

**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**

**INPATIENT DATA COLLECTION INSTRUCTIONS**



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**Effective June 1, 2007**

**DATA REPORTING REQUIREMENTS:**

Rule 11.4.7.11 requires all worker compensation payers to report inpatient hospital services data from information collected on the UB04 form (*Effective June 2007*). The schedule for reporting is determined by the date of payment of the services provided. All information requested as being mandatory must be provided to the WCA. Conditional field requirements are also outlined in these instructions. Information provided must be complete and accurate. Inpatient hospital services are those services provided to injured or ill workers under state workers' compensation coverage that has a service period of greater than 24 hours. Additionally, the inpatient worker has been admitted to a general hospital or an acute hospital and is provide a room and meals.

**WHEN TO FILE:**

The insurer must report an inpatient hospital bill to the WCA within 10 to 90 days of payment of the bill. Reports may be submitted by mail, fax or electronic media in batches daily, weekly or monthly from the insurer or insurer's representative. In any event, the insurer must report the inpatient bill not later than the 92nd day from the date of payment.

**HOW TO FILE:**

The insurer or insurer representative has three methods to file inpatient bills to the WCA: Paper (UB-04 and Supplement), Electronic CD, or Email (Excel file). Under the paper process the insurer must complete the information on a supplemental form (E10-2, see Appendix) for each inpatient billing that is being submitted to the WCA. The paper billing information may be faxed or mailed using the following:

- To fax the information the phone number to use is (505) 841-6883.
- The Mailing address: NM Workers' Compensation Adm.  
P.O. Box 27198  
Albuquerque, NM 87125-7198  
Attention: Statistics

To submit an electronic format to the WCA, a profile of the sender must be established. To do this, the sender of the information must contact the Economic Research Bureau at (505) 841-6044 and provide the following using the Inpatient Data Provider Partner form (E9) (See Appendix):

1. Sender Name and Address
2. Sender FEIN
3. The Payers the sender is sending for and their FEINs
4. Contact person
5. Phone number of Contact person
6. The email address of contact person
7. Method of reporting, CD, Excel-email,
8. Frequency of reporting

**REPORT RECORD FORMATS**

The sender of the inpatient data should have a clear understanding of the report record format for the UB-04 information. Table B (in Appendix) shows the data element (Field-Name), UB-04 location block, the data type, New Mexico's requirements, length of the field, Column beginning and ending points, and format notes. The

data element definitions are also explained in Table (A). Note, for paper submission a supplemental form needs to accompany each inpatient bill. This information is provided in the Appendix.

The reporting organization must be aware that the record lengths remain constant for all records. Each data field within the record has a WCA technical requirement designation (i.e. M = Mandatory, C = Conditional, O = Optional). Data elements that are not available or have no values will have a blank entry in that field except for the following technical requirements designated under the NM Req. column (see Table B in Appendix):

- M = Mandatory field. A data element having this designation must be included in every transmission of a record. If a mandatory field element is not contained in the UB-04 transmission, a critical error will result and a statistical staff member will contact the sender party.
- C = Conditional field. A non-null data element having this designation must be transmitted with every UB-04 record. This information is often time sensitive and is not provided at every stage of the claim process. Once the information is known it must be provided to the WCA at all of the reporting events.
- O = Optional field. A non-null data element having this designation may be transmitted.

**TECHNICAL FILING REQUIREMENTS (FOR ELECTRONIC)**

The following rules apply for submission of the inpatient UB-04 billing information. A diagram in the appendix shows the transaction flow for the billing information:

