



ODJFS Encounter Data Specifications

**Ohio Department of Job & Family Services
Office of Ohio Health Plans
Bureau of Managed Health Care**

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General Information About Encounter Data

Contents of Encounter Data and Definition of an Encounter

Each managed care plan (MCP) is required to report encounter data to the Ohio Department of Job & Family Services (ODJFS) in accordance with Ohio Administrative Code rule 5101:3-26-06 and ODJFS is required to collect this data pursuant to federal requirements. The Bureau of Managed Health Care (BMHC) relies heavily on encounter data for monitoring MCP performance. The BMHC uses encounter data to measure clinical performance, conduct access and utilization reviews, reimburse MCPs for newborn deliveries and help set MCP capitation rates. For these reasons, it is important that encounter data is timely, accurate, and complete. Data quality and performance measures and standards are described in the MCP Provider Agreement.

An encounter represents all of the services, including medical supplies and medications, provided to a member of the MCP by a particular provider, regardless of the payment arrangement between the MCP and the provider. For example, if a member had an emergency department visit and was examined by a physician, this would constitute two encounters, one related to the hospital provider and one related to the physician provider. However, for the purposes of calculating a utilization measure, this would be counted as a single emergency department visit. If a member visits their PCP and the PCP examines the member and has laboratory procedures done within the office, then this is one encounter between the member and their PCP. If the PCP sends the member to a lab to have procedures performed, then this is two encounters; one with the PCP and another with the lab. For pharmacy encounters, each prescription filled is a separate encounter. Please note, this definition is consistent with all prior discussions of encounter data submissions and no change is anticipated for MCPs following current specifications.

Encounters include services paid for retrospectively through fee-for-service payment arrangements, and prospectively through capitated arrangements. Only encounters with services (line items) that are paid by the MCP, fully or in part, and for which no further payment is anticipated, are acceptable encounter data submissions, except for immunization services. Immunization services submitted to the MCP must be submitted to ODJFS if these services were paid for by another entity (e.g., free vaccine program). All other services that are unpaid or paid in part and for which the MCP anticipates further payment (e.g., unpaid services rendered during a delivery of a newborn) are not to be submitted to ODJFS until they are paid.

Acceptance Testing

Acceptance testing of encounter data is required:

- (a) Before a MCP may submit “production” encounter tapes; and/or
- (b) Whenever a MCP changes the method or preparer of the electronic media; and/or
- (c) When the ODJFS determines an MCP’s data submissions have an unacceptably high error rate.

For more detailed information on acceptance testing, please see the document entitled “MCP Encounter Data Testing Procedure” in Appendix 2.

Encounter Data Tape Submission Procedures

A certification letter must accompany the submission of an encounter data tape. The certification letter must be signed by the MCPs Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCPs CEO or CFO.

No more than two production tapes per format (e.g., NSF) should be submitted each month. If it is necessary for a MCP to submit more than two production tapes for a particular format in a month, they must request permission to do so through their Contract Administrator. See Appendix 2 for further details.

Completeness & Accuracy of Encounter Data

On an ongoing basis, ODJFS monitors the completeness and accuracy of encounter data through performance measures, rejection reports, and studies conducted by the External Quality Review Organization. For a listing of these measures, the standards, and the penalties for noncompliance with the standards, see Appendix J of the Provider Agreement.

Timing of Encounter Data Submissions

ODJFS recommends submitting encounters no more than thirty-five days after the end of the month in which they were paid. For example, claims paid in January are due March 5. Also, ODJFS recommends that MCPs submit tapes by the 5th of each month. This will help to ensure that the encounters are included in the ODJFS master file in the same month in which they were submitted.

Encounter Data Minimum Data Set

The below list of ODJFS provider types indicates the services to be reported through encounter data.

Within physician services, all services should be reported OTHER THAN anesthesia. It has been determined that because of the lack of a single standard way of billing anesthesia services that this data will not be collected initially. Similarly, due to a lack of billing standards, data on transportation services will not be collected initially. The services are listed under the appropriate claim type, that is CMS 1500 (NSF) or UB92 . Services with (*) will be accepted in either format.

