



**ACS EDI Gateway Services  
Electronic Claims Acquisition Services**

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**West Virginia Workers' Compensation  
UB92  
Version 5**

**June 11, 2001**

**ACS  
2324 Killearn Center Boulevard  
Tallahassee, FL 32309**

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## DOCUMENT REVISION LIST

We make revisions to this document on an as-needed basis. To help you easily identify information that has changed, we provide a graphical element with the date of revision inside it. Depending on the chapter, the graphic is located in one of two areas:

Rev.01/01/01

- For text areas, graphic is placed on the left-most page margin.
- For matrix areas, graphic is placed on the right-most margin.

Rev.01/01/01

In addition, the following is a list of changes with their page numbers and revision date.

Rev. 7/11/02

### Revisions/Details

### Date

Page 14, Payer-Specific Data

7/03/01

- Claims Edits, **Records**, changed “320” to **192** and added the words “Uniform Billing” after “West Virginia Workers’ Compensation.”

Page 13, Enrollment Information

11/21/01

- Changed the web site address to [www.acs-gcro.com](http://www.acs-gcro.com)

### 2002

Page ii, added –2002 to year 2001

7/11/02

Page 13, Transmission Telephone Number – updated phone number

7/11/02

### 2003

Page 1, Changed [www.hcfa.gov/medicare/edi/ed.htm](http://www.hcfa.gov/medicare/edi/ed.htm) to <http://cms.hhs.gov/providers/edi/edi3.asp>

1/7/03

Page 31, Field No. 60-09 ,under comments, changed “9(07)v99” to “9(05)v99”

4/11/03

Page 31, Field No. 60-10 ,under comments, changed “9(07)v99” to “9(05)v99”

4/11/03

Page 32, Field No. 61-10, under comments, changed 9(07)v99” to “9(05)v99”

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Page 32, Field No. 61-11, under comments, changed 9(07)v99” to “9(05)v99”

4/11/03

Page 36, Field No. 90-13, under comments, changed 9(07)v99” to “9(05)v99”

4/11/03

Page 36, Field No. 90-15, under comments, changed 9(07)v99” to “9(05)v99”

4/11/03

Page 20, Field No. 10-09, under Field Req, changed “-“ to “R”

10/09/03

## Chapter 1 Introduction

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ACS, a leader in health care technology, provides Gateway services to providers enrolled in contracted health care plans. Our electronic claims acquisition services provide an array of tools that allow you to:

- Easily submit all of your claims to one source
- Submit claims twenty-four hours a day, seven days a week
- Receive confirmation of receipt of each file transferred
- Receive payment from health care plans on a regular basis

Health care plans that participate with ACS are referred to as “payers.” Claims are accepted electronically into our data center in Tallahassee, Florida and are processed through various electronic systems to payment. As a gateway service, we provide connectivity to various health care plans and states where ACS is the fiscal agent.

This manual outlines the procedures necessary for the transmission of electronic claims. It targets billing services and software vendors who are developing electronic claims submission capabilities for transmission to ACS.

Chapter 4 of this manual contains important payer-specific information required by ACS. The ACS Clearinghouse System (CCHS) Requirements Matrix, which follows Chapter 4, details the records and fields required for claims processing.

This manual is intended to be used in conjunction with the national format specifications published by HCFA. These publications offer field-by-field breakdowns, definitions, and valid values. They can be accessed at <http://cms.hhs.gov/providers/edi/edi3.asp>. For UB92 claims, access the link to [UB92 Version 5.0 Flat File Format](#). For HCFA 1500 claims, access the link to [HCFA National Standard Format Version 3.01](#).

Rev.01/07/03

## Chapter 2 Communications

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### ACS' EDI Gateway

ACS' EDI Gateway consists of an interactive, menu-driven bulletin board that allows you to upload your claim files and receive immediate confirmation of the status of your transfer. The EDI Gateway is accessed using a standard modem and supports modem speeds of up to 33,600 BPS.

### Communication Protocols

ACS currently supports the following options:

- Async – XMODEM, YMODEM, ZMODEM, Kermit

### Transmission Hours

Claims transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible.

## **Teleprocessing Requirements**

The general specifications for communication with ACS are:

<b><i>Telecommunications</i></b>	Hayes-compatible 2400-33.6K BPS asynchronous modem
<b><i>File Format</i></b>	ASCII text data
<b><i>Compression Techniques</i></b>	<p>PKZIP will compress one-to-many files in a single ZIP archive.</p> <p>Microsoft Compress will compress only a single file.</p> <p>GnuZip will compress only a single file.</p> <p>ARC (Archive) will compress one-to-many files in a single file.</p> <p>LHA or LHARC will compress one-to-many files in a single file.</p> <p>ACS accepts transmissions with any of the above compression techniques, as well as non-compressed files.</p>
<b><i>Data Format</i></b>	8 data bit, 1 stop bit, no parity, full duplex
<b><i>Transmission Protocol</i></b>	<p>ZMODEM uses 128 byte to 1024 byte variable packets and a 16-bit or 32-bit CRC (Cyclical Redundancy Check).</p> <p>XMODEM uses 128 byte blocks and a 16-bit CRC.</p> <p>YMODEM uses 1024 byte blocks and a 16-bit CRC.</p> <p>KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software.</p>

## Transmission Procedures

CALLING SYSTEM	HOST SYSTEM
<i>1. Dials ACS' HOST</i>	Answers call, negotiates a common baud rate, and sends to the caller->  “Enter your User Name=>”
<i>2. Enters User Name &amp; &lt;CR&gt;</i>	Receives User Name (Logon Name) and sends to the caller->  “Enter your User Number=>”
<i>3. Enters User Number &amp; &lt;CR&gt;</i>	Receives User Number (Logon User ID) and verifies if caller is an authorized user.  Sends HOST selection menu followed by a user prompt->  “Please Enter Your Selection=>”
<i>4. Enter Desired Selection &amp; &lt;CR&gt;</i>	<b>#1. Electronic Claim Submission:</b> Assigns and sends the transmission file name, then waits for ZMODEM (by default) file transfer to be initiated by the caller.  <b>#3. Select File Transfer Protocol:</b> Allows submitter to change the protocol for the current submission only. The protocol may be changed to <b>(K)</b> ermit, <b>(X)</b> Modem, <b>(Y)</b> Modem, or <b>(Z)</b> Modem. Enter the first letter of the protocol that you wish to use.  <b>#9. Exit &amp; Disconnect:</b> Terminates connection.
<i>5. Enter “1” to send file &amp; &lt;CR&gt;</i>	Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report.  Sends HOST selection menu followed by a user prompt=>  “Please Enter Your Selection=>”

**6. Enter Desired Selection & <CR>**

**#1. Electronic Claim Submission:** Assigns and sends the transmission file name, then waits for ZMODEM (by default) file transfer to be initiated by the caller.

