
Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form

November 14, 2006

As defined by the Commissioner of Health

CMS-1500 Manual Sixth Edition



This page intentionally blank

Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form

November 14, 2006

As defined by the Commissioner of Health

CMS-1500 Manual Sixth Edition



For further information contact:
Minnesota Department of Health
Division of Health Policy
Center for Data Initiatives
P.O. Box 64882
St. Paul, Minnesota 55164-0882
Phone: (651) 201-3570
Fax: (651) 201-5179
Internet: cdi@health.state.mn.us

Copyright 2006

Administrative Uniformity Committee and Minnesota Department of Health
CPT is a registered trademark of the American Medical Association

Permission to copy this document is granted, as long as the copies are not
sold, and as long as the material contained is included in its entirety
and is not modified.

Table of Contents

From the Commissioner of Health.....	i
Uniform Billing Formats.....	1
Foreword.....	3
Electronic Concordance.....	5
How to Use this Manual.....	7
Designation of Data Elements.....	9
Acronyms.....	11
Errors and Comments.....	13
Summary of Changes to this Manual.....	15
Minnesota Standards for the Use of the CMS-1500 Claim Form.....	17
Sample CMS 1500 HICF Form.....	19
Appendices	
Table of Contents.....	Appendix Page 1
Appendix 1 Printing Standards.....	Appendix Page 3
Appendix 2 Place of Service Codes (from CMS).....	Appendix Page 7
Appendix 3 Units Grid.....	Appendix Page 13
Appendix 4 Standard US Post Office Abbreviations.....	Appendix Page 25
Appendix 5 Resource List.....	Appendix Page 27
Appendix 6 Specific Anesthesia Guidelines.....	Appendix Page 29
Appendix 7 AUC Mission Statement, History, and Governing Principles ..	Appendix Page 31
Appendix 8 <i>Minnesota Statutes 2006, Chapter 62J.50-62J.61</i>	Appendix Page 35

This page intentionally blank



Protecting, maintaining and improving the health of all Minnesotans

October 16, 2006

Notice Of Adoption of the CMS 1500 Health Insurance Claim Form (HICF) Manual as Defined by the Commissioner of Health; Per *Minnesota Statutes*, section 62J.52, Subdivision 2, paragraph (b)

Adoption: Notice is hereby given that the CMS 1500 HICF Manual, as proposed at State Register, Volume 31, Number 10, page 327, September 5, 2006, is adopted with the following changes:

Page 65. Instructions: Enter Y for "Yes" or N for "No" in the unshaded area if the claim is related to EPSDT (C&TC). If the EPSDT C&TC indicator is "Y", enter the correct referral code that pertains to the entire claim in the shaded area starting above box 24A. The same referral code is entered on each line.

Appendix page 7. ~~Please check with individual payers. Some definitions may be bound by contract.~~

Manual Available: The "CMS 1500 HICF Manual, as defined by the Commissioner of Health, is available for use for paper claims submitted on the CMS 1500 HICF form. The manual is available on the internet at www.mmaonline.net/auc and in the Minnesota's Bookstore at (651) 297-3000 or (800) 657-3757.

Description and Statutory Reference: The manual is a description of the conventions of use for the CMS 1500 paper form published by the Centers for Medicare and Medicaid (CMS). The manual has been developed per *Minnesota Statutes*, section 62J.52. The statute reads in relevant part: (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the Administrative Uniformity Committee entitled Minnesota Standards for the use of the CMS 1500 Claim Form, dated February 1994, as further defined by the commissioner. The updated edition of this manual, in this announcement, is the further definition mentioned.

Development: The Administrative Uniformity Committee (AUC) and its subcommittee on Data Definitions developed and revised the manual. All editions of the manual have been submitted for public comment; the most recent (sixth) edition was announced in the *State Register* on September 5, 2006. The comment period for the sixth edition was from September 5 to October 4, 2006. The Minnesota Department of Health collected the public comments. Four comments were received. The AUC subcommittee on Data Definitions reviewed the comments and made the modification to the manual noted above.

Date of Implementation: The CMS 1500 Manual is to be used by providers and non-government payers in Minnesota as of November 14, 2006.

Dianne M. Mandernach, Commissioner
Minnesota Department of Health

This page intentionally blank



November 14, 2006

Effective January 1, 1996, Minnesota providers are required to use uniform billing formats for medical, allied health, hospital and dental bills. Payers are required to accept these forms for claim payment purposes.

Minnesota Statutes section 62J.52, part of the Health Care Administrative Uniformity Act of MinnesotaCare legislation, requires providers to use the CMS-1500 claim form, also known as the 1500 health insurance claim form as named by the National Uniform Claim Committee (formerly known as HCFA-1500) claim form, or Uniform Bill claim form, or American Dental Association (ADA) Dental claim form to submit their bills to payers. *Minnesota Statutes* section 62J.53 requires payers to accept these forms for billing.

The Minnesota Administrative Uniformity Committee (AUC) voted to adopt the transition timeline as recommended by the National Uniform Claim Committee (NUCC) with one modification. The NUCC recommended that payers be able to accept the revised (8/05) version of the 1500 Claim Form on October 1, 2006. The AUC recommends that Minnesota payers be able to accept the revised (8/05) Claim Form on November 1, 2006. The current (12/90) version of the 1500 Claim Form is discontinued as of April 1, 2007. All rebilling of claims should use the revised (08/05) form as of April 1, 2007, even though earlier claim submissions may have been on the current (12/90) 1500 Claim Form.

The bar code that existed on some forms in the upper left margin has been eliminated. In order to distinguish this version from previous versions, the 1500 symbol and the date approved by the NUCC have been added to the top left margin.

To help providers and payers complete the 1500 claim form, the AUC, a committee consisting of public and private payers and providers, has developed a user manual. Using the criteria outlined in the manual will improve consistency in data and will help reduce health care costs.

Allina Hospitals and Clinics ◊ American Association of Healthcare Administrative Management ◊ Blue Cross Blue Shield of MN ◊ CentraCare Health System ◊ Children's Hospitals and Clinics ◊ Delta Dental Plan of MN ◊ Fairview Hospital and Health Care Services ◊ HCPCS Committee ◊ Health Care Payer and Provider Advisory Council ◊ HealthEast ◊ HealthPartners ◊ Hennepin County Medical Center ◊ Hennepin Faculty Associates ◊ Mayo Clinic ◊ Medica Health Plan ◊ Metropolitan Health Plan ◊ MN Dental Association ◊ MN Department of Health ◊ MN Department of Human Services ◊ MN Department of Labor and Industry ◊ MN Hospital Association ◊ MN Medical Association ◊ MN Medical Group Management Association ◊ MN Pharmacists Association ◊ MN Uniform Billing Committee ◊ Noridian Administrative Services, L.L.C. - Medicare Part A ◊ Park Nicollet Health Services ◊ PreferredOne ◊ St. Mary's/Duluth Clinic Health System ◊ UCare MN ◊ University of Minnesota Physicians ◊ Wisconsin Physician Services – Medicare Part B

Visit our website at: www.mmaonline.net/auc/

The Standards for the Use of the CMS-1500 Claim Form manual is available from Minnesota's Bookstore at (651) 297-3000 or 1-800-657-3757 or it may be downloaded from the AUC Web site www.mmaonline.net/auc/. Updates will be available as often as required by changes in the claim form or billing practices and will seek to reduce variation in billing practices over time. The AUC will continue to work to improve the clarity and usefulness of the manual.

Questions?

- Questions about specific patients and their insurance claims should be directed to the payer of the claim.
- Questions, comments and recommendations for clarification or updates to the manual may be directed in writing to:

Administrative Uniformity Committee
c/o Minnesota Department of Health
Division of Health Policy
P.O. Box 64882
St. Paul, MN 55164-0882

Foreword

November 14, 2006

History:

This manual for completing the CMS-1500 (formerly known as HCFA-1500) form is the sixth edition, an update of the first edition published October 1, 1995. The manual is part of the Administrative Simplification Act (ASA) of 1994, *Minnesota Statutes* 62J.52, Subdivision 2, which requires:

“(a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.”

The updated editions of this manual are the further definition mentioned.

The Administrative Uniformity Committee (AUC) and the Data Definition Technical Advisory Group (DD TAG) developed and revised the manual. This manual has been developed by the AUC to help reduce administrative burden on providers and payers, associated with varied billing practices. The AUC also seeks to improve the consistency of claims data. The AUC and the DD TAG consist of providers, payers, professional associations and government agencies. Public comment from any interested parties was solicited during the development and before publication of this manual.

Intent:

The intent of this manual, and indeed the entire ASA, is to promote uniformity among payers and providers in completing billing formats. One payer must not require a field to be completed while another payer refuses to accept claims in which that field has been completed. This manual provides Minnesota norms. The AUC anticipates that Minnesota payers will standardize themselves to these norms, and promote this uniformity to the extent possible.

Note: Submissions for government programs, such as Medicare and Medicaid (Medical Assistance) must conform to federal and state regulations, which sometimes require variations from usual practice. See Appendix 5 for resource information.

This page intentionally blank

Electronic Concordance

The ANSI ASC X12-837 version 004010A1 (HIPAA compliant) concordance with electronic claims has been included in this sixth edition of the CMS-1500 Manual.

The AUC believes that electronic submission of claims is more cost and time effective; and expects most providers will move to electronic claims. The electronic concordance in this manual is informational, and intended to help providers become accustomed to the interaction between the paper and electronic formats. They are not intended for implementation of electronic claims.

Further information on HIPAA and Electronic Data Interchange (EDI) is available from the Centers for Medicare and Medicaid Services (CMS).

This page intentionally blank

How to Use this Manual

To remain in compliance with Minnesota State Law, payers and providers are required to adopt all conventions in this manual. Each page of the manual refers to a specific item or “box” on the CMS-1500 form. The title of each box is listed on the claim form followed by the requirements for the data. The electronic concordance for ANSI is listed for each box for reference.

Instructions: How to complete the box for commercial payers. Describes punctuation that is allowed; in general, avoid punctuation on claim forms. When billing directly to government programs such as Medicare or Medicaid (Medical Assistance) information must conform to state and federal regulations, which sometimes require variations from usual practice. Please see Appendix 5 for resource information.

Example: A simple example of the data to be entered. Examples given are for illustrative purposes, and may not describe every claim situation. Some boxes may have multiple examples.

Definitions: Explanations of the words used in the titles or instructions. Definitions given are for illustrative purposes, and may not describe every claim situation.

Format: Describes whether the data is alpha, alphanumeric, numeric or other conventions, as needed.

Used for: Describes how the data element is used.

Required: Describes the level of need for the data element. See Designation of Data Elements page 9 for definition.

Electronic

concordance: Describes how the data element fits into ANSI electronic format. Electronic commerce is preferred by many payers and has financial and time advantages for payers and providers. This information is provided for informational purposes.

This page intentionally blank

Designation of Data Elements

Each data element on the CMS-1500 form is designated as: required, may be required by contract, recommended, or not required.

- Required:** Required means that the data element is needed and used by the payer to process and/or adjudicate the claim. Claims sent to the payer without a required data element may be pended for further information, denied and/or returned to the provider.
- May be required by contract:** May be required by contract means that some payers need the data element to process and/or adjudicate the claim. When a contractual agreement or requirement in a published manual exists that requires such a data element, the payer may pend or deny claims sent without it.
- Recommended:** Recommended means that the data element may assist the payer, but is not required to process and/or adjudicate the claim. Recommended data elements:
- expand on the required data identifying the patient, insured, or insurance program
 - allow more efficient coordination of benefits
 - allow payers to be aware that another insurance exists
- Not required:** Not required means that the data element is not used by payers to process and/or adjudicate the claim.

This manual does not attempt to include information on government programs such as Medicare or Medicaid (Medical Assistance) claims. Please refer to the manuals for these programs when needed. See Appendix 5 for resource information.

This page intentionally blank

Acronyms

ADA	American Dental Association
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI ASC Committee	American National Standards Institute Administrative Simplification
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
AUC	Administrative Uniformity Committee
CHAMPUS	Civilian Health & Medical Program of Uniformed Service. CHAMPUS is also known as TRICARE
CHAMPVA	The Department of Veteran's Affairs Civilian Health & Medical Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CPT-4	Current Procedural Terminology – 4 th Edition
C&TC	Child and Teen Checkups (Minnesota's EPSDT program)
DD TAG	Data Definitions Technical Advisory Group
DHS	Department of Human Services
DLI	Department of Labor and Industry
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
EIN	Employer Identification Number
EMG	Emergency
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FECA	Federal Employees' Compensation Act, 5 USC 8101 et seq.
GTIN	Global Trade Item Number
HCFA	Health Care Financing Administration (see CMS)
HCPCS	Healthcare Common Procedural Coding System
HIBCC	Health Industry Business Communications Council
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
ICD-9-CM	International Classification of Disease, 9 th Revision, Clinical Modification
ICN	Internal Control Number
LMP	Last Menstrual Period
MDH	Minnesota Department of Health
MHCP	Minnesota Health Care Programs (also referred to as DHS)
NDC	National Drug Codes
NPI	National Provider Identification
NSF	National Standard Format
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OZ	Product Number Health Care Uniform Code Council
PCN	Payer Claim Control Number
PIN	Personal Identification Number
PMAP	Prepaid Medical Assistance Program
POS	Place of Service

PPO	Preferred Provider Organization
SOF	Signature on File
SSN	Social Security Number
TCN	Transaction Control Number
TPA	Third Party Administrator
UPC	Universal Product Code
UPIN	Unique Personal Identification Number
USIN	Unique Supplier Identification Number
WC	Workers' Compensation
VP	Vendor Product Number

Errors and Comments

The Minnesota AUC and the DD TAG developed this guide.

However, you may find errors, or business needs, which the guide does not address. We encourage you to report these issues to the AUC using the format below. When possible, members of the AUC will take substantive issues forward to the appropriate state or national claims-related committee.

Date of manual: _____

Page number (in manual): _____

Box Number: _____

Narrative description of error or comment:

Report errors to: **Administrative Uniformity Committee**
 c/o Minnesota Department of Health
 Division of Health Policy
 Center for Data Initiatives
 P.O. Box 64822
 St. Paul, MN 55164-0882
 www.mmaonline.net/auc/

Thank you for bringing these issues to our attention.

This page intentionally blank

Summary of Changes to this Manual

Summary of changes from “Minnesota Standards for the Use of the CMS-1500 Claim Form As Defined by the Commissioner of Health, CMS-1500 Manual Fifth Edition” dated May 19, 2004, to the “Sixth Edition” dated November 14, 2006.

- The 1500 paper claim form is updated to include the National Provider Identifier (NPI)
- Electronic concordance ANSI ASC X12-837 Version 004010A1 updated
- NSF electronic concordance deleted
- Acronym definitions page updated
- EPSDT/Family Plan, box 24H, updated/revised
- Place of Service Codes, Appendix 2, updated/revised
- Units of Service, Appendix 3, updated/revised
- Sample CMS-1500 Claim Form, replaced
- Minnesota Statutes 2006, Chapter 62J.50 - 62J.61, Appendix 8, updated

This page intentionally blank

Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form

November 14, 2006

Sixth Edition



This page intentionally blank

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Main form body containing sections 1-33, including patient information, insurance details, and provider information.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

This page intentionally blank

Carrier Block

Instructions: Enter in the upper right hand margin of the form the name and address of payer to whom this claim is being sent. If an “Attention” flag is needed, place in second line.