MCPs must submit rendering provider information using Medicaid provider numbers. For providers who are also part of the Medicaid fee for service (FFS) program, their existing Medicaid number must be used. For providers who are not FFS Medicaid providers one of two things may occur. The provider can either sign a Medicaid provider agreement and receive a Medicaid provider number or the MCP can apply for a “ Provider Reporting Number” (PRN) on behalf of the provider. This PRN number would be used for reporting encounter data but would not entitle the provider to participate in the FFS Medicaid program.

The Department will also allow the use of a miscellaneous provider number, 9111115, in cases where the provider is either out of state or out of network and without a provider number. The use of this number should be an exception, not the rule, and the ODJFS will monitor its utilization. Before using the miscellaneous number, it should be determined that the provider does not have an existing Medicaid provider number or a “provider reporting number.”

MCPs wishing to submit data for provider types not currently recognized by the ODJFS may do so by applying for a generic, not otherwise specified (NOS) “provider reporting number.” A copy of the application can be found in Appendix 4.

MEDICAID PROVIDER TYPES BY CLAIM FORM

HCFA 1500

Advanced Practice Nurse Group
ASC*
Chiropractor, group
Clinic, Rehabilitation
Clinical Nurse Specialist
Comprehensive Clinic
CRNA group
Dentist, group
Dentist, individual
Diagnostic Clinic
Dialysis Clinic*
FQHC
Independent X-Ray Laboratory
Independent Laboratory
Medical Equipment Supplier
Nurse, private duty
Nurse Midwife
Nurse Practitioner
Optician
Optometrist, individual
Optometrist, individual
Outpatient Health Facility
Physical Therapist, individual
Physical Therapist, group
Physician, individual D.O.
Physician, group D.O.
Physician, individual M.D.
Physician, group M.D.
Physiology Laboratory
Planned Parenthood Clinic
Podiatrist, individual
Podiatrist, group
Prof School Clinic, Optometry
Prof School Clinic, Dental
Public Health Dept. Clinic
Rural Health Facility

UB 92

ASC*
Dialysis Clinic*
General Hospital (in& out pt)
Home Health Agency

NCPDP - 32

Pharmacy

***Data from these providers may be submitted in either claim format**

HFCA 1500 BILLING INSTRUCTIONS

- Item 1 **MEDICAID:** Optional.
- Item 1a **INSURED’S I.D. NUMBER:** Mandatory. Enter the 12 digit Medicaid Billing Number.
- Item 2 **PATIENT’S NAME:** Optional
- Item 3 **PATIENT’S BIRTHDATE AND SEX:** Optional.
- Item 4 **INSURED’S NAME:** Optional.
- Item 5 **PATIENT’S ADDRESS:** Optional.
- Item 6 **PATIENT’S RELATIONSHIP TO INSURED:** Optional.
- Item 7 **INSURED’S ADDRESS:** Optional.
- Item 8 **PATIENT STATUS:** Optional.
- Item 9 **OTHER INSURED’S NAME:** Optional.
- Item 9a **OTHER POLICY OR GROUP NUMBER:** Optional.
- Item 9b **DATE OF BIRTH/SEX:** Optional.
- Item 9c **EMPLOYER NAME:** Optional.
- Item 9d **INSURANCE PLAN OR PROGRAM NAME:** Optional.
- Item 10a-c **PATIENT STATUS:** Optional.
- Item 10d **RESERVED FOR LOCAL USE:** Optional.
- Item 11 **INSURED’S POLICY GROUP:** Optional.
- Item 11a-c Optional.
- Item 11d Optional.
- Item 12 **SIGNATURE:** Optional.
- Item 13 **SIGNATURE:** Optional.