**#3. Select file Transfer Protocol:** Allows submitter to change the protocol for the current transmission only.

**#4. Download Confirmation:** Allows submitter to download the confirmation report. See below for further explanation.

**#9. Exit & Disconnect:** Terminates connection.

## Confirmation Reports

After the transmission is complete, a confirmation report describing the success or failure of the transmission is produced. The confirmation report will appear briefly on the monitor of the computer that is used to submit the data. You may download the report by selecting Option 4 (as outlined above). The file will be sent to the download directory of the communications software that is used for transmission. The file naming convention is line##.txt, with ## representing the last two digits of the file number assigned by ACS. For example, the name of the electronic confirmation report for file name 02010001.621 will be line21.txt.

The following is an example of a confirmation report. The first line indicates successful file transmission. The second line indicates a rejected transmission. Below the sample confirmation report is a detailed explanation of the components of a confirmation report. Please notify an EDI Business Analyst during the testing process if your communications package does not allow you to receive the confirmation report.

Date: 10/05/01		ACS Host System				Time: 07:02		
User Name: JANED						User Number: 123456789		
File Number	Payer	Frmt	Type	Claims	Batches	Tot. Charges	Status	Msg.
-----	-----	-----	-----	-----	-----	-----	-----	-----
06050001.609	77027	UB	UB92	1000	1	69500.00	PROD	001
06050001.609	77027	NSF	HCFA	100	1	2500.00	PROD	001
Messages								
001 – File Received								
** End of Report **								

**Field Name**

**Explanation**

*Date*

(MM/DD/YY) date transmission received

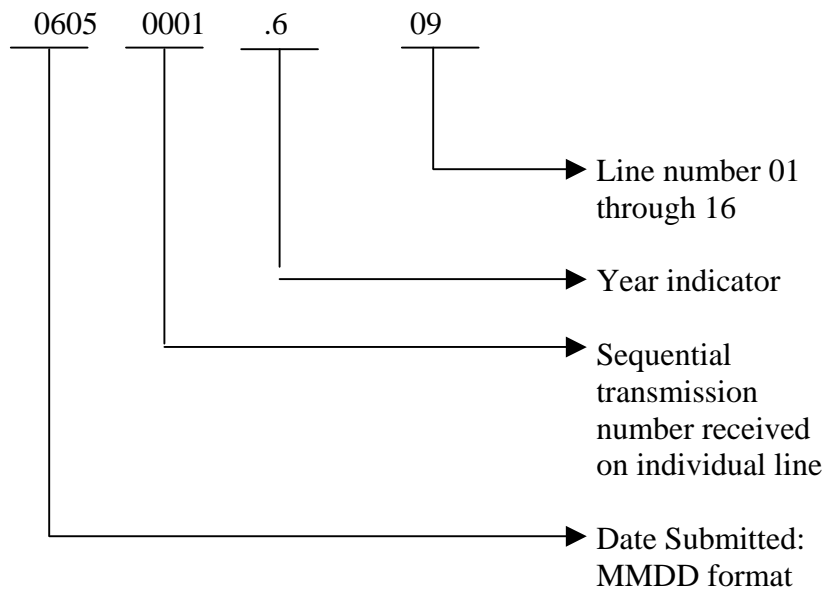
*Time*

(HH:MM) time transmission received

*User Name*

Name that identifies the submitter to the host system

<b><u>Field Name</u></b>	<b><u>Explanation</u></b>
<i>User Number</i>	Number that allows the submitter access to the host system
<i>File Number</i>	(MMDDnnnn.x0n) tracking number for file receipt verification



<i>Payer</i>	Entity to receive the claims. Identified by a five-digit ID.
<i>Frmt</i>	Format. File structure of the logical files transmitted. "NSF" = National Standard Format, "UB" = Uniform Billing Format
<i>Type</i>	Claim type received. "HCFA" = HCFA 1500 claims, "DENT" = dental claims, "UB92" = Institutional Claims
<i>Claims</i>	Number of claims
<i>Batches</i>	Number of batches
<i>Tot. Charges</i>	Total charges

<b><u>Field Name</u></b>	<b><u>Explanation</u></b>
<i>Status</i>	Disposition of the file as determined by the host system. “Test” = file is processed as a test, “Prod” = file is processed as production, “Reject” = file is not accepted for processing and must be resubmitted, “Hold” = file is accepted but will not be processed
<i>Msg</i>	Message number. Reference the corresponding entry in the “Messages” area of the confirmation report for interpretation. Message numbers are assigned sequentially as files are processed. A “Msg” of 001 may not always imply the same condition. 001 is the first condition that occurred, 002 is the second condition that occurred, and so on
<i>Messages</i>	Explanation of the “Msg” field. Files that are not accepted have a status of “reject.” These files are not processed; they must be corrected and transmitted again by the submitter

## **Confirmation Messages**

The following edits are applied to incoming transmissions before the confirmation report is generated. One or more of the following messages will be on the confirmation report if a condition is present.

<b><u>MESSAGE</u></b>	<b><u>DESCRIPTION</u></b>
<i>Invalid record length, Rec. 9999</i>	Specific to file format. Record indicated is too long or too short.
<i>Invalid (non-text) characters, Rec. 9999</i>	Record number indicated contains non-text characters. Sequence of control characters may be incorrect. Must have both a Carriage Return character and a Line Feed character at the end of every line. Must be a CR character (hex 0D) followed by a LF character (hex 0A).
<i>Invalid record sequence, Rec. 9999</i>	Record ID is incorrect. Refer to the record number indicated and its preceding record.
<i>User not approved for Payer/Format/Type</i>	File does not match criteria of submitter's enrollment. One (or more) of these fields is incorrect (Payer ID, file format, claim type).
<i>Number of detail recs exceeds maximum</i>	Number of line items exceeds the maximum allowed by the payer for this claim type.
<i>Unknown format/type</i>	File format and claim type could not be determined. Unable to accept the file.