Example: MAJOR HEALTH PLAN
ATTN GEORGE JETSON - CLAIMS
56789 ALTA VISTA DRIVE #100
ANYWHERE MN 55440-1234

Definitions: Carrier is the health plan, Third Party Administrator or other payer who will handle the claim.

Format: Use two-digit state code and, if available, nine-digit zip code. Avoid punctuation except “#” and “-”. Scanning technology may read punctuation as delimiters and therefore process the information incorrectly.

Used for: Direct the claim to the carrier.

Required: Recommended for commercial payers. Government programs such as Medicare or Medicaid may require variations from usual practice. Required for Workers’ Compensation claims. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not mapped	Position:	Segment:
--------------------------------------	-------------------------	-----------	----------

Box Number 1

Title: MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

Instructions: Enter a capital X for the appropriate insurance type. Mark only one box..

Example:

1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/>	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN (SSN or ID) <input checked="" type="checkbox"/>	FECA BLK LUNG (SSN) <input type="checkbox"/>	OTHER <input type="checkbox"/> (ID)
--	---	---	--	--	---	--

Definitions: Medicare, Medicaid, TriCare CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other means the insurance type to whom the claim is being submitted. Other indicates health insurance including HMOs, PPOs, commercial insurance, automobile accident, liability and Workers' Compensation.

Format: Alpha. This field allows for entry of one character.

Used for: Directs the claim to the correct government or other program; establishes primary liability.

Required: Not required for commercial payers. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2000B Subscriber Information	Position: 2-005	Segment: SBR-09
--	--	--------------------	--------------------

Box Number 1a

Title: INSURED'S I.D. NUMBER

Instructions: Enter insured's ID number as shown on insured's ID card for the payer to whom the claim is being submitted.

Example:

1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
X0123456789	

Definitions: Insured's ID number means the identification number of the person who holds the policy.

Note: For Workers' Compensation injury, insured means the employer, and insured's ID means the patient's social security number.

Format: Alphanumeric. This field allows for entry of 29 characters.

Used for: Identify the patient to the payer.

Required: Required for all programs.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010BA Subscriber Name	Position: 2-015	Segment: NM1-09
--------------------------------------	---------------------------------	--------------------	--------------------

Box Number 2

Title: PATIENT'S NAME

Instructions: Enter the patient's last name, first name and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Do not use punctuation except "-", which may be used for hyphenated names. Titles (e.g. Sister, Capt, Dr) and professional suffixes (e.g. PhD, MD, Esq) should not be included with the name.

Example: Anderson Edwin J
Anderson Jr Edwin J
Anderson III Edwin J

Definitions: Patient's name means the name of the person who received the treatment or supplies.

Format: Alphanumeric. Use spaces to separate parts of field. This field allows for the entry of 28 characters.

Used for: Identify the patient.

Required: Required for all programs.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010CA Patient Name	Position: 2-015	Segment: NM1-03, 04, 05, 07
--	-------------------------------------	---------------------------	---------------------------------------

Box Number 3

Title: PATIENT'S BIRTH DATE SEX

Instructions: Enter the patient's eight-digit date of birth (MM DD CCYY). Use spaces to separate parts of field. Enter an X in the correct box to indicate sex of the patient. Mark only one box. If gender is unknown, leave blank.

Example:

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY	M	F
01	01	1987	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Definitions: Patient's birth date and sex means the patient's date of birth and the gender of the patient.

Format: Alphanumeric. This field allows for the entry of nine characters.

Used for: Identify the patient; distinguishes persons with similar names.

Required: Required for all programs.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010CA Patient Name	Position: 2-032	Segment: DMG-02,03
--------------------------------------	------------------------------	--------------------	-----------------------

Box Number 4

Title: INSURED'S NAME

Instructions: Enter the insured's last name, first name and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Do not use punctuation, except "-" which may be used in hyphenated names. Titles (e.g. Sister, Capt, Dr) and professional suffixes (e.g. PhD, MD, Esq) should not be included with the name. Note: For Workers' Compensation, enter name of patient's employer.

Example: Anderson Edwin J
Anderson Jr Edwin J
Anderson III Edwin J

Definitions: Insured's name means the name of the person who holds the policy; usually the employee, for employer-provided group health insurance.

Format: Alphanumeric. This field allows for the entry of 29 characters. Use spaces to separate characters.

Used for: Identify the patient's source of insurance.

Required: Required for all commercial payers. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010BA Subscriber Name	Position: 2-015	Segment: NM1-03, 04, 05, 07
--	--	---------------------------	---------------------------------------

Box Number 5

Title: PATIENT'S ADDRESS (multiple fields)

Instructions: Enter the patient's number, street, city, state, zip code and phone number. If an Attention line is needed, add to first line of address (e.g., Guardian or Legal Representative). Do not use punctuation except "-" when using a nine-digit zip code. If patient's telephone number is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code. For foreign addresses, use abbreviations stated in Appendix 4. When entering telephone number, include area code. Do not use a hyphen or space as a separator within the telephone number.

Example:

5. PATIENT'S ADDRESS (No., Street)	
1234 Main Street	
CITY	STATE
Anytown	MN
ZIP CODE	TELEPHONE (Include Area Code)
55000-1111	(612)555-1212

Definitions: Patient's address means the patient's per

Format: Alphanumeric. This field allows for the following: 28 characters for street address, 24 characters for city, three characters for state, 12 characters for zip code, three characters for area code, and 10 characters for phone number.

Used for: Further identifies patient; allows contact for questions.

Required: Address required for all commercial payers. Telephone number not required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010CA Patient Name Patient Phone # is not mapped.	Position: 2-025 2-030	Segment: N3 N4
--	--	-----------------------------	----------------------

Box Number 6

Title: PATIENT RELATIONSHIP TO INSURED

Instructions: Enter a capital X in the correct box. Mark only one box.

Example:

6. PATIENT RELATIONSHIP TO INSURED							
Self	<input type="checkbox"/>	Spouse	<input type="checkbox"/>	Child	<input checked="" type="checkbox"/>	Other	<input type="checkbox"/>

Definitions: Patient relationship to insured means how the patient is related to the insured. Self means the insured is the patient. Spouse means the patient is the husband or wife or qualified partner as defined by the insured’s plan. Child means the patient is the minor dependent as defined by the insured’s plan. Other means the patient is other than the self, spouse or child. Other may include employee, ward, or dependent as defined by the insured’s plan.

Format: Alpha. This field allows for one character.

Used for: Identify patient’s source of insurance, and distinguish patient from insured.

Required: Required for all commercial payers. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2000B Subscriber Information 2000C Patient Information	Position: 2-005 2-007	Segment: SBR-02 Only if the Patient is the Subscriber PAT-01 Patient is not the Subscriber
--	---	---------------------------------	--

Box Number 7

Title: INSURED'S ADDRESS (multiple fields)

Instructions: Enter the insured's number, street, city, state, zip code and phone number. If an Attention line is needed, add to first line of address (e.g., Guardian or Legal Representative). Do not use punctuation except "--" when using a nine-digit zip code. If patient's address or telephone number is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code. For foreign addresses, use abbreviations stated in Appendix 4. When entering telephone number, include area code. Do not use a hyphen or space as a separator within the telephone number.

Note: For Workers' Compensation, enter address of patient's employer.

Example:

7. INSURED'S ADDRESS (No., Street) Attn Mary Smythe 1234 Main Street	
CITY Anytown	STATE MN
ZIP CODE 55000-1111	TELEPHONE (Include Area Code) (612) 5551212

Definitions: Insured's address means the insured's permanent residence.

Format: Alphanumeric. This field allows for the following: 29 characters for street address, 23 characters for city, four characters for state, 12 characters for zip code, three characters for area code, and 10 characters for phone number.

Used for: Further identifies insured; allows contact for questions.

Required: Address is recommended for all commercial payers. Telephone number is not required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010BA Subscriber Phone # is not mapped	Position: 2-025 2-030	Segment: N3 N4
--------------------------------------	---	-----------------------------	----------------------

Box Number 8

Title: PATIENT STATUS

Instructions: Enter a capital X in the box for the patient’s marital status, and for the patient’s employment status. Mark only one box on each line.

Example:

8. PATIENT STATUS			
Single	<input checked="" type="checkbox"/>	Married	<input type="checkbox"/>
Other	<input type="checkbox"/>		
Employed	<input checked="" type="checkbox"/>	Full-Time Student	<input type="checkbox"/>
		Part-Time Student	<input type="checkbox"/>

Definitions: Patient status means the patient’s marital and employment standing. Employed means the patient has a job. Full-time student means the patient is registered for a full course load as defined by the post-secondary school or university. Part-time student means the patient is registered for less than a full course load as defined by the post-secondary school or university.

Format: Alpha. This field allows for entry of one character per line.

Used for: Allows determination of liability and COB. Persons who have Medicare and also work may have primary insurance before Medicare. COB may apply if married. Parents may have primary or secondary insurance if patient is a student.

Required: Recommended.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not Mapped	Position:	Segment:
--------------------------------------	---------------------	-----------	----------

Box Number 9

Title: OTHER INSURED’S NAME

Instructions: Enter the other insured’s name if box 11d is marked and different from box 2, otherwise leave blank. Enter the other insured’s full last name, first name, and middle initial.

If the other insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Do not use punctuation, except “-” which may be used in hyphenated names. Titles (e.g. Sister, Capt, Dr) and professional suffixes (e.g. PhD, MD, Esq) should not be included with the name.

Enter the employee’s group health insurance information for Workers’ Compensation claims.

Example: Anderson Edwin J
Anderson Jr Edwin J
Anderson III Edwin J

Definitions: Other insured’s name means the holder of another policy that may cover the patient.

Format: Alphanumeric. This field allows for the entry of 28 characters.

Used for: Identify additional insurance source.

Required: Recommended if other insurance exists. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2330A Other Subscriber Name	Position: 2-325	Segment: NM1-03, 04, 05, 07
--	---	--------------------	--------------------------------

Box Number 9a

Title: OTHER INSURED'S POLICY OR GROUP NUMBER

Instructions: Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number.

Example:

a. OTHER INSURED'S POLICY OR GROUP NUMBER X9876543210
--

Definitions: Other insured's policy or group number means the policy or group number for coverage of insured as indicated in box 9.

Format: Alphanumeric. This field allows for the entry of 28 characters. .

Used for: Identify additional insurance source.

Required: Recommended when box 9 is completed. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2320 Other Subscriber Information	Position: 2-290	Segment: SBR-03
--	---	--------------------	--------------------

Box Number 9b

Title: OTHER INSURED'S DATE OF BIRTH SEX

Instructions: Enter the other insured's eight-digit date of birth (MM DD CCYY). Use spaces to separate parts of field. Enter an X in the correct box to indicate sex of the patient. Mark only one box. If gender is unknown, leave blank.

Example:

b. OTHER INSURED'S DATE OF BIRTH			SEX	
MM	DD	YY	M	F
01	01	1960	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Definitions: Other insured's date of birth and sex means the birth date and gender of the insured as indicated in box 9.

Format: Alphanumeric. This field allows for the entry of nine characters.

Used for: Identify additional insurance source. Used to determine primary source of insurance.

Required: Recommended when box 9 is completed. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2320 Other Subscriber Information	Position: 2-305	Segment: DMG-02, 03
--	---	--------------------	------------------------

Box Number 9c

Title: EMPLOYER'S NAME OR SCHOOL NAME

Instructions: Enter the name of the other insured's employer or school.

Example:

<small>e. EMPLOYER'S NAME OR SCHOOL NAME</small> Community Hospital
--

Definitions: Employer's name or school name means the name of the employer or school attended by the other insured as indicated in box 9.

Format: Alphanumeric. This field allows for the entry of 28 characters.

Used for: Identify additional insurance source.

Required: Recommended when box 9 is completed. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not Mapped	Position:	Segment:
--------------------------------------	---------------------	-----------	----------

Box Number 9d

Title: INSURANCE PLAN NAME OR PROGRAM NAME

Instructions: Enter the other insured's insurance plan or program name.

Example:

d. INSURANCE PLAN NAME OR PROGRAM NAME XYZ Insurance Company

Definitions: Insurance plan name or program name means the name of the plan or program of the other insured as indicated in box 9.

Format: Alphanumeric. This field allows for the entry of 28 characters.

Used for: Identify additional insurance source.

Required: Recommended when box 9 is completed. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2320 Other Subscriber Information	Position: 2-290	Segment: SBR-04
--------------------------------------	---	--------------------	--------------------

Box Number 10a-c

Title: IS PATIENT'S CONDITION RELATED TO:

Instructions: Enter a capital X in the correct box. Enter state code for auto accident. Mark only one box on each line.

Example:

10. IS PATIENT'S CONDITION RELATED TO:			
a. EMPLOYMENT? (Current or Previous)			
<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO
b. AUTO ACCIDENT?			
<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO
		PLACE (State)	<input type="text" value="MN"/>
c. OTHER ACCIDENT?			
<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO

Definitions: Is patient's condition related to means whether the patient's illness or injury is related to employment, auto accident or other accident. Employment (current or previous) means that the condition is related to patient's job or workplace. Auto accident means that the condition is the result of an automobile accident. Other accident means that the condition is the result of any other type of accident.

Format: Alpha. This field allows for the entry of the following: one character in either box per line and two character state abbreviation.

Used for: Indicate primary liability for condition.

Required: Required when condition is related to one of the above a, b, or c. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: CLM-11
--------------------------------------	--	--------------------	--------------------

Box Number 10d

Title: RESERVED FOR LOCAL USE

Instructions: Enter the information as required by payer.

Example:

10d. RESERVED FOR LOCAL USE

Definitions: Reserved for local use means a free form field used to provide additional information as required by payer.

Format: **Alphanumeric. This field allows for the entry of 19 characters.**

Used for: Report the correct condition code as defined by the NUCC.

- AA Abortion Performed due to Rape
- AB Abortion Performed due to Incest
- AC Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality
- AD Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or Exacerbated by the Pregnancy Itself
- AE Abortion Performed due to Physical Health of Mother that is not Life Endangering
- AF Abortion Performed due to Emotional/psychological Health of the Mother
- AG Abortion Performed due to Social or Economic Reasons
- AH Elective Abortion
- AI Sterilization

Required: Not required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not mapped.	Position:	Segment:
--------------------------------------	----------------------	-----------	----------

Box Number 11

Title: INSURED’S POLICY GROUP OR FECA NUMBER

Instructions: Enter the insured’s policy, group or FECA number as it appears on the insured’s health care identification card if box 4 is completed. Do not use a hyphen or space as a separator within the policy or group number. For Workers’ Compensation, enter the Workers’ Compensation payer claim number if available.