- Item 14 **DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY:** Conditionally mandatory for pregnancy only. Enter the date of the last menstrual period.
- Item 15 **SAME OR SIMILAR ILLNESS:** Optional.
- Item 16 **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:** Optional.
- Item 17 **NAME OF REFERRING PHYSICIANS:** Optional.
- Item 17a **ID NUMBER OF REFERRING PHYSICIAN:** Mandatory for referrals. If the enrollee was referred from another provider for the billed or reported service, the referring provider's Medicaid provider number is required. That is, for services that an MCP requires a referral, the referring provider's Medicaid provider number must be reported. If the referring physician does not have a Medicaid provider number, for example the referral was made by a resident, enter 9111115 in this place.
- Item 18 **HOSPITALIZATION DATES:** Optional.
- Item 19 **RESERVED FOR LOCAL USE:** Optional.
- Item 20 **OUTSIDE LAB:** Optional.
- Item 21 **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:** Mandatory. Enter all the ICD-9 diagnosis codes in order of significance, up to a maximum of four, that apply for the services listed in item 24. Note: only primary and secondary codes will be read by Medicaid. (NOTE: Currently NSF only accommodates 2 diagnoses) A diagnosis code must be present on all claims other than independent laboratory, physiological laboratory, portable x-ray and waiver claims.
- Item 22 **MEDICAID RESUBMISSION NUMBER:** This does not exist in NSF format. Encounters submitted with the same identifier as an accepted encounter will overlay the accepted encounter.
- Item 23 **PRIOR AUTHORIZATION NUMBER:** Conditionally mandatory. Complete only if prior/payment authorization is required by the MCP for any of the services billed. Use the value "1" if prior authorization is required, otherwise leave blank.
- Item 24a **DATE(S) OF SERVICE:** Mandatory. Under "From" enter the dates of service in chronological order(first to last). Enter all six digits consecutively without dashes/slashes, or spaces. *Do not enter a date under "To."* A separate line is required for each date of service.

Item 24b **PLACE OF SERVICE:** Enter the appropriate place of service from the list below.

- 11 Office
- 12 Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room - Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance - Land
- 42 Ambulance - Air or Water
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 73 Clinic Not Otherwise Specified
- 81 Independent Laboratory
- 99 Other Unlisted Facility

NOTE: All claims, other than those submitted by independent laboratories, portable x-ray suppliers, and independent physiological laboratories, require a place of service.

Item 24c **TYPE OF SERVICE:** Optional.

Item 24d **PROCEDURES/SERVICES/SUPPLIES:** Mandatory. Use appropriate CPT, HCPC, local Medicare HCPC, or local ODJFS HCPC code. Local codes must be converted to nationally recognized codes prior to submission. Anesthesia services do not need to be reported.

Item 24e **DIAGNOSIS CODE INDICATOR:** Optional.

Item 24f **CHARGES:** Optional.

Item 24g **UNITS:** Mandatory. Enter the number of units of service. Only whole numbers may be reported.

Item 24h **EPSDT/FAMILY PLANNING:** Optional.

- Item 24i **EMG:** Optional.
- Item 24j **COB:** Optional.
- Item 24k **RESERVED FOR LOCAL USE:** Optional.
- Item 25 **FEDERAL TA I.D. NUMBER:** Optional.
- Item 26 **PATIENT'S ACCOUNT NO.:** Optional.
- Item 27 **ACCEPT ASSIGNMENT:** Optional.
- Item 28 **TOTAL CHARGE:** Optional.
- Item 29 **AMOUNT PAID:** Optional.
- Item 30 **BALANCE DUE:** Optional.
- Item 31 **SIGNATURE:** Optional.
- Item 32 **NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED:** Optional.
- Item 33 **PROVIDER NUMBER, NAME AND ADDRESS:** The Medicaid provider number is mandatory. When the billing provider is the same as the servicing provider, use the 7-digit Medicaid provider number for the individual provider. When the billing provider is a group practice, both the provider number assigned to the individual performed the service and the group provider number is required.

INPATIENT HOSPITAL
UB-92 CLAIM FORM INSTRUCTIONS

NOTE: ALL VALID UB-92 CODES, AS DESCRIBED IN THE OHIO UB-92 INSTRUCTIONAL MANUAL, WILL BE ACCEPTED, UNLESS OTHERWISE NOTED.

Item 1: Hospital Name, Address and Telephone Number - Optional.

Item 2: Unlabeled Field Not Required.

Item 3: Patient Control Number - Required. The patient's unique alphanumeric number assigned by the hospital to facilitate the retrieval of individual case records at the hospital.

Note: This field is used by the department to link all records from a single electronic claim.

Item 4: Type of Bill - Required. A nationally recognized code indicating the type of bill.

Item 5: Federal Tax Number - Not Required.

Item 6: Statement Covers Period - Required. Enter the beginning and ending service dates of the period covered by this bill.

Item 7: Covered Days - Required.

Item 8: Noncovered Days - Not Required.

Item 9: Co-Insurance Days - Not Required.

Item 10: Lifetime Reserve Days - Not Required.

