Value Code Revisions
for the
v. 7030 837 Institutional Claim

Presented by:
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June 8, 2016

NUBC
National Uniform Billing Committee

Presentation Objectives

- To alert providers, health plans and vendors about upcoming changes in the Value Code segment in the 7030 version of the 837 Institutional claim.
- Explain why and how these changes came about.
- Describe the new methodology.
- Publicize this change to give vendors and others a head start in updating their systems.
  - The effective date of these changes coincides with the implementation of the post-5010 HIPAA Standard, so there should be adequate lead time.

5010 Chronology

- 2010 - 5010 Production Mode begins
- 2/2011 - Issue first came to attention of NUBC
- 1/1/12 - 5010 Compliance Date
- 3/2012 - First RFI submitted on issue
- 7/1/2012 - 5010 Enforcement date
- 9/2012 - DSMO CRS submitted
- 10/2012 - X12 DM submitted and subsequently approved
- 2014 - Last RFI on issue finalized
- 2015 - X12 CR was submitted and completed
- 2015-2016 - Drafts of NUBC value code revisions document
- 2016 - Publicity activities begin

What is a Value Code?

- It has two pieces – a code and an amount
- The code is a two byte alpha numeric string
- The amount (or “value”) is a number

These Numbers Include:

- Dollars & Cents
- Number of Patients
- Units
- Days
- Counts
- Proportions
- Military Time
- Visits
- Pressures
- Hours
- Percentages

- MSA Numbers (Metropolitan Statistical Area)
- Clinical Trial Numbers
- ZIP Codes
- Medicaid Rate Codes
- Arterial Blood Gas Values
- Kilograms (Weight of Patient
- Grams (Newborn Birth Weight)
- Centimeters (Patient Height)
- Mathematical Formulas
- CBSA Numbers (Core Based Statistical Area)

Brief History of the Issue

- The HI segment was introduced in a pre-3040 version of the 837 about 25 years ago as a way to organize the transaction for greater efficiency.
- "Value Information" was one of several HI segments grouped together in the 2300 Loop. Others included claim level diagnosis codes, procedure codes as well as four other NUBC Code sets.
- Values are reported in HI-05 under data element 782 - Monetary Amount, a Data Type R (decimal number).
- A faulty assumption was made in the design that value codes were all monetary amounts.
- There were no apparent problems with this data element in 4010. The only question raised in 4010 related to ZIP Codes and the use of the decimal point.
- However, with the adoption of 5010, we started hearing about problems.

The Problem is Surfacing

- **Some value code amounts contain leading zeroes.**
- **ASC X12 Data Type R requires suppression of leading zeroes.**
- **Claims were being rejected because of incorrect syntax.**
- **5010 translators were set to be very strict and apparently those were the ones causing problems.**

Examining the Issue

- This issue came to the attention of the NUBC in early 2011.
- Value codes with leading zeroes represented the main problem.
- The principal culprits were Accident Hour (45) and Special ZIP Code Reporting (A0).
- Prompted a thorough discussion of options over several meetings in terms of something the NUBC could do about this.
- Formed a Value Code Workgroup that in general it found that the value codes section had a myriad of problems.
- In 2012, after much study and deliberation, the NUBC recommended making no changes to the UB code set at that time.

Resolving the Issue

- **Three RFIs were submitted with contradictory Recommendations.**
- **The last and final RFI (1750) addressed leading zeroes in ZIP Codes only.**
- **There was a year's worth of debate among members of X12C and X12N.**
- **Dissected the language in the X12.6 Application Control Structure documents.**
- **Varying opinions.**
- **Ended with basically a compromise Recommendation:**

  "Until corrections are made with the next guide, receivers must allow, but not require, leading zeroes in HIxx-05 when the related value code in HIxx-02 is "A0", indicating Zip Code, and the leading zero(s) are necessary to identify a complete ZIP Code."

The Solution

- DSMO request was submitted
- X12 agreed to develop technical solution
- DM was submitted and approved to add a new component data element in the Value Information HI using Data Element 1271 Industry Code
- A CR (1485) was submitted to ASC X12
- BRTS was developed. The technical solution specified:
  - Adding an new Situational component (HIxx-10) to the segment for values that are not monetary amounts
  - For HIxx-05 change TR3 Usage from Required to Situational
  - Adding a TR3 note to see the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual for instruction on how to report each value code
  - Changing the Hix-05 Industry Name to Value Code – Monetary Amount
  - Adding Industry Name to Hixx-10 : Value Code – Non-monetary Value
  - Adding element notes: If HIxx-10 is populated, HIxx-05 must not be used.