- Billing Type = 111: This bill establishes a new inpatient bill for the injured worker for the admission's date provided on the UB-04. There must be one billing type of 111 for a general acute hospital inpatient bill per injured worker for a specific admission date. Duplicate billing type 111 or subsequent billing types of 121 and 851 will not be accepted for the specific SSN and Admissions date. The payment information must reflect the actual payment made to the HCP based on the bill.
- Billing Type = 115: This bill establishes additional charges based on the original billing information provided under billing-type 111. There must be a Billing Type = 111 established in the database prior to the filing and acceptance of a billing type = 115. This billing type is used only for general acute hospitals for inpatient services. More than one billing type 115 may be filed for the same SSN and admissions date. Note: this billing type maybe used for additional revenue lines that were not available on the original bill (type = 111).
- Billing Type = 117: This billing type is used to correct a previously submitted bill. The sender uses this billing type to replace the billing information previously submitted under billing type 111 for a particular injured worker (SSN) and specific admission's date. Note, a previous bill must have been established for the worker and admission's date prior to sending this billing type. This billing type is only used for general acute hospital inpatient services. Once this billing type has been sent, only subsequent billing type =117 will be processed for the same SSN and Admissions date. Note: This billing type replaces all of the billed charge information from the original and subsequent bills.
- Billing Type = 121: This bill establishes a new inpatient bill for the injured worker for the admission's date provided on the UB-04. This billing type is used for inpatient services that are special in nature and are not covered under the billing type of 111. One example might be dialysis services (long-term). There must be one billing type of 121 for special services under general acute hospital inpatient bill per injured

worker for a specific admission date. Duplicate billing type 121 or subsequent billing type of 111 and 851 will not be accepted for the specific SSN and admission's date.

- Billing Type = 125: This bill establishes additional charges based on the original billing information provided under billing-type 121. There must be a Billing Type = 121 established in the database prior to the filing and acceptance of a billing type = 125. This billing type is used only for general acute hospitals for inpatient (special) services. More than one billing type 125 may be filed for the same SSN and admissions date. Note: this billing type maybe used for additional revenue lines that were not available on the original bill (type = 121).
- Billing Type = 127: This billing type is used to correct a previously submitted bill. The sender uses this billing type to replace the billing information previously submitted under billing type 121 for a particular injured worker (SSN) and specific admission's date. Note, a previous bill must have been established for the worker and admission's date prior to sending this billing type. This billing type is only used for special services under general hospital inpatient services. Once this billing type has been sent, only subsequent billing type =127 will be processed for the same SSN and Admissions date. Note: This billing type replaces all of the billed charge information from the original and subsequent bills.
- Billing Type = 851: This bill establishes a new inpatient bill for the injured worker for the admission's date provided on the UB-04 (For Critical Access Hospitals, CAH only). Under this billing type, a room charge must be indicated on the UB-04 for it to be considered an inpatient bill. There must be one billing type of 851 for a Critical Access hospital inpatient bill per injured worker for a specific admission date. Duplicate billing type 851 or subsequent billing types 111 and 121 will not be accepted for the specific SSN and admission's date.
- Billing Type = 855: This bill establishes additional charges based on the original billing information provided under billing-type 851. Under billing type 851 and 855, a room charge must be indicated on the UB-04 for it to be considered an inpatient bill. There must be a Billing Type = 851 established in the database prior to the filing and acceptance of a billing type = 855. This billing type is used only for critical access hospitals (CAH) for inpatient services. More than one billing type 855 may be filed for the same SSN and admissions date. Note: this billing type maybe used for additional revenue lines that were not available on the original bill (type = 851).
- Billing Type = 857: This billing type is used to correct a previously submitted bill. Under billing type 857, a room charge must be indicated on the UB-04 for it to be considered an inpatient bill. The sender uses this billing type to replace the billing information previously submitted under billing type 851 for a particular injured worker (SSN) and specific admission's date. Note a previous bill must have been established for the worker and admission's date prior to sending this billing type. This billing type is only used for Critical Access Hospitals (CAH) for inpatient services. Once this billing type has been sent, only subsequent billing type =857 will be processed for the same SSN and Admissions date. Note: This billing type replaces all of the billed charge information from the original and subsequent bills.

### **DATA DEFINITIONS**

The following table outlines the definitions of the data requested. The source of the data provide to the database is outlined under column UB-04 of Table A.