**MESSAGE**

**DESCRIPTION**

*Payer ID not found*

Payer ID on the TPL record is spaces and Receiver ID on the header record is spaces. Unable to accept the claim(s).

*Editor Off*

Not a true error message. For information only. File accepted with no edits performed during communications link. No file statistics are returned to the submitter.

*File received*

File successfully transmitted and received.

*Too many logical files in physical file*

Current max of 500 logical files per physical file transmission.

### Testing Procedures

You must complete the testing process before you can submit electronic claims for payment. ACS' EDI Business Analysts are available to assist you through the testing process. Each test transmission is inspected thoroughly to ensure that no format errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, we request that you send real claim data. The number of test transmissions required depends on the percentage of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to your software or ACS' host system.

Before testing, contact an EDI Business Analyst at (850) 201-1171 to obtain a Vendor ID and test Logon Name and password. The Vendor ID, a five-digit alphanumeric code that must appear in the VENDOR ID field of the file header record, is used to identify the software that is being used to transmit claims.

When the testing process is complete and the software is approved, software vendors must send a client list to ACS. This list must detail the names and Submitter IDs of all clients who will use the approved software to submit electronic claims directly to ACS. All clients submitting claims for payment, including billing agents and clearinghouses, must be enrolled with ACS' EDI Support Unit. The EDI Support Unit will assign all direct submitters a Submitter ID, Logon Name, and Logon ID. Refer to Chapter 4 of this manual for the EDI Support Unit telephone number.

### **Testing Steps**

Refer to “Transmission Procedures” in Chapter 2 for directions on using the Logon Name and Logon User ID. Each test transmission must contain ten to twenty claims. When the transmission is complete, select menu option 4 to receive a brief confirmation notice verifying receipt of the data or indicating that the transmission failed. A sample confirmation report and detailed instructions on interacting with the host menu system is located in Chapter 2 of this manual. If the transmission fails continuously, contact the EDI Business Analyst Unit.

ACS processes the data through several validation and reformatting programs. The resulting edit/error report is used to determine if problems exist with your record formats.

An EDI Business Analyst will determine if problems exist with the format and will contact you with the results of your test.

# Chapter 4 Payer-Specific Data for West Virginia Workers' Compensation

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## EDI Support

The EDI Support Unit assists users with questions about electronic claims submission. ACS' EDI Support Unit is available to all Workers' Compensation clients and providers Monday through Friday from 8:00 a.m. to 6:00 p.m. EST. Contact the EDI Support Unit at 1-800-827-5328. The EDI Support Unit:

- Provides information on available services
- Enrolls users for claims submission
- Verifies receipt of electronic transmissions
- Provides technical assistance to users who are experiencing transmission difficulties

## Enrollment Information

Clearinghouses, billing agents, and providers using self-programmed systems who will be sending electronic claims to ACS for Workers' Compensation must complete a Workers' Compensation Electronic Media Agreement. This form provides ACS the information necessary to assign a Logon Name, Logon ID, and Submitter ID, which are required to submit electronic claims. You can obtain a copy of this form by contacting the EDI Support Unit at 1-800-827-5328, or by downloading it from our website at [www.acs-gcro.com](http://www.acs-gcro.com).

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## Transmission Telephone Number

ACS provides availability for claims transmission 24 hours a day, 7 days a week. There are no restrictions on the number of claims or the frequency of transmissions. The claims transmission telephone number is 1-850-385-7455.

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## Tracking Transmission/Production Problems

Please have the following information available when calling the EDI Support Unit regarding transmission and production issues.

**Submitter ID:** Your Submitter ID is our key to accessing your submitter information. Please have this number available each time you contact the EDI Support Unit.

***Logon Name and Logon User ID:*** These allow asynchronous submitters access to the host system for claims submission. The EDI Support Unit uses this information to reference your submitted data.

***File Name:*** When inquiring about the receipt of a transmission, please have the host system file name available. The host system file name, unique to each transmission, is found on each confirmation report. An example and explanation of the host system file name is found in Chapter 2 of this manual.

## **Claims Edits**

<b><i>Dates</i></b>	All dates must be numeric, valid dates												
<b><i>Records</i></b>	All records are 192 characters in length. Records must follow the sequence dictated by the West Virginia Workers' Compensation Uniform Billing format.												
<b><i>Fields</i></b>	Numeric fields must be unsigned, right-justified, zero-filled, and can only contain numeric characters (0-9).  Alphanumeric fields must be left-justified, space-filled, and can contain alpha (A-Z) and numeric (0-9) characters.												
<b><i>Control Characters</i></b>	The sequence of control characters must be correct on every record. There must be a carriage return character and a line feed character at the end of every line.												
<b><i>Field Requirements</i></b>	The FIELD REQ column on the CCHS Requirements Matrix uses these values:  <table><tr><td><b>R</b></td><td>Required</td><td><b>Record:</b> Must send this record <b>Field:</b> Claim can not be paid without this information.</td></tr><tr><td><b>C</b></td><td>Conditional</td><td>Under certain conditions, this information must be included for payment. See comments where necessary.</td></tr><tr><td><b>O</b></td><td>Optional</td><td>Does not affect processing.</td></tr><tr><td><b>-</b></td><td>Not Used</td><td>Not currently used.</td></tr></table>	<b>R</b>	Required	<b>Record:</b> Must send this record <b>Field:</b> Claim can not be paid without this information.	<b>C</b>	Conditional	Under certain conditions, this information must be included for payment. See comments where necessary.	<b>O</b>	Optional	Does not affect processing.	<b>-</b>	Not Used	Not currently used.
<b>R</b>	Required	<b>Record:</b> Must send this record <b>Field:</b> Claim can not be paid without this information.											
<b>C</b>	Conditional	Under certain conditions, this information must be included for payment. See comments where necessary.											
<b>O</b>	Optional	Does not affect processing.											
<b>-</b>	Not Used	Not currently used.											

