CALIFORNIA MEDICAL BILL PAYMENT DICTIONARY
Version 1.0

ADMISSION DATE – DN513
Definition: Inpatient/Outpatient hospital admission date.
Revised: 09/26/98
Business Need: Verify date(s) of service and length of stay.
Source: UB92 Field 17
Format: ANSI A/N 1/35 IAIABC DATE 8

ADMITTING DIAGNOSIS CODE – DN535
Definition: Code indicating admitting diagnosis.
Revised: 09/26/98
Business Need: Monitor quality of medical care.
Source: UB92 Field 76
Format: ANSI A/N 1/30 IAIABC ID6
Values: See Appendix – A131
Imp Note: Used when Code List Qualifier – ANSI DE 1270 = BJ. Decimal point is required.

BASIS OF COST DETERMINATION – DN565
Definition: Method by which drug cost was calculated.
Revised: 09/26/98
Business Need: Statistical analysis and cost comparison. Source: Payor
Format: ANSI ID 1/2 IAIABC ID 2
Values: 0 = Not Specified
1 = Average Wholesale Price (AWP)
2 = Local Wholesaler
3 = Direct
4 = Estimated Acquisition Cost
5 = Acquisition Cost
6 = Maximum Allowable Cost (MAC) 7 = Usual, Customary and Reasonable (UCR)
8 = Unit Dose
9 = Brand Medically Necessary

BILL ADJUSTMENT AMOUNT – DN545
Definition: The amount of the adjustment identified by the Bill Adjustment Reason Code (DN544) at the bill level.
Revised: 03/21/99
Business Need: Required in order to access the appropriateness of the adjustment or the basis of the adjustment being made.
Source: Payor
Format: ANSI R 1/18 IAIABC $9.2
Values: See Appendix – A139
Max Occur: 3

BILL ADJUSTMENT GROUP CODE – DN543

Definition: Codes indicating general category of payment adjustment at the bill level.
Revised: 09/26/98
Business Need: Identifies potential litigation; tracking medical costs; used for statistical analysis.
Source: Payor
Format: ANSI ID 1/2 IAIABC ID 2
Values: CO = Contractual Obligations
MA = Medicare (Jurisdictional Regulatory Requirement)
OA = Other Adjustments
PI = Payor initiated reductions
PR = Patient Responsibility

BILL ADJUSTMENT REASON CODE

Definition: Codes indicating detailed reason an adjustment was made at the bill level.
Revised: 09/26/98
Business Need: Required in order to access the appropriateness of the adjustment or the basis of the adjustment being made.
Source: Payor
Format: ANSI ID 1/5 IAIABC ID 3
Values: See Appendix – A139
Max Occur: 3

BILL ADJUSTMENT UNITS – DN546

Definition: The number of units applicable to the Bill Adjustment Amount (DN545) at the bill level.
Revised: 03/21/99
Business Need: Required in order to access the appropriateness of the adjustment or the basis of the adjustment being made.
Source: Payor
Format: ANSI R 1/15 IAIABC N7
Max Occur: 3

BILL SUBMISSION REASON CODE – DN508

Definition: Code indicating bill submission/re-submission type.
Revised: 09/26/98
Business Need: Determine status and reason for submission; monitors medical costs.
Source: Payor
Format: ANSI ID 2/2 IAIABC ID 2
Values: Claim Submission Reason – ANSI DE1383
00 = Original
This is the first time a medical bill is submitted to the jurisdiction, including the re-submission of a medical bill that was rejected due to a critical error.
01 = Cancellation
The original bill was sent in error. This transaction cancels the original (00)
02 = Corrected and verified original claim (bill)
This corrected data element value is transmitted in response to an acknowledgment containing non-critical errors (TE – Transaction accepted with errors)
05 = Replace
This is a complete or partial replacement of a medical bill that was previously sent. MUST have a "00" or "09" on file. A complete or partial replacement will be determined in the trading partner table.
09 = Encounter
This is a submission of data within a pre-paid managed care context.
Imp Note: If value is 09 = Encounter, billing or reimbursement information may not be sent.

BILLING FORMAT CODE – DN503

Definition: Code indicating if data is from a UB92 or HCFA 1500.
Revised: 09/26/98
Business Need: Identifies source document billing data.
Source: Payor
Format: ANSI ID 1/2 IAIABC ID 2
Values: A = UB92
B = HCFA 1500
Imp Note: If the bill is not a UB92 or HCFA 1500, use "B" as the default.

BILLING PROVIDER FEIN – DN629

Definition: Federal Tax ID number of the billing provider.
Revised: 09/26/98
Business Need: Identification of health care provider; monitor provider's compliance with treatment guidelines.
Source: HCFA Field 25 UB92 Field 5
Format: ANSI A/N 2/80 IAIABC A/N 9
Imp Note: If billing provider does not have an assigned FEIN, submit an assigned Social Security Number.