Example:

11. INSURED'S POLICY GROUP OR FECA NUMBER ABC9876543

Definitions: Insured’s policy, group or FECA number means the alphanumeric identifier for the health, auto, or other insurance plan coverage. Workers’ Compensation claims use the Workers’ Compensation carrier’s alphanumeric identifier. FECA number is the nine-digit alphanumeric identifier assigned to a patient claiming work-related condition(s) under the Federal Employees Compensation Act 5 USC 8101.

Format: Alphanumeric. This field allows for the entry of 29 characters.

Used for: Identify insured’s policy, group or FECA number.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2000B Subscriber Information	Position: 2-005	Segment: SBR-03
--------------------------------------	--	--------------------	--------------------

Box Number 11a

Title: INSURED'S DATE OF BIRTH SEX

Instructions: Enter the insured's eight-digit date of birth (MM DD CCYY) when the insured is not the patient. Use spaces to separate parts of field. Enter an X in the correct box to indicate sex of the insured. Mark only one box. If gender is unknown, leave blank.

Example:

a. INSURED'S DATE OF BIRTH			SEX	
MM	DD	YY	M	F
01	01	1958	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Definitions: Insured's date of birth and sex means the birth date and gender of the insured as indicated in box 1a.

Format: Alphanumeric. This field allows for the entry of nine characters.

Used for: Identify additional insurance source. Used to determine primary source of insurance.

Required: Recommended when box 11 is completed. Workers compensation and government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2000B Subscriber Information	Position: 2-032	Segment: DMG-02, 03
--	--	--------------------	------------------------

Box Number 11b

Title: EMPLOYER'S NAME OR SCHOOL NAME

Instructions: Enter the name of the insured's employer or school.

Example:

b. EMPLOYER'S NAME OR SCHOOL NAME Acme Engineering

Definitions: Insured's employer's name or school name means the name of the employer or school attended by the insured as indicated in box 1a.

Format: Alphanumeric. This field allows for the entry of 29 characters.

Used for: Identify additional insurance source.

Required: Recommended. Workers compensation and government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not Mapped	Position:	Segment:
--------------------------------------	---------------------	-----------	----------

Box Number 11c

Title: INSURANCE PLAN NAME OR PROGRAM NAME

Instructions: Enter the insurance plan or program name of the insured.

Example:

<small>G. INSURANCE PLAN NAME OR PROGRAM NAME</small> ABC Insurance Company
--

Definitions: Insurance plan name or program name means the name of the plan or program of the insured as indicated in box 1a.

Format: Alphanumeric. This field allows for the entry of 29 characters.

Used for: Identify additional insurance source.

Required: Recommended when box 11 is completed. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2000B Subscriber Information	Position: 2-032	Segment: SBR-04
--	--	--------------------	--------------------

Box Number 11d

Title: IS THERE ANOTHER HEALTH BENEFIT PLAN?

Instructions: Enter a capital X in the correct box. When YES, complete 9 a-d. Mark only one box.

Example:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<i>If yes, return to and complete item 9 a-d.</i>

Definitions: Is there another health benefit plan means the patient has insurance coverage other than the plan indicated in box 1.

Format: Alpha. This field allows for the entry of one character in either box.

Used for: Identify additional insurance source.

Required: Recommended. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not Mapped	Position:	Segment:
--------------------------------------	---------------------	-----------	----------

Box Number 12

Title: PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

Instructions: Enter “Signature on File”, “SOF” or legal signature. When legal signature, enter date signed in six-digit format (MM DD YY) or eight-digit format (MM DD CCYY). If there is no signature on file leave blank or enter “No Signature on File.”

Example:

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	
<small>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</small>	
SIGNED	SOF _____ DATE _____

Definitions: Patient’s or authorized person’s signature means there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

Format: Alphanumeric.

Used for: Release of medical information.

Required: Recommended. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: CLM-09
--	--	--------------------	--------------------

Box Number 13

Title: INSURED’S OR AUTHORIZED PERSON’S SIGNATURE

Instructions: Enter “Signature on File”, “SOF” or legal signature. If there is no signature on file, leave blank or enter “No Signature on File.”

Example:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SOF
--

Definitions: Insured’s or authorized person’s signature means there is a signature on file authorizing payment of medical benefits.

Format: Alpha.

Used for: Authorize payment of medical benefits to provider listed in box 33.

Required: Recommended. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: CLM-08
--	--	--------------------	--------------------

Box Number 14

Title: DATE OF CURRENT ILLNESS, INJURY, PREGNANCY

Instructions: Enter the date in six-digit (MM DD YY) or eight-digit (MM DD CCYY) format of the current illness, injury or pregnancy. For pregnancy, use the date of LMP as the date. Use spaces to separate parts of field.

Example:

14. DATE OF CURRENT:	ILLNESS (First symptom) OR
MM DD YY	INJURY (Accident) OR
09 30 2005	PREGNANCY(LMP)

Definitions: Date of current illness, injury, pregnancy means the first date of onset of illness, the actual date of injury or the LMP for pregnancy.

Format: Numeric. This field allows for the entry up to eight characters.

Used for: Assist payers in identifying benefits.

Required: Specific date is required for Workers' Compensation, auto and other liability. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: DTP-03
--------------------------------------	--	--------------------	--------------------

Box Number 15

Title: IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

Instructions: Enter the first date in six-digit (MM DD YY) or eight-digit (MM DD CCYY) format that the patient had the same or a similar illness. Previous pregnancies are not a similar illness. Use spaces to separate parts of field. Leave blank if unknown.

Example:

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.			
GIVE FIRST DATE	MM	DD	YY
	09	25	2005

Definitions: If patient has had same or similar illness means the patient had a previously related condition.

Format: Numeric. This field allows for the entry of up to eight characters.

Used for: Allow determination of liability and COB.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: DTP-03
--	--	--------------------	--------------------

Box Number 16

Title: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

Instructions: Enter dates patient is unable to work in six (MM DD YY) or eight (MM DD CCYY) digit format if known. Use spaces to separate parts of field. Leave blank if unknown.

Example:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION							
	MM	DD	YY		MM	DD	YY
FROM	09	25	2005	TO	10	28	2005

Definitions: Dates patient unable to work in current occupation means the time span the patient is or was unable to work.

Format: Numeric. This field allows for the entry of up to 16 characters total.

Used for: Identify dates of disability.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: DTP-03
--------------------------------------	--	--------------------	--------------------

Box Number 17

Title: NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Instructions: Enter the name and credentials of the physician or other source who referred the patient to the billing provider or ordered the test(s) or item(s). Use spaces to separate names. Do not use punctuation except “-” which may be used for hyphenated names.

Example:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Jane A Smith MD

Definitions: Name of referring physician or other source means the complete name and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim.

Format: Alphanumeric. The field allows for the entry of 26 characters.

Used for: Identify referral source.

Required: Recommended. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2310A Referring Provider Name	Position: 2-250	Segment: NM1-03, 04, 05, 07
--	--	---------------------------	---------------------------------------

Box Number 17a

Title: OTHER ID #

Instructions: Enter the two-character qualifier in the field to the immediate right of 17a and then enter the other ID number of the referring or ordering physicians or other source.

Valid qualifiers are:

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The Social Security Number may not be used for Medicare)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

Example:

17a.	1B	ABC1234567890
17b.	NPI	0123456789

Definitions: Other ID # means the non-NPI qualifier and related ID number of referring physician such as the UPIN or UPIN surrogate, MHCP ID number or other identifiers required by contract.

Format: Alphanumeric. This field allows for a total of 19 characters.

Used for: Identify referral source.

Required: Recommended. Government programs such as Medicare and Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2310A Referring Provider Name	Position: 2-271	Segment: REF-01,02
--	---	--------------------	-----------------------

Box Number 17b

Title: NPI #

Instructions: Enter the NPI of the referring or ordering physicians or other source.

Example:

17a.	1B	ABC1234567890
17b.	NPI	0123456789

Definitions: NPI means the ten-digit national provider identifier as required under HIPAA regulations.

Format: Numeric. This field allows for the entry of 19 characters.

Used for: Identify referral source.

Required: Recommended. Government programs such as Medicare and Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2310A Referring Provider Name	Position: 2-250	Segment: NM1-09
--	---	------------------------	------------------------

Box Number 18

Title: HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

Instructions: Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred) using the six (MM DD YY) or eight (MM DD CCYY) digit format. Use spaces to separate parts of field. If not discharged, leave discharge date blank.

Example:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
MM	DD	YY	MM	DD	YY
FROM	09	25	2005	TO	09 28 2005

Definitions: Hospitalization dates related to current services means the admission and discharge dates associated with the service(s) on the claim.

Format: Numeric. This field allows for the entry up to 16 characters.

Used for: Identify services related to an inpatient stay.

Required: Recommended when related to an inpatient hospitalization. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: DTP-03
--------------------------------------	--	--------------------	--------------------

Box Number 19

Title: RESERVED FOR LOCAL USE

Instructions: Enter information as directed by payer.

Example:

19. RESERVED FOR LOCAL USE

Definitions: Reserved for local use means a free form field used to provide additional information as required by payer.

Format: Alphanumeric. This field allows for entry up to 83 characters.

Used for: Provide additional information.

Required: Not required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not mapped.	Position:	Segment:
--	----------------------	-----------	----------

Box Number 20

Title: OUTSIDE LAB? \$CHARGES

Instructions: Enter a capital X for Yes for lab services if a reported service was performed by an outside laboratory. Do not use a dollar sign, when entering the charge amount. Enter the charge amount in the field to the left of the vertical line. Do not use commas or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Use 00 for cents if the amount is a whole number. Leave the right-hand field blank.

Enter a capital X in No if no outside lab service is included on the claim. Mark only one box.

Examples:

20. OUTSIDE LAB?	\$ CHARGES
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	112500

20. OUTSIDE LAB?	\$ CHARGES
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	112575

Definitions: Outside lab? \$charges means services have been rendered by an independent provider as indicated in Box 32 and the related costs.

Format: Alphanumeric. This field allows for the entry up to nine characters. One character in either box in the outside lab area and eight characters to the left of the vertical line in the \$Charges area.

Used for: Identify purchased laboratory, pathology, or radiology services.

Required: Recommended. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-175	Segment: AMT-02
--------------------------------------	--	--------------------	--------------------

Box Number 21

Title: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Instructions: Enter up to four ICD-9-CM diagnosis codes. Relate lines 1,2,3,4 to lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this box. Use no punctuation.

When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than three beginning digits (e.g. E codes), enter the fourth digit on top of the period.

Example:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			
1. I998 . 59		3. I18 . 0	
2. I780 . 6		4. E87 8 8	

Definitions: Diagnosis or nature of illness or injury means the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

Format: Alphanumeric. This box allows for the entry of up to eight characters in each field; three characters prior to the period, one character above the period, and four characters after the period in each of the four line areas.

Used for: Support the reason for the service(s) and provide information necessary to process and adjudicate the claim. Relate the diagnosis to the service(s) performed.

Required: Required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-231	Segment: HI-01, 02, 03, 04
--------------------------------------	--	--------------------	-------------------------------

Box Number 22

Title: MEDICAID RESUBMISSION

Instructions: Enter the correct three-digit replacement reason code followed by the 17-digit PCN of the most current incorrectly paid claim. Refer to code list in Medicaid Manual.

Example:

22. MEDICAID RESUBMISSION CODE	406	ORIGINAL REF. NO.	60004600131000000
-----------------------------------	-----	-------------------	-------------------

Definitions: Medicaid resubmission means the code and number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

Format: Numeric. This field allows for the entry of 29 characters.

Used for: Resubmission of an incorrectly processed claim.

Required: Required for Medicaid resubmission claims. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-180	Segment: REF-02
--------------------------------------	--	-----------------	-----------------

Box Number 23

Title: PRIOR AUTHORIZATION NUMBER

Instructions: Enter the prior authorization or service agreement number as assigned by the payer for the current service.

Example:

23. PRIOR AUTHORIZATION NUMBER 1234567890A

Definitions: Prior authorization number means the payer assigned number approving service(s).

Format: Alphanumeric. This field allows for entry of 29 characters.

Used for: Determine eligibility of the current service.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-180	Segment: REF-02
--------------------------------------	--	--------------------	--------------------

Section 24 Shaded Area

Title: This section is untitled.

Instructions: Enter the supplemental information in the shaded section of 24A through 24G above the corresponding service line.

Example:

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. Q/JAL	J. RENDERING PROVIDER ID. #
	From	To							(Explain Unusual Circumstances)							
	MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER							
1																
2																
3																
4																
5																
6																

Definitions: The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Supplemental information can only be entered with a corresponding, completed service line.

Format: The shaded area of lines 1 through 6 allows for the entry of 61 characters from the beginning of 24A to the end of 24G.

Used for: Provide supplemental information.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

This page intentionally blank

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services.

- 7 Anesthesia Information
- ZZ Narrative description of unspecified code
- N4 National Drug Codes (NDC)
- VP Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard
- OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
- CTR Contract rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- ML Milliliter
- GR Gram
- UN Unit

Please note: The following examples are of how to enter different types of supplemental information in the shaded area of Box 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services.

C&TC

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	SPSD/ Fairly Pen	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER	POINTER					
10	01	05	10	01	05	11			99392	P2	1	100.00	1	Y	1B	12345678901
															NPI	0123456789

Unspecified Code:

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	SPSD/ Fairly Pen	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER	POINTER					
10	01	05	10	01	05	12			E1399		12	165.00	1	N	1B	12345678901
															NPI	0123456789

NDC Code:

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	SPSD/ Fairly Pen	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER	POINTER					
10	01	05	10	01	05	11			J1563	UN2	13	500.00	20	N	1B	12345678901
															NPI	0123456789

Vendor Product Number Health Industry Business Communications Council (HIBCC):

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	SPSD/ Fairly Pen	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER	POINTER					
10	01	05	10	01	05	11			A6410		13	15.00	1	N	1B	12345678901
															NPI	0123456789

Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN):

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	SPSD/ Fairly Pen	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER	POINTER					
10	01	05	10	01	05	12			A6410		13	500.00	2	N	1B	12345678901
															NPI	0123456789

Box Number 24A

Title: DATE (S) OF SERVICE [lines 1-6]

Instructions: Enter the six-digit date(s) of service (MM DD YY) in the unshaded area. Use spaces to separate parts of field. If one date of service only, enter that date under From. Leave To blank or re-enter From date. If grouping services, the place of service, type of service, procedure code, charges and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in Box 24G.

Supplemental information may be entered in the shaded area to support billing the code recorded in the unshaded area. Enter the narrative or applicable identifier and number/code starting with the first space in the shaded area of 24A. This may extend through 24G. There are not identifiers for all supplemental information. When reporting supplemental information that has an identifier, preface the number/code with the identifier. Do not enter spaces or hyphens. The following are types of supplemental information that can be entered in the shaded area:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs, identifier N4
- Vendor Product Number – Health Industry Business Communications Council (HIBCC), identifier VP
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products, identifier OZ
- EPSDT (C&TC) Referral Codes

Example:

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
09	30	05	09	30	05

Definitions: Date(s) of service means the actual month, day, and year the service(s) was provided. Grouping services means to charge for a series of identical services without listing each date of service.