TABLE A

Screen Name	Table Field	Definition	UB-92 Location	UB-04 Location	REQ
Admin-Clm-No	Admin_Claim-No.	Claim Number assigned by insurer's claim administrator. Inpatient bill is not filed with the WCA until a claim number has been established and payment has been made.	Insurer Provided	Insurer Provided	M
Worker Last Name	Worker_last_name	The last name of the injured worker off of the UB-04 paper form. For the electronic or CD records, the last name of the worker has been added to the record format.	12	08,b	M
SSN	SSN	Social Security Number of the injured worker. This identifier is used with the Admission date to identify a unique inpatient case.	60	60A,08A	M
Birth	Date_of_Birth	Date of birth of the injured worker.	14	10	M
Date of Admin	Date of Admission	Date of injured worker admitted into the hospital for services extending beyond 24 hours.	17	12	M
Type of Bill	Bill_Type	Bill Type describing how the bill is generated from the hospital or payer. Valid Codes for WCA are 111= Admission through Discharge Claim 115= Additional Charges of Claim 117 = Replacement of Claim Others: 121, 125, 127: For Special Services 851 = Admission through Discharge of CAH 855 =Additional Charges of Claims 857 = Replacement of Claim	04	04	M
Type of Admin	Admission_type	Describes under what conditions the injured worker was admitted as inpatient status to the hospital. Valid codes: 1= Emergency, 2= Urgent, 3= Elective, 5 =Trauma Center, 9 = unavailable	19	14	M
Source of Admin	Admission_source	Defines where the admission of the injured worker originated. Valid codes: 1= Physician Referral, 2 = Clinic Referral 3= HMO Referral, 4 = Transfer from Hospital 5= Transfer from Skilled Nursing Facility 6= Transfer from another HCF 7= Emergency Room 8= Law Enforcement 9 = Information unavailable A = Transfer from a Critical Access Hospital	20	15	M
Date of Discharge	Discharge_dt	Date that the injured worker is discharged or inpatient services have ended at the hospital.	06	06	C
Discharge Status	Discharge_Status	Indicator describing the state or status of the injured worker at the time of the hospital discharge. Valid codes (01 -76) (see UB-04 Definitions, Medicare)	22	17	C
Medical Record Number	Medical Record No	Hospital 's Medical -Record Number of Patient.	23	03,b	C
Insurer Name	Payer	Name of the insurer from UB-04.	50	50A	M
FEIN	Insurer_fein	Federal Tax-id number of insurer.	Insurer	Insurer	M
Employer FEIN	Emplyer_fein	Federal Tax-id number of employer.	Insurer	Insurer	M
Sender	Sender_Name	Name of the Medical Review Co. or Sender of Medical Data to WCA	Sender	Sender	M