VALUE INFORMATION MOCKUP (837I v. 7030)

SEGMENT DETAIL

HI – VALUE INFORMATION

X12 Name	Health Care Information Codes
X12 Purpose	To supply information related to the delivery of health care
Loop	**2300 – CLAIM INFORMATION**
Segment Repeat	**2**
Usage	**SITUATIONAL**
Situational Rule	**Required when there is a Value Code that applies to this claim. If not required by this implementation guide, do not send.**
TR3 Example	**HI*BE:08:::1740*BE:A7:::940~**

ELEMENT DETAIL

USAGE	REF DES.	D.E. NUM.	NAME	ATTRIBUTES		
REQUIRED	**HI01**	**C022**	**Health Care Code Information** To send health care codes and their associated dates, amounts and quantities	**M**	**1**	
REQUIRED	**-01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** / **DEFINITION** BE / Value **CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes**	**M**	**ID**	**1/3**
REQUIRED	**-02**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**-03**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**-04**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
SITUATIONAL	**-05**	**782**	**Monetary Amount** **INDUSTRY NAME: Value Code - Monetary Amount** **SITUATIONAL RULE:** Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send. If HI01-05 is populated, then HI01-10 must not be used. The maximum length of this instance of data element 782 is 10.	**O**	**R**	**1/18**
NOT USED	-06	380	Quantity	**O**	**R**	**1/15**
NOT USED	-07	799	Version Identifier	**O**	**AN**	**1/30**
NOT USED	-08	1271	Industry Code	**X**	**AN**	**1/30**
NOT USED	-09	1271	Industry Code	**X**	**AN**	**1/30**
SITUATIONAL	-10	1271	Industry Code **INDUSTRY NAME: Value Code Non-Monetary Value** **SITUATIONAL RULE:** Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send. If HI01-10 is populated, then HI01-05 must not be used.	**O**	**AN**	**1/30**

Sample Page – Value Code Revisions

Effective Date: Implementation of post-5010 HIPAA Standard **Meeting Date: 3/3/15, 8/4/15, 4/6/16**			**Form Locators 39-41** Page 7 of 19
31	Patient Liability Amount	$	Approved amount to charge the beneficiary for non-covered accommodations, diagnostic procedures or treatments.
32	Multiple Patient Ambulance Transport	NM	When more than one patient is transported in a single ambulance trip, report the total number of patients transported.
33	Offset to the Patient-Payment Amount - Podiatric Services	$	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount - Other Medical Services	$	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount - Health Insurance Premiums	$	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
36	RESERVED	N/A	Reserved for assignment by the NUBC.
37	Units of Blood Furnished	NM	The total number of units of whole blood or packed red cells furnished to the patient, regardless of whether the hospital charges for blood or not.
38	Blood Deductible Units	NM	The number of unreplaced deductible units of packed red cells furnished for which the patient is responsible. If all deductible units furnished have been replaced, no entry is made.
39	Units of Blood Replaced	NM	The total number of units of whole blood or packed red cells furnished to the patient that have been replaced by or on behalf of the patient.
40	New Coverage not Implemented by HMO (for inpatient service only)	$	Amount shown is for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO.) Note: Condition Codes 04 and 78 should also be reported.

Summary Page - Value Code Revisions

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Form Locators 39-41
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Monetary Value Codes Right-justified (837I, Loop ID 2300; HIxx-5; DE 782 (X12 Data Type R))			Non-monetary Left-justified Value Codes (837I, Loop ID 2300; HIxx-10; DE 1271 (X12 Data Type AN)		Not Applicable/Non-designated Value Codes (All RESERVED, DISCONTINUED and Payer Internal use Only Codes)	
01	29	AA	24	59	03	BC-C0
02	30	AB	32	60	07	C4-C6
04	31	B1	37	61	17-20	C8-C9
05	33	B2	38	67	36	CC-D2
06	34	B3	39	68	62-65	D6-DQ
08	35	B7	45	69	70-79	DR
09	40	BA	46	80	85-99	DS-DZ
10	41	BB	48	81	AC-AZ	E0-FB
11	42	C1	49	82	B0	FE-G7
12	44	C2	50	83	B8-B9	G9-Y0
13	43	C3	51	84		Y6-ZZ
14	47	C7	52	A0		
15	55	CA	53	A8		
16	66	CB	54	A9		
21	A1	D3	56	D4		
22	A2	FC	57	D5		
23	A3	FD	58	G8		
25	A4	Y1				
26	A5	Y2				
27	A6	Y3				
28	A7	Y4				
		Y5				