***Field Definition***

The FIELD DEFINITION column on the CCHS Requirements Matrix uses standard COBOL methods for describing data.

**X(02)** = Where X denotes alphanumeric characters and 02 is the length of the data.

**9(06)** = Where 9 denotes numeric data and 06 is the length of the data

**9(07)v99** = Where the v denotes an implied decimal. This is the method for describing amount fields. The value to the left indicates a seven-character field with no decimal. The last two characters in the field represent the cents associated with the amount. The total length of this field is nine characters with no decimal.

## **UB-92 Format**

ACS uses version 050 of the National Uniform Billing Committee (NUBC) UB-92 format.

This sequence of file records identifies the order of the records and the type of record.

### Record Type

01	Processor Data
	10 Provider Data
	20 Patient Data
	30 Third Party Payer Data
	31 Third Party Payer Data
	34 Authorization
	40 Claim Data TAN-Occurrence
	41 Claim Data Condition-Value
	50 IP Accommodations Data
	60 IP Ancillary Services Data
	61 Outpatient Procedures
	70 Medical Data
	80 Physician Data
	90 Claim Control Screen
	91 Remarks
	95 Provider Batch Control
99	File Control

## **Highlights**

Please note the following:

- Inpatient and outpatient claim batches can be submitted in the same transmission file (01-99 record set).
- Users are assigned **one** five-digit Submitter ID for all claim types they send.
- The Receiver ID and Payer ID for West Virginia Workers' Compensation are now **"77025"**. Transmissions without this value in the appropriate fields will be not be processed.
- The Version Code on record 01 is required and must be "050".
- An 11-digit Workers' Compensation Original Submitter ID is required on the header record of all files. This number is assigned by Workers' Compensation.
- Unless otherwise indicated, use the UB92-defined values for data fields.
- Fields marked as "Required" are required for all claim types unless otherwise noted.
- Field 90-17.3, Date of Inquiry, required on every claim submitted to Workers' Compensation. Batches with claims without this date are rejected.
- Field 30-07, Insured's ID Number, is a nine-digit SSN. No claim numbers are accepted in this field. Batches with claims containing alphabetical characters or more than nine digits are rejected.

## CCHS REQUIREMENTS MATRIX

UB92

VER 050

PROCESSOR DATA

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
01-01	Record Type	X(02)	01	02	R	“01”
01-02	Submitter EIN	9(10)	03	12	R	Must match 99-02
01-03	Multiple Provider Billing File Indicator	9(01)	13	13	-	
01-04	Filler	X(17)	14	30	-	SPACES
01-05	Receiver Type Code	X(01)	31	31	R	“B” = Workers’ Comp.
01-06	Receiver Identification	9(05)	32	36	R	“77025” = Workers’ Comp. Assigned by ACS. Must match 95-03, 99-03.
01-07	Receiver Sub-Identification	X(04)	37	40	-	
01-08	Filler	9(06)	41	46	-	SPACES
01-09	Submitter Name	X(21)	47	67	R	
01-10	Submitter Address	X(18)	68	85	R	
01-11	Submitter City	X(15)	86	100	R	
01-12	Submitter State	X(02)	101	102	R	
01-13	Submitter Zip Code	X(09)	103	111	R	
01-14	Submitter Fax	9(10)	112	121	O	
01-15	Country Code	X(04)	122	125	-	
01-16	Submitter Telephone Number	9(10)	126	135	R	
01-17	File Sequence & Serial Number	X(07)	136	142	O	
01-18	Test/Production Indicator	X(04)	143	146	-	
01-19	Date of Receipt	9(08)	147	154	-	
01-20	Processing Date	9(08)	155	162	-	
01-21	<b>FILLER – Redefined by ACS</b>					
01-21.1	Submitter ID	9(05)	163	167	R	Five-digit ID assigned by ACS during enrollment
01-21.2	Vendor ID	X(05)	168	172	C	Assigned by ACS. Required for software vendors only.

## CCHS REQUIREMENTS MATRIX

UB92

PROCESSOR DATA

VER 050

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u> <u>FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
01-21.3	Filler	X(17)	173	178	-	Spaces
01-21.4	WVWC Submitter ID	X(11)	179	189	R	Eleven-digit ID assigned by Workers' Comp.
01-22	Version Code	X(03)	190	192	R	Must equal "050." File will reject if invalid.

## CCHS REQUIREMENTS MATRIX

UB92 PROVIDER DATA						VER 050
<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>RECORD REQUIRED COMMENTS</u>
10-01	Record Type	X(02)	01	02	R	“10”
10-02	Type of Batch	X(03)	03	05	R	Must match 95-05
10-03	Batch Number	9(02)	06	07	R	
10-04	Federal Tax Number or EIN	9(10)	08	17	R	
10-05	Federal Tax Sub ID	X(04)	18	21	-	
10-06	National Provider ID	X(13)	22	34	-	
10-07	Medicaid Provider Number	X(13)	35	47	-	
10-08	CHAMPUS Insurer Provider Number	X(13)	48	60	-	
10-09	Other Insurer Provider Number – 1	X(13)	61	73	R	Eleven-digit WVWC provider ID (Tax ID plus location code). Identifies provider to be paid.
10-10	Other Insurer Provider Number – 2	X(13)	74	86	-	
10-11	Provider Telephone Number	9(10)	87	96	R	
10-12	Provider Name	X(25)	97	121	R	
10-13	Provider Address	X(25)	122	146	R	
10-14	Provider City	X(14)	147	160	R	
10-15	Provider State	X(02)	161	162	R	
10-16	Provider ZIP Code	X(09)	163	171	R	
10-17	Provider FAX Number	9(10)	172	181	R	
10-18	Country Code	X(04)	182	185	-	
10-19	Filler	X(04)	186	189	-	SPACES
10-20	Filler	X(03)	190	192	-	SPACES