Format: Numeric. This field allows for the entry of up to 12 characters.

Used for: Inform payers of the dates or date span of the current service(s).

Required: Required. Grouping may be disallowed by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2400 Service Line	Position: 2-455	Segment: DTP-03
--------------------------------------	----------------------------	--------------------	--------------------

Box Number 24B

Title: Place of Service [lines 1-6]

Instructions: Enter the two-digit code from the place of service list in Appendix 2 in the unshaded area. For the shaded area, refer to Section 24 Shaded Area on page 56.

Example:

B. PLACE OF SERVICE
11

Definitions: Place of service means the location where the service was rendered.

Format: Numeric. This field allows for the entry of two characters.

Used for: Inform the payer where the service was rendered.

Required: Required.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2400 Service Line	Position: 2-365 2-130	Segment: SV1-05 CLM-05
--	----------------------------	-----------------------------	------------------------------

Box Number 24C

Title: EMG [lines 1 – 6]

Instructions: Enter information as directed by payer. If required, enter Y for “Yes” or leave blank for “No” in the unshaded area. For the shaded area, refer to Section 24 Shaded Area on page 56.

Example:

C.
EMG
Y

Definitions: EMG means emergency as defined by federal or state regulations or programs, payer contract, or as defined by the electronic 837 professional 4010A1 implementation guide.

Format: This field allows for the entry of up to two characters.

Used for: Inform payers, if required, that the service(s) was rendered as the result of an emergency.

Required: Not required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not mapped	Position:	Segment:
--------------------------------------	---------------------	-----------	----------

Box Number 24D

Title: PROCEDURES, SERVICES, OR SUPPLIES [lines 1-6]

Instructions: Enter the CPT or HCPCS code and up to four sets of two-character modifier(s) (if applicable) from the coding manual(s) in effect on the date of service in the unshaded area. Use spaces to separate parts of field. For the shaded area, refer to Section 24 Shaded Area on page 56.

Example:

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
CPT/HCPCS	MODIFIER			
73530	26	76	RT	

Definitions: Procedures, services or supplies means a listing of identifying codes for reporting medical services and procedures.

Format: Alphanumeric.. This field allows for the entry of up to 14 characters.

Used for: Inform payer what services were performed.

Required: Required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop:	Position:	Segment:
	2400 Service Line	2-370 2-485 2-470	SV1-01 NTE 01,02 (NOC codes) REF 01,02 (Product numbers)
	2410 Drug Identification	2-494	LIN 02,03 (NDC Number) CTP 03 (NDC Unit price) CTP04 (NDC Quantity) CTP05-1 (NDC Unit of Measure)

Box Number 24E

Title: DIAGNOSIS POINTER [lines 1 - 6]

Instructions: Enter the diagnosis code reference number(s) 1, 2, 3, and/or 4 in the unshaded area from box 21 that relate the diagnosis to the applicable service. Up to four line numbers may be used to refer to each service. If more than one line number applies to a service, the first number listed should refer to the primary diagnosis. (ICD-9-CM Diagnosis codes must be entered in box 21 only. Do not enter them in 24E.) For the shaded area, refer to Section 24 Shaded Area on page 56.

Example:

E. DIAGNOSIS POINTER
143
24
21

Definitions: Diagnosis pointer means the item number from box 21 that relates to the reason the service(s) was performed.

Format: Numeric. Do not use punctuation or spaces. This field allows for the entry of up to four characters.

Used for: Inform payer which diagnosis(es) relates to each procedure.

Required: Required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2400 Service Line	Position: 2-370	Segment: SV1-07
--------------------------------------	----------------------------	--------------------	--------------------

Box Number 24F

Title: \$ CHARGES [lines 1 – 6]

Instructions: Enter the dollar amount for each service in the unshaded area. Do not use dollar signs. Do not use commas as thousands marker. Use a space to separate parts of field. If more than one date or unit is shown in 24G, the dollars shown should reflect the TOTAL of the services. If grouping services, the charges for each item within a group must be identical (24F must be evenly divisible by 24G). For the shaded area, refer to Section 24 Shaded Area on page 56.

Example:

F.
\$ CHARGES
50 00

Definitions: \$ charges means the total billed amount for each service line.

Format: Numeric. This field allows for the entry of up to eight characters.

Used for: Inform the payer of the total amount charged for each service line.

Required: Required.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2400 Service Line	Position: 2-370	Segment: SV1-02
--	-----------------------------------	---------------------------	---------------------------

Box Number 24G

Title: DAYS OR UNITS [lines 1 – 6]

Instructions: Enter the number of days or units on each service line in the unshaded area. Multiple units may indicate either services on consecutive days (grouping) or more than one unit billed for a single date of service. Grouping services entered must correspond with the number of days in box 24A. Grouping is allowed only for services on consecutive days. For the shaded area, refer to Section 24 Shaded Area on page 56.

Example:

G. DAYS OR UNITS
1

Definitions: Days or units means the number of days corresponding to the dates entered in box 24A or units as defined in CPT or HCPCS coding manual(s). Additional discussion of units can be found in Appendix 3.

Format: Numeric. This field allows for the entry of up to three characters.

Used for: Inform payer of the number or quantity of each service provided.

Required: Required. Grouping may be disallowed by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2400 Service Line	Position: 2-370	Segment: SV1-03
--	----------------------------	--------------------	--------------------

Box Number 24H

Title: EPSDT / Family Plan [lines 1 – 6]

Instructions: Enter Y for “Yes” or N for “No” in the unshaded area if the claim is related to EPSDT (C&TC). If the EPSDT indicator is “Y”, enter the correct referral code in the shaded area starting above box 24A. The same referral code is entered on each line.

EPSDT (C&TC) Referral Codes :

NU means no referral was made.

AV means the patient refused referral.

S2 means the patient is currently under treatment for referred diagnostic or corrective health problem.

ST means a referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (does not include dental referrals).

Example:



Definitions: EPSDT / Family Plan means the indicator and codes used to identify services that may be covered under some state plans.

Format: Alphanumeric. This field allows for the entry of up to one character.

Used for: Indicate the C&TC referral status.

Required: Required only for Medicaid and Medicaid Managed Care Programs (i.e., PMAP). See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2400 Service Line	Position: 2-370	Segment: SV1-11
--	-----------------------------------	---------------------------	---------------------------

Box Number 24I

Title: ID. QUAL [lines 1 – 6]

Instructions: Enter the two-character qualifier in the shaded area if the number reported in box number 24J is not an NPI. Valid qualifiers are:

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer’s Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The Social Security Number may not be used for Medicare)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

Example:



Definitions: ID Qual means the code indicating the type or source of other ID reported in box 24J.

Format: Alphanumeric. This field allows for entry of two characters.

Used for: Identify the source of non-NPI ID number.

Required: Required if non-NPI ID number is entered in 24J shaded area.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2420A Rendering Provider Name	Position: 2-525	Segment: REF-01
--	---	--------------------	------------------------

Box Number 24J

Title: Rendering Provider ID #[lines 1 – 6]

Instructions: Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

Example:

J. RENDERING PROVIDER ID. #
Z5678901234
9876543210

Definitions: Rendering provider ID number means the individual rendering or performing the service. The non-NPI number means the payer-assigned identifier of the rendering provider. The NPI means the ten-digit national provider identifier as required under HIPAA regulations.

Format: Alphanumeric. This field allows for the entry of up to 11 characters in the shaded area and entry of ten characters in the unshaded area.

Used for: Identify the service provider.

Required: Certain payers, including Medicare and Medicaid, may have variations for completion of this field. See Appendix 5 for government payer resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2420A Rendering Provider Name	Position: 2-500 2-525	Segment: NM1-09 (NPI) REF-02 (Other ID)
--	---	-----------------------------	---

Box Number 25

Title: FEDERAL TAX I.D. NUMBER

Instructions: Enter the provider’s federal tax identification number, social security number or employer identification number. Specify type by entering a capital X in the correct box.

Examples:

25. FEDERAL TAX I.D. NUMBER	SSN EIN
41 1400000	<input type="checkbox"/> <input checked="" type="checkbox"/>

25. FEDERAL TAX I.D. NUMBER	SSN EIN
468 00 8888	<input checked="" type="checkbox"/> <input type="checkbox"/>

Definitions: Federal tax ID number means the unique identifier assigned by a federal or state agency.

Format: Numeric. This field allows for the entry of 15 characters for the Federal Tax ID Number and one capital X in either box.

Used for: Identify provider.

Required: Required. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010AA Billing Provider Name	Position: 2-015 2-035	Segment: NM1-09 REF-02
--------------------------------------	--	-----------------------------	------------------------------

Box Number 26

Title: PATIENT'S ACCOUNT NO.

Instructions: Enter the patient's account number assigned by the provider.

Example:

26. PATIENT'S ACCOUNT NO. 12341234

Definitions: Patient's account number means the identifier assigned by the provider.

Format: Alphanumeric. This field allows for entry of 14 characters.

Used for: Identify patient account for the application of benefits.

Required: Recommended. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: CLM-01
--------------------------------------	--	--------------------	--------------------

Box Number 27

Title: ACCEPT ASSIGNMENT?

Instructions: Enter a capital X in the correct box. (For government claims, see back of CMS-1500 form.)

Example:

27. ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small>	
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO

Definitions: Accept assignment means the provider agrees to payment directly from the payer.

Format: Alpha. This field allows for entry of one capital X in either box.

Used for: Indicate if the provider accepts assignment of benefits.

Required: Required only for Medicare and Medicaid. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: CLM-07
--------------------------------------	--	--------------------	--------------------

Box Number 28

Title: TOTAL CHARGE

Instructions: Enter the sum of the charges in column 24F [lines 1– 6]. Use a space to divide dollars and cents. Do not use dollar signs. Negative dollar amounts are not allowed. Do not use commas as thousands marker.

Instructions for multiple

page claims: Enter “continued” on first page and all subsequent pages, if applicable. On final page, enter sum of line charges (24F) from all pages.

Example:

28. TOTAL CHARGE
\$ 1125 00

Definitions: Total charge means the total billed amount for all services entered in 24F [lines 1– 6].

Format: Numeric. This field allows for entry of up to seven characters to the left of the vertical line and two characters to the right of the vertical line.

Used for: Inform the payer of the total dollars charged for the billed services.

Required: Required. Special contract requirements may apply.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-130	Segment: CLM-02
--------------------------------------	--	--------------------	--------------------

Box Number 29

Title: AMOUNT PAID

Instructions: Enter payment amount from patient or third party payer. Use a space to divide dollars and cents. Do not use dollar signs. Do not use commas as thousands marker.

Example:

29. AMOUNT PAID
\$ 10 00

Definitions: Amount paid means payment received from patient or other payers.

Format: Numeric. This field allows for entry of up to six characters to the left of the vertical line and two characters to the right of the vertical line.

Used for: Report payments made by patient or other payers.

Required: Required only for Medicaid and Medicare. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2300 Claim Level Information	Position: 2-175	Segment: AMT-02
--------------------------------------	--	--------------------	--------------------

Box Number 30

Title: BALANCE DUE

Instructions: Leave blank.

Example: NA

Definitions: NA

Format: NA

Used for: NA

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: Not Mapped	Position:	Segment:
--------------------------------------	---------------------	-----------	----------

Box Number 31

Title: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

Instructions: Enter the signature of the physician, provider, supplier or representative with the degree, credentials, or title and the date signed in six (MM DD YY) or eight (MM DD CCYY) digit format. Personal signature, computer generated signature (facsimile signature, or typed name of authorized person), signature stamp and/or authorized signature is acceptable.

Example:

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
<i>Joe Smith MD</i>	<i>09/30/05</i>
SIGNED	DATE

Definitions: Signature of physician or supplier including degrees or credentials means the authorized or accountable person and the degree, credentials or title.

Format: Alphanumeric.

Used for: Identify the provider of service(s) or supply(s) or authorized representative.

Required: Required.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010AA Billing Provider Name Provider Signature Date is not mapped	Position: 2-175	Segment: NM1-03, 04, 05, 07
--------------------------------------	--	--------------------	--------------------------------

Box Number 32

Title: SERVICE FACILITY LOCATION INFORMATION

Instructions: Enter the name and actual address of the organization or facility where services were rendered if other than box 33 or patient’s home. Suppliers should enter the location where supplies were accepted. Use two-digit state code and, if available, nine-digit zip code. Avoid punctuation except “#” and “-”.

Example:

32. SERVICE FACILITY LOCATION INFORMATION	
XYZ Diagnostic 123 Healthcare Lane St. Paul MN 55101-1234	
a. 9876543210	b. 1BZ5678901234

Definitions: Name and address of facility where services were rendered means the site where service(s) was provided or location where supply(s) was accepted.

Format: Alphanumeric. This field allows for entry of 78 characters in the Service Facility Location Information.

Used for: Identify where services were rendered or supplies accepted.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2310D Facility Name	Position: 2-250 2-265 2-270	Segment: NM1-03 N3 N4
--	-------------------------------------	---	---------------------------------------

Box Number 32a

Title: NPI #

Instructions: Enter the NPI number of the service facility location.

Example:

32. SERVICE FACILITY LOCATION INFORMATION	
XYZ Diagnostic 123 Healthcare Lane St. Paul MN 55101-1234	
a. 9876543210	b. 1BZ5678901234

Definition: NPI number means the ten-digit National Provider Identifier as required under HIPAA regulations.

Format: Numeric. This field allows for entry of ten characters.

Used for: Identify where services were rendered or supplies accepted.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2310D Facility Name	Position: 2-250	Segment: NM1-09
--	------------------------------	--------------------	--------------------

Box Number 32b

Title: Other ID #

Instructions: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number of the service facility location. Do not enter a space, hyphen, or other separator between the qualifier and number. Valid qualifiers are:

- 0B State License Number
- 1A Blue Cross Provider Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- TJ Federal Taxpayer's Identification Number
- SY Social Security Number (The Social Security Number may not be used for Medicare)
- X4 Clinical Laboratory Improvement Amendment Number
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

Example:

32. SERVICE FACILITY LOCATION INFORMATION	
XYZ Diagnostic 123 Healthcare Lane St. Paul MN 55101-1234	
a. 9876543210	b. 1BZ5678901234

Definition: Other ID # means the non-NPI qualifier and related ID number of service provider such as the, UPIN, UPIN surrogate, MHCP ID number, or other identifiers required by contract.

Format: Alphanumeric. This field allows for entry of up to 14 characters.

Used for: Identify where services were rendered or supplies accepted.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2310D Facility Name	Position: 2-271	Segment: REF-01,02
--	-------------------------------------	---------------------------	------------------------------

Box Number 33

Title: BILLING PROVIDER INFO & PH #

Instructions: Enter billing provider's name and address and phone number. The phone number is entered in the area to the right of the box title. The area code is entered in the parenthesis; do not use a hyphen or space as a separator. Use two-character state code and, if available, nine-digit zip code. When entering the nine-digit zip code, include the hyphen.

