Optum

Assurance Reimbursement Management™

1500 Claim Field Help

This document contains the Help topics for claim fields in the 1500 professional claim form. It does not contain lists for ICD-9-CM, HCPCS, modifier, or other industry-standard codes. Refer to your official source for those.

Tips

- You can print this entire document to use as reference. Just click the print button at the top of this window.
- The *837 Professional Implementation Guide* contains allowed codes for any field added to the 1500 claim to meet 5010 requirements. The implementation guides can be downloaded from WPC-EDI.com.
- Two documents in the product Help - *Help Index, Claim Field Help*, *4010 1500 837 Fields (PDF*) and *5010 837 Fields (PDF)* match the claim fields in CFI with their locations in the implementation guides.

Claim-level fields

The fields in this section occur only once in a claim - claim data, patient, provider, etc.

Calculated money fields

The three money fields in FL 28, 29, and 30 are calculated by validate:

- **Total charges** (FL 28) - Sum of service line charges
- **Amount paid** (FL 29) - Sum of the three Amount fields in Other Payment Information on the Electronic tab
- **Balance due** (FL 30) - Difference between Total Charges and Amount Paid

The rules for calculating these fields are:

- **Total charges** - Total Charges must be recalculated whenever service line charges are changed. To recalculate Total Charges, delete the amount in the field and validate the claim.
- **Amount paid** - Validate erases whatever might be in Amount Paid (FL 29) and replaces it with the sum of the amounts in Other Payment Information on the Electronic tab.
- **Balance due** - Validate erases and recalculates: Total Charges - Amount Paid.

CHAMPUS status (CHAMSTAT)

A = Active duty | **R** = Retired | **D** = Deceased

CHAMPUS branch of service (CHAMBRAN)

USA = U.S. Army
USN = U.S. Navy
USAF = U.S. Air Force
USMC = U.S. Marine Corps
USCG = U.S. Coast Guard
USPHS = U.S. Public Health Service
NOAA = National Oceanic and Atmospheric Administration
NATO = North Atlantic Treaty Organization
VA = Veterans Administration

Date indicator (DATE_IND)

0 = Not applicable, or other | 1 = First symptom/illness | **2** = Last menstrual period (LMP)
3 = Routine services (not illness or accident related) | **4** = Accident

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Employee information (EM_EID)

P	=	Patient	**F**	=	Patient's father
S	=	Patient's spouse	**M**	=	Patient's mother

Financial class

(Top of form)

0	=	No payer	**4**	=	Employer/Union
1	=	Medicaid	**5**	=	Medicare Part B
2	=	Private insurance	**6**	=	Other state agency
3	=	Blue Cross	**9**	=	Other

Insured employment status (EM_ESC)

F	=	Employed full-time	**R**	=	Retired
P	=	Employed part-time	**M**	=	On active military duty
N	=	Not employed	**U**	=	Unknown
S	=	Self-employed			

Patient birth weight

(Patient Information on Electronic tab / Dropped in the 5010 837 standard.)

Patient birth weight is entered in grams. When required, it applies to patients who are less than one month old at the time of service.

Tip: To convert ounces to grams, use the Windows calculator and multiply ounces by 28.35.

Patient employment (P_EMPL)

F	=	Employed full-time	**R**	=	Retired
P	=	Employed part-time	**Y**	=	Employed
N	=	Not employed			

Patient marital status (P_MS)

S	=	Single	**D**	=	Divorced
M	=	Married	**W**	=	Widowed
X	=	Legally separated	**U**	=	Unknown

Patient student (P_STU)

F	=	Patient is a full-time student.	**N**	=	Patient is not a student.
P	=	Patient is a part-time student.			

Pay-to provider

Contains information for the provider that should receive payment for services on this claim. It is needed when the payment address differs from the standard provider/facility address in the facility master.

- **On a UB claim**, pay-to provider name and address is FL 2. The pay-to provider IDs are on the Electronic tab.
- **On a 1500 claim**, all pay-to provider information and IDs appear together at the bottom of the Electronic tab.

The facility's pay-to address can be set up in *facility master*. When set up in *facility master*, claim submission will copy pay-to provider address to the claim as it is submitted into the product. In addition in claim display, facility auto-entry will copy the pay-to provider information to the claim.

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Physician qualifying codes

This information applies to any physician (claim -level or service line-level) that uses an ID qualifier code to distinguish legacy ID numbers.

- On a UB claim, these physicians are on the Electronic and Detail tabs.
- On a 1500 claim, they are on the Additional and Detail tabs.