**New Mexico Workers' Compensation**

**Inpatient Data Collection Instructions**

Screen Name	Table Field	Definition	UB-92 Location	UB-04 Location	REQ
Total Charges	Total Gross Charges	Total amount of billed charges of medical services designated by revenue code (001). <i>When reporting use both dollars and cents in the format without the decimal point and zero fill before first digit (right justify).</i>	47	47	M
Total Paid	Total Paid Amount	The amount paid by the payer for the inpatient services. <i>When reporting use both dollars and cents in the format without the decimal point and zero fill before first digit (right justify).</i>	Insurer	Insurer	M
Date Paid	Date paid	The date the bill was paid by the payer	Insurer	Insurer	M
PDC	Principle Diagnosis Code	The ICD-9-CM code indicating the principal or major diagnosis of the injured worker injuries or illness.	67	67	M
2 <sup>nd</sup> -9 <sup>th</sup> Diag.	2 <sup>nd</sup> -9 <sup>th</sup> diagnosis codes	Secondary and additional ICD-9-CM code describing the diagnosis of the injury or illness of the injured worker.	68-75	67A-67H	C
DRG	Diagnosis Related Group (DRG)	The group code describing the overall diagnosis of the injury or illness of the injured worker.	56	37	M
PPC	Principle Procedure Code	The ICD-9-CM code describing the procedures used to treat the injured worker.	80	74	M
Date	PPC Date	The date of the principle procedure used to treat the injured worker.	80	74	M
2 <sup>nd</sup> – 6 <sup>th</sup> Proc.	2 <sup>nd</sup> -6 <sup>th</sup> Procedure Codes	Secondary and additional ICD-9-CM codes to describe to procedures used to treat the injured worker.	81 A-E	74 A-E	C
REV-CD(X)	Revenue Code (XX)	The description of the medical services provided under inpatient status (code is 4 digit): <b>Note, the first revenue code is mandatory.</b>	42	42	C
REV-CD Rate	Revenue Code (XX) Rate	The cost per services based on Revenue Code. <i>(This is the Accommodation Rate for revenue codes 100 through 219)</i>	44	44	C
REV-CD Amt	RC-XX Total Charges	The amount of the medical services provided under the specific revenue code. <b>Note, for the first revenue code, total charges are mandatory. Numerical format without decimal point and zero fill before first digit (right justified).</b>	47	47	C
HOSP ID	Hospital_FEIN	The Federal Identification number of the Hospital (9-digit Field)	5	5	M
Dt-Occurrence	Date of Occurrence	The date of the occurrence for the injury or illness of the patient.	32	31a	M
Occurrence_cd	Occurrence Code	The initial occurrence code relates to the reason for the inpatient stay related to an event. In Workers Compensation codes may be any of the following values {01-06, 11} for Billing type 111. Note, Inpatient codes are used for Medicare.	32b	31b	M
National Provider Indicator	NPI	Number assigned to Hospital Facility by Medicare. This number will replace the hospital FEIN in the future.		56	M
External Cause of injury code	ECI_CD	External Injury code use by the Department of Health to capture injury information	77	72a	C

**ELECTRONIC LAYOUT FOR MAILED DATA SUBMISSIONS**

Table B (in appendix) record layout should be used when data is submitted by mail in electronic form (on CD or diskette). The UB-04 form locators are printed in the table below as a guide to reporting the required data. A Header and Trailer record (see Table C, appendix) is used for each submission. Each file should be separated by insurer billed data information. Note, the order of the billing type is critical to the success of the acceptance of the transmission. All billing types = 111, 121, 851 should be processed first.

**Media:** CD or diskette

**File Format:** ASCII TEXT: with a header record first, then the data records followed by the trailer record.

**File Length:--- 823 Header and Trailer record not included in file length**

**Other Instructions:** Submit data as a fixed column input text file where each row represents the data from one discharge. All data fields should be left justified. Leave unused spaces blank - do not fill.

**EXCEL EMAIL SPECIFICATIONS**

Table B record layout should be used when data is submitted by email. Three worksheets in excel should be established: (1) the first is the Header Worksheet, which has the header information. (2) The second worksheet has the inpatient data records by row based on the column headings. (3) The third worksheet outlines the trailer information. Note: for excel files, the first row has column headers as defined by the first column in Table B. Data submissions that are mailed (in an Excel format) must also use this record layout. The UB-04 form locators are printed in the Table B as a guide to reporting the required data and data required by the insurer or sender is also outlined.

**File Format:** Microsoft Excel spreadsheet (version 1997 or more recent)

**File Name (required for all emailed data submissions):** Please contact the WCA for the file naming convention.

**File Password (required for all emailed data submissions):** Please contact the WCA for a file password.

**Other Instructions:** Put the names of the column headers in order in the first row of the Excel worksheet. Each row following the first row will represent the data for one hospital billing type for a particular SSN and admission date. Leave unused cells blank - do not fill.

**PAPER REQUIREMENTS**

The Sender must provide a clear copy of the UB-04 for each inpatient hospital bill submitted for a workers' compensation case (See Rule 11.4.7.11). The bill must be submitted no later than 90 days from the date of payment of the bill to the WCA. Each UB-04 submitted must have a supplemental form (E10-1) shown in the Appendix. The supplemental form is used to collect that information that is not on the UB-04 and is in Table B outlined as "insurer" under the UB-04 column. Note all of the mandatory fields outlined in Table B must be present on the UB-04 when submitted to the WCA.