Example:

33. BILLING PROVIDER INFO & PH # 612-555-1212	
Physician Practice, Inc 1234 Healthcare Street Anytown, MN 55000-1111	
a. AB1234	b. 6789

Definitions: Billing provider info & ph # means the billing office location and telephone number of the provider or supplier.

Format: Alphanumeric. This field allows for entry of three characters for area code, nine characters for phone number, and 87 characters in the Billing Provider Info area.

Used for: Identify billing provider.

Required: Name and address required. Phone number is not required but recommended. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010AA Billing Provider	Position: 2-015 2-025 2-030 2-040	Segment: NM1-03, 04, 05, 07 N3 N4 PER
--	---	--	--

Box Number 33a

Title: NPI #

Instructions: Enter the NPI number of the billing provider.

Example:

33. BILLING PROVIDER INFO & PH # 612-555-1212 Physician Practice, Inc 1234 Healthcare Street Anytown, MN 55000-1111	
a. AB1234	b. 6789

Definition: NPI number means the ten-digit National Provider Identifier as required under HIPAA regulations.

Format: Numeric. This field allows for entry of ten characters.

Used for: Identify billing provider.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010AA Billing Provider Name	Position: 2-015	Segment: NM1-09
--	--	--------------------	--------------------

Box Number 33b

Title: Other ID #

Instructions: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. Valid qualifiers are:

- 0B State License Number
- 1A Blue Cross Provider Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- IJ Facility ID Number
- B3 Preferred Provider Organization Number
- BQ Health Maintenance Organization Code Number
- FH Clinic Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
- G5 Provider Site Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The Social Security Number may not be used for Medicare)
- U3 Unique Supplier Identification Number (USIN)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

Example:

33. BILLING PROVIDER INFO & PH # 612-555-1212	
Physician Practice, Inc 1234 Healthcare Street Anytown, MN 55000-1111	
a. AB1234	b. 6789

Definition: Other ID # means the non-NPI qualifier and related ID number of service provider such as the, UPIN, UPIN surrogate, MHCP ID number, or other identifiers required by contract.

Format: Alphanumeric. This field allows for entry of up to 17 characters.

Used for: Identify billing provider.

Box 33b continued

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 5 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004010A1	Loop: 2010AA Billing Provider Name	Position: 2-035	Segment: REF 01,02
--	--	--------------------	-----------------------

Appendices Table of Contents

Appendix 1	Printing Standards	Appendix Page 3
Appendix 2	Place of Service Codes (from CMS).....	Appendix Page 7
Appendix 3	Units Grid	Appendix Page 13
Appendix 4	Standard US Post Office Abbreviations	Appendix Page 25
Appendix 5	Resource List	Appendix Page 27
Appendix 6	Specific Anesthesia Guidelines	Appendix Page 29
Appendix 7	AUC Mission Statement, History, and Governing Principles ..	Appendix Page 31
Appendix 8	Minnesota Statutes 2006, Chapter 62J.50-62J.61	Appendix Page 35

This page intentionally blank

APPENDIX 1 Printing Standards

Form Name - 1500 Health Insurance Paper Claim Form, Approved by the National Uniform Claims Committee (NUCC).

Form Identification - The lower right-hand margin will contain the approved OMB numbers and should be consistent throughout.

The NUCC has approved the printing standards for form 1500 Claim Form (08-05) paper version. These standards are as follows:

The 1500 Claim Form (08-05) is designed to accommodate 10-pitch Pica type, 6 lines per inch vertical and 10 characters per inch (cpi) horizontal. Once adjusted to the left and right, PICA Alignment blocks in the first print line and characters appear within form lines as shown in the print file matrix.

Also provided on the 1500 Claim Form (08-05) is a position bar. This is a thick horizontal line that is at the base of the PICA alignment Boxes.

The 1500 Claim Form (08-05) is used in four different styles. Any one of these four styles may be printed from two negatives in concurrence with the layout that was approved by the NUCC. The face/back negative furnished must be used for all parts.

The NUCC requires the use of an approved 1500 Claim Form in the formats provided displaying the 1500 symbol as approved by the NUCC. All printing of 1500 Claim Forms must occur in accordance with the NUCC requirements.

Compliance with these standards is required to facilitate the use of image processing technology such as Optical Character Recognition (OCR), facsimile transmission, and image storing.

No modification is to be made to the 1500 Claim Form (08-05) without prior approval from the NUCC and CMS.

SPECIFICATIONS

Cut Sheet:

Size - 8.5 inches (plus or minus 0.1 inch) by 11 inches (plus or minus 1/16 inch). 217 mm by 281 mm plus or minus 2 mm.

Print - Face and back, head to head.

Margins - Face – The top margin from the top edge of the form to the first print position is 1 1/3 inches or 34 mm. The left margin is 0.3 inch to the left end of the first print position.
Back – 0.25 inch head and foot, 0.25 inch left and right.

Offset – The X and Y offset for margins must not vary by more than +/-0.1 inch from sheet to sheet. (The X offset refers to the horizontal distance from the left edge of the paper to the beginning of the printing. The Y offset refers to the vertical distance between the top of the paper and the beginning of the printing.)

Askewity- The askewity of the printed image must be no greater than 0.15 mm in 100 mm.

Paper Stock - Basis weight 20# recycled 30% post consumer waste, White Environmental Paper Alliance (EPA) or approved paper stock. Smoothness: FS to be (140-160), or equivalent stock.

Ink color - Face – (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match, formerly known as Sinclair Valentine). There is to be no contamination with "Black" ink or pigment. Printer must maintain proper ink reflections limits of the OCR reader specified by the purchaser.
Back – Same as face.

Titles - Color of any titles, if applicable, are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.

Two Part Snap-set:

Size - Dimensions are same as Cut Sheet (detached 8.5 inches by 11 inches), Plus top stub (0.5 inch – 0.75 inch).

Print - Part 1 – Face and back, head to head.

Part 2 – Face and back, head to head.

Margins - Same as Cut Sheet.

Askewity - Same as Cut Sheet.

Stock - Part 1 – Carbonless, 20 CB – Recycled White.

Part 2 – Any color that will not interfere with scanning of Part 1 sheet.

Ink Color - Part 1 – OCR-Red Ink must be in Flint J-6983 Red OCR "dropout" ink or an exact match.

Part 2 – Any color that will not interfere with scanning of Part 1 sheet.

Perforations - Perforate top stub along 8.5 inches X dimensions for disassembly of parts.

Titles - Color of any titles, if applicable, are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the

PICA boxes is to be in black ink.

One Part Marginally Punched Continuous Form:

Size - Same dimensions as for Cut Sheet, plus 0.5 inch left and right, (overall: 9.5 inches by 11 inches, detached: 8.5 inches by 11 inches).

Print - Face and back, head to head.

Margins - On detached sheet, same as for Cut Sheet.

Askewity - On detached sheet, same as for Cut Sheet.

Paper Stock - Same as for Cut Sheet.

Ink Color - Same as for Cut Sheet (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match.

Perforations - Marginally 0.5 inch left and right, tear line horizontally every 11 inches

Titles - Color of any titles, if applicable, are to be in the same ink as the form,

Flint J6983 OCR Red "dropout" ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the

PICA boxes is to be in black ink.

Two Part Marginally Punched Continuous Forms:

Size- Same dimensions as for Cut Sheet, plus 0.5 inch left and right, (overall: 9.5 inches x 11 inches, detached: 8.5 inches x 11 inches).

Print - Part 1 – Face and back, head to head.

Part 2 – Face and back, head to head.

Margins - On detached sheet, same as for Cut Sheet.

Askewity - On detached sheet, same as for Cut Sheet.

Paper Stock - Part 1 – Carbonless, 20 CB – Recycled White.

Part 2 – Any color or weight that does not interfere with scanning of part 1 sheet.

Suggest the following sequence:

Paper Weight:

- 1st part is 20 CB - OCR Bond
- 2nd part is 14 CFB (if not last part)
- Last part is 15CF

CB = Coated Back (Carbonless black print)

CFB = Coated Front and Back (Carbonless black print)

CF = Coated Front (Carbonless black print)

Ink color - Part 1 – Same as for cut sheet, (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match.

Part 2 – Any color that will not interfere with scanning of the part 1 sheet.

Perforations - Marginally 0.5 inch left and right, tear line horizontally every 11 inches.

Joining - Crimp left and right.

Titles - Color of any titles, if applicable, are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the

PICA boxes is to be in black ink.

Note: Users may determine the number of parts that are applicable to their needs. Up to four total parts

are feasible on some printers; some other printers may limit the readability of multiple plies.

Color of any

titles, if applicable, are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.

This page intentionally blank

Appendix 2: Place of Service Codes (from CMS)

Published March 22, 2006

<http://www.cms.hhs.gov/PlaceofServiceCodes/Downloads/POSDatabase.pdf>

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payer (e.g., Medicare, Medicaid, other private insurance) to determine whether a particular code will be recognized for payment purposes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

Independent Lab Services: If specimen is obtained and billed by the clinic and sent out to an independent lab, use POS 11 with modifier 90.

Place of Service		
Code(s)	Name	Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

Place of Service		
Code(s)	Name	Description
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison – Correctional Facility***	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home *	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g. medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Place of Service		
Code(s)	Name	Description
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

Place of Service		
Code(s)	Name	Description
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Place of Service		
Code(s)	Name	Description
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A

Place of Service		
Code(s)	Name	Description
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

- * Revised, effective April 1, 2004
- ** Revised, effective October 1, 2005
- *** Revised, effective July 1, 2006

Appendix 3: Units Grid

This document was created by the AUC DD TAG for reporting units for each type of service. To ensure that information on this grid is used correctly, you will need to refer to the footnotes for additional qualifying information.

Codes are listed in the same order as the current CPT Manual. Not every valid CPT or HCPCS code is listed in this document. Not every valid CPT or HCPCS code is accepted by all payers.

- A) Definition of CPT/HCPCS coding: The HCPCS coding system was developed by CMS to standardize coding systems used to process Medicare claims and is also used by Medicaid and other third-party payers.

HCPCS is a two level coding system.

- Level I consists of CPT codes. These codes are listed in the 2006 CPT manual. These codes cover visits, medicine, surgery, radiology, pathology, etc. The 2006 CPT manual and the HCPCS manual are separate publications.
- Level II consists of codes for supplies, materials, injections and services. HCPCS codes are used because CPT has a limited code selection for these areas. Level II is the national level and is recognized throughout the United States. Level II codes begin with alpha characters A–V.

Disclaimers: Please check with individual payers. Some definitions of units may be bound by contract.

- B) Encounter: Interaction between a patient and a healthcare provider. Need not be face to face (e.g., telemedicine) and may occur more than once in a day.
- C) Grouping like services for Span of Dates: See CMS-1500 manual box 24A for grouping information.
- D) Modifiers: Modifiers are not addressed in this document.
- E) Units: Only whole units are accepted. No decimals or fractions are allowed. If the CPT/HCPCS code includes a time increment in the definition, round up the unit if more than half of the time increment is performed.
- F) Unlisted Codes: Unlisted Codes require further description. This may include a narrative on the billing form or electronic records and / or medical records (for example, operative report). Please check individual payer requirements.

CPT/HCPCS	Category	Definitions	Comments
99201-99499	Evaluation and Management	1 unit = 1 encounter as defined by CPT / HCPCS.	No additional comments are necessary.

CPT/HCPCS	Category	Definitions	Comments
00100-01999	Anesthesia	1 unit = 1 minute.	Anesthesia units should be reported as minutes, i.e., one hour would be reported as sixty units, one hour and ten minutes would be reported as seventy units. 01996 = 1 unit. 01999 units based on the nature of the service provided. For Dental Anesthesia see dental codes category of this grid. For Qualifying Circumstances for Anesthesia see codes 99100 – 99140 on this grid.
10021- 69990	Surgery	1 unit = 1 service as defined by CPT/HCPCS	Use CPT & HCPCS level modifiers when appropriate to further describe the surgery performed. Bilateral services should not be reported with multiple units.
70010-79999	Imaging/ Radiology	1 unit = 1 CPT / HCPCS code as defined by CPT / HCPCS.	<p>1. Specified Views Some radiology / imaging codes specify a number of views which = 1 unit. Example: 71020 Chest (2 views)</p> <p>2. Complete / limited service = 1 unit A complete / limited service equals 1 unit only if complete / limited terminology is included in the CPT / HCPCS definition. Example: 71030 Chest, complete minimum for four views, 76815 Echocardiography, pregnant uterus, real time with image documentation; limited, one or more fetuses.</p> <p>3. Bilateral Services Bilateral Services = 1 unit only if bilateral is included in the CPT / HCPCS definition. Example 76092 mammogram bilateral.</p> <p>4. Each When each is used in the definition then report 1 unit per service. If the description in CPT / HCPCS is each you may bill the code with multiple units. The number of units will indicate the number of times the service was performed. Example: 75960 transcatheter intravascular stent(s) ...each vessel.</p>

CPT/HCPCS	Category	Definitions	Comments
80048-89399	Lab/Pathology	1 unit = 1 CPT / HCPCS code as defined by CPT / HCPCS.	<p>1. Each Example: 87106 Culture fungi, definitive identification, each organism; yeast, 87300 Infectious agent antigen detection by immunofluorescent technique polyvalent for multiple organisms, each polyvalent antiserum.</p> <p>2. Up to a specified number included in the verbiage These codes should be reported with 1 unit. Example: 82270: Blood, occult, by peroxidase activity (e.g., Guaiac) qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection).</p> <p>3. No indication of number These codes should be reported as 1 line item with 1 unit per service as defined by CPT code. Example: 83026 Hemoglobin; by cooper sulfate method, non-automated.</p> <p>4. Panel. These codes should be reported as 1 line item with 1 unit per panel as defined by CPT code. CPT defines the components of that panel. Example: 80048 Basic metabolic panel.</p> <p>5. For Surgical Pathology The unit is the specimen. Refer to surgical pathology section of the CPT manual for further description of specimens.</p>

CPT/HCPCS	Category	Definitions	Comments
90281-90779	Medicine – Immune Globulins Imunization Administration for Vaccines/ Toxoids Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions	1 unit = 1 dose as defined by CPT/HCPCS code.	Codes 90281 - 90399 identify the immune globulin product only and must be reported in addition to the administration codes of 90765-90779. Maximum amount 1 unit for 90471 and 90473. 90472 and 90474 should be reported as 1 unit for each additional vaccine administration.
90801-90899	Medicine – Psychiatry	When no time is specified, 1 unit = 1 event or encounter. When time is specified, 1 unit = 1 event as defined by CPT / HCPCS.	For example 90806, 1 unit = 45 – 50 minutes as specified in CPT. For 90801 no time is specified, 1 unit = 1 event or encounter. See Footnote # 2.
90901-90911	Medicine – Biofeedback	1 unit = 1 event or encounter.	No additional comments are necessary.
90918-90999	Medicine – Dialysis	1 unit = 1 event as defined by CPT/HCPCS	No additional comments are necessary.
91000-91299	Medicine – Gastroenter- ology	1 unit = 1 event as defined by CPT / HCPCS.	No additional comments are necessary.
92002-92499	Medicine – Ophthalmology	1 unit = 1 event as defined by CPT / HCPCS.	Some codes are defined as bilateral. Some codes are defined as unilateral for example 92312 = 1 unit. Bilateral services should not be reported with multiple units. Bilateral services should be reported using modifiers. If the code is defined as bilateral no bilateral modifier should be used. 92081 should be reported as 1 unit.
92502-92700	Medicine – Special Otorhinolaryngo logic Services	1 unit = 1 event as defined by CPT / HCPCS.	See Footnote # 1 and # 2.