Item 11: Unlabeled Field - Not Required.

Item 12: Patient Name - Optional.

Item 13: Patient Address - Optional.

Item 14: Patient Birthdate - Optional.

Item 15: Patient Sex - Optional.

Item 16: Patient Marital Status - Not Required.

Item 17: Admission Date or Start of Care Date - Required. Enter the date the patient was admitted for care.

Item 18: Admission Hour - **Optional**.

Item 19: Type of Admission - Required. Enter the appropriate one-digit code.

Item 20: Source of Admission - Not Required.

Item 21: Discharge Hour - **Optional**.

Item 22: Patient Status Code - Required. Enter the appropriate two-digit code for patient status.

Item 23: Medical Record Number - **Optional**.

Items 24-30: Condition Codes - Required only for newborn claims. Enter the appropriate two-digit code from the list below.

88-Birthweight condition code for newborn weight of 0-749 grams.

89-Birthweight condition code for newborn weight of 750-999 grams.

90-Birthweight condition code for newborn weight of 1000-1250 grams.

91-Birthweight condition code for newborn weight of 1251-1500 grams.

92-Birthweight condition code for newborn weight of 1501-1750 grams.

93-Birthweight condition code for newborn weight of 1751-2000 grams.

94-Birthweight condition code for newborn weight of 2001-2250 grams.

95-Birthweight condition code for newborn weight of 2251-2500 grams.

96-Birthweight condition code for newborn weight of 2501 grams and over.

Item 31: Unlabeled Field - Not Required.

Items 32a, 32b, 33a, 33b, 34a, 34b, 35a, and 35b:
Occurrence Codes and Dates - Optional.

Item 36 a & b:
Occurrence Span Code and Dates - Not Required.

Item 37: Internal Control Number/Document Control Number/Transaction Control Number
- Not Required.

Item 38: Responsible Party Name and Address - Not Required.

Items 39a-d, 40a-d, 41a-d:
Value Codes and Dollar Amounts - Optional.

Item 42: Revenue Code - Required. Enter the appropriate three-digit revenue center code.

Item 43: Revenue Description - Optional.

Item 44: HCPCS/Rates - Not Required.

Item 45: Service Date - Not Required.

Item 46: Units of Service - Required for inpatient room and board codes--enter the number of days.

Item 47: Total Charges - Optional.

Item 48: Non-covered Charges - Optional.

Item 49: Unlabeled Field. Not Required.

Item 50 A, B, C:
Payer Identification - Required. Enter the appropriate payer codes and names from the UB-92 manual.

Note: The Medicaid payer code, code number 100, must be entered in Item 50 C.

Item 51 A, B, C:

Provider Number - Required. Enter the number assigned to the provider by the payer indicated in Items 50 A, B, and C.

Note: Enter the hospital's Medicaid number assigned by ODJFS in item 51 C.

Item 52 A, B, C:

Release of Information Certification - Not Required.

Item 53 A, B, C:

Assignment of Benefits Certification - Not Required.

Item 54 A, B, C, P:

Prior Payments - Optional.

Item 55 A, B, C, P:

Estimated Amount Due - Not Required.

Item 56: Unlabeled Field - Not Required.

Item 57: Unlabeled Field - Not Required.

Item 58 A, B, C:

Insured's Name - Not Required.

Item 59 A, B, C:

Patient's Relationship to Insured - Optional.

Item 60 A, B, C:

Cert-SSN-HIC-ID Number - Required. Enter the twelve (12) digit Medicaid billing number in Item 60 C.

Item 61 A, B, C:

Insured's Group Name - Not Required.

Item 62 A, B, C:

Insurance Group Number - Not Required.

Item 63 A, B, C:

Treatment Authorization Number - Not Required.

Item 64 A, B, C:
Employment Status Code - Not Required.

Item 65 A, B, C:
Employer Name - Not Required.

Item 66 A, B, C:
Employer Location - Not Required.

Item 67: Principal Diagnosis Code - Required. Enter the ICD-9-CM code for the principal diagnosis. Hospitals must code to the last available digit of the ICD-9-CM code structure. The principal diagnosis is the condition established after study (discharge diagnosis) to be chiefly responsible for causing the hospitalization. Diagnosis codes are found in ICD-9-CM, Volumes One and Two. Do not use decimal points.