Distribution Summary
64 monetary
34 non-monetary
937 N/A codes

Questions

- **Todd Omundson – tomundson@aha.org**

- **Slides of Presentation and Draft of Value Code Revisions will remain freely available. Circulation and distribution is encouraged. Updates will be made based on comments received. Permanent location:**

  http://www.nubc.org/subscribersonly/index.dhtml

Effective Date: Implementation of post-5010 HIPAA Standard **Meeting Date: 3/3/15, 8/4/15, 4/6/16**	**Form Locators 39-41** Page 1 of 19

Data Element	**Value Codes**	
Definition:	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. The Value Code fields allow for the reporting of numeric expressions. These expressions can be categorized as monetary amounts as well as percentages, units, integers and other identifiers. All numeric expressions except monetary amounts are left-justified. Monetary amounts are right-justified with cents reported to the right of the dollar/cents delimiter.	
Reporting	• UB-04: Situational. Required when there is a Value Code that applies to this claim. • 0070XX: Situational. Required when there is a Value Code that applies to this claim.	
Field Attributes	3 Fields (codes) 4 Lines 2 Positions Alphanumeric Left-justified	3 Fields (amounts/values) 4 Lines 9 Positions For monetary (dollar) amounts: Numeric Right-justified Cents are reported in Positions 8 and 9 to the right of the dollar/cents delimiter. (X12 Data Type R-Decimal) For non-monetary values: Left-justified Report decimals when applicable (X12 Data Type AN-String - alpha-numeric)

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Notes

1. The designation of monetary and non-monetary value codes is documented next to the applicable code definition. "$" denotes a monetary amount, "NM" denotes a non-monetary value, "N/A" denotes Not Applicable/Non-designated Value Codes such as those marked "RESERVED", "DISCONTINUED", and "Payer Codes"

2. The dollar/cents delimiter is an implied decimal and is only applicable to value codes designated as monetary amounts.

3. Percentages are designated as non-monetary and are reported in decimal form with a leading 0 for percentages under 100. Position by position examples are included with the applicable code definition.

4. If all of the Value Code fields are filled, use FL 81 Code-Code field with the appropriate qualifier code (A4) to indicate that a Value Code is being reported.

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Monetary Value Codes Right-justified (837I, Loop ID 2300; HIxx-5; DE 782 (X12 Data Type R))				Non-monetary Left-justified Value Codes (837I, Loop ID 2300; HIxx-10; DE 1271 (X12 Data Type AN)			Not Applicable/Non-designated Value Codes (All RESERVED, DISCONTINUED and Payer Internal use Only Codes)	
01	29	AA		24	59		03	BC-C0
02	30	AB		32	60		07	C4-C6
04	31	B1		37	61		17-20	C8-C9
05	33	B2		38	67		36	CC-D2
06	34	B3		39	68		62-65	D6-DQ
08	35	B7		45	69		70-79	DR
09	40	BA		46	80		85-99	DS-DZ
10	41	BB		48	81		AC-AZ	E0-FB
11	42	C1		49	82		B0	FE-G7
12	44	C2		50	83		B8-B9	G9-Y0
13	43	C3		51	84			Y6-ZZ
14	47	C7		52	A0			
15	55	CA		53	A8			
16	66	CB		54	A9			
21	A1	D3		56	D4			
22	A2	FC		57	D5			
23	A3	FD		58	G8			
25	A4	Y1						
26	A5	Y2						
27	A6	Y3						
28	A7	Y4						
		Y5						