5010 Update: Only four of the codes shown here are recognized by 5010: **0B**, **1G**, **G2**, **LU**

Allowable codes include:

0B = State License Number
1A = Blue Cross Provider Number
1B = Blue Shield Provider Number
1C = Medicare Provider Number
1D = Medicaid Provider Number
1G = Provider UPIN
1H = CHAMPUS ID Number
EI = Employer ID Number
G2 = Provider Commercial Number
LU = Location Number
N5 = Provider Plan Network ID Number
SY = Social Security Number
X5 = State Industrial Accident Provider Number

When not associated with the payer of the claim, this field can contain any of the above codes except **0B**, **SY**, or **X5**.

Provider type of bill (PR_TOB)

100 = Physician office
110 = Hospital-based physician
200 = Independent lab
300 = Group practice
400 = Clinic
500 = Supplier

Relation to insured (P_RELA)

The ANSI allowable codes include:

18 = Patient is insured (Self)
01 = Spouse
04 = Grandfather or grandmother
05 = Grandson or granddaughter
07 = Nephew or niece
09 = Adopted child (1500 only)
10 = Foster child
15 = Ward
17 = Stepson or stepdaughter
19 = Child
20 = Employee
21 = Unknown relationship to insured
22 = Handicapped dependent
23 = Sponsored dependent
24 = Dependent of a minor dependent
29 = Significant other
32 = Mother
33 = Father
34 = Other adult (1500 only)
36 = Emancipated minor
39 = Organ donor
40 = Cadaver donor
41 = Injured plaintiff
43 = Child where insured has no financial responsibility
53 = Life partner
G8 = Other relationship

Bold codes are supported by the 5010 837 format. Not all codes are applicable to all payers and/or states.

Release status code

Release status code indicates the claim's release status and format. In CFI, the release code displays in RELEASE STATUS at the top of the claim form tab. The allowable codes include:

Y = Yes, release this claim for transmission to the clearinghouse.
P = Yes, release this claim for transmission; send the claim on paper (non-electronic).
L = Yes, release this claim; print the claim locally on paper claim form.
N = No, do not release this claim for transmission to the clearinghouse.

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Notes:

- Any other characters will cause an error on Release Status and must be changed before the claim can be released.
- When this product detects certain problems with a claim, it places an error on Release Code. To eliminate the error, correct the reported problem and validate the claim.

Rule out indicator (RODXIND)

For Hawaii only, the allowable codes include:

@ = The primary diagnosis is a rule out diagnosis.
Blank = Not applicable.

Type of claim (SOP)

FL 1 for active payer and SOP on Electronic tab for other payers.

Type of Claim	CFI	837
Automobile medical	Q	AM
Blue Cross/Blue Shield	7	BL
TRICARE/CHAMPUS	3	CH
Commercial	8	CI
Dental maintenance organization	X	17
Disability	R	DS
Exclusive provider organization (EPO)	W	14
Federal employees program	Y	FI
HMO	6	HM
HMO Medicare risk	P	16
Indemnity insurance	O	15
Liability medical	U	LM
Medicaid	2	MC
Medicare Part A	C	MA
Medicare Part B	1	MB
Mutually defined	Z	ZZ
Other federal program	5	OF
Other non-federal programs	J	11
Point of Service (POS)	M	13
Preferred provider organization (PPO)	L	12
Title V	T	TV
Veterans Affairs plan	V	VA
Workers' comp	9	WC

Type of claim (Electronic tab > Managed care information)

1 = Managed Care (HMO, IPA)
2 = PPO
3 = DMO
4 = Indemnity

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Status codes - Local (History tab)

Local status codes are added to the claim by events that occur in its history. These codes are always three (3) digits and display on the Status History tab. When the claim form appears, click the History tab. To print a current list of codes, click the Help for STATUS CODES on the History tab and open the list for local codes.

You can filter for claims with these codes. In the advanced filter range group, click the Select a Field box and scroll down to Local Status Codes. Enter a code in the From box. You can also enter a second code in the Through box. In addition, you can use a combination of Assoc Status Date and a range of local codes to filter for claims that were marked with a code on a specific day. For instance, an Assoc Status Date of Today and a Local Status Code 145 will return all claims that were rebilled today.

Status codes - CLS/Payer (History tab)

CLS/Payer status codes are added to the claim by responses returned to the claim by the clearinghouse or payer. These codes are always four (4) digits and show in the Status History table. When the claim form appears, click the History tab. To print a current list of codes, click the Help for STATUS CODES on the History tab and open the list for local codes.

You can filter for claims with these codes. In the advanced filter range group, click the Select a Field box and scroll to Local Status Codes. Enter a code in the From box. You can also enter a second code in the Through box.

Service line fields

Fields in this section are found in the service lines of the claim form.

Diagnosis code pointer (SL_DIAG)

The allowable pointer numbers correspond to the diagnosis codes on the claim.