NOTE: DO NOT use "E" codes as a principal diagnosis. DO NOT use "unspecified" diagnosis codes as a principal diagnosis (e.g., 5909-Kidney infection, unspecified).

Items 68-75: Other Diagnosis Codes - Required, if applicable. Hospitals must code to the last available digit of the ICD-9-CM code structure for secondary diagnoses for cases which require supplementary medical treatment. When services are rendered as a result of an accident (see Items 32-35), appropriate accident ICD-9-CM coding may be used. Do not use decimal points.

NOTE FOR ITEMS 67 AND 68-75: The Medicaid encounter data system may in the future require a total of nine (9) diagnosis codes (one (1) "principal diagnosis code" and eight (8) "other diagnosis codes") to be entered on the UB-92. If applicable, a minimum of one (1) other diagnosis code must be submitted by

Four (4) other diagnosis codes must be submitted beginning July 1, 1997.

Item 76: Admitting Diagnosis - Optional

Item 77: External Cause of Injury Code (E-Code) - Not Required.

Item 78: Unlabeled Field. - Not Required.

Item 79: Procedure Coding Method Used - Not Required.

Item 80: Principal Procedure Code and Date - Required. Only ICD-9-CM coding is acceptable. Enter the ICD-9-CM code identifying the principal surgical, obstetrical or medical procedure. Hospitals must code to the last available digit of the ICD-9-CM code structure. Procedure codes are found in ICD-9-CM Volume Three.

Note: Enter the date the procedure was performed. **The date the procedure was performed must be submitted effective 7/1/97.**

Items 81 A-E:

Other Procedure Codes and Dates - Required. If applicable, enter the ICD-9-CM codes of other procedures and the dates performed. Hospitals must code to the last available digit of the ICD-9-CM code structure. Enter the date the procedure was performed.

NOTE FOR ITEMS 80 AND 81 A-E: The Medicaid encounter data system will require a total of three (3) procedure codes (one (1) "principal procedure code" and two (2) "other procedure codes") to be entered on the UB-92. **If applicable, a minimum of one (1) other procedure code and date must be submitted beginning July 1, 1997.**

Item 82: Attending Physician I.D. - Optional.

Item 83 A & B:

Other Physician I.D. - Optional.

Item 84: Remarks - Not Required.

Item 85: Provider Representative Signature - Not Required.

Item 86: Date Bill Submitted - Not Required.

OUTPATIENT HOSPITAL
UB-92 CLAIM FORM INSTRUCTIONS

NOTE:ALL VALID UB-92 CODES, AS DESCRIBED IN THE OHIO UB-92 INSTRUCTIONAL MANUAL, WILL BE ACCEPTED, UNLESS OTHERWISE NOTED.

Item 1: Hospital Name, Address, and Telephone Number - Optional.

Item 2: Unlabeled Field - Not Required.

Item 3: Patient Control Number - Required. The patient's unique alphanumeric number assigned by the hospital to facilitate the retrieval of individual case records at the hospital.

Note: This field is used by the department to link all records from a single electronic claim.

Item 4: Type of Bill - Required. A code indicating the type of bill.

Item 5: Federal Tax Number - Not Required.

Item 6: Statement Covers Period - Not Required.

Item 7: Covered Days - Not Required.

Item 8: Noncovered Days - Not Required.

Item 9: Co-Insurance Days - Not Required.

Item 10: Lifetime Reserve Days - Not Required.

Item 11: Unlabeled Field - Not Required.

Item 12: Patient Name - Optional.

Item 13: Patient Address - Optional.

Item 14: Patient Birthdate - Optional.

Item 15: Patient Sex - Optional.

Item 16: Patient Marital Status - Not Required.

Item 17:Admission Date or Start of Care Date - Not Required.

Item 18:Admission Hour - Not Required.

Item 19:Type of Admission - Required.

Item 20:Source of Admission - Not Required.

Item 21:Discharge Hour - Not Required.

Item 22:Patient Status Code - **Optional**.

Item 23:Medical Record Number - **Optional**.

Items 24-30:Condition Codes - Optional.

Item 31:Unlabeled Field - Not Required.

Items 32 a & b, 33 a & b, 34 a & b, 35 a & b:
Occurrence Codes and Dates - Optional.

Item 36 a & b:
Occurrence Span Code and Dates - Not Required.