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01	Most Common Semi-private Rate	$	To provide for the recording of hospital's most common semi-private rate.
02	Hospital has no Semi-private Rooms	$	Entering this code requires $0.00 amount.
03	RESERVED	N/A	Reserved for assignment by the NUBC.
04	Professional Component Charges which are Combined Billed	$	Code indicates the amount shown is the sum of technical and professional charges, which are combined billed. *Medicare uses this information in internal processes and in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all inclusive rate hospitals.)*
05	Professional Component Included in Charges and also Billed Separate to Carrier	$	Amount shown is the combined billed charges (technical and professional); however the provider is submitting a separate professional bill to the health plan. *For use on Medicare or TRICARE bills and all Medicaid bills if state specifies need for this information.*
06	Blood Deductible	$	Total cash blood deductible. *If appropriate, enter Medicare Part A or Part B blood deductible amount. (To report other than the blood deductible, that is to report the program deductible, see Value Codes (FL39-FL41) A1, B1, and C1.)*
07	RESERVED	N/A	Reserved for assignment by the NUBC.
08	Life Time Reserve Amount in the First Calendar Year	$	Lifetime reserve amount charged in the year of admission. *Note: For Medicare, use this code only for Part A bills. For Part B Coinsurance use Value Codes (FL39-41) A2, B2, and C2).*

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09	Coinsurance Amount in the First Calendar Year	$	Coinsurance amounts, charged in the year of admission.
10	Lifetime Reserve Amount in the Second Calendar Year	$	Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
11	Coinsurance Amount in the Second Calendar Year	$	Coinsurance amount charged in the year of discharge where the inpatient bill spans two calendar years.
Note: A zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (i.e., payment for services for which another insurer is the primary payer).			
12	Working Aged Beneficiary/Spouse with Employer Group Health Plan	$	Amount shown reflects that portion of a payment from a higher priority employer group health insurance made on behalf of an aged beneficiary. *For Medicare purposes the provider is billing Medicare as the secondary payer (based on MSP development) for covered services on this bill.*
13	ESRD Beneficiary in a Medicare Coordination Period with an Employer Group Health Plan	$	Amount shown is that portion of a payment from a higher priority employer group health insurance payment made on behalf of an ESRD beneficiary that the provider is applying to Medicare covered services on this bill.
14	No-Fault, Including Auto/Other	$	Amount shown is that portion from a higher priority no-fault insurance, including auto/other made on behalf of the patient or insured. *For Medicare beneficiaries, the provider should apply this amount to the Medicare covered services on this bill.*
15	Worker's Compensation	$	Amount shown is that portion of a payment from a higher priority worker's compensation insurance made on behalf of the patient or insured. For Medicare beneficiaries the provider should apply this amount to Medicare covered services on this bill.

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16	PHS, or Other Federal Agency	$	Amount shown is that portion of a payment from a higher priority Public Health Service or the Federal Agency made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
17-20	Payer Codes	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
21	Catastrophic	$	Catastrophic Medicaid-eligibility and coverage requirements determined at the state level.
22	Surplus Income	$	Surplus (or excess) income as designated by Medicaid eligibility requirements determined at the state level.
23	Recurring Monthly Income	$	Monthly income as designated by Medicaid-eligibility requirements determined at the state level.
24	Medicaid Rate Code	NM	Code indicating the payment or reimbursement rate designated by Medicaid at the state level.
25	Offset to the Patient-Payment Amount - Prescription Drugs	$	Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount - Hearing and Ear Services	$	Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-Payment Amount - Vision and Eye Services	$	Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount - Dental Services	$	Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount - Chiropractic Services	$	Chiropractic services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
30	Preadmission Testing	$	This code reflects charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.

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31	Patient Liability Amount	$	Approved amount to charge the beneficiary for non-covered accommodations, diagnostic procedures or treatments.
32	Multiple Patient Ambulance Transport	NM	When more than one patient is transported in a single ambulance trip, report the total number of patients transported.
33	Offset to the Patient-Payment Amount - Podiatric Services	$	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount - Other Medical Services	$	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount - Health Insurance Premiums	$	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
36	RESERVED	N/A	Reserved for assignment by the NUBC.
37	Units of Blood Furnished	NM	The total number of units of whole blood or packed red cells furnished to the patient, regardless of whether the hospital charges for blood or not.
38	Blood Deductible Units	NM	The number of unreplaced deductible units of packed red cells furnished for which the patient is responsible. If all deductible units furnished have been replaced, no entry is made.
39	Units of Blood Replaced	NM	The total number of units of whole blood or packed red cells furnished to the patient that have been replaced by or on behalf of the patient.
40	New Coverage not Implemented by HMO (for inpatient service only)	$	Amount shown is for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO.) Note: Condition Codes 04 and 78 should also be reported.