BILLING PROVIDER LAST/GROUP NAME – DN528

Definition: This is the person or organization receiving payment. It is assumed to be the rendering provider for all services unless a specific rendering provider is identified at the bill or service line levels. If the billing provider is a non-person, a specific individual rendering provider may be required by a jurisdiction.
Revised: 09/26/98
Business Need: Identification of provider; monitor provider's compliance with treatment guidelines.
Source: HCFA Field 33 UB92 Field 1
Format: ANSI A/N 1/35 IAIABC A/N 40

BILLING PROVIDER POSTAL CODE – DN542

Definition: Postal code of provider's mailing address of the billing provider.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: HCFA Field 33 UB92 Field 1
Format: ANSI ID 3/15 IAIABC A/N 9
Values: See Appendix – A51

BILLING PROVIDER PRIMARY SPECIALTY CODE – DN537

Definition: Code indicating primary medical specialty of billing provider.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 1/30 IAIABC ID 10
Values: See Appendix – B2

BILLING PROVIDER STATE LICENSE NUMBER – DN630

Definition: The specific license number issued by a jurisdiction to billing provider that licenses the provider to practice in that jurisdiction.
Revised: 09/26/98
Business Need: Identification of provider; monitor compliance of health care providers for compliance with fee and treatment guidelines.
Source: Jurisdictional Licensing Board
Format: ANSI A/N 1/30 IAIABC A/N 30

BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER – DN523

Definition: The unique number assigned by the billing provider to a specific bill within a batch of bills that are being sent to the payor.
Revised: 09/25/98
Business Need: Track billing provider information.
Source: Health Care Provider
Format: ANSI A/N 1/38 IAIABC A/N 30

BILLING TYPE CODE – DN502

Definition: Code indicating type of bill.
Revised: 09/26/98
Business Need: Statistical analysis and audit information, tracing medical costs.
Source: Health Care Provider and/or Payor
Format: ANSI ID 1/2 IAIABC ID 2
Values: Non-Institutional Claim Type Code – ANSI DE 1343:
DM = Durable Medical
MO = Mail Order Drug

RX = Pharmacy or Drug

CLAIM ADMINISTRATOR CLAIM NUMBER – DN15
Definition: An identifier, which distinguishes a specific, claim within a claim administrator's claims processing system.
Revised: 09/25/98
Business Need: Used to identify a specific claim throughout the life of the claim.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 1/30 IAIABC A/N 25

CLAIM ADMINISTRATOR FEIN – DN187
Definition: The FEIN of the entity licensed or allowed by a jurisdiction to adjust a claim.
Revised: 07/01/97
Business Need: Used to identify a specific claim administrator throughout the life of the claim.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 2/80 IAIABC A/N 9
Imp Note As there exists a one-to-one relationship between a Claim Administrator State ID and the Claim Administrator FEIN, this will replace Claim Administrator State ID. If a state utilizes a unique Claim Administrator State ID, they must build a crosswalk table prior to testing/implementation.

CLAIM ADMINISTRATOR NAME – DN188
Definition: The entity licensed or allowed by a jurisdiction to adjust a claim that is:
- Designated to answer inquiries and resolve issues
- Performing but may have subcontracted portion(s) of the adjusting process
- Submitting or contracting jurisdiction reporting.
Revised: 07/01/97
Business Need: Identifies specific claim administrator.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 1/35 & 1/60 IAIABC A/N 40
Imp Note: For ANSI, a combination of segments NM1 and N2. NM103 contains the first 35 characters and if necessary N2 contains the remaining characters.
Imp Note: Always required. May match Insurer Name. May be determined respectively when Insurer/Claim Administrator is/is not the same.

CONTRACT TYPE CODE – DN515
Definition: Code indicating the bill level contractual arrangement for provider reimbursement.
Revised: 09/26/98
Business Need: Statistical analysis for various reimbursement arrangements.
Source: Health Care Provider and/or Payor
Format: ANSI ID 2/2 IAIABC ID 2
Values: Contract Type Code – ANSI DE 1166
01 = Diagnosis Related Group
02 = Per Diem
03 = Variable per diem
04 = Flat – fee for service
05 = Capitate
06 = Percent
09 = Other

DATE INSURER PAID BILL – DN512
Definition: Date insurer or financially responsible party paid bill or received credit from provider.
Revised: 09/26/98
Business Need: Measure carrier/adjuster performance and determine timeliness of payment.
Source: Payor
Format: ANSI A/N 1/35 IAIABC DATE 8

DATE INSURER RECEIVED BILL – DN511
Definition: Date insurer received bill from provider.
Revised: 09/26/98
Business Need: Determine timeliness of payment.
Source: Payor
Format: ANSI A/N 1/35 IAIABC DATE 8

DATE OF BILL – DN510
Definition: Provider's bill date.
Revised: 09/26/98
Business Need: External audit information and timeliness of submission.
Source: HCFA Field 31 UB92 Field 86
Format: ANSI A/N 1/35 IAIABC DATE 8

DATE OF INJURY – DN31
Definition: For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.
Revised: 03/11/94; 07/01/97
Business Need: To determine compensability.
Source: HCFA Field 14 UB92 Field 2
Format: ANSI A/N 1/35 IAIABC DATE 8

DAY(S)/UNIT(S) BILLED – DN554
Definition: Number of services billed per line item in days or units.
Revised: 09/26/98
Business Need: Statistical analysis and measurement of cost/treatment codes.
Source: HCFA Field 24G UB92 Field 46
Format: ANSI R 1/15 IAIABC N7

DAY(S)/UNIT(S) CODE – DN553
Definition: Code indicating days/units paid or billed.
Revised: 09/26/98
Business Need: Internal/external analysis.
Source: Health Care Provider
Format: ANSI ID 2/2 IAIABC ID2
Values: DA = Days
MJ = Minutes
UN = Units

DIAGNOSIS POINTER – DN557

Definition: Points to all diagnosis code(s) for which the medical services were rendered.
Revised: 09/26/98
Business Need: Measure cost trends; monitor quality of medical care.
Source: HCFA Field 24E
Format: ANSI N0 1/2 IAIABC A/N 1
Values: 1-4
Max Occur: 4
Imp Note: Applicable only for HCFA 1500. The Diagnosis Pointers references the ICD-9 CM Diagnosis Codes that relate to the line item.