CPT/HCPCS	Category	Definitions	Comments
92950-93799	Medicine – Cardiovascular	1 unit = 1 event as defined by CPT / HCPCS.	1. CPT unit defined service. For example, to report multiple vessels, if 5 vessels report 92982 – 1 unit, 92984 – 4 units 2. CPT defined period of time. For example, 93268 is to be reported as 1 unit for 30 day period of recording time.
93875-93990	Medicine – Non-Invasive Vascular Diagnostic Studies	1 unit = 1 event as defined by CPT / HCPCS.	No additional comments are necessary
94010-94799	Medicine – Pulmonary	1 unit = 1 service as defined by CPT / HCPCS.	CPT defined period of time. For example ventilation assist and management for 5 days. Day 1 is reported with 94656 1 unit. Report 94657 1 unit for each subsequent day.
95004-95199	Medicine – Allergy and Clinical Immunology	1 unit = 1 service as defined by CPT / HCPCS.	1.If CPT instructs you to specify the number of tests, vials, doses, injections or hours then 1 unit = 1 test or 1 vial etc... 2. If CPT does not instruct you to specify the number of tests, vials, injections, doses or hours then the unit should always be reported as 1 unit.
95250 - 95251	Medicine – Endocrinology	1 unit = 1 event as defined by CPT/HCPCS	No additional comments are necessary.
95805-96004	Medicine – Neurology and Neuromuscular Procedures	1 unit = 1 service as defined by CPT / HCPCS.	Note: Some codes are reported by time. Other codes are reported by service or site. Refer to CPT manual for further description of service.
96101-96120	Medicine – Central Nervous System Assessments/ Tests	1 unit = 1 service or 1 unit = 1 hour as defined by CPT / HCPCS.	96110 limited to 1 unit regardless of the time spent.
96150-96155	Medicine – Health and Behavior Assessment / Intervention	1 unit = 1 services or increment of time as defined by CPT / HCPCS.	No additional comments are necessary.

CPT/HCPCS	Category	Definitions	Comments
96401-96549	Medicine – Chemotherapy Administration	1 unit = 1 service or increment of time as defined by CPT / HCPCS.	No additional comments are necessary.
96567-96571	Medicine – Photodynamic Therapy	1 unit = 1 service as defined by CPT / HCPCS.	No additional comments are necessary.
96900-96999	Medicine – Special Dermatological Procedures	1 unit = 1 service as defined by CPT / HCPCS.	No additional comments are necessary.
97001-97799	Medicine – Physical Medicine and Rehabilitation	1 unit = 1 service or increment of time as defined by CPT / HCPCS.	See footnotes # 1 and # 2.
97802-97804	Medicine – Medical Nutrition Therapy	1 unit = 1 service or increment of time as defined by CPT / HCPCS.	No additional comments are necessary.
97810-97814	Medicine – Acupuncture	1 unit = 1 service or increment of time as defined by CPT / HCPCS.	No additional comments are necessary.
98925-98929	Medicine – Osteopathic Manipulative Treatment	1 unit = 1 service as defined by CPT / HCPCS.	See footnote # 1.
98940-98943	Medicine – Chiropractic Manipulative Treatment	1 unit = 1 service as defined by CPT / HCPCS.	No additional comments are necessary.
98960-98962	Medicine – Education and Training for Patient Self-Management	1 unit = 1 service as defined by CPT / HCPCS.	No additional comments are necessary.
99000-99091	Medicine – Special Services and Reports	1 unit = 1 service as defined by CPT / HCPCS.	No additional comments are necessary.

CPT/HCPCS	Category	Definitions	Comments
99100-99140	Medicine – Qualifying Circumstances for Anesthesia	1 unit = 1 service as defined by CPT / HCPCS.	No additional comments are necessary. For Anesthesia codes 00100 – 01999 see page 3.
99143-99150	Medicine – Moderate (Conscious) Sedation	1 unit = 1 service as defined by CPT / HCPCS.	No additional comments are necessary.
99170-99199	Medicine – Other Services and Procedures	1 unit = 1 service as defined by CPT/HCPCS	Bilateral services should not be reported with multiple units (i.e., 99173 would be reported as 1 unit).
99500-99602	Medicine – Home Health Procedures / Services	1 unit = 1 service or visit as defined by CPT / HCPCS.	See footnote #2.
0001F-6000F	Category II Codes	1 unit = 1 services as defined by CPT / HCPCS.	No additional comments are necessary.
0001T-0161T	Category III Codes	1 unit = 1 services as defined by CPT / HCPCS.	No additional comments are necessary.
A0021-A0999	Transportation Services Including Ambulance	1 unit as defined by HCPCS.	No additional comments are necessary.
A4206-A7527	Medical and Surgical Supplies	1 unit as defined by HCPCS.	No additional comments are necessary.
A9150-A9999	Administrative, Miscellaneous and Investigational	1 unit as defined by HCPCS.	No additional comments are necessary.
B4034-B9999	Enteral and Parenteral Therapy	1 unit as defined by HCPCS.	No additional comments are necessary.
C1178-C9725	Hospital Outpatient PPS Codes	1 unit as defined by HCPCS.	These codes are intended only for hospital outpatient UB-92 claims.
D0120-D9999	Dental Procedures	1 unit = 1 service as defined by CDT-3.	See footnote # 3 for dental anesthesia D9210 – D9248. CDT – 4 manual may be purchased from the ADA. See Appendix 5 of the Minnesota CMS- 1500 manual for ordering information.

CPT/HCPCS	Category	Definitions	Comments
E0100-E8002	Durable Medical Equipment	1 unit as defined by HCPCS. Follow national HCPCS guidelines.	<p>Due to contractual obligations and/or state requirements, payers may have different unit increments. Please check with individual payers.</p> <p>For quantity HCPCS codes; A4259 - lancets, per box of 100 = 1 unit A4253 - blood glucose test or reagent strips for home bloodglucose monitor, per 50 strips A4367 - ostomy belt, each</p> <p>For size / volume HCPCS codes; A6266 - gauze, ... per linear yard J7070 - infusion, D-5-W, 1,000cc</p> <p>For kit / set HCPCS codes; A4625 - tracheostomy care kit for new tracheostomy</p>
G0008-G9044	Procedures and Professional Services	1 unit as defined by HCPCS.	No additional comments are necessary.
H0001-H2037	Rehabilitative Services	1 unit as defined by HCPCS.	No additional comments are necessary.
J0120-J9999	Drugs Administreed Other Than Oral	1 unit as defined by HCPCS.	<p>No additional comments are necessary.</p> <p>Report units for injections based on the code's common dosage. For example, for J1565, 50 mgs is a common dosage. If 150 mgs given, report 3 units.</p>
K0001-K0730	Temporary Codes For DMERC Use	1 unit as defined by HCPCS.	<p>No additional comments are necessary.</p> <p>K codes represent DME and supplies.</p>
L0100-L9900	Orthotic Procedures	1 unit as defined by HCPCS.	<p>No additional comments are necessary.</p> <p>This category includes prosthetic procedures.</p>
M0064-M0301	Medical Services	1 unit as defined by HCPCS.	No additional comments are necessary.
P2028-P9615	Pathology and Laboratory	1 unit as defined by HCPCS.	No additional comments are necessary.
Q0035-Q9964	Temporary Codes	1 unit as defined by HCPCS.	<p>No additional comments are necessary.</p> <p>Q codes represent a variety of services including labs, supplies and drugs.</p> <p>For Q0083, Q0084 and Q0085 the number of units = the number of visits.</p>

CPT/HCPCS	Category	Definitions	Comments
R0070-R0076	Diagnostic Radiology Services	1 unit as defined by HCPCS.	No additional comments are necessary.
S0012-S9999	Private Payer Codes	1 unit as defined by HCPCS.	No additional comments are necessary. S codes represent a wide variety of services including surgeries, therapies, supplies and drugs.
T1000-T5999	State Medicaid Agency Codes	1 unit as defined by HCPCS.	No additional comments are necessary. T codes represent a variety of services including supplies and professional services.
V2020-V2799	Vision Services	1 unit as defined by HCPCS.	No additional comments are necessary.
V5008-V5364	Hearing Services	1 unit as defined by HCPCS.	No additional comments are necessary.
	Room and Board	1 unit = 1 day of accommodation	UB-92 billing under appropriate revenue code.
	Ancillary charges	1 unit = designated fee amount for special charges, nursing increment charges, or all inclusive ancillary charges.	UB-92 billing under appropriate revenue code.
	Outpatient Special Residence Charges	1 unit = 1 designated fee amount	UB-92 billing under appropriate revenue code.
	Recovery room	1 unit = 1 designated fee amount	UB-92 billing under appropriate revenue code.
	Labor Room / delivery	1 unit = 1 day for revenue code 0724 Birthing Center – per national UB92 manual. When using revenue codes to report procedures then units should be assigned based on the CPT / HCPCS code that describes the service provided. If no procedure, 1 unit = 1 designated fee amount for labor room/ delivery services.	UB-92 billing under appropriate revenue code.

CPT/HCPCS	Category	Definitions	Comments
	Treatment or Observation Room	1 unit = 1 hour for revenue code 0762 – Observation room. When using revenue codes to report procedures then units should be assigned based on the CPT / HCPCS code that describes the service provided. If no procedure, 1 unit = 1 designated fee amount for treatment room (0760, 0761 and 0769) services.	UB-92 billing under appropriate revenue code.
	Organ Acquisition	1 unit = 1 designated fee amount for the acquisition and storage costs of organ(s) used for transplantations.	UB-92 billing under appropriate revenue code.
	Other Diagnostic Services	When using revenue codes to indicate professional fee, if CPT / HCPCS codes are required units of service should be assigned based on the CPT/HCPCS code(s) that describes the service(s) provided.	The selection of the correct billing form (CMS-1500 or UB-92) must conform to Minnesota Statutes, Section 62J.52. This Minnesota law identifies the billing form providers are required to use.
	Other Therapeutic Services	When using revenue codes to indicate professional fee, if CPT / HCPCS codes are required units of service should be assigned based on the CPT/HCPCS code(s) that describes the service(s) provided.	The selection of the correct billing form (CMS-1500 or UB-92) must conform to Minnesota Statutes, Section 62J.52. This Minnesota law identifies the billing form providers are required to use.

CPT/HCPCS	Category	Definitions	Comments
	Professional Fees	When using revenue codes to indicate professional fee, if CPT / HCPCS codes are required units of service should be assigned based on the CPT/HCPCS code(s) that describes the service(s) provided.	The selection of the correct billing form (CMS-1500 or UB92) must conform to Minnesota Statutes, Section 62J.52. This Minnesota law identifies the billing form providers are required to use.

Footnotes
1. Medical Assistance / Dept of Human Services: For most Physical Therapy, Occupational Therapy, and Speech Therapy codes where time is not specified, the Department of Human Services has defined 1 unit as 15 minutes to allow for uniform threshold counting.
2. Disclaimers: Please check with individual payers. Some definitions of units may be bound by contract.
3. Dental Anesthesia – check with individual payers on dental anesthesia.

This page intentionally blank

Appendix 4: Standard US Post Office Abbreviations

For addresses other than in the United States, territories, and Canada, reference the US Postal Service web page for correct abbreviations: <http://www.usps.gov/ncsc>.

Alabama	AL	Oregon	OR
Alaska	AK	Pennsylvania	PA
Arizona	AZ	Rhode Island	RI
Arkansas	AR	South Carolina	SC
California	CA	South Dakota	SD
Colorado	CO	Tennessee	TN
Connecticut	CT	Texas	TX
Delaware	DE	Utah	UT
District of Columbia	DC	Vermont	VT
Florida	FL	Virginia	VA
Georgia	GA	Washington	WA
Hawaii	HI	West Virginia	WV
Idaho	ID	Wisconsin	WI
Illinois	IL	Wyoming	WY
Indiana	IN		
Iowa	IA		
Kansas	KS	American Samoa	AS
Kentucky	KY	Canal Zone	CZ
Louisiana	LA	Guam	GU
Maine	ME	Puerto Rico	PR
Maryland	MD	Trust Territories	TT
Massachusetts	MA	Virgin Islands	VI
Michigan	MI		
Minnesota	MN		
Mississippi	MS	Alberta	AB
Missouri	MO	British Columbia	BC
Montana	MT	Labrador	LB
Nebraska	NE	Manitoba	MB
Nevada	NV	New Brunswick	NB
New Hampshire	NH	Newfoundland	NF
New Jersey	NJ	Northwest Territories	NT
New Mexico	NM	Nova Scotia	NS
New York	NY	Ontario	ON
North Carolina	NC	Pr. Edward Island	PE
North Dakota	ND	Quebec	QB
Ohio	OH	Saskatchewan	SK
Oklahoma	OK	Yukon	YK

This page intentionally blank

Appendix 5: Resource List

Use of organization or business names does not constitute endorsement; names are provided for user convenience only.

Workers' Compensation (WC)

Workers' compensation insurer information should be obtained from the patient; identity of an employer's WC carrier may be obtained from the MN Department of Labor and Industry insurance verification unit. Phone: 1-800-DIAL-DLI (1-800-342-5354) or (651) 284-5170.

Medicare (Part B) manual or program information:

Wisconsin Physicians Services (WPS)
8120 Penn Avenue South #200
Bloomington, MN 55431-1394
(952) 884-3030

P.O. Box 1787
Madison, WI 53701
(608) 221-3218

<http://www.wpsic.com>

Medicare provider manual is available from the MN Medicare Carrier and is available on their Web site.

Minnesota Health Care Programs (MHCP) information:

Minnesota Department of Human Services
Provider Relations
P.O. Box 64987
St. Paul, MN 55164-0987
MHCP Provider Call Center (651) 431-2700 or 1-800-366-5411

<http://www.dhs.state.mn.us>

MHCP manuals are available online.

CMS-1500 Claim Forms:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
(202) 512-1800
Fax (202) 512-2250

<http://www.gpoaccess.gov/index.html>

May also be available from large commercial bookstores, and from medical office supply firms.

Current Procedural Terminology (CPT)

Published by the American Medical Association. May be purchased from the American Medical Association or other large commercial bookstores, and from medical office supply firms.

Healthcare Common Procedural Coding System (HCPCS)

The HCPCS procedure, supply and modifier coding system was developed by CMS to standardize coding systems used to process Medicare and Medicaid (Medical Assistance) claims. It is also used by other third party payers. May be purchased from the American Medical Association or other large commercial bookstores, and from medical office supply firms.