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41	Black Lung	$	Code indicates the amount shown is that portion of a higher priority Black Lung (federal program) payment made on behalf of a Medicare beneficiary. <u>Note:</u> *The reporting of zero indicates the provider is claiming a conditional payment because there has been a substantial delay in payment from the Black Lung Program. (See Medicare manual for further instructions on the use of this code along with other related UB code.)*
42	VA	$	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a Medicare beneficiary and that you are applying to Medicare as secondary payer for covered Medicare services on this claim. *(See Medicare manual for further instructions on the use of this code along with other related UB codes.)*
43	Disabled Beneficiary Under Age 65 with LGHP	$	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that you are applying to covered Medicare charges on this bill. *(See Medicare manual for further instructions on the use of this code along with other related UB codes.)*

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44	Amount Provider Agreed to Accept from Primary Payer when this Amount is less than Charges but Higher than Payment Received	$	Report the amount the provider was obligated to accept from a primary payer when the amount is less than charges but higher than or equal to the payment received. Secondary payment may be due. <u>Note:</u> *The following value codes report the actual amounts paid: 12- 16, 41-43, and 47. Value Code 44 should always be equal to, or, greater than the amounts indicated in the value codes indicated immediately above.*
45	Accident Hour	NM	The hour when the accident occurred that necessitated medical treatment.
	00 12:00 - 12:59 (Midnight) 01 01:00 - 01:59 02 02:00 - 02:59 03 03:00 - 03:59 04 04:00 - 04:59 05 05:00 - 05:59 06 06:00 - 06:59 07 07:00 - 07:59 08 08:00 - 08:59 09 09:00 - 09:59 10 10:00 - 10:59 11 11:00 - 11:59 12 12:00 - 12:59 (Noon) 13 01:00 - 01:59 14 02:00 - 02:59 15 03:00 - 03:59 16 04:00 - 04:59 17 05:00 - 05:59 18 06:00 - 06:59 19 07:00 - 07:59 20 08:00 - 08:59 21 09:00 - 09:59 22 10:00 - 10:59 23 11:00 - 11:59 99 Unknown		

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46	Number of Grace Days	NM	Follows the QIO determination. This is the number of days determined by the QIO (medical necessity reviewer) as necessary to arrange for the patient's post-discharge care.
47	Any Liability Insurance	$	Amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. *Enter zero in the amount field if you are claiming a conditional payment.*
48	Hemoglobin Reading	NM	The most recent hemoglobin reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset if treatment. The reading is a 3-byte numeric element (XX.X). Results exceeding 3-position numeric elements (e.g., 10.50) are reported as 10.5.
49	Hematocrit Reading	NM	The most recent hematocrit reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset if treatment. The reading is a 3-byte numeric element (XX.X). Results exceeding 3-position numeric elements (e.g., 10.50) are reported as 10.5.

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50	Physical Therapy Visits	NM	Report the number of physical therapy visits provided from the onset of treatment from this billing provider through this billing period.
51	Occupational Therapy Visits	NM	Report the number of occupational therapy visits provided from the onset of treatment t from this billing provider) through this billing period.
52	Speech Therapy Visits	NM	Report the number of speech therapy visits provided from the onset of treatment by this billing provider through this period.
53	Cardiac Rehab Visits	NM	The number of cardiac rehabilitation visits from the onset of treatment from the billing provider through this billing period.
54	Newborn Birth Weight in Grams	NM	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with Priority (Type) of Admission of 4 and on other claims as required by state law.
55	Eligibility Threshold for Charity Care	$	The amount at which a health care facility determines the eligibility threshold for charity care.