**SPECIAL PROCESSING INSTRUCTIONS (Paper Only):** If partial payment is made to an original bill (X11) and is previously filed with the WCA and an additional payment is made for the same bill at a later date, then a new E10 -1 is filed with the original bill (X11) with both the previous payment and new payment noted in the total paid field.



**APPENDIX**

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**INPATIENT RECORD FORMAT****TABLE B**

Field Name	UB-04 Loc.	Type	NM Req.	Length	Begin	End	Notes
Admissions_dt	12	Date	M	8	1	8	mmddccyy
Discharge_dt	6	Date	C	8	9	16	mmddccyy
Principle Diagnosis Code (PDC)	67	A-N	M	6	17	22	No periods
2 <sup>nd</sup> Diagnosis code	67A	A-N	C	6	23	28	No Periods
3 <sup>rd</sup> Diagnosis code	67B	A-N	C	6	29	34	No Periods
4 <sup>th</sup> Diagnosis code	67C	A-N	C	6	35	40	No Periods
5 <sup>th</sup> Diagnosis code	67D	A-N	C	6	41	46	No Periods
6 <sup>th</sup> Diagnosis code	67E	A-N	C	6	47	52	No Periods
7 <sup>th</sup> Diagnosis code	67F	A-N	C	6	53	58	No Periods
8 <sup>th</sup> Diagnosis code	67G	A-N	C	6	59	64	No Periods
9 <sup>th</sup> Diagnosis code	67H	A-N	C	6	65	70	No Periods
Diagnosis Related Group code (DRG)	**37	A-N	M	3	71	73	3 –digit code
Revenue Code 1 (RC-1)	42	A-N	M	4	74	77	
RC-1 HCPCS Rate	44	A-N	C	10	78	87	
RC-1 Total Charge	47	Num.	M	10	88	97	Format: 9999999999
Revenue Code 2 (RC-2)	42	A-N	C	4	98	101	
RC-2 HCPCS Rate	44	A-N	C	10	102	111	
RC-2 Total Charge	47	Num.	C	10	112	121	Format: 9999999999
Revenue Code 3 (RC-3)	42	A-N	C	4	122	125	
RC-3 HCPCS Rate	44	A-N	C	10	126	135	
RC-3 Total Charge	47	Num.	C	10	136	145	Format: 9999999999
Revenue Code 4 (RC-4)	42	A-N	C	4	146	149	
RC-4 HCPCS Rate	44	A-N	C	10	150	159	
RC-4 Total Charges	47	Num.	C	10	160	169	Format: 9999999999
Revenue Code 5 (RC-5)	42	A-N	C	4	170	173	
RC-5 HCPCS Rate	44	A-N	C	10	174	183	
RC-5 Total Charges	47	Num.	C	10	184	193	Format: 9999999999
Revenue Code 6 (RC-6)	42	A-N	C	4	194	197	
RC-6 HCPCS Rate	44	A-N	C	10	198	207	
RC-6 Total Charges	47	Num.	C	10	208	217	Format: 9999999999
Revenue Code 7 (RC-7)	42	A-N	C	4	218	221	
RC-7 HCPCS Rate	44	A-N	C	10	222	231	
RC-7 Total Charges	47	Num.	C	10	232	241	Format: 9999999999
Revenue Code 8 (RC-8)	42	A-N	C	4	242	245	
RC-8 HCPCS Rate	44	A-N	C	10	246	255	
RC-8 Total Charges	47	Num.	C	10	256	265	Format: 9999999999
Revenue Code 9 (RC-9)	42	A-N	C	4	266	269	
RC-9 HCPCS Rate	44	A-N	C	10	270	279	
RC-9 Total Charges	47	Num.	C	10	280	289	Format: 9999999999
Revenue Code 10 (RC-10)	42	A-N	C	4	290	293	
RC-10 HCPCS Rate	44	A-N	C	10	294	303	
RC-10 Total Charges	47	Num.	C	10	304	313	Format: 9999999999
Revenue Code 11 (RC-11)	42	A-N	C	4	314	317	
RC-11 HCPCS Rate	44	A-N	C	10	318	327	
RC-11 Total Charges	47	Num.	C	10	328	337	Format: 9999999999
Revenue Code 12 (RC-12)	42	A-N	C	4	338	341	
RC-12 HCPCS Rate	44	A-N	C	10	342	351	
RC-12 Total Charges	47	Num.	C	10	352	361	Format: 9999999999
Revenue Code 13 (RC-13)	42	A-N	C	4	362	365	
RC-13 HCPCS Rate	44	A-N	C	10	366	375	
RC-13 Total Charges	47	Num.	C	10	376	385	Format: 9999999999
Revenue Code 14 (RC-14)	42	A-N	C	4	386	389	

