4 = Interim – Last claim
- 5 = Late charges
- 6 = Adjustment of prior claim
- 7 = Replacement of prior claim
- 8 = Voiding/cancellation of prior claim

Edit: Type of Bill Code must be present and valid.

UB-04 FL 04

Field Name: Facility Assigned Ambulatory Patient Classification (APC) (2-3)

Type: A

Position: 1920-1927

Length: 8 (2 fields, 4 positions each)

Definition: The Ambulatory Patient Classification assigned to the outpatient record by the facility. Up to three APCs may be reported

Comments: The APC field must be:

- Four digits in length
- Left justified

Edit: The APC field must be:

- Present
- Valid
- Consistent with age and sex

Currently not a UB-04 field.

Table 3 - Revenue Codes and Units of Service

This section defines valid revenue codes representing services provided to a patient, and the unit of measure associated with each revenue service. Only these codes are valid. The source of the codes and definitions is the published manual of the National Uniform Billing Committee.

Revenue Code: The revenue code is a four-digit code and identifies a specific accommodation, ancillary service or billing calculation.

Subcategory: The fourth digit denotes a subcategory number. The subcategory number provides a more detailed list generally ranging from 0 – 9. When reporting the revenue code the fourth position must include one of the numeric choices available in that category.

Units of Service: The units used to measure the patient services in each revenue category, such as number of accommodation days, miles, pints, or treatments.

<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
0001		Total Charges – The total for all revenue codes associated with a patient stay.	
001x		Reserved	
002x		Health Insurance - Prospective Payment System (HIPPS)- This revenue code is used to denote that a HIPPS rate code is being reported in FL44	2-4
003x - 009x		Reserved	
010x	Days	All-inclusive rate—a flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.	0-1
011x	Days	Room and board - Private - One bed. Routine service charges for accommodations in a private room.	0-9
012x	Days	Room and board - Semi-private - two beds. Routine service charges for accommodations in a semi-private room.	0-9
013x	Days	Room and Board - Three and Four Beds. Routine service charges for rooms with three or four beds.	0-9
014x	Days	Room and Board - Deluxe Private - Deluxe accommodations substantially in excess of private room services.	0-9
015x	Days	Room and board - Ward. Routine service charges for accommodations with five or more beds.	0-9
016x	Days	Room and board, other - Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.	0,4,7,9

<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
017x	Days	Nursery - Accommodation charges for nursing care to newborns and premature infants in nurseries.	0-4, 9
018x	Days	Leave of absence - charges for holding a room while the patient is temporarily away from the provider.	0-5, 9
019x	Days	Subacute care - Accommodations charges for subacute care to inpatients or skilled nursing facilities.	0-4, 9
020x	Days	Intensive care - routine service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.	0-9
021x	Days	Coronary care - routine service charges for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.	0-4, 9
022x	None	Special charges - charges incurred during an inpatient stay or on a daily basis for certain services.	0-4, 9
023x	Hours	Incremental nursing charge - Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unit.	0-5, 9
024x	None	All-inclusive ancillary - A flat-rate charge that is applied on a daily basis or on a total stay basis for ancillary services only.	0-3, 9
025x	None	Pharmacy (also see 063x, and extension of 025x) - Charges for medications produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.	0-9
026x	None	IV therapy - equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment.	0-4, 9
027x	None	Medical/surgical supplies and devices (See also 062x, and extension of 027x) - Charges for supply items required for patient care.	0-9
028x	None	Oncology - charges for the treatment of tumors and related diseases.	0, 9
029x	None	Durable medical equipment (other than renal) - charges for medical equipment that can withstand repeated use.	0-4, 9
030x	Tests	Laboratory - Charges for the performance of diagnostic and routine clinical laboratory tests.	0-9
031x	Tests	Laboratory pathology - charges for diagnostic and routine laboratory tests on tissues and cultures.	0-4, 9