## CCHS REQUIREMENTS MATRIX

UB92 PATIENT DATA						VER 050
FIELD NO	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u>		<u>FIELD REQ</u>	<u>RECORD REQUIRED COMMENTS</u>
			<u>FROM</u>	<u>TO</u>		
20-01	Record Type	X(02)	1	2	R	“20”
20-02	Filler (National Use)	X(02)	3	4	-	SPACES
20-03	Patient Control Number	X(20)	5	24	R	Must be the same on each record within a claim (20-90 record set)
20-04	Patient Last Name	X(20)	25	44	R	
20-05	Patient First Name	X(09)	45	53	R	
20-06	Patient Middle Initial	X(01)	54	54	-	
20-07	Patient Sex	X(01)	55	55	-	
20-08	Patient Birthdate	9(08)	56	63	O	CCYYMMDD
20-09	Patient Marital Status	X(01)	64	64	-	
20-10	Type of Admission	X(01)	65	65	C	Required on inpatient claims
20-11	Source of Admission	X(01)	66	66	-	Required on inpatient claims
20-12	Patient Address - Line 1	X(18)	67	84	-	
20-13	Patient Address - Line 2	X(12)	85	96	-	
20-14	Patient City	X(15)	97	111	-	
20-15	Patient State	X(02)	112	113	-	
20-16	Patient ZIP Code	X(09)	114	122	-	
20-17	Admit / Start of Care Date	9(08)	123	130	O	CCYYMMDD
20-18	Admission Hour	X(02)	131	132	-	
20-19	Statement Covers From	9(08)	133	140	R	CCYYMMDD
20-20	Statement Covers Thru	9(08)	141	148	R	CCYYMMDD
20-21	Patient Status	9(02)	149	150	C	Required on inpatient claims. See Appendix A for valid values.

## CCHS REQUIREMENTS MATRIX

UB92 PATIENT DATA						VER 050
<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u>	<u>FROM TO</u>	<u>FIELD REQ</u>	<u>RECORD REQUIRED COMMENTS</u>
20-22	Discharge Hour	X(02)	151	152	C	Required on inpatient claims
20-23	Payments Received (Patient line)	9(08)v99	153	162	-	
20-24	Estimated Amount Due (Patient line)	9(08)v99	163	172	-	
20-25	Medical Record Number	X(17)	173	189	O	
20-26	Filler (National Use)	X(03)	190	192	-	SPACES

## CCHS REQUIREMENTS MATRIX – UB92

UB92 THIRD PARTY PAYER DATA						VER 050 RECORD REQUIRED
FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	TO	FIELD REQ	COMMENTS
30-01	Record Type	X(02)	1	2	R	“30”
30-02	Sequence Number	9(02)	3	4	R	
30-03	Patient Control Number	X(20)	5	24	R	Must be the same on each record within a claim (20-90 record set). Limited to 17 characters for WWWC.
30-04	Source of Payment Code	X(01)	25	25	R	“B” = Workers’ Comp.
30-05, 06	Payer Identification	X(05)	26	30	R	“77025” = Workers’ Comp. Assigned by ACS.
30-07	Insured’s ID Number	X(19)	35	53	R	SSN. Do not include dashes.
30-08a	Payer Identification Indicator	X(02)	54	55	-	
30-08b	Payer Name	X(23)	56	78	R	“WV Workers’ Comp”
30-09	Payer Code	X(01)	79	79	-	
30-10	Insurance Group Number	X(17)	80	96	-	
30-11	Insured Group Name	X(14)	97	110	-	
30-12	Insured’s Last Name	X(20)	111	130	-	
30-13	Insured’s First Name	X(09)	131	139	-	
30-14	Insured’s Middle Initial	X(01)	140	140	-	
30-15	Insured’s Sex	X(01)	141	141	-	
30-16	Release of Information Certification Indicator	X(01)	142	142	-	
30-17	Assignment of Benefits Certification Indicator	X(01)	143	143	-	
30-18	Patient’s Relationship to Insured	9(02)	144	145	-	
30-19	Employment Status Code	9(01)	146	146	-	

## CCHS REQUIREMENTS MATRIX – UB92

UB92 THIRD PARTY PAYER DATA						VER 050 RECORD REQUIRED
<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u> <u>FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
30-20	Covered Days	9(03)	147	149	-	
30-21	Noncovered Days	9(04)	150	153	-	
30-22	Coinsurance Days	9(03)	154	156	C	
30-23	Lifetime Reserve Days	9(03)	157	159	O	
30-24	Provider Identification No	X(13)	160	172	-	
30-25	Payments Received	9(08)v99	173	182	C	WVWC limited to 9(5)v99
30-26	Estimated Amount Due	9(08)v99	183	192	O	

### CCHS REQUIREMENTS MATRIX

UB92  
THIRD PARTY PAYER DATA  
FIELD

VER 050  
RECORD OPTIONAL

<u>NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
31-01	Record Type	X(02)	1	2	R	“31”
31-02	Sequence Number	9(02)	3	4	R	Must match corresponding “30” record.
31-03	Patient Control Number	X(20)	5	24	R	
31-04	Insured’s Address – Line 1	X(18)	25	42	-	
31-05	Insured’s Address – Line 2	X(12)	43	54	-	
31-05A	Filler	X(6)	55	60	-	SPACES
31-06	Insured’s City	X(15)	61	75	-	
31-07	Insured’s State	X(02)	76	77	-	
31-08	Insured’s ZIP Code	X(09)	78	86	-	
31-09	Employer Name	X(24)	87	110	-	
31-10	Employer Address	X(18)	111	128	-	
31-11	Employer City	X(15)	129	143	-	
31-12	Employer State	X(02)	144	145	-	
31-13	Employer ZIP Code	X(09)	146	154	-	
31-14	Form Locator 37 (ICN/DCN)	X(23)	155	177	-	
31-15	Contract Number	X(5)	178	182	-	
31-16	Filler (National Use)	X(10)	183	192	-	SPACES