DISCHARGE DATE – DN514

Definition: The date the claimant was discharged from the facility.
Revised: 09/26/98
Business Need: Measure medical outcomes; cost trends.
Source: UB92 Field 33 through any one of 34, 35, or 36 with the Occurrence code of 42.
Format: ANSI A/N 1/35 IAIABC DATE 8
Imp Note: If the Statement Covers Period Through date in box 6 is not equal to the discharge date, then the occurrence code in field 33, 34, 35, or 36 must equal 42.

DISPENSE AS WRITTEN CODE – DN562

Definition: A code denoting methodology utilized in dispensing medication.
Revised: 09/26/98
Business Need: Measuring medical cost trends; managed care certification, impact of medical treatment guidelines.
Source: Health Care Provider
Format: ANSI ID 1/1 IAIABC ID 1
Values: Dispense as Written Code – ANSI DE 1329
0 = Not dispense as written
1 = Physician dispense as written
2 = Patient dispense as written
3 = Pharmacy dispense as written
4 = No generic available
5 = Brand dispensed as generic
6 = Override
7 = Substitution not allowed – brand name drug mandated by law
8 = Substitution not allowed – generic not available in marketplace
9 = Other

DME BILLING FREQUENCY CODE – DN567

Definition: Code indicating frequency of billing Durable Medical Equipment (DME).
Revised: 09/26/98
Business Need: Measure cost trends and impact of managed care; monitoring compliance with fee schedules.
Source: Health Care Provider
Format: ANSI ID 1/1 IAIABC ID 1
Values: Frequency Code – ANSI DE 594
1 = Weekly
4 = Monthly
6 = Daily

DRG CODE – DN518

Definition: Code indicating the diagnostic related group.
Revised: 09/26/98
Business Need: Monitor utilization of medical expenses.
Source: Health Care Provider
Format: ANSI A/N 1/30 IAIABC ID 5
Values: See Appendix – A229

DRUG NAME – DN563
Definition: Name of the dispensed drug.
Revised: 09/26/98
Business Need: Monitor medical cost trends.
Source: Health Care Provider
Format: ANSI A/N 1/80 IAIABC A/N 40

DRUGS/SUPPLIES BILLED AMOUNT – DN572
Definition: Amount billed for drugs/supplies.
Revised: 09/26/98
Business Need: Monitor medical cost trends; utilization review.
Source: Health Care Provider
Format: ANSI R 1/18 IAIABC $9.2

DRUGS/SUPPLIES DISPENSING FEE – DN579
Definition: Amount billed for dispensing drugs/supplies.
Revised: 09/26/98
Business Need: Monitor medical cost trends; utilization review.
Source: Health Care Provider
Format: ANSI R 1/18 IAIABC $9.2

DRUGS/SUPPLIES NUMBER OF DAYS – DN571
Definition: Number of units of drugs/supplies.
Revised: 09/26/98
Business Need: Monitor medical cost trends; utilization review.
Source: Health Care Provider
Format: ANSI R 1/15 IAIABC N4

DRUGS/SUPPLIES QUANTITY DISPENSED – DN570
Definition: Number of units of drugs/supplies dispensed.
Revised: 09/26/98
Business Need: Monitor medical cost trends.
Source: Health Care Provider
Format: ANSI R 1/15 IAIABC N4

EMPLOYEE EMPLOYMENT VISA – DN152
Definition: The number assigned to an endorsement to a passport, by the proper authority, to note examination of the passport, and authorization of the bearer to proceed.
Revised: 07/01/97
Business Need: Identification of employee in jurisdiction's system.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 2/80 IAIABC A/N 15

EMPLOYEE FIRST NAME – DN44
Definition: The employee's legally recognized first name.
Revised: 06/07/95; 07/01/97
Business Need: Identification of employee in jurisdiction's system.
Source: HCFA Field 2 UB92 Field 12

Format: ANSI A/N 1/25 IAIABC A/N 15

EMPLOYEE GREEN CARD – DN153
Definition: The number assigned by the United State Government and issued on an Official Document to foreign nationals permitting them to work in the United States. (Alien identification number)
Revised: 07/01/97
Business Need: Identification of employee in jurisdiction's system.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 2/80 IAIABC A/N 15

EMPLOYEE LAST NAME – DN43
Definition: The employee's legally recognized last name.
Revised: 06/07/95; 07/01/97
Business Need: Identification of employee in jurisdiction's system.
Source: HCFA Field 2 UB92 Field 12
Format: ANSI A/N 1/35 IAIABC A/N 40
Imp Note: Last name will not include suffix.

EMPLOYEE MIDDLE NAME/INITIAL – DN45
Definition: The employee's legally recognized middle name or initial.
Revised: 09/26/98
Business Need: Identification of employee in jurisdiction system.
Source: HCFA Field 2 IAIABC Field 12
Format: ANSI A/N 1/25 IAIABC A/N 15

EMPLOYEE PASSPORT NUMBER – DN156
Definition: The number assigned to an officially recognized passport by a country's government, to one of its citizens, that authenticates the bearer's identity citizenship right to protection while abroad, and right to re-enter his or her native country.
Revised: 07/01/97
Business Need: Identification of employee to establish key in jurisdiction's system.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 2/80 IAIABC A/N 15

EMPLOYEE SSN – DN42
Definition: An identification number, issued by the Social Security Administration, used to record an individual's reported wages or self-employment income.
Revised: 06/07/95; 07/01/97
Business Need: Identification of employee in jurisdiction's system.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 2/80 IAIABC A/N 15

FACILITY CODE – DN504
Definition: Code indicating type of facility where treatment was rendered.
Revised: 09/26/98
Business Need: Utilization review, audit, statistical analysis.
Source: UB92 Field 4 – First and second position
Format: ANSI A/N 1/2 IAIABC ID 2
Values: See Appendix – B4