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<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
032x	Tests	Radiology - Diagnostic - Charges for diagnostic radiology services Including interpretation of radiographs and fluorographs.	0-4, 9
033x	Tests	Radiology - Therapeutic - Charges for therapeutic radiology services and chemotherapy administration to care and treat patients. Includes therapy by injection or ingestion of radioactive substances. Excludes charges for chemotherapy drugs.	0-5, 9
034x	Tests	Nuclear medicine - Charges for procedures, tests and radiopharmaceuticals performed by a department handling radioactive materials as required for diagnosis and treatment of patients.	0-4, 9
035x	Tests	CT scan - charges for computed tomographic scans of the head and other parts of the body.	0-2, 9
036x	None	Operating room services - charges for services provided to patients by specifically trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.	0-2, 7, 9
037x	None	Anesthesia - charges for anesthesia services.	0-2,4,9
038x	Pints	Blood and blood components.	0-7, 9
039x	Pints	Administration, Processing and Storage for Blood and Blood components - Charges for administration, processing and storage of whole blood, red blood cells, platelets and other blood components.	0-2, 9
040x	Tests	Other imaging services	0-4, 9
041x	Treatment	Respiratory services - charges for respiratory services including administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy.	0-3, 9
042x	HCPCS	Physical therapy - charges for therapeutic exercises, massage and utilization of effective date properties of light, heat, cold, water, electricity, and assisting devices for diagnosis and rehabilitation of patients whom have neuromuscular, orthopedic and other disabilities.	0-4, 9
043x	HCPCS	Occupational therapy - charges for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance, of activities of daily living and work, including, therapeutic activities, therapeutic exercises, sensorimotor processing, psychosocial skills training, cognitive retraining, fabrication and application of orthotic devices, and training in the use of orthotic and prosthetic devices, adaptation of environments, and applications of physical agent modalities.	0-4, 9

<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
044x	HCPCS	Speech Therapy - charges for services related to impaired functional communications skills.	0-4, 9
045x	Visit	Emergency room - charges for emergency treatment to those ill and injured persons who require immediate and unscheduled medical or surgical care.	0-2,6,9
046x	Tests	Pulmonary function - charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other exhaled gases.	0,9
047x	Tests	Audiology - charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.	0-2, 9
048x	Tests	Cardiology - charges for cardiac procedures.	0-3, 9
049x	HCPCS	Ambulatory surgical care - charges for ambulatory surgery that is not covered by other categories.	0,9
050x	Tests	Outpatient services - Charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. Medicare no longer requires this revenue code.	0,9
051x	Visit	Clinic - charges for providing diagnostic, preventative, curative, rehabilitative, and education services to ambulatory patients.	0-7, 9
052x	Visit	Free-standing clinic	0-9
053x	Visit	Osteopathic services - charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.	0-1, 9
054x	Mile/ Item/ Unit	Ambulance - Charges for ambulance service necessary for the transport to the ill and injured who require medical attention at a healthcare facility.	0-9
055x	Visit/ Hour	Home Health - Skilled Nursing - Charges for nursing services provided under the direct supervision of a home health licensed nurse.	0-2, 9
056x	Visit/ Hour	Home Health - Medical social services - Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.	0-2, 9
057x	Visit/ Hour	Home Health - Aide - Home Health charges for personnel (aides) that are primarily responsible for the personal care of the patient.	0-2, 9
058x	Visit/ Hour	Home Health - Other Visits - Home Health agency charges for the visits other than physical therapy, occupational therapy or speech therapy, requiring specific identification.	0-2, 9

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<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
059x	Unit	Home Health - Units of Service - Home Health charges for services billed according to the units of service provided.	0
060x	Ft/Lbs/ Mos	Home Health - Oxygen - Home Health agency charges for oxygen equipment, supplies or contents, excluding purchased equipment.	0-4, 9
061x	Tests	Magnetic Resonance Technology (MRT) - Charges for Magnetic Resonance Imaging and Magnetic Resonance Angiography.	0-2, 4-6, 8-9
062x	HCPCS	Medicare/Surgical supplies - Extension of 027x - Charges for supply items required for patient care. The category is an extension of code 27x for reporting additional breakdown where needed. Subcategory code 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcategory code 2 is for providers that cannot bill supplies used for other diagnostic procedures.	0-4
063x	HCPCS	Pharmacy - Extension of 025x - Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist. The category is an extension of 025x for reporting additional breakdown where needed.	0-7
064x	Hours	Home IV Therapy Services - Charge for intravenous therapy services performed in the patient's residence. For Home IV providers enter the HCPCS code for all equipment, and all types of covered therapy.	0-9
065x	Hours/ Days/ HCPCS	Hospices service - charges for hospice care services for a terminally ill patient if he elects these services in lieu of other medical services for the terminal condition.	0-2, 5-9
066x	Hours/ Days	Respite Care - Charge for non-hospice respite care.	0-3,9
067x	Days	Outpatient Special Residence Charges - Residence arrangements for patients requiring continuous outpatient care.	0-2,9
068x	Activa- tion	Trauma Response - Charges representing the activation of the trauma team.	0-4, 9
069x		Reserved	
070x	None	Cast room - charges for services related to the application, maintenance and removal of casts.	0
071x	None	Recovery room	0
072x	Days/ Each	Labor room and delivery - charges for labor and delivery room services provided by specially trained nursing personnel to patients including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecological procedures if they are performed in the delivery suite.	0-4, 9