## CCHS REQUIREMENTS MATRIX

UB92

CLAIM DATA TAN – OCCURRENCE

VER 050

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
40-01	Record Type	X(02)	1	2	R	“40”
40-02	Sequence Number	9(02)	3	4	R	
40-03	Patient Control Number	X(20)	5	24	R	Must be the same on each record within a claim (20-90 record set). Limited to 17 characters for WVWC.
40-04	Type of Bill	X(03)	25	27	R	Must match “10” record
40-05	Treatment Authorization Code-A	X(18)	28	45	C	Nine-character Prior Authorization number assigned by WVWC, if applicable.
40-06	Treatment Authorization Code-B	X(18)	46	63	-	
40-07	Treatment Authorization Code-C	X(18)	64	81	-	
40-08	Occurrence Code - 1	X(02)	82	83	-	
40-09	Occurrence Date - 1	9(08)	84	91	-	CCYYMMDD
40-10	Occurrence Code - 2	X(02)	92	93	-	
40-11	Occurrence Date - 2	9(08)	94	101	-	CCYYMMDD
40-12	Occurrence Code - 3	X(02)	102	103	-	
40-13	Occurrence Date - 3	9(08)	104	111	-	CCYYMMDD
40-14	Occurrence Code - 4	X(02)	112	113	-	
40-15	Occurrence Date - 4	9(08)	114	121	-	CCYYMMDD
40-16	Occurrence Code - 5	X(02)	122	123	-	
40-17	Occurrence Date - 5	9(08)	124	131	-	CCYYMMDD
40-18	Occurrence Code - 6	X(02)	132	133	-	
40-19	Occurrence Date - 6	9(08)	134	141	-	CCYYMMDD

## CCHS REQUIREMENTS MATRIX

UB92

CLAIM DATA TAN – OCCURRENCE

VER 050

RECORD REQUIRED

FIELD

<u>NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
40-20	Occurrence Code - 7	X(02)	142 143	-	
40-21	Occurrence Date - 7	9(08)	144 151	-	CCYYMMDD
40-22	Occurrence Span Code - 1	X(02)	152 153	-	
40-23	Occurrence Span From Date - 1	9(08)	154 161	-	
40-24	Occurrence Span Thru Date - 1	9(08)	162 169	-	
40-25	Occurrence Span Code - 2	X(02)	170 171	-	
40-26	Occurrence Span From Date - 2	9(08)	172 179	-	
40-27	Occurrence Span Thru Date - 2	9(08)	180 187	-	
40-28	Filler (National Use)	X(05)	188 192	-	SPACES

## CCHS REQUIREMENTS MATRIX

UB92 CLAIM DATA CONDITION – VALUE						VER 050 RECORD REQUIRED
<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
41-01	Record Type	X(02)	1	2	R	“41”
41-02	Sequence Number	9(02)	3	4	R	
41-03	Patient Control Number	X(20)	5	24	R	Must be the same on each record within a claim (20-90 record set). Limited to 17 characters for WVWC.
41-04	Condition Code - 1	X(02)	25	26	-	
41-05	Condition Code - 2	X(02)	27	28	-	
41-06	Condition Code - 3	X(02)	29	30	-	
41-07	Condition Code - 4	X(02)	31	32	-	
41-08	Condition Code - 5	X(02)	33	34	-	
41-09	Condition Code - 6	X(02)	35	36	-	
41-10	Condition Code - 7	X(02)	37	38	-	
41-11	Condition Code - 8	X(02)	39	40	-	
41-12	Condition Code - 9	X(02)	41	42	-	
41-13	Condition Code - 10	X(02)	43	44	-	
41-14	Form Locator 31 (upper)	X(05)	45	49	-	
41-15	Form Locator 31 (lower)	X(06)	50	55	-	
41-16	Value Code - 1	X(02)	56	57	-	
41-17	Value Amount - 1	9(07)v99	58	66	-	
41-18	Value Code - 2	X(02)	67	68	-	
41-19	Value Amount - 2	9(07)v99	69	77	-	
41-20	Value Code - 3	X(02)	78	79	-	

## CCHS REQUIREMENTS MATRIX

UB92  
CLAIM DATA CONDITION – VALUE

VER 050  
RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
41-21	Value Amount - 3	9(07)v99	80	88	-	
41-22	Value Code - 4	X(02)	89	90	-	
41-23	Value Amount - 4	9(07)v99	91	99	-	
41-24	Value Code - 5	X(02)	100	101	-	
41-25	Value Amount - 5	9(07)v99	102	110	-	
41-26	Value Code - 6	X(02)	111	112	-	
41-27	Value Amount - 6	9(07)v99	113	121	-	
41-28	Value Code - 7	X(02)	122	123	-	
41-29	Value Amount - 7	9(07)v99	124	132	-	
41-30	Value Code - 8	X(02)	133	134	-	
41-31	Value Amount - 8	9(07)v99	135	143	-	
41-32	Value Code - 9	X(02)	144	145	-	
41-33	Value Amount - 9	9(07)v99	146	154	-	
41-34	Value Code - 10	X(02)	155	156	-	
41-35	Value Amount - 10	9(07)v99	157	165	-	
41-36	Value Code - 11	X(02)	166	167	-	
41-37	Value Amount - 11	9(07)v99	168	176	-	
41-38	Value Code - 12	X(02)	177	178	-	
41-39	Value Amount - 12	9(07)v99	179	187	-	
41-40	Filler (National Use)	X(05)	188	192	-	Spaces

## CCHS REQUIREMENTS MATRIX

UB92  
INPATIENT ACCOMODATIONS DATA

VER 050  
RECORD CONDITIONAL

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
50-01	Record Type	X(02)	1	2	R	“50”
50-02	Sequence Number	9(02)	3	4	R	
50-03	Patient Control Number	X(20)	5	24	R	Must be the same on each record within a claim (20-90 record set). Limited to 17 characters for WVWC.
	<b>Accommodations - 1</b>	<b>X(42)</b>	<b>25</b>	<b>66</b>		
50-04	Accommodations Revenue Code	9(04)	25	28	C	Not required when DRG code used.
50-05	Accommodations Rate	9(07)v99	29	37	C	Required on Inpatient claims. WVWC limited to 9(05)v99.
50-06	Accommodations Days	9(04)	38	41	R	
50-07	Accommodations Total Charges	9(08)v99	42	51	R	WVWC limited to 9(05)v99.
50-08	Accommodations Noncovered Charges	9(08)v99	52	61	R	WVWC limited to 9(05)v99.
50-09	Form Locator 49	X(04)	62	65	-	
50-10	Filler (National Use)	X(01)	66	66	-	SPACES
50-11	Accommodations - 2	X(42)	67	108	C	
50-12	Accommodations - 3	X(42)	109	150	C	
50-13	Accommodations - 4	X(42)	151	192	C	