FACILITY FEIN – DN679
Definition: Federal Tax ID number of facility.
Revised: 09/26/98
Business Need: Identification of provider; monitor of health care providers for compliance with fee guidelines.
Source: Health Care Provider
Format: ANSI A/N 2/80 IAIABC A/N 9

FACILITY MEDICARE NUMBER – DN681
Definition: The unique number assigned to a facility by the Medicare Program.
Revised: 09/26/98
Business Need: Identification of provider; monitors of health care providers for compliance with fee guidelines.
Source: Health Care Provider
Format: ANSI A/N 1/30 IAIABC A/N 30

FACILITY NAME – DN678
Definition: Name of the facility where the medical service(s) was rendered.
Revised: 09/26/98
Business Need: Identification of provider; monitor of health care providers for compliance with fee guidelines.
Source: HCFA Field 32 UB92 Field 1
Format: ANSI A/N 1/35 & 1/60 IAIABC A/N 40
Imp Note: For ANSI, a combination of Segment NM1 and N2. NM103 contains the first 35 characters and, if necessary, N201 contains the remaining characters.

FACILITY POSTAL CODE – DN688
Definition: Postal code of facility's mailing address.
Revised: 09/26/98
Business Need: Identification of providers; monitor health care providers for compliance with fee guidelines.
Source: HCFA Field 32 UB92 Field 1
Format: ANSI ID 3/15 IAIABC A/N 9
Values: See Appendix – A51

FACILITY STATE LICENSE NUMBER – DN680
Definition: The unique number assigned by the jurisdiction to identify the facility.
Revised: 09/26/98
Business Need: Identification of provider, monitor health care providers for compliance with fee guidelines.
Source: Jurisdictional Licensing Board
Format: ANSI A/N 1/30 IAIABC A/N 30

HCPCS BILL PROCEDURE CODE – DN737
Definition: HCPCS (Health Care Financing Administration's Common Procedure Coding System) code billed that identifies treatment rendered.
Revised: 09/26/98
Business Need: Auditing medical charges; determination of reimbursements.
Source: HCFA Field 24D UB92 Fields 81-85 A, B, C, D, E
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A130
Max Occur: 5
Imp Note: HCPCS codes include Level 1 CPT (Physician's Current Procedural Terminology).

HCPCS LINE PROCEDURE BILLED CODE – DN714
Definition: HCPCS (Health Care Financing Administration's Common Procedure Coding System) code billed that identifies treatment rendered.
Revised: 09/26/98
Business Need: Auditing medical charges; determination of reimbursements.
Source: HCFA Field 24D UB92 Field 44
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A130
Imp Note: HCPCS codes include Level 1 CPT (Physician's Current Procedural Terminology) procedure codes.

HCPCS LINE PROCEDURE PAID CODE – DN726

Definition: HCPCS (Health Care Financing Administration's Common Procedure Coding System) code paid for specific treatment rendered.
Revised: 09/26/98
Business Need: Monitoring medical charges quality of medical care and utilization.
Source: Payor
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A130

HCPCS MODIFIER BILLED CODE – DN717

Definition: HCPCS (Health Care Financing Administration's Common Procedure Coding System) code identifying special circumstances related to procedure billed.
Revised: 09/26/98
Business Need: Monitor cost trends and adjustment factors.
Source: HCFA Field 24D UB92 Field 44
Format: ANSI A/N 2/2 IAIABC ID 2
Values: See Appendix – A130
Max Occur: 2

HCPCS MODIFIER PAID CODE – DN727

Definition: HCPCS (Health Care Financing Administration's Common Procedure Coding System) code identifying special circumstances related to procedure paid.
Revised: 09/26/98
Business Need: Monitor cost trends and adjustment factors.
Source: Payer
Format: ANSI A/N 2/2 IAIABC ID 2
Values: See Appendix – A130
Max Occur: 2

HCPCS PRINCIPAL PROCEDURE BILLED CODE – DN626

Definition: HCPCS (Health Care Financing Administration's Common Procedure Coding System) code indicating the principal procedure billed.
Revised: 09/26/98
Business Need: Monitor cost trends and compliance with state regulators.
Source: UB92 Field 80
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A130

ICD-9 CM DIAGNOSIS CODE – DN522

Definition: ICD-9 CM (International Classification Diseases, 9th Edition, Clinical Modification) code denoting the diagnosis of the work related injury or illness.
Revised: 09/26/98
Business Need: To determine reimbursements, measure impact of managed care and measure medical outcomes.
Source: HCFA Field 21 1-4 UB92 Field 68-75
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A131
Max Occur: 4 – HCFA
9 – UB92
Imp Note: For UB92 – Used when Code List Qualifier (ANSI DE 1270) = BK for first occurrence, BF for occurrences 2-9. Decimal point required.
For HCFA Field 21, 1 must be primary diagnosis.

ICD-9 CM PROCEDURE CODE – DN736

Definition: ICD-9 CM (International Classification of Diseases, 9th Edition, Clinical Modification) code identifying a procedure (other than principal procedure).
Revised: 09/26/98
Business Need: Monitor cost trends and compliance with state regulators.
Source: UB92 Field 81 A, B, C, D, E
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A131
Max Occur: 5

ICD-9 CM PRINCIPAL PROCEDURE CODE – DN525

Definition: ICD-9 CM (International Classification of Diseases, 9th Edition, Clinical Modification) code indicating the principal procedure rendered.
Revised: 09/26/98
Business Need: Monitor cost trends and compliance with state regulations.
Source: UB92 Field 80
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A131

INSURER FEIN – DN6

Definition: The Federal Employment Identification Number (FEIN) of the carrier or self-insured assuming responsibility for workers' compensation claims.
Revised: 09/26/98
Business Need: To identify the insurer to the jurisdiction system.
Source: Payor
Format: ANSI A/N 2/80 IAIABC A/N 9
Imp Note: As there exists a one to one relationship between an Insurer State ID and the Insurer FEIN, this will replace Insurer State ID. If a state utilizes a unique Insurer State ID, they must build a crosswalk table prior to testing/implementation.