International Classification of Diseases, Ninth Edition (ICD-9-CM)

Published by the World Health Organization and updated yearly by CMS. May be purchased from large commercial bookstores, and from medical office supply firms.

Appendix 6: Specific Anesthesia Guidelines

Effective date of the following is **October 1, 1999**.

1. Anesthesia units should be reported as minutes, i.e., one hour would be reported as sixty units, one hour and ten minutes would be reported as seventy units. The time is not reported separately on the CMS-1500 billing form.
2. The anesthesia ASA CPT codes should be used to bill for anesthesia services.
3. Qualifying circumstances should be accepted as reportable services. All qualifying circumstances should be billed with the appropriate anesthesia modifier on a separate line item from the primary procedure.
4. Physical status modifiers P1 through P6 should be billed as defined by the Physicians' CPT Manual and the ASA despite current limitations of some providers' and payers' billing and processing systems. The P modifiers should be reported as either the second or third modifier position, consistent with CPT billing methodology. Providers should not add any additional units of time for the physical status modifiers.
5. Standardized reporting of anesthesia modifiers among payers. The modifiers listed below are recommended:
 - AA M.D. performed
 - QY M.D. directed - for supervision of 1 case
 - QK M.D. directed - for supervision of 2 - 4 cases
 - AD M.D. directed - for more than 4 cases
 - QZ CRNA performed
 - QX CRNA directed
 - QS monitored anesthesia care services

These modifiers were chosen as appropriate because:

- they are recognized and defined by CMS and are level II modifiers listed in the HCPCS manual.
 - they are considered as industry standards for reporting in the first modifier field for anesthesia services; and
 - they would provide consistency for secondary claims processing, enabling crossover claims to be more easily processed with less opportunity for errors.
6. Professional anesthesia services are to be billed using the CMS-1500 billing form to be consistent with the Minnesota Administrative Simplification Act.

This page intentionally blank

Appendix 7: AUC Mission Statement, History and Governing Principles

(last updated November, 2002)

1. Mission: To develop agreement among Minnesota payers and providers on standardized administrative processes when implementation of the processes will reduce administrative costs.
2. History: The Administrative Uniformity Committee (AUC) is a broad-based group representing Minnesota health care public and private payers, hospitals, physicians, other providers and State agencies. The impetus for its establishment came from the Minnesota Council of Health Plans, whose member plans committed in 1991 to standardize their administrative processes and requirements with the goal of reducing administrative costs for both payers and providers. Recognizing that costs can be reduced effectively only if all major stakeholders are involved, the Council's committee sought the endorsement and active participation of other payers, state agencies, and representatives of key provider groups. By mid-1992, virtually all groups contacted had offered their enthusiastic support and had named representatives to the committee. The expanded AUC agreed that the initial priority was to respond to the MinnesotaCare health care reform mandates. Although the AUC originally reported to the Minnesota Council of Health Plans, the AUC no longer formally reports to any organization, although it may from time to time act as a consulting body to various public and private entities.
3. Purpose and Objectives:
 - 3.1 To develop agreement among Minnesota payers and providers regarding uniform billing forms, uniform claims procedures, and uniform electronic billing procedures;
 - 3.2 To participate actively in the implementation of standardization plans enacted as part of health care reform. It is understood that implementation will be a multi-year process;
 - 3.3 To function as a consulting body on matters related to the AUC's mission statement;
 - 3.4 To continue research into new issues that may lead to enhanced administrative uniformity and bring issues and recommendations to private industry and/or governmental entities;
 - 3.5 To undertake educational efforts and facilitate the members' understanding about how the different stakeholders address specific administrative simplification issues.
4. Membership:
 - 4.1 Criteria: In order to be considered for membership in the AUC, an individual must represent a stakeholder as defined in this paragraph. A stakeholder must: (1) be a Minnesota broad-based health care provider, association, society, payer, or governmental organization and (2) be capable of implementing recommendations and decisions of the AUC. Each stakeholder will be entitled only to one vote, even if represented by more than one member at any given meeting. Membership

of provider associations will be evaluated on a case by case basis taking into account size, geographic representation, specialty and so forth.

- 4.2 Roster: As of November, 2000, the members and stakeholders of the AUC shall be those persons listed on the roster attached as Appendix A. As stated in section 5.1, the AUC chair shall be responsible for maintaining the roster and keeping it up-to-date.
- 4.3 New member approval: Organizations that wish to be AUC members must qualify as a stakeholder as defined in paragraph 4.1 and request membership in writing to the AUC. The request will be presented to the AUC at the next scheduled meeting and voted on at the following meeting. New members and stakeholders may be subject to approval by a two-thirds majority vote of stakeholders represented at a meeting.

5. AUC Membership Structure and Meetings:

- 5.1 The AUC will annually elect a chair and chair-elect. Nominations for the chair-elect will be considered from the voting membership. It is the intent of the committee to rotate the chair position between representatives from the payer and provider community. Stakeholders making nominations should consider this before the nomination is made. At the end of the chair's one-year-term, the chair-elect will automatically be elected chair for the coming year. The chair, or a person designated by the chair, shall be responsible for maintaining the AUC's meeting schedule and membership roster. The chair shall also be responsible for chairing AUC meetings. The chair-elect will be responsible for chairing those meetings which the chair cannot attend, and it is the chair's responsibility to coordinate with the chair-elect to ensure that at least one of them is present at each meeting.
- 5.2 Members must commit to participate actively in the AUC by attending meetings, or sending an alternate, and taking minutes. It is the member's responsibility to arrange for an alternate to represent him or her at meetings which the member cannot attend. Non-voting stakeholders may serve as an alternate member.
- 5.3 Failure to attend or send an alternate to three meetings in one year shall be grounds for revoking membership of stakeholder organization or individual representative.
- 5.4 Any stakeholder, whether voting or non-voting, may make a motion or bring forth a proposal to the committee during the meeting.
- 5.5 Meeting Agenda:
 - 5.5.1 The chair shall be responsible for determining and circulating meeting agendas. AUC members may submit agenda items to the chair a reasonable amount of time in advance of the meeting.

- 5.5.2 At the outset of each meeting, the chair shall ask the members if the agenda should be supplemented or otherwise changed.
- 5.5.3 The last item of business for each meeting will be to confirm the time and location of the next meeting, to confirm who will be responsible for taking the minutes, and to set, to the extent possible, the agenda for the meeting.
- 5.6 If a member is scheduled to take minutes at a particular meeting and cannot do so, it is that member's responsibility to arrange in advance for another AUC member to take the minutes. Within 14 days of the meeting, the member shall provide the minutes to a designated staff person who shall be responsible for circulating them to all of the AUC members.
- 5.7 The AUC may from time to time establish one or more subgroups which are called Technical Action Groups (TAGs).
 - 5.7.1 Unless otherwise determined by the AUC, membership in a TAG shall be open both to (1) representatives of stakeholders that can implement the TAG's recommendations or decisions and (2) those who can offer technical expertise to the TAG. Only stakeholders may vote, and each stakeholder shall be limited to one vote, regardless of how many of its representatives are in attendance at any particular meeting. New TAG members and stakeholders may be subject to approval by the AUC.
 - 5.7.2 Each TAG shall include (1) an AUC member or (2) a person who reports to an AUC member. Such AUC member shall be responsible for facilitating communication between the AUC and TAG and conveying the AUC's directions to the TAG. This AUC member shall also be responsible for presenting, or arranging for another TAG member to present periodic TAG reports to the AUC on the dates designated by the AUC.
 - 5.7.3 TAG members must commit to participate actively in their TAG by attending meetings, or sending an alternate, taking minutes, and chairing meetings upon request. Unless the TAG members agree otherwise, the duties of chairing and taking minutes shall rotate among the TAG members, with the minute taker from one meeting chairing the next. It is each TAG member's responsibility to arrange for an alternate to represent him or her at meetings which the TAG member cannot attend. If a TAG member is scheduled to take minutes at or chair a particular meeting and cannot do so, it is also that TAG member's responsibility to arrange in advance for another TAG member to take the minutes or chair the meeting. The minute-taker shall be responsible for circulating the minutes to the TAG members and to an AUC designee who shall then circulate the TAG minutes to the AUC members.
- 5.8 The AUC may from time to time designate certain of its meetings, or certain TAG meetings, as public meetings.
- 5.9 Unless the members agree otherwise, the AUC's standing meetings shall be from 1:00 to 4:00 p.m. on the first Tuesday of every other month. If the first Tuesday follows a holiday, then the AUC will meet on the second Tuesday.

Appendix 8: Minnesota Statutes 2006, Chapter 62J.50 - 62J.61 Administrative Simplification Provisions of 2006 Minnesota Statutes, Chapter 62J

Editor's Notes:

This excerpt of Minnesota Statutes includes only the administrative simplification provisions of *Minnesota Statutes, sections 62J.50 to 62J.61*, the Administrative Simplification Act (ASA). The official 2006 version of chapter 62J was obtained from the Revisor of Statutes Web site.

MINNESOTA STATUTES 2006, CHAPTER 62J HEALTH CARE COST CONTAINMENT

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50	Citation and purpose.	62J.57	Minnesota center for health care electronic data interchange.
62J.51	Definitions.	62J.58	Implementation of standard transaction sets.
62J.52	Establishment of uniform billing forms.	62J.581	Standards for Minnesota uniform health care reimbursement documents.
62J.53	Acceptance of uniform billing forms by group purchasers.	62J.59	Implementation of NCPDP telecommunications standard for pharmacy claims.
62J.535	Uniform billing requirements for claim transactions.	62J.60	Standards for the Minnesota uniform health care identification card.
62J.54	Identification and implementation of unique identifiers.	62J.61	Rulemaking; implementation.
62J.55	Privacy of unique identifiers.		
62J.56	Implementation of electronic data interchange standards.		

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50 Citation and purpose.

Subdivision 1. **Citation.** Sections 62J.50 to [62J.61](#) may be cited as the Minnesota Health Care Administrative Simplification Act of 1994.

Subd. 2. **Purpose.** The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal Health Care Financing Administration in its implementation of nationally accepted electronic transaction sets for its Medicare program. The legislature further recognizes the work done by the workgroup for electronic data interchange and the American National Standards Institute and its accredited standards committee X12, at the national level, and the Minnesota administrative uniformity committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

HIST: 1994 c 625 art 9 s 1

62J.51 Definitions.

Subdivision 1. **Scope.** For purposes of sections [62J.50](#) to [62J.61](#), the following definitions apply.

Subd. 2. **ANSI.** "ANSI" means the American National Standards Institute.

Subd. 3. **ASC X12.** "ASC X12" means the American National Standards Institute committee X12.

Subd. 3a. **Card issuer.** "Card issuer" means the group purchaser who is responsible for

printing and distributing identification cards to members or insureds.

Subd. 4. **Category I industry participants.** "Category I industry participants" means the following: group purchasers, providers, and other health care organizations doing business in Minnesota including public and private payers; hospitals; claims clearinghouses; third-party administrators; billing service bureaus; value added networks; self-insured plans and employers with more than 100 employees; clinic laboratories; durable medical equipment suppliers with a volume of at least 50,000 claims or encounters per year; and group practices with 20 or more physicians.

Subd. 5. **Category II industry participants.** "Category II industry participants" means all group purchasers and providers doing business in Minnesota not classified as category I industry participants.

Subd. 6. **Claim payment/advice transaction set (ANSI ASC X12 835).** "Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format developed and approved for implementation in October 1991, and used for electronic remittance advice and electronic funds transfer.

Subd. 6a. **Claim status transaction set (ANSI ASC X12 276/277).** "Claim status transaction set (ANSI ASC X12 276/277)" means the transaction format developed and approved for implementation in December 1993 and used by providers to request and receive information on the status of a health care claim or encounter that has been submitted to a group purchaser.

Subd. 6b. **Claim submission address.** "Claim submission address" means the address to which the group purchaser requires health care providers, members, or insureds to send health care claims for processing.

Subd. 6c. **Claim submission number.** "Claim submission number" means the unique identification number to identify group purchasers as described in section [62J.54](#), with its suffix identifying the claim submission address.

Subd. 7. **Claim submission transaction set (ANSI ASC X12 837).** "Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format developed and approved for implementation in October 1992, and used to submit all health care claims information.

Subd. 8. **EDI or electronic data interchange.** "EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. **Eligibility transaction set (ANSI ASC X12 270/271).** "Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

Subd. 10. **Enrollment transaction set (ANSI ASC X12 834).** "Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format developed and approved for implementation in February 1992, and used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan.

Subd. 11. **Group purchaser.** "Group purchaser" has the meaning given in section [62J.03](#), subdivision 6.

Subd. 12. **ISO.** "ISO" means the International Standardization Organization.

Subd. 13. **NCPDP.** "NCPDP" means the National Council for Prescription Drug Programs, Inc.

Subd. 14. **NCPDP telecommunication standard format 3.2.** "NCPDP telecommunication standard format 3.2" means the recommended transaction sets for claims transactions adopted by the membership of NCPDP in 1992.

Subd. 15. **NCPDP tape billing and payment format 2.0.** "NCPDP tape billing and

payment format 2.0" means the recommended transaction standards for batch processing claims adopted by the membership of the NCPDP in 1993.

Subd. 16. **Provider.** "Provider" or "health care provider" has the meaning given in section [62J.03](#), subdivision 8.

Subd. 17. **Uniform billing form CMS 1450.** "Uniform billing form CMS 1450" means the uniform billing form known as the CMS 1450 or UB92, developed by the National Uniform Billing Committee in 1992 and approved for implementation in October 1993, and any subsequent amendments to the form.

Subd. 18. **Uniform billing form CMS 1500.** "Uniform billing form CMS 1500" means the 1990 version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim and any subsequent amendments to the form.

Subd. 19. **Uniform dental billing form.** "Uniform dental billing form" means the most current version of the uniform dental claim form developed by the American Dental Association.

Subd. 19a. **Uniform explanation of benefits document.** "Uniform explanation of benefits document" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a patient.

Subd. 19b. **Uniform remittance advice report.** "Uniform remittance advice report" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a provider.

Subd. 20. **Uniform pharmacy billing form.** "Uniform pharmacy billing form" means the National Council for Prescription Drug Programs/universal claim form (NCPDP/UCF).

Subd. 21. **WEDI.** "WEDI" means the National Workgroup for Electronic Data Interchange report issued in October 1993.

HIST: 1994 c 625 art 9 s 2; 1996 c 440 art 1 s 22-25; 2000 c 460 s 2,3; 2002 c 307 art 2 s 3; 2002 c 330 s 19; 2005 c 106 s 1,2

62J.52 Establishment of uniform billing forms.

Subdivision 1. **Uniform billing form CMS 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form CMS 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee, as adopted and finalized by the Minnesota uniform billing committee.

(c) Services to be billed using the uniform billing form CMS 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as waived services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health

intravenous therapy providers, waived services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Subd. 2. Uniform billing form CMS 1500.

(a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

Subd. 3. Uniform dental billing form.