Item 37: InternalControl Number/Document Control Number/Transaction Control Number
- Not Required.

Item 38:Responsible Party Name and Address - Not Required.

Item 39 a-d, 40 a-d, 41 a-d:
Value Codes and Dollar Amounts - Optional.

Item 42:Revenue Code - Required. Enter the appropriate three-digit revenue center code. Enter revenue center code 001 as the last revenue center code.

Note: Both revenue codes and HCPCS codes are required to be reported effective 7/1/97.

Item 43:Revenue Description - Not Required.

Item 44:HCPCS/Rates - Required. Enter the HCPCS codes for the outpatient services rendered.

Item 45:Service Date - Required. For each line item on an outpatient bill the corresponding date of service must be reported.

Item 46:Units of Service - Required. If the units of service equals one (1), the MCP may leave the field blank.

Item 47:Total Charges - Optional.

Item 48:Noncovered Charges - Optional.

Item 49:Unlabeled Field - Not Required.

Item 50 A, B, C:

Payer Identification - Required. Enter the appropriate payer codes and names from the UB-92 manual.

Note:The Medicaid payer code, code number 100, must be entered in Item 50 C.

Item 51 A, B, C:

Provider Number - Required. Enter the number assigned to the provider by the payer indicated in Items 50 A, B, and C.

Note:Enter the hospital's Medicaid number assigned by ODJFS in item 51 C.

Item 52 A, B, C:

Release of Information Certification - Not Required.

Item 53 A, B, C:

Assignment of Benefits Certification - Not Required.

Item 54 A, B, C, P:

Prior Payments - Optional.

Item 55 A, B, C, P:

Estimated Amount Due - Not Required.

Item 56:Unlabeled Field - Not Required.

Item 57:Unlabeled Field - Not Required.

Item 58 A, B, C:

Insured's Name - Not Required.

Item 59 A, B, C:

Patient's Relationship to Insured - Not Required.

Item 60 A, B, C:

Cert-SSN-HIC-ID Number - Required. Enter the twelve (12) digit Medicaid billing number in Item 60 C.

Item 61 A, B, C:

Insured's Group Name - Not Required.

Item 62 A, B, C:

Insurance Group Number - Not Required.

Item 63 A, B, C:

Treatment Authorization Number - Required, if applicable. Enter the code number of 1 in Item 63 C if authorization was required for the services rendered to a Medicaid recipient.

Item 64 A, B, C:

Employment Status Code - Not Required.

Item 65 A, B, C:

Employer Name - Not Required.

Item 66 A, B, C:

Employer Location - Not Required.

Item 67: Principal Diagnosis Code - Required on all invoices. Hospitals should code to the last available digit of the ICD-9-CM code structure. Diagnosis codes are found in ICD-9-CM, Volumes One and Two. In the case of cycle bills, this diagnosis code must be associated with all claims on the invoice. Do not use decimal points.

Items 68-75:Other Diagnosis Codes - Required. Hospitals must code to the last available digit of the ICD-9-CM code structure for secondary diagnosis for cases which require supplementary medical treatment. When services are rendered as a result of an accident (see Items 32-35), appropriate accident ICD-9-CM coding may be used. Do not use decimal points.

NOTE FOR ITEMS 67 AND 68-75: The Medicaid encounter data system may in the future require a total of nine (9) diagnosis codes (one (1) "principal diagnosis code" and eight (8) "other diagnosis codes") to be entered on the UB-92. If applicable, a minimum of one (1) other diagnosis code must be submitted by July 1, 1996 **and four (4) other diagnosis codes must be submitted beginning July 1, 1997**. We will continue to discuss the need for submission of the final four (4) other diagnosis codes.

Item 76:Admitting Diagnosis - Not Required.

Item 77:External Cause of Injury Code (E-Code) - Not Required.

Item 78:Unlabeled Field - Not Required.

Item 79:Procedure Coding Method Used - Not Required.

Item 80:Principal Procedure Code and Date - Optional.

Item 81 A-E:

Other Procedure Codes and Dates - Optional.

Item 82:Attending Physician I.D. - Optional.

Item 83 A & B:

Other Physician I.D. - Optional.

Item 84:Remarks - Not Required.

Item 85:Provider Representative Signature - Not Required.

Item 86:Date Invoice Submitted - Not Required.