INSURER NAME – DN7

Definition: The name of the carrier or self-insured assuming the employee's financial responsibility for workers' compensation claims.
Revised: 06/07/95
Business Need: To identify the insurer to the jurisdiction system.
Source: UB92 Field 50
Format: ANSI A/N 1/35 & 1/60 IAIABC A/N 40
Imp Note: For ANSI, a combination of Segment NM1 and N2. NM103 contains the first 35 characters and, if necessary, N201 contains the remaining characters.

INTERCHANGE VERSION IDENTIFICATION - DN105

Definition: Reference or Identification number as defined as a particular Transaction Set.
Source: Sender
Format: ANSI A/N 1/30
Value: MED01 = Medical Version 1

JURISDICTION CLAIM NUMBER – DN5
Definition: A number assigned by the jurisdiction to identify a specific claim. It is assigned at time of the first report.
Revised: 03/11/94; 07/01/97
Business Need: To provide tracking mechanism for jurisdiction system.
Source: Payor
Format: ANSI A/N 1/30 IAIABC A/N 25
Imp Note: This number may be changed during the life of the claim by the jurisdiction.

JURISDICTION MODIFIER BILLED CODE – DN718
Definition: Jurisdictional code identifying special circumstances related to jurisdiction procedure billed.
Revised: 09/26/98
Business Need: Monitor cost trends and adjustment factors.
Source: HCFA Field 24D
Format: ANSI A/N 2/2 IAIABC ID 2
Values: Jurisdiction Specific Codes as defined in Trading Partner Agreement
Max Occur: 2

JURISDICTION MODIFIER PAID CODE – DN730
Definition: Jurisdictional code identifying special circumstances related to jurisdiction procedure paid.
Revised: 09/26/98
Business Need: Monitor cost trends and adjustment factors.
Source: Payor
Format: ANSI A/N 2/2 IAIABC ID 2
Values: Jurisdiction Specific Code as defined in Trading Partner Agreement.
Max Occur: 2

JURISDICTION PROCEDURE BILLED CODE – DN715
Definition: Jurisdictional special code identifying a procedure, service or product billed that is not currently identified by a HCPCS code.
Revised: 09/26/98
Business Need: Monitoring medical charges, quality of medical care, and utilization.
Source: Payor
Format: ANSI A/N 1/48 IAIABC ID 6
Values: Jurisdiction Specific Code as defined in Trading Partner Agreement.

JURISDICTION PROCEDURE PAID CODE – DN729
Definition: Jurisdictional special code identifying a procedure, service or product paid that is not currently identified by HCPCS code.
Revised: 09/26/98
Business Need: Monitoring medical charges, quality of medical care, and utilization.
Source: Payor
Format: ANSI A/N 1/48 IAIABC ID 6
Values: Jurisdiction Specific Code as defined in Trading Partner Agreement.

LINE NUMBER – DN547
Definition: Bill sequential line item number.
Revised: 09/26/98
Business Need: Linking information for auditing and analysis purposes.
Source: Payor
Format: ANSI N0 1/6 IAIABC N 6

MANAGED CARE ORGANIZATION FEIN – DN704
Definition: The Federal Tax Identification number for the managed care organization.
Revised: 09/26/98
Business Need: Identification of provider, monitor the quality of medical care and monitor costs.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 2/80 IAIABC A/N 9

MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER – DN208
Definition: The jurisdiction assigned number that corresponds to and uniquely identifies the managed care organization involved in the claim.
Revised: 09/26/98
Business Need: Identification of provider; monitor the quality of medical care and costs.
Source: Jurisdictional Licensing Board
Format: ANSI A/N 1/30 IAIABC A/N 9

MANAGED CARE ORGANIZATION NAME – DN209
Definition: The legal name of the managed care organization involved in the claim.
Revised: 07/01/97
Business Need: Identification of provider; monitor both the quality of medical care and costs.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 1/35 & 1/60 IAIABC A/N 40
Imp Note: For ANSI, a combination of Segment NM1 and N2. NM103 contains the first 35 characters and N201 contains the remaining 60 characters.

MANAGED CARE ORGANIZATION POSTAL CODE – DN712
Definition: Postal code of managed care mailing address.
Revised: 09/26/98
Business Need: Identifying provider location.
Source: Health Care Provider and/or Payor
Format: ANSI ID 3/15 IAIABC A/N 9
Values: See Appendix – A51

NDC BILLED CODE – DN721
Definition: NDC (National Drug Code) identifying drugs or pharmaceuticals billed.
Revised: 09/26/98
Business Need: Monitoring medical charges, quality of medical care, and utilization.
Source: Health Care Provider
Format: ANSI A/N 1/48 IAIABC ID 11
Values: See Appendix – A134

NDC PAID CODE – DN728
Definition: NDC (National Drug Code) identifying drugs and pharmaceuticals paid.
Revised: 09/26/98
Business Need: Monitoring medical charges, quality of medical care, and utilizations.
Source: Payor
Format: ANSI A/N 1/48 IAIABC ID 11
Values: See Appendix – A134

PLACE OF SERVICE BILL CODE – DN555
Definition: Code indicating the place of service at the bill level.
Revised: 09/26/98
Business Need: Utilization review, monitor cost trends.
Source: Health Care Provider
Format: ANSI A/N 1/2 IAIABC ID 2
Values: See Appendix – B4