There can be up to 12 diagnosis codes on a claim: The first four are on the CMS 1500 tab and the remaining eight are on the Additional tab of the claim. The service line pointer codes can be 1 to 12 to correspond to any of the diagnosis codes that are on the claim.

DME PPI (SL_PRIME)

- **0** = Not a DME rental, repeat purchase, or PEN claim
- **1** = First charge for DME rental or repeat purchase
- **2** = Subsequent charge for DME rental, repeat purchase, or PEN claim
- **3** = Recertified PEN claim or new caloric values

Condition code (SL_RCOD1 and SL_RCOD2)

- **AC** = Accident
- **AL** = Alcohol related
- **CA** = Cancer
- **DR** = Disaster related
- **EM** = Emergency care (payer specific)
- **ME** = Mental and nervous
- **NO** = None
- **PR** = Pregnancy
- **TB** = Tuberculosis

Special pricing indicator (SL_SPI)

- **01** = Psychiatric services for patient who is not a hospital inpatient
- **02** = Radiological services or pathological services to a hospital inpatient
- **03** = Secondary unrelated surgical procedure
- **04** = Diagnostic lab service involving fees from an independent lab
- **05** = Anesthesia performed by physician or CRNA in physician's employment
- **06** = Anesthesia performed by CRNA not in physician's employment.

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Payer Fields

Payer indicator

The Payer Indicator is the code letter that identifies the payer to whom the claim is being sent. Payer Indicator for a claim is shown at the top of every claim. Payers must be entered in the following order:

Payer **A** is the **primary** payer.

Payer **B** is the **secondary** payer.

Payer **C** is the **tertiary** payer, etc.

For example: If the claim is being sent to the secondary payer, the payer indicator will be B.

Payer code (TP_PCODE)

A = Working aged beneficiary/spouse with employer group health plan
B = ESRD benefits in twelve-month period with employer group health insurance
C = Conditional primary
D = Automobile no-fault or any liability insurance
E = Workers Compensation, including black lung
F = VA, PHS, or other federal agency
(Blank) = Not applicable (e.g., leave field blank)

Payer ID

On each service line up to 4 additional IDs (REF segments) for physicians, 3 additional IDs for service facility, 5 authorization numbers, and 5 referral numbers are supported for the 837 5010. The 5010 expansion provides display fields and storage for these additional IDs. To tie each extra ID back to the payer that assigns it, a new Payer ID field has been added for each extra ID. The Payer ID is the main ID of the payer that has assigned the extra ID.

For example, if Some Insurance has assigned ID 2 to the referring physician on a service line, the number in Payer ID 2 will be the main ID number of Some Insurance.

Notes:

- If the assigning payer is the active payer on the claim, the Payer ID field can be empty.
- When NHPIDs become required, the payer ID will be the NHPID of the payer.

Payer IDs have been added to the IDs of the following service line items:

Entity	ID range	Claim form
Attending/Rendering physician	IDs 2-5	UB and 1500
Referring physician	IDs 2-5	UB and 1500
Service facility	IDs 2-4	1500 only
Supervising physician	IDs 2-5	1500 only
Purchased service physician	IDs 2-5	1500 only
Ordering physician	IDs 2-5	1500 only
Prior authorization no.	IDs 1-5	1500 only
Referral no.	IDs 1-5	1500 only
Operating physician	IDs 2-5	UB only
Other physician 1	IDs 2-5	UB only

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Special program indicator

Services included on this bill are related to a special program. The allowable codes include:

02 = Physically Handicapped Children's Program
03 = Special federal funding
05 = Disability
07 = *Induced abortion - danger to life**
08 = *Induced abortion - victim of rape/incest**
09 = Second opinion or surgery (new for 5010)

** Not used in 5010*

Not all codes are applicable to all payers and/or states.

Secondary billing calculation values

The secondary billing calculation values are two figures that are used when calculating the prior payment and estimated amount due amount that are placed on the secondary or subsequent claims. These figures are displayed in the 835 (Payer Activity tab) on claims that have remits attached to them.

- **Prior payment** is the amount paid by the current payer. It will be placed in the Prior Payment field on the secondary claim.
- **Excluded amount** is the figure used to calculate the estimated amount due for a subsequent claim. Generally, it is the total of any charges that should not be sent on to the subsequent payer. Examples of these charges are contractual adjustments and patient responsibility charges.

The calculations that result in the values for these fields can be adjusted on a per-client basis. Contact Support for information about customizing calculations.

Zero payment indicator (TP_ZERO)

Z **Zero payment** - Provider certifies that the primary claim was filed and the primary payer returned a payment of zero for the claim on which this adjustment/secondary claim is based.
N **Payment amount is greater than zero** -Provider certifies that the primary insurer has paid the amount shown in the Prior Payments field of this adjustment/secondary claim.
BLANK **Claim not processed** - Remittance information has not been received for the primary claim.

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