## CCHS REQUIREMENTS MATRIX

UB92

VER 050

INPATIENT ANCILLARY SERVICES DATA

RECORD CONDITIONAL

FIELD NO	FIELD NAME	FIELD DEF	POSITION FROM	TO	FIELD REQ	COMMENTS
60-01	Record Type	X(02)	1	2	R	“60”
60-02	Sequence Number	9(02)	3	4	R	
60-03	Patient Control Number	X(20)	5	24	R	
	<b>Inpatient Ancillaries - 1</b>	<b>X(56)</b>	<b>25</b>	<b>80</b>		
60-04	Inpatient Ancillary Revenue Code	9(04)	25	28	C	Not required when DRG code used.
60-05	HCPCS Procedure Code/HIPPS	X(05)	29	33	-	
60-06	Modifier 1 (HCPCS & CPT-4)	X(02)	34	35	-	
60-07	Modifier 2 (HCPCS & CPT-4)	X(02)	36	37	-	
60-08	Inpatient Ancillary Units of Service	9(07)	38	44	R	Default = “1”
60-09	Inpatient Ancillary Total Charges	9(8)v99	45	54	C	Not required when DRG code used. WVWC limited to 9(05)v99
60-10	Inpatient Ancillary Noncovered Charges	9(8)v99	55	64	R	WVWC limited to 9(05)v99
60-11	Form Locator 49	X(04)	65	68	-	
60-12	Assessment Date	X(08)	69	76	-	
60-12a	Filler (National Use)	X(04)	77	80	-	SPACES
60-13	Inpatient Ancillaries - 2	X(56)	81	136	C	
60-14	Inpatient Ancillaries - 3	X(56)	137	192	C	

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## CCHS REQUIREMENTS MATRIX

UB92  
OUTPATIENT PROCEDURES

VER 050  
RECORD CONDITIONAL

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u> <u>FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
61-01	Record Type	X(02)	1	2	R	“61”
61-02	Sequence Number	9(02)	3	4	R	
61-03	Patient Control Number	X(20)	5	24	R	
	<b>Revenue Center - 1</b>	<b>X(56)</b>	<b>25</b>	<b>80</b>		
61-04	Revenue Center Code	9(04)	25	28	C	Not required when DRG code used. Required on outpatient.
61-05	HCPCS Procedure Code	X(05)	29	33	-	
61-06	Modifier 1 (HCPCS & CPT-4)	X(02)	34	35	-	
61-07	Modifier 2 (HCPCS & CPT-4)	X(02)	36	37	-	
61-08	Units of Service	9(07)	38	44	R	
61-09	Form Locator 49	X(06)	45	50	-	
61-10	Outpatient Total Charges	9(8)v99	51	60	C	Not required when DRG code used. WVWC limited to 9(05)v99.
61-11	Outpatient Noncovered Charges	9(8)v99	61	70	R	WVWC limited to 9(05)v99.
61-12	Date of Service	X(8)	71	78	-	Not used by WVWC.
61-13	Filler (National Use)	X(02)	79	80	-	SPACES
61-14	Revenue Center - 2	X(56)	81	136	C	
61-15	Revenue Center - 3	X(56)	137	192	C	

Rev.4/1002

## CCHS REQUIREMENTS MATRIX

UB92  
MEDICAL DATA

VER 050  
RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
			<u>FROM</u>	<u>TO</u>		
70-01	Record Type	X(02)	1	2	R	“70”
70-02	Sequence	9(02)	3	4	R	Must be “01”
70-03	Patient Control Number	X(20)	5	24	R	
70-04	Principal Diagnosis Code	X(06)	25	30	R	
70-05	Other Diagnosis Code – 1	X(06)	31	36	O	
70-06	Other Diagnosis Code – 2	X(06)	37	42	O	
70-07	Other Diagnosis Code – 3	X(06)	43	48	O	
70-08	Other Diagnosis Code – 4	X(06)	49	54	O	
70-09	Other Diagnosis Code – 5	X(06)	55	60	O	
70-10	Other Diagnosis Code - 6	X(06)	61	66	O	
70-11	Other Diagnosis Code - 7	X(06)	67	72	O	
70-12	Other Diagnosis Code - 8	X(06)	73	78	O	
70-13	Principal Procedure Code	X(07)	79	85	O	
70-14	Principal Procedure Date	9(08)	86	93	O	CCYYMMDD
70-15	Other Procedure Code - 1	X(07)	94	100	O	
70-16	Other Procedure Date - 1	9(08)	101	108	O	CCYYMMDD
70-17	Other Procedure Code – 2	X(07)	109	115	O	
70-18	Other Procedure Date - 2	9(08)	116	123	O	CCYYMMDD
70-19	Other Procedure Code - 3	X(07)	124	130	O	
70-20	Other Procedure Date – 3	9(08)	131	138	O	CCYYMMDD
70-21	Other Procedure Code – 4	X(07)	139	145	O	

## CCHS REQUIREMENTS MATRIX

UB92  
MEDICAL DATA  
FIELD

VER 050  
RECORD REQUIRED

<u>NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u> <u>FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
70-22	Other Procedure Date – 4	9(08)	146	153	O	CCYYMMDD
70-23	Other Procedure Code – 5	X(07)	154	160	O	
70-24	Other Procedure Date – 5	9(08)	161	168	O	CCYYMMDD
70-25	Admitting Diagnosis Code	X(06)	169	174	O	
70-26	External Cause of Injury (E-Code)	X(06)	175	180	O	
70-27	Procedure Coding Method Used	9(01)	181	181	O	
70-28	Filler (National Use)	X(11)	182	192	-	SPACES