PLACE OF SERVICE LINE CODE – DN600
Definition: Code indicating the place of service at line level.
Revised: 09/26/98
Business Need: Utilization review, monitor cost trends.
Source: HCFA Field 24B
Format: ANSI A/N 1/2 IAIABC ID 2
Values: See Appendix – B4

PRESCRIPTION BILL DATE – DN527
Description: The date that the prescription was filled by the pharmacist at the bill level.
Revised: 07/16/97
Business Need: Link information to patient/claimant.
Source: Health Care Provider
Format: ANSI A/N 1/35 IAIABC DATE 8

PRESCRIPTION LINE DATE – DN604
Description: The date that the prescription was filled by the pharmacist at the line level.
Revised: 07/16//97
Business Need: Link information to patient/claimant.
Source: Health Care Provider
Format: ANSI A/N 1/35 IAIABC DATE 8

PRESCRIPTION LINE NUMBER – DN561
Description: Unique number assigned by the dispenser to identify the prescription at the line level.
Revised: 09/26/98
Business Need: Link information to patient/claimant; required by ANSI if used.
Source: Health Care Provider
Format: ANSI A/N 1/30 IAIABC A/N 30

PRINCIPAL DIAGNOSIS CODE – DN521
Definition: Code indicating principal diagnosis.
Revised: 09/26/98
Business Need: Utilization review; monitor medical outcomes.
Source: UB92 Field 67
Format: ANSI A/N 1/30 IAIABC ID 6
Values: See Appendix – A131
Imp Note: Used when Code List Qualifier ANSI DE 1270 = BK. Decimal point required.

PRINCIPAL PROCEDURE DATE – DN550
Definition: Date the principal procedure was performed.
Revised: 10/28/96
Business Need: Utilization review, auditing.
Source: UB92 Field 80
Format: ANSI A/N 1/35 IAIABC DATE 8

PROCEDURE DATE – DN524
Definition: Date on which procedure was performed.
Revised: 09/26/98
Business Need: Utilization review, auditing.
Source: UB92 Field 81
Format: ANSI A/N 1/35 IAIABC DATE 8
Max Occur: ANSI = 1 IAIABC = 2

PROVIDER AGREEMENT CODE – DN507
Definition: Code indicating type of provider agreement applicable to bill.
Revised: 09/26/98
Business Need: Medical billing/payment.
Source: Health Care Provider and/or Payor
Format: ANSI ID 1/1 IAIABC ID 1
Values: H = HMO Agreement
N = No Agreement
P = Participation Agreement
Y = PPO Agreement

RELEASE OF INFORMATION CODE – DN526
Definition: A code that identifies that there is or is not authorization to release of information.
Revised: 07/15/97
Business Need: Enables entities that transmit data and receive data to determine that there is or is not authorization to release information.
Source: Health Care Provider
Format: ANSI ID 1/1 IAIABC ID 1
Values: A = Appropriate release of information on file at health care service provider or at a Utilization Review Organization.
I = Informed consent to release medical information for conditions or diagnosis regulated by Federal Statutes
M = The provider has a limited or restricted ability to release data related to a claim
N= No, Provider is not allowed to release data
O = On file at payor or at plan sponsor
Y = Yes, Provider has signed statement permitting release of medical billing data related to claim.

RENDERING BILL PROVIDER FEIN – DN642
Definition: The Federal Tax ID number of the rendering bill provider.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: HCFA Field 25
Format: ANSI ID 2/80 IAIABC A/N 9
Imp Note: If billing provider does not have an assigned FEIN submit an assigned Social Security Number.

RENDERING BILL PROVIDER LAST/GROUP NAME – DN638

Definition: Individual provider actually rendering care. If not present, the billing provider is assumed to be the rendering provider for all services on this bill. If the billing provider was not an individual, a jurisdiction may require a rendering bill provider to be specified.
Revised: 09/26/98
Business Need: Identification of provider, monitor health care providers for compliance with fee and treatment guidelines.
Source: HCFA Field 31 UB92 Field 82
Format: ANSI A/N 1/35 IAIABC A/N 40

RENDERING BILL PROVIDER POSTAL CODE – DN656

Definition: Postal Code of rendering bill provider's mailing address.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: HCFA Field 32 UB92 Field 1
Format: ANSI A/N 3/15 IAIABC A/N 9
Values: See Appendix – A51

RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE – DN651

Definition: Code indicating medical specialty of the rendering bill provider.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 1/30 IAIABC ID 10
Values: See Appendix – B2

RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER – DN649

Definition: The specific license number issued by the jurisdiction to the rendering bill provider that denotes the specialty of the rendering provider.
Revised: 09/26/99
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: Jurisdictional Licensing Board
Format: ANSI A/N 1/30 IAIABC A/N 30

RENDERING BILL PROVIDER STATE LICENSE NUMBER – DN643

Definition: The specific license number issued by a jurisdiction to a rendering bill provider that permits the provider to practice in that state.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: Jurisdictional Licensing Board
Format: ANSI A/N 1/30 IAIABC A/N 30

RENDERING LINE PROVIDER LAST/GROUP NAME – DN589
Definition: Individual provider actually rendering care. If not present, the billing provider is assumed to be the rendering provider for all services on this bill. If the billing provider was not an individual, a jurisdiction may require a rendering line provider to be specified.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: Health Care Provider
Format: ANSI A/N 1/35 IAIABC A/N 40

RENDERING LINE PROVIDER NATIONAL PROVIDER ID – DN592
Definition: Unique national provider ID of the rendering provider at the line level.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 1/30 IAIABC A/N 30