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56	Skilled Nurse - Home Visit Hours (HHA only)	NM	The number of home visit hours of skilled nursing provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, rounded to the nearest whole hour.
57	Home Health Aide - Home Visit Hours (HHA only)	NM	The number of hours of home health aide services provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, rounded to the nearest whole hour.
58	Arterial Blood Gas (PO2)	NM	Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or the value in Value Code 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill. Report two digits rounded to the nearest whole number. Example: A value of 56.5 should be reported as 57.
59	Oxygen Saturation Oximetry	NM	Oxygen percent saturation at the beginning of each reporting period for oxygen therapy. This value or the value in Value Code 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill. Report two digits rounded to the nearest whole percent. Example: 93.5 percent should be reported as 0.94. A value of 100 percent would be reported as 1.
60	HHA Branch MSA	NM	MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's.
61	Place of Residence where Service is Furnished (HHA and Hospice)	NM	MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the place of residence where the home health or hospice service is delivered.
62-65	Payer Codes	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.

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66	Medicaid Spend Down Amount	$	The dollar amount that was used to meet the recipient's spend down liability for this claim.
67	Peritoneal Dialysis	NM	The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, rounded to the nearest whole hour.
68	EPO-Drug	NM	Number of units of EPO administered and/or supplied relating to the billing period. Report amount in whole units.
69	State Charity Care Percent	NM	Code indicates the percentage of charity care eligibility for the patient. For example, a rate of 10.5% is shown as: 0 . 1 0 5
70-79	Payer Codes	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
80	Covered Days	NM	The number of days covered by the primary payer as qualified by the payer.
81	Non-covered Days	NM	Days of care not covered by the primary payer.
82	Co-insurance Days	NM	The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness.
83	Lifetime Reserve Days	NM	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
84	Shorter Duration Hemodialysis (Effective 7/1/17)	NM	The number of sessions per week as specified in the patient's plan of care for hemodialysis that is shorter in duration (Revenue Code 0826) than conventional sessions (reported under Revenue Code 0821).
85-99	RESERVED	N/A	Reserved for assignment by the NUBC.

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A0	Special ZIP Code Reporting	NM	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1*(a)*	Deductible Payer A	$	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. *(Note: Report Medicare blood deductibles under Value Code 6.)*
A2*(a)*	Coinsurance Payer A	$	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. *(Note: For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.)*
A3	Estimated Responsibility Payer A	$	The amount estimated by the provider to be paid by the indicated payer; it is not the actual payment.
A4	Covered Self-administrable Drugs - Emergency	$	The covered charge amount for self-administrable drugs administered to the patient in an emergency situation (e.g., diabetic coma). For use with Revenue Code 0637.
A5	Covered Self-administrable Drugs - not Self-administrable in the Form and Situation Furnished to Patient	$	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-administrable Drugs - Diagnostic Study and Other	$	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reason (e.g., the drug is specifically covered by the payer).
A7	Co-payment Payer A	$	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
A8	Patient Weight	NM	Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54

(a) This code is to be used only on paper claims. For electronic 837 claims, use Loop ID 2320 | CAS segment (Claim Adjustment Group Code "PR").

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A9	Patient Height	NM	Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	$	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer.
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	$	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.
AC-AZ	RESERVED	N/A	Reserved for assignment by the NUBC.
B0	RESERVED	N/A	Reserved for assignment by the NUBC.
B1*(a)*	Deductible Payer B	$	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
B2*(a)*	Coinsurance Payer B	$	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.)
B3	Estimated Responsibility Payer B	$	The amount estimated by the provider to be paid by the indicated payer; it is not the actual payment.
B7*(a)*	Co-payment Payer B	$	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
B8-B9	RESERVED	N/A	Reserved for assignment by the NUBC.
BA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer B	$	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer.
(a) This code is to be used only on paper claims. For electronic 837 claims, use Loop ID 2320 | CAS segment (Claim Adjustment Group Code "PR").			

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BB	Other Assessments or Allowances (e.g., Medical Education) Payer B	$	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.
BC-C0	RESERVED	N/A	Reserved for assignment by the NUBC.
C1*(a)*	Deductible Payer C	$	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
C2*(a)*	Coinsurance Payer C	$	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.)
C3	Estimated Responsibility Payer C	$	The amount estimated by the provider to be paid by the indicated payer; it is not the actual payment.
C4-C6	RESERVED	N/A	Reserved for assignment by the NUBC.
C7*(a)*	Co-payment Payer C	$	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
C8-C9	RESERVED	N/A	Reserved for assignment by the NUBC.
CA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer C	$	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer.
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C	$	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.
CC-D2	RESERVED	N/A	Reserved for assignment by the NUBC.