(a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American Dental Association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the administrative uniformity committee dated February 1994, and as amended or further defined by the commissioner.

Subd. 4. Uniform pharmacy billing form.

(a) On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the NCPDP/universal claim form, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform claim form shall be in accordance with instructions specified by the commissioner of health, except as provided in subdivision 5.

Subd. 5. State and federal health care programs.

(a) Skilled nursing facilities and ICF/MR services billed to state and federal health care programs administered by the department of human services shall use the form designated by the department of human services.

(b) On and after July 1, 1996, state and federal health care programs administered by the department of human services shall accept the CMS 1450 for community mental health center services and shall accept the CMS 1500 for freestanding ambulatory surgical center services.

(c) State and federal health care programs administered by the department of human services shall be authorized to use the forms designated by the department of human services for pharmacy services.

(d) State and federal health care programs administered by the department of human services shall accept the form designated by the department of human services, and the CMS 1500 for supplies, medical supplies, or durable medical equipment. Health care providers may choose which form to submit.

(e) Personal care attendant and waived services billed on a fee-for-service basis directly to state and federal health care programs administered by the department of human services shall use either the CMS 1450 or the CMS 1500 form, as designated by the department of human services.

HIST: 1994 c 625 art 9 s 3; 2000 c 460 s 4-6; 1Sp 2003 c 14 art 7 s 14, 15; 2005 c 106 s 3-5

62J.53 Acceptance of uniform billing forms by group purchasers.

On and after January 1, 1996, all category I and II group purchasers in Minnesota shall accept the uniform billing forms prescribed under section [62J.52](#) as the only nonelectronic billing forms used for payment processing purposes.

HIST: 1994 c 625 art 9 s 4

62J.535 Uniform billing requirements for claim transactions.

Subdivision 1. Repealed, 2002 c 307 art 2 s 9; 2002 c 330 s 35

Subd. 1a. **Electronic claim transactions.** Group purchasers, including government programs, not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, that voluntarily agree with providers to accept electronic claim transactions, must accept them in the ANSI X12N 837 standard electronic format as established by federal law. Nothing in this section requires acceptance of electronic claim transactions by entities not covered under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 1b. **Paper claim transactions.** All group purchasers that accept paper claim transactions must accept, and health care providers submitting paper claim transactions must submit, these transactions with use of the applicable medical and nonmedical data code sets specified in the federal electronic claim transaction standards adopted under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. The paper claim transaction must also be conducted using the uniform billing forms as specified in section [62J.52](#) and the identifiers specified in section [62J.54](#), on and after the compliance date required by law. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 2. **Compliance.** Subdivision 1a is effective concurrent with the date of required compliance for covered entities established under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time.

HIST: 1999 c 245 art 2 s 8; 2000 c 483 s 16; 2000 c 488 art 11 s 1; 2002 c 307 art 2 s 4-6,8; 2002 c 330 s 20-22,33

62J.54 Identification and implementation of unique identifiers.

Subdivision 1. **Unique identification number for health care provider organizations.**
(a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and any health care provider organization that meets the

definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a national provider identifier to identify health care provider organizations in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a national provider identifier to identify health provider organizations no later than 36 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for health care provider organizations in Minnesota under this section.

(d) All health care provider organizations in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify health care provider organizations when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Health care provider organizations in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 2. Unique identification number for individual health care providers.

(a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers in Minnesota and any individual health care provider that meets the definition of a health care provider under United States Codes, title 42, sections 1320d to 1320d-8, as amended regulations adopted thereunder shall use the national provider identifier to identify an individual health care provider in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use the national provider identifier to identify an individual health care provider no later than 36 months after the date on which a national provider identifier for health care providers is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for individual health care providers.

(d) All individual health care providers in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the

federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify individual health care providers when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Individual health care providers in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United State Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 3. Unique identification number for group purchasers.

(a) Not later than 24 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify group purchasers no later than 36 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for health plans and employers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for group purchasers.

(d) Group purchasers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) The unique group purchaser identifier, as described in this section, shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 4. Unique patient identification number.

(a) Not later than 24 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify each patient who receives health care services in Minnesota no later than 36 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for individuals adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique patient identification number, except as provided in paragraphs (e) and (f).

(d) The unique patient identification number shall be used by group purchasers and

health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) Within the limits of available appropriations, the commissioner shall develop a proposal for an alternate numbering system for patients who do not have or refuse to provide their social security numbers, if:

- (1) a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments);
- (2) the unique health identifier is the social security number of the patient;
- (3) there is no federal alternate numbering system for patients who do not have or refuse to provide their social security numbers; and
- (4) federal law or the federal Secretary of Health and Human Services explicitly allows a state to develop an alternate numbering system for patients who do not have or refuse to provide their social security numbers.

(f) If an alternate numbering system is developed under paragraph (e), patients who use numbers issued by the alternate numbering system are not required to provide their social security numbers and group purchasers or providers may not demand the social security numbers of patients who provide numbers issued by the alternate numbering system. If an alternate numbering system is developed under paragraph (e), group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their social security number used as the unique patient identifier.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

HIST: 1994 c 625 art 9 s 5; 1995 c 234 art 5 s 17; 1996 c 440 art 1 s 26-28; 1997 c 228 s 2; 1Sp1997 c 5 s 16; 2005 c 106 s 6,7

62J.55 Privacy of unique identifiers.

(a) When the unique identifiers specified in section [62J.54](#) are used for data collection purposes, the identifiers must be encrypted, as required in section [62J.321](#), subdivision 1. Encryption must follow encryption standards set by the National Bureau of Standards and approved by the American National Standards Institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the social security number if it is used as a unique patient identifier, in accordance with section [144.335](#). The social security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section [144.05](#).

HIST: 1994 c 625 art 9 s 6; 1995 c 234 art 5 s 18

62J.56 Implementation of electronic data interchange standards.

Subdivision 1. **General provisions.** (a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for

a systematic phase in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

(c) The commissioner may grant exemptions to category I and II industry participants from the requirements to implement some or all of the provisions in this section if the commissioner determines that the cost of compliance would place the organization in financial distress, or if the commissioner determines that appropriate technology is not available to the organization.

Subd. 2. Identification of core transaction sets.

(a) All category I and II industry participants in Minnesota shall comply with the standards developed by the ANSI ASC X12 for the following core transaction sets, according to the implementation plan outlined for each transaction set.

- (1) ANSI ASC X12 835 health care claim payment/advice transaction set.
- (2) ANSI ASC X12 837 health care claim transaction set.
- (3) ANSI ASC X12 834 health care enrollment transaction set.
- (4) ANSI ASC X12 270/271 health care eligibility transaction set.
- (5) ANSI ASC X12 276/277 health care claims status request/notification transaction set.

(b) The commissioner, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards, or new versions of existing standards, as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Subd. 3. Implementation guides.

(a) The commissioner, with the advice of the Minnesota administrative uniformity committee, and the Minnesota center for health care electronic data interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American Hospital Association through the national Uniform Billing Committee and its state representative organization; the American Medical Association through the uniform claim task force; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

HIST: 1994 c 625 art 9 s 7; 1996 c 440 art 1 s 29

62J.57 Minnesota center for health care electronic data interchange.

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota center for health care electronic data interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota center for health care electronic data interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

- (1) coordinating and ensuring the availability of quality electronic data interchange education and training in the state;
- (2) developing an extensive, cohesive health care electronic data interchange education curriculum;
- (3) developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;
- (4) administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents database, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and
- (5) providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

HIST: 1994 c 625 art 9 s 8

62J.58 Implementation of standard transaction sets.

Subdivision 1. **Claims payment.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I industry participants and all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version/release 3051) for electronic submission of payment information to health care providers.

Subd. 2. **Claims submission.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim information.

Subd. 2a. **Claim status information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets under section [62J.56](#), subdivision 3, all category I and II industry participants, excluding pharmacists, may accept or submit the ANSI ASC X12 276/277 health care claim status transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim status information.

Subd. 3. **Enrollment information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I and category II industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version/release 3051) for the electronic transfer of enrollment and health benefit information.

Subd. 4. **Eligibility information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section [62J.56](#), subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health benefit eligibility information.

Subd. 5. **Applicability.** This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

HIST: 1994 c 625 art 9 s 9; 1995 c 234 art 5 s 19; 1996 c 440 art 1 s 30

62J.581 Standards for Minnesota uniform health care reimbursement documents.

Subdivision 1. **Minnesota uniform remittance advice report.** (a) All group purchasers shall provide a uniform remittance advice report to health care providers when a claim is adjudicated. The uniform remittance advice report shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 2. Minnesota uniform explanation of benefits document.

(a) All group purchasers shall provide a uniform explanation of benefits document to health care patients when an explanation of benefits document is provided as otherwise required or permitted by law. The uniform explanation of benefits document shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections [62J.50](#) to [62J.61](#), the uniform remittance advice report and the uniform explanation of benefits document format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in subdivisions 1 and 2 if they comply with section [62A.01](#), subdivisions 2 and 3.

Subd. 4. **Specifications.** The uniform remittance advice report and the uniform explanation of benefits document shall be provided by use of a paper document conforming to the specifications in this section or by use of the ANSI X12N 835 standard electronic format as established under United States Code, title 42, sections 1320d to 1320d-8, and as amended from time to time for the remittance advice. The commissioner, after consulting with the administrative uniformity committee, shall specify the data elements and definitions for the uniform remittance advice report and the uniform explanation of benefits document. The commissioner and the administrative uniformity committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform remittance advice report for dental care services.

Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

HIST: 2000 c 460 s 7; 2002 c 307 art 2 s 7; 2002 c 330 s 23; 2005 c 106 s 8

62J.59 IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS STANDARD FOR PHARMACY CLAIMS.

(a) Beginning January 1, 1996, all category I and II pharmacists licensed in this state shall accept the NCPDP telecommunication standard format 3.2 or the NCPDP tape billing and payment format 2.0 for the electronic submission of claims as appropriate.

(b) Beginning January 1, 1996, all category I and category II group purchasers in this state shall use the NCPDP telecommunication standard format 3.2 or NCPDP tape billing and payment format 2.0 for electronic submission of payment information to pharmacists.

HIST: 1994 c 625 art 9 s 10

62J.60 Standards for the Minnesota uniform health care identification card.

Subdivision 1. **Minnesota uniform health care identification card.** All individuals with health care coverage shall be issued Minnesota uniform health care identification cards by group purchasers as of January 1, 1998, unless the requirements of section [62A.01](#), subdivisions 2 and 3, are met. If a health benefit plan issued by a group purchaser provides coverage for prescription drugs, the group purchaser shall include uniform prescription drug information on the uniform health care identification card issued to its enrollees on or after July 1, 2003. Nothing in this section requires a group purchaser to issue a separate card containing uniform prescription drug information, provided that the Minnesota uniform health care identification card can accommodate the information necessary to process prescription drug claims as required by this section. The Minnesota uniform health care identification cards shall comply with the standards prescribed in this section.

Subd. 1a. **Definition; health benefit plan.** For purposes of this section, "health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a group purchaser for the coverage of medical and hospital benefits. A health benefit plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
- (2) automobile or homeowners medical payment coverage;
- (3) liability insurance or supplemental to liability insurance;
- (4) accident-only coverage;
- (5) credit accident and health insurance issued under chapter 62B;
- (6) designed solely to provide dental or vision care;
- (7) designed solely to provide coverage for a specified disease or illness;
- (8) coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or
- (9) hospital income or indemnity.

Subd. 2. General characteristics.

(a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder

(insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements.

Subd. 2a. **Issuance.** A new Minnesota uniform health care identification card must be issued to individuals upon enrollment. Except for the medical assistance, general assistance medical care, and MinnesotaCare programs, a new card must be issued upon any change in an individual's health care coverage that impacts the content or format of the data included on the card or no later than 24 months after adoption of any change in the NCPDP implementation guide or successor document that affects the content or format of the data included on the card. Anytime that a card is issued upon enrollment or replaced by the medical assistance, general assistance medical care, or MinnesotaCare program, the card must conform to the adopted NCPDP standards in effect and to the implementation guide in use at the time of issuance. Newly issued cards must conform to the adopted NCPDP standards in effect at the time of issuance and to the implementation guide in use at the time of issuance. Stickers or other methodologies may be used to update cards temporarily.

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

(4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

(5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health.; and

(7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the

Appendix Page 46

Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

- (1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;
- (2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and
- (3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:
 - (i) eligibility and benefit information;
 - (ii) utilization review;
 - (iii) precertification; or
 - (iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

- (1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and
- (2) one of the following:
 - (i) telephone number to call to appeal to or file a complaint with the commissioner of health; or
 - (ii) for persons enrolled under section [256B.69](#), [256D.03](#), or [256L.12](#), the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section [256B.69](#) and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Subd. 4. **Machine readable data content.** The Minnesota uniform health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

Subd. 5. **Annual reporting.** As part of an annual filing made with the commissioner of health or commerce on or after January 1, 2003, a group purchaser shall certify compliance with this section and shall submit to the commissioner of health or commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

HIST: 1994 c 625 art 9 s 11; 1996 c 440 art 1 s 31,32; 1997 c 205 s 17; 1997 c 225 art 2 s 62; 2000 c 460 s 8; 2001 c 110 s 1; 2006 c 255 s 22,23

62J.61 RULEMAKING; IMPLEMENTATION.

Subdivision 1. **Exemption.** The commissioner of health is exempt from chapter 14, including section 14.386, in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59.

Subd. 2. **Procedure.** (a) The commissioner shall publish proposed rules in the State Register or, if the commissioner determines that publishing the text of the proposed rules would

be unduly cumbersome, shall publish notice of the proposed rules that contains a detailed description of the rules along with a statement that a free copy of the entire set of rules is available upon request to the agency.

(b) Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish notice in the State Register that the rules have been adopted 30 days before they are to take effect.

(c) If the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules which differ from the proposed rules shall be included in the notice of adoption together with a citation to the prior State Register that contained the notice of the proposed rules.

(d) The commissioner may use rulemaking to implement sections 62J.54, subdivision 4, 62J.55, and 62J.60.

Subd. 3. **Restrictions.** The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Subd. 4. **Patient privacy.** The commissioner shall seek comments from the ethics and confidentiality committee of the Minnesota health data institute and the department of administration, public information policy analysis division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

Subd. 5. **Biennial review of rulemaking procedures and rules.** The commissioner shall biennially seek comments from affected parties about the effectiveness of and continued need for the rulemaking procedures set out in subdivision 2 and about the quality and effectiveness of rules adopted using these procedures. The commissioner shall seek comments by holding a meeting and by publishing a notice in the State Register that contains the date, time, and location of the meeting and a statement that invites oral or written comments. The notice must be published at least 30 days before the meeting date. The commissioner shall write a report summarizing the comments and shall submit the report to the Minnesota health data institute and to the Minnesota administrative uniformity committee by January 15 of every even-numbered year.

HIST: 1994 c 625 art 9 s 12; 1997 c 187 art 4 s 3; 1998 c 254 art 1 s 14