RENDERING LINE PROVIDER POSTAL CODE – DN593
Definition: Postal code of rendering line provider's mailing address.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: Health Care Provider
Format: ANSI A/N 3/15 IAIABC A/N 9
Values: See Appendix – A51

RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE – DN595
Definition: Code indicating medical specialty of the rendering line provider.
Revised: 09/26/98
Business Need: Identification of providers; monitor health care providers for compliance with fee and treatment guidelines.
Source: Health Care Provider and/or Payor
Format: ANSI A/N 1/30 IAIABC ID 10
Values: See Appendix – B2

RENDERING LINE PROVIDER STATE LICENSE NUMBER - DN599
Definition: The specific license number issued by a jurisdiction to a rendering line provider that permits the provider to practice in that state.
Revised: 09/26/98
Business Need: Identification of provider; monitor health care providers for compliance with fee and treatment guidelines.
Source: Jurisdictional Licensing Board
Format: ANSI A/N 1/30 IAIABC A/N 30

REPORTING PERIOD – DN615
Definition: Date or date range during which the information included in the transaction was processed.
Revised: 08/13/96
Business Need: For periodic reporting to the jurisdiction when required.
Source: Payor
Format: ANSI A/N 1/35 IAIABC PERIOD 16

REVENUE BILLED CODE – DN559
Definition: Code indicating specific cost center billed.
Revised: 09/26/98
Business Need: Determines reimbursement and treatment provided.
Source: UB92 Field 42
Format: ANSI A/N 1/48 IAIABC ID 4
Values: See Appendix – B5

REVENUE PAID CODE – DN576
Definition: Code indicating specific cost center paid.
Revised: 09/26/98
Business Need: Determines reimbursement and treatment provided.
Source: Payor
Format: ANSI A/N 1/48 IAIABC ID 4
Values: See Appendix – B5

SERVICE ADJUSTMENT AMOUNT – DN733
Definition: Code indicating general category or adjustment made per service line.
Revised: 03/21/99
Business Need: Required in order to access the appropriateness of the adjustment or the basis of the adjustment being made.
Source: Payor
Format: ANSI R 1/18 IAIABC $9.2
Max Occur: 5
Values: See Appendix – A139

SERVICE ADJUSTMENT GROUP CODE – DN731
Definition: Code indicating general category of adjustment made per service line.
Revised: 09/26/98
Business Need: Identifies potential litigation.
Source: Payor
Format: ANSI ID 1/2 IAIABC ID 2
Values: CO = Contractual Obligations
OA = Other Adjustments
PI = Payor initiated reductions
PR = Patient Responsibility

SERVICE ADJUSTMENT REASON CODE – DN732
Definition: Code indicating detailed reason and adjustment that was made per service line.
Revised: 09/26/98
Business Need: Required by ANSI. Identifies potential litigation; tracks patterns and practices of adjustments.
Source: Payor
Format: ANSI ID 1/5 IAIABC ID 3
Max Occur: 5
Values: See Appendix – A139

SERVICE BILL DATE(S) RANGE – DN509
Definition: Starting date and ending date on which service(s) were performed at the bill level.
Revised: 09/26/98
Business Need: Utilization review and auditing purposes.
Source: HCFA Field 18 UB92 Field 6
Format: ANSI A/N 1/35 IAIABC PERIOD 16
Imp Note: If data submitted, both starting date and ending date must be submitted. If starting and ending date are the same, repeat.

SERVICE LINE DATE(S) RANGE – DN605
Definition: Starting date and ending date on which service(s) were performed at the line level.
Revised: 09/26/98
Business Need: Utilization review and auditing purposes.
Source: HCFA Field 24A UB92 Field 45
Format: ANSI AN 1/35 IAIABC PERIOD 16
Imp Note: If data submitted, both starting date and ending date must be submitted. If starting and ending dates are the same, repeat.

TOTAL AMOUNT PAID PER BILL – DN516
Definition: Total amount paid or credited for a submitted bill by payor after adjustments.
Revised: 09/26/98
Business Need: Medical billing and payment.
Source: UB92 Field 47
Format: ANSI R 1/18 IAIABC $9.2

TOTAL AMOUNT PAID PER LINE – DN574
Definition: Total amount paid or credited per line item.
Revised: 09/26/98
Business Need: Medical billing and payment.
Source: UB92 Field 47
Format: ANSI R 1/18 IAIABC $9.2

TOTAL CHARGE PER BILL – DN501
Definition: Cumulative charge amount of all line items per bill.
Revised: 09/26/98
Business Need: Medical billing and payment.
Source: HCFA Field 28 UB92 Field 47
Format: ANSI R 1/18 IAIABC $9.2

TOTAL CHARGE PER LINE – DN552
Definition: Service charge per line item.
Revised: 09/26/98
Business Need: Medical billing and payment.
Source: HCFA Field 24F UB92 Field 47
Format: ANSI R 1/18 IAIABC $9.2

TOTAL CHARGE PER LINE – PURCHASE – DN566
Definition: Purchase price of DME (durable medical equipment)
Revised: 09/26/98
Business Need: Medical billing and payment
Source: HCFA Field 24F
Format: ANSI R 1/18 IAIABC $9.2

TOTAL CHARGE PER LINE – RENTAL – DN565
Definition: Rental price of DME (durable medical equipment).
Revised: 09/26/98
Business Need: Medical billing and payment.
Source: HCFA Field 24F
Format: ANSI R 1/18 IAIABC $9.2

UNIQUE BILL ID NUMBER – DN500
Definition: Unique number assigned by the insurer to individual bills/invoices.
Revised: 09/26/98
Business Need: Internal and external control; acknowledgment match up.
Format: ANSI A/N 1/30 IAIABC A/N 30