<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
073x	Tests	EKG/ECG (Electrocardiogram) - charges for operation of specialized equipment to record variations in actions of the heart muscle for diagnosis of heart ailments.	0-2, 9
074x	Tests	EEG (Electroencephalogram) - charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.	0
075x	Tests	Gastrointestinal services - Charges for gastrointestinal procedures not performed in the operating room.	0
076x	None	Specialty Room - Treatment/observation room - Charges for the use of a specialty room such as a treatment or observation room.	0-2, 9
077x	None	Preventive Care Services - Revenue Code used to capture preventive care services established by payers.	0-1
078x	None	Telemedicine - Facility charges related to the use of telemedicine services.	0
079x	None	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) - Charges related to Extra-Corporeal Shock Wave Therapy.	0
080x	Sessions	Inpatient Renal Dialysis - Charges for the use of equipment designed to remove waste when the body's own kidneys have failed.	0-4, 9
081x	None	Acquisition of Body Components - the acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.	0-4,9
082x	Sessions	Hemodialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed.	0-5,9
083x	Sessions	Peritoneal Dialysis - Outpatient or Home - Charges for a waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed.	0-5, 9
084x	Days	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home - Charges for continuous dialysis process performed in an outpatient or home setting which uses the patient peritoneal membrane as a dialyzer.	0-5, 9
085x	Days	Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home - Charges for continuous dialysis process performed in an outpatient or home setting which uses a machine to make automatic exchanges at night.	0-5, 9
086x		Reserved	

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<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
087x		Reserved	
088x	Sessions	Miscellaneous Dialysis - Charges for dialysis services not identified elsewhere.	0-2, 9
089x		Reserved	
090x	Visit	Behavioral Health Treatment/Services (see also 091x, and extension of 090x) - Charges for prevention, intervention and treatment services in the areas of mental health, substance abuse, developmental disabilities, and sexuality. Behavioral Health Care services are individualized, holistic, and culturally competent and may include on-going care and support and non-traditional services.	0-7
091x	Visit	Behavioral Health Treatment/Services - Extension of 090x - See Revenue code 090x	1-9
092x	Tests	Other diagnostic services - Charges for various diagnostic services specific to common screenings for disease, illness or medical condition.	0-5, 9
093x	Hours	Medical Rehabilitation Day Program - Medical rehabilitation services as contracted with a payer and /or certified by the state. Services may include physical therapy, occupational therapy, and speech therapy	1-2
094x	Visit	Other therapeutic services (see also 095x, and extension of 094x) - charges for other therapeutic services not otherwise categorized.	0-7, 9
095x	Visit	Other Therapeutic services - (Extension of 094x) - See Revenue Code 094x	1-2
096x	None	Professional fees (see also 097x and 098x) - Charges for medical professionals that the institutional health care provider along with the third party payer require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by Critical Access Hospitals that bill both the technical and professional component on the UB.	0-4, 9
097x	None	Professional fees (Extension of 096x) - See Revenue Code 096x.	1-9
098x	None	Professional fees (Extension of 096x and 097x) - Charges for medical professionals that the institutional health care provider along with the third-party payer require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by critical access hospitals.	1-9