## CCHS REQUIREMENTS MATRIX

UB92  
PHYSICIAN DATA

VER 050  
RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
80-01	Record Type	X(02)	1	2	R	“80”
80-02	Sequence	9(02)	3	4	R	
80-03	Patient Control Number	X(20)	5	24	R	
80-04	Physician Number Qualifying Codes	X(02)	25	26	O	
80-05	Attending Physician Number	X(16)	27	42	O	
80-06	Operating Physician Number	X(16)	43	58	O	
80-07	Other Physician Number	X(16)	59	74	C	Eleven-digit WVWC provider ID (Tax ID plus two-digit location code). Identifies referring provider
80-08	Other Physician Number	X(16)	75	90	O	
80-09	Attending Physician Name	X(25)	91	115	O	
80-10	Operating Physician Name	X(25)	116	140	O	
80-11	Other Physician Name	X(25)	141	165	O	
80-12	Other Physician Name	X(25)	166	190	O	
80-13	Filler (National Use)	X(02)	191	192	-	SPACES

## CCHS REQUIREMENTS MATRIX

UB92 CLAIM CONTROL SCREEN						VER 050 RECORD REQUIRED
<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
90-01	Record Type	X(02)	1	2	R	“90”
90-02	Filler (National Use)	X(02)	3	4	-	SPACES
90-03	Patient Control Number	X(20)	5	24	R	
90-04	Physical Record Count (Excluding RT 90 + 91)	9(03)	25	27	R	
90-05	Record Type 2n Count	9(02)	28	29	R	
90-06	Record Type 3n Count	9(02)	30	31	R	
90-07	Record Type 4n Count	9(02)	32	33	R	
90-08	Record Type 5n Count	9(02)	34	35	R	
90-09	Record Type 6n Count	9(02)	36	37	R	
90-10	Record Type 7n Count	9(02)	38	39	R	
90-11	Record Type 8n Count	9(02)	40	41	R	
90-12	Record Type 91 Qualifier	9(01)	42	42	C	
90-13	Total Accommodation Charges Revenue Centers Noncovered	9(08)v99	43	52	R	WVWC limited to 9(05)v99. <span style="float: right;">Rev.4/1002</span>
90-14	Accommodation Charges – Revenue Centers	9(08)v99	53	62	R	WVWC limited to 9(05)v99.
90-15	Total Ancillary Charges Revenue Centers	9(08)v99	63	72	R	WVWC limited to 9(05)v99. <span style="float: right;">Rev.4/1002</span>
90-16	Noncovered Ancillary Charges - Revenue Centers	9(08)v99	73	82	R	WVWC limited to 9(05)v99.
90-17	<b>Remarks Redefined by ACS</b>					
90-17.1	DRG CODE	X(03)	83	85	C	DRG Code, if none spaces
90-17.2	Discharge Destination	X(01)	86	86	C	Required on inpatient claims. See Appendix A for valid values.
90-17.3	Date of Injury	X(08)	87	94	R	CCYYMMDD
90-17.4	Remarks	X(98)	95	192	-	Spaces

## CCHS REQUIREMENTS MATRIX

UB92 PROVIDER BATCH CONTROL						VER 050 RECORD REQUIRED
<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION</u>	<u>FROM TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
95-01	Record Type	X(02)	1	2	R	“95”
95-02	Federal Tax Number (EIN)	9(10)	3	12	R	
95-03	Receiver Identification	9(05)	13	17	R	“77025” = WVWC. Assigned by ACS. Must match 01-06,99-03.
95-04	Receiver Sub-Identification	X(04)	18	21	-	Must match 10-02
95-05	Type of Batch	X(03)	22	24	R	
95-06	Number of Claims	9(06)	25	30	R	
95-07	Filler (National Use)	X(06)	31	36	-	SPACES
95-08	Accommodations Total Charges for the Batch	9(10)v99	37	48	R	
95-09	Accommodations Noncovered Charges for the Batch	9(10)v99	49	60	R	
95-10	Ancillary Total Charges for the Batch	9(10)v99	61	72	R	WVWC limited to 9(07)v99.
95-11	Ancillary Noncovered Charges for the Batch	9(10)v99	73	84	R	WVWC limited to 9(05)v99.
95-12	Filler (National Use)	X(54)	85	138	-	SPACES
95-13	Filler (Local Use)	X(54)	139	192	-	SPACES

## CCHS REQUIREMENTS MATRIX

UB92  
FILE CONTROL

VER 050  
RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
99-01	Record Type	X(02)	1	2	R	“99”
99-02	Submitter EIN	9(10)	3	12	R	Must match 01-02
99-03	Receiver Identification	9(05)	13	17	R	“77025” = Workers’ Comp. Assigned by ACS. Must match 01-06, 95-03.
99-04	Receiver Sub-Identification	X(04)	18	21	C	
99-05	Number of Batches Billed this File	9(04)	22	25	R	
99-06	Accommodations Total Charges for the File	9(11)v99	26	38	R	WVWC limited to 9(07)v99.
99-07	Accommodations Noncovered Charges for the File	9(11)v99	39	51	R	WVWC limited to 9(05)v99.
99-08	Ancillary Total Charges for the File	9(11)v99	52	64	R	WVWC limited to 9(07)v99.
99-09	Ancillary Noncovered Charges for the File	9(11)v99	65	77	R	WVWC limited to 9(05)v99.
99-10	Filler (National Use)	X(58)	78	135	-	SPACES
99-11	<b>FILLER – Redefined by ACS</b>					
99-11.1	Submitter ID	X(05)	136	140	R	Five-digit ID assigned by ACS.
99-11.2	Filler	X(52)	141	192	-	SPACES

## Appendix A: Valid Values

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### Valid values for Patient Status field 20-21

<u>Value</u>	<u>Description</u>
01	Discharged
02	Transferred to general hospital
03	Transferred to skilled nursing facility
04	Transferred to intermediate care facility
05	Transferred to other
07	Left against medical advice
10	Transferred to mental health facility
20	Expired
30	Still a patient

### Valid values for Discharge Destination field 90-17.2

<u>Value</u>	<u>Description</u>
1	Transferred to Hospital
2	Transferred to Other
3	Transferred to Nursing Home
4	Patient Died
5	Discharged
7	Transferred to State Hospital
8	Leave of Absence