(a) This code is to be used only on paper claims. For electronic 837 claims, use Loop ID 2320| CAS segment (Claim Adjustment Group Code "PR").

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D3	Patient Estimated Responsibility	$	The amount estimated by the provider to be paid by the indicated patient.
D4*(b)*	Clinical Trial Number Assigned by NLM/NIH	NM	8-digit, numeric National Library of Medicine/ National Institutes of Health assigned clinical trial number.
D5	Last Kt/V Reading (Effective 7/1/10)	NM	Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service.
D6-DQ	RESERVED	N/A	Reserved for assignment by the NUBC.
DR	RESERVED	N/A	Reserved for Disaster Related Value Code.
DS-DZ	RESERVED	N/A	Reserved for assignment by the NUBC.
E0	RESERVED	N/A	Reserved for assignment by the NUBC.
E1	DISCONTINUED	N/A	Discontinued 3/1/07.
E2	DISCONTINUED	N/A	Discontinued 3/1/07.
E3	DISCONTINUED	N/A	Discontinued 3/1/07.
E4-E6	RESERVED	N/A	Reserved for assignment by the NUBC.
E7	DISCONTINUED	N/A	Discontinued 3/1/07.
E8-E9	RESERVED	N/A	Reserved for assignment by the NUBC.
EA	DISCONTINUED	N/A	Discontinued 3/1/07.
EB	DISCONTINUED	N/A	Discontinued 3/1/07.
EC-EZ	RESERVED	N/A	Reserved for assignment by the NUBC.
F0	RESERVED	N/A	Reserved for assignment by the NUBC.
F1	DISCONTINUED	N/A	Discontinued 3/1/07.
F2	DISCONTINUED	N/A	Discontinued 3/1/07.
F3	DISCONTINUED	N/A	Discontinued 3/1/07.
F4-F6	RESERVED	N/A	Reserved for assignment by the NUBC.

b) This code is to be used only on paper claims. For electronic 837 claims, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4).

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F7	DISCONTINUED	N/A	Discontinued 3/1/07.
F8-F9	RESERVED	N/A	Reserved for assignment by the NUBC.
FA	DISCONTINUED	N/A	Discontinued 3/1/07.
FB	DISCONTINUED	N/A	Discontinued 3/1/07.
FC	Patient Paid Amount	$	The amount the provider has received from the patient toward payment of this bill. (Effective 7/1/08)
FD	Credit Received from the Manufacturer for a Medical Device	$	The amount the provider has received from a medical device manufacturer as credit for a medical device. (Effective 7/1/15)
FE-G0	RESERVED	N/A	Reserved for assignment by the NUBC.
G1	DISCONTINUED	N/A	Discontinued 3/1/07.
G2	DISCONTINUED	N/A	Discontinued 3/1/07.
G3	DISCONTINUED	N/A	Discontinued 3/1/07.
G4-G6	RESERVED	N/A	Reserved for assignment by the NUBC.
G7	DISCONTINUED	N/A	Discontinued 3/1/07.
G8	Facility where Inpatient Hospice Service is Delivered	NM	MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice service is delivered.
G9	RESERVED	N/A	Reserved for assignment by the NUBC.

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GA	DISCONTINUED	N/A	Discontinued 3/1/07.
GB	DISCONTINUED	N/A	Discontinued 3/1/07.
GC-OZ	RESERVED	N/A	Reserved for assignment by the NUBC.
P0-PZ	RESERVED	N/A	Reserved for PUBLIC HEALTH DATA REPORTING.
Q0-QZ	Payer Codes	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
R0-Y0	RESERVED	N/A	Reserved for assignment by the NUBC.
Y1	Part A Demonstration Payment	$	This is the portion of the payment designated as reimbursement for Part A services under the demonstration/model.
Y2	Part B Demonstration Payment	$	This is the portion of the payment designated as reimbursement for Part B services under the demonstration/model. No deductible or coinsurance has been applied.
Y3	Part B Coinsurance	$	This is the amount of Part B coinsurance applied by the A/B MAC to this demonstration/model claim.
Y4	Conventional Provider Payment	$	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration/model.
Y5	Part B Deductible (Effective 4/1/13)	$	This is the amount of Part B deductible applied by the A/B MAC to this demonstration/model claim.
Y6-ZZ	RESERVED	N/A	Reserved for assignment by the NUBC.