<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
099x	None	Patient convenience items - charges for items that are generally considered by the third party payers to be strictly convenience items and therefore are not covered by many health plans.	0-9
100x	Days	Behavioral Health Accommodations - Charges for routine accommodations at specified behavioral health facilities.	0-5
101x - 209x		Reserved	
210x	Sessions	Alternative Therapy Services - Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042x, 043x, 044x, 091x, 094x, 095x) or services such as anesthesia or clinic (0374, 0511)	0-6, 9
211x - 309x		Reserved	
310x	Hour/ Day	Adult Care - Charges for person, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADL).	1-5, 9
311x - 999x		Reserved	

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OUTPATIENT CODE EDITOR

Outpatient code editing (OCE) will be applied to the records submitted for the patient's encounter. The edit process checks for potential problems in a record identifying highly improbable clinical situations, which in most cases, prove to be in error. The OCE will flag records when any of ___ conditions are detected. ***The Department will send letters to facilities with flagged records requesting clarification of the errors recorded.***

Invalid diagnosis code - The OCE checks each diagnosis entered in the record against a table of valid ICD-9-CM codes. If a code is not found in the table the record is flagged as in error. The OCE also edits for a complete diagnosis code. If a diagnosis code is on a claim without a required fourth or fifth digit, it is considered invalid.

Age conflict - The OCE detects inconsistencies between a patient's age and any diagnosis on the patient's claim. Examples of such conflicts are a 5-year-old patient with benign prostatic hypertrophy. In such cases the diagnosis or the age is presumed to be incorrect.

Diagnosis and sex conflict - The OCE detects inconsistencies between a patient's sex and any diagnosis on the patient's record. Examples of such conflicts are a male patient with cervical cancer. In such cases either the patient's diagnosis or sex is presumed to be incorrect.

E-Code as reason for visit - E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore, are not accepted by OCE as a principal diagnosis.

Invalid procedure code – The OCE checks each HCPCS procedure code against a table of valid HCPCS codes for the time period shown on the claim. If the reported code is not in this table, the code is considered invalid. Valid HCPCS codes are listed in the Current Procedural Terminology, 4th Edition, published by the American Medical Association. Some national codes from the Health Care Financing Administration's Common Procedure Coding System (HCPCS) Level II codes are also included for services not described by CPT codes.

Procedure and sex conflict – The OCE detects inconsistencies between a patient’s sex and any HCPCS procedure code. An example of a sex conflict is a male patient reported to have had a dilation and curettage (D&C). Since the procedure conflicts with the sex of the patient, either the patient’s sex or the procedure is presumed incorrect.

Invalid date - The OCE checks the dates for validity. This edit occurs if there is not date or if the date is not within the normal calendar range.

Date out of OCE range – The OCE checks the date and applies this edit if the dates of service are prior to July 1, 1987. The OCE was not established until this date.

Invalid or unknown age - OCE allows entry of patient age from 0 through 124 years. Any other entry is considered an error.

Invalid or unknown sex – The sex code reported must be either “M” for male or “F” for female. If anything else is entered on the claim, it is invalid.

Procedure and age conflict – The OCE detects inconsistencies between a patient’s age and any HCPCS procedure code.

Multiple bilateral procedures without modifier 50 – The OCE identifies HCPC codes that can be performed bilaterally when the code is entered more than once for a single date of service if modifier 50 is not on either of the codes. Modifier 50 is defined as “bilateral procedure.” For example, if the physician performed HCPCS 25066 (Biopsy, soft tissue of forearm and /or wrist; deep) on both the right and left wrist, 25066 should not be on two lines. The correct way is to show the code for the biopsy on one line with 2506650.

Inappropriate specification of bilateral procedure – The OCE identifies HCPCS codes that can be performed bilaterally if the code is entered more than one time for the same date of service when all or some codes include modifier 50. This edit will also identify when a procedure with “bilateral” in its HCCPCS definition is entered on more than one time.

NOTICE

This Oklahoma Outpatient Surgery Discharge Data Reporting Manual, issued in December 2006, supersedes and replaces all previous versions. Please note there have been major changes in the submission format of this version to coincide with the implementation of the UB-04. Major changes are listed inside the cover.

If you have any questions regarding submission of this data, please contact

Lou Ann Sanders, at (405)271-6225 or louanns@health.ok.gov. If you would like to schedule a site visit at your facility, please contact Lou Ann Sanders at (405) 271-6225 and she will schedule a visit at your convenience.

NOTES:

For questions please call: 405-271-6225

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Department of Health
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