ACKNOWLEDGMENT TRANSACTION SET ID – DN110
Definition: Identifies the type of transaction being acknowledged.
Revised: 09/26/98
Source: IAIABC
Format: ANSI ID 3/3 IAIABC ID 3
Values: 837 = Medical Transactions

APPLICATION ACKNOWLEDGMENT CODE – DN111
Definition: A code used to identify the accepted/rejected status of the transaction being acknowledged.
Revised: 08/09/95, 0701/97
Source: IAIABC
Format: ANSI ID2 IAIABC ID 2
Values: BA = Batch Accepted
BR = Batch Rejected
TA = Transaction Accepted
TE = Transaction Accepted with Error
TR = Transaction Rejected

BATCH CONTROL NUMBER – DN532
Definition: The inventory number of the transmission which is assigned by the sender's system.
Revised: 05/15/98
Business Need: Identifies the exact inventory number within the sender's system to aid tracking
Source: Sender
Format: ANSI A/N 1/30 IAIABC N/A

DATE PROCESSED – DN108
Definition: The date that the receiver processed the detail transaction. Together with the time processed and a record sequence number, it will uniquely identify a specific acknowledgment detail record.
Revised: 08/09/95
Source: IAIABC
Format: ANSI DT 8/8 IAIABC DATE 8

DATE TRANSMISSION SENT – DN100
Definition: Actual date the batch of data was sent.
Revised: 06/07/95, 07/01/97
Source: IAIABC
Format: ANSI DT 8/8 IAIABC DATE 8

ELEMENT ERROR NUMBER – DN116
Definition: A number to uniquely identify the edit performed on an element and is part of the error code.
Revised: 07/21/93, 07/01/97
Source: IAIABC Edit Matrix
Format: ANSI A/N 1/30 IAIABC ID 3

ELEMENT NUMBER – DN115
Definition: A unique number assigned to each data element and is part of the error code. Abbreviation used "DN".
Revised: 08/18/94
Source: IAIABC Edit Matrix
Format: ANSI N0 1/4 IAIABC ID 4

ORIGINAL TRANSMISSION DATE – DN102
Definition: The value obtained from the Date Transmission Sent of the Header Record of the originating batch.
Revised: 08/19/94, 07/01/97
Business Need: To allow a receiving party the ability to match back to the original batch file for reconciliation purposes. Used in conjunction with the Original Transmission Time field in the acknowledgment process.
Source: IAIABC
Format: ANSI DT 8/8 IAIABC DATE 8

ORIGINAL TRANSMISSION TIME – DN103
Definition: The value obtained from the Time Transmission Sent field of the Transmission Header Record of the originating batch.
Revised: 08/19/94, 07/01/97
Business Need: To allow a receiving party the ability to match back to the original batch file for reconciliation purposes. Used in conjunction with the Original Transmission Date field in the acknowledgment process
Source: IAIABC
Format: ANSI TM4/8 IAIABC TIME 6

RECEIVER ID – DN99
Definition: A composite or group level made up of Receiver FEIN (Primary FEIN of the receiving party), Filler and Receiver Postal Code (Primary Postal code of the receiving party).
Revised: 08/18/94,07/01/97
Source: IAIABC
Format: Receiver FEIN ANSI A/N 2/80 IAIABC – A/N 9
Filler ANSI N/A IAIABC – A/N 7
Receiver Postal Code ANSI ID 3/15 IAIABC A/N 9
Imp Note: ANSI does not combine their fields. NM1 carries the FEIN and N4 carries the postal code in the header section.

SENDER ID – DN98

Definition: Composition or group level made up of Sender FEIN (Primary FEIN of the sending party), Filler, and Sender Postal Code (Primary Postal Code of the sending party).
Revised: 08/18/94
Source: IAIABC
Format: Sender FEIN ANSI A/N 2/80 IAIABC A/N 9
Filler ANSI N/A IAIABC A/N 7
Sender Postal Code ANSI ID 3/15 IAIABC A/N 9
Imp Note: ANSI does not combine their fields. NM1 carries the FEIN and N4 carries the postal code.

TEST/PRODUCTION INDICATOR – DN104

Definition: Reflects an EDI participation status for a specific transaction. It indicates whether the transaction being sent is being targeted to a receiver's "production" or "test" system. Transactions performed while under "parallel" status should have the "test" indicator set.
Revised: 08/18/94, 07/01/97
Source: IAIABC
Format: ANSI N/A IAIABC ID 1
Values: P = Production
T = Test (Pilot parallel or Test)
Imp Note: This data element is applicable to the IAIABC Medical Flat File only.
Tech Note: This flag is set at the batch header level in the HD1. Therefore, all transactions within a batch must be at the same test/production level

TIME PROCESSED – DN109

Definition: The time the receiver processed the detail transaction. Together with date processed and a record sequence number it will uniquely identify a specific acknowledgment detail record.
Revised: 08/09/95, 07/01/97
Source: IAIABC
Format: ANSI TM 4/8 IAIABC TIME 6

TIME TRANSMISSION SENT – DN101

Definition: The time the sender prepared the batch file for transmission. Together with the Date Transmission Sent will uniquely identify a specific transmission batch.
Revised: 08/09/95, 07/01/97
Source: IAIABC
Format: ANSI TM 4/8 IAIABC TIME 6

TRANSACTION TRACKING NUMBER – DN266

Definition: Unique number assigned to the transaction by the sender (organization actually sending data to the jurisdiction).
Revised: 07/01/97
Business Need: To match incoming acknowledgment transaction to the appropriate original transaction.
Source: IAIABC
Format: ANSI A/N 1/30 IAIABC A/N 9