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Field Name	UB-04 Loc.	Type	NM Req.	Length	Begin	End	Notes
RC-14 HCPCS Rate	44	A-N	C	10	390	399	
RC-14 Total Charges	47	Num.	C	10	400	409	Format: 999999999
Revenue Code 15 (RC-15)	42	A-N	C	4	410	413	
RC-15 HCPCS Rate	44	A-N	C	10	414	423	
RC-15 Total Charges	47	Num.	C	10	424	433	Format: 999999999
Revenue Code 16 (RC-16)	42	A-N	C	4	434	437	
RC-16 HCPCS Rate	44	A-N	C	10	438	447	
RC-16 Total Charges	47	Num.	C	10	448	457	Format: 999999999
Revenue Code 17 (RC-17)	42	A-N	C	4	458	461	
RC-17 HCPCS Rate	44	A-N	C	10	462	471	
RC-17 Total Charges	47	Num.	C	10	472	481	Format: 999999999
Revenue Code 18 (RC-18)	42	A-N	C	4	482	485	
RC-18 HCPCS Rate	44	A-N	C	10	486	495	
RC-18 Total Charges	47	Num.	C	10	496	505	Format: 999999999
Revenue Code 19 (RC-19)	42	A-N	C	4	506	509	
RC-19 HCPCS Rate	44	A-N	C	10	510	519	
RC-19 Total Charges	47	Num.	C	10	520	529	Format: 999999999
Revenue Code 20 (RC-20)	42	A-N	C	4	530	533	
RC-20 HCPCS Rate	44	A-N	C	10	534	543	
RC-20 Total Charges	47	Num.	C	10	544	553	Format: 999999999
Revenue Code 21 (RC-21)	42	A-N	C	4	554	557	
RC-21 HCPCS Rate	44	A-N	C	10	558	567	
RC-21 Total Charges	47	Num.	C	10	568	577	Format: 999999999
Revenue Code 22 (RC-22)	42	A-N	C	4	578	581	
RC-22 HCPCS Rate	44	A-N	C	10	582	591	
RC-22 Total Charges	47	Num.	C	10	592	601	Format: 999999999
Revenue Code 23 (RC-23)	42	A-N	C	4	602	605	
RC-23 HCPCS Rate	44	A-N	C	10	606	615	
RC-23 Total Charges	47	Num.	C	10	616	625	Format: 999999999
TOTAL GROSS CHARGES	47	Num.	M	10	626	635	Format: 999999999
Total Paid Amount	Insurer	Num.	M	10	636	645	Format: 999999999
Principle Procedure Code (PPC)	74	A-N	M	6	646	651	No Periods
PPC Date	74	Date	M	8	652	659	Format MMDDCCYY
2 <sup>nd</sup> Procedure Code	74, a	A-N	C	6	660	665	No Periods
3 <sup>rd</sup> Procedure Code	74, b	A-N	C	6	666	671	No Periods
4 <sup>th</sup> Procedure Code	74, c	A-N	C	6	672	677	No Periods
5 <sup>th</sup> Procedure Code	74, d	A-N	C	6	678	683	No Periods
6 <sup>th</sup> Procedure Code	74, e	A-N	C	6	684	689	No Periods
Clm-Admin Claim Number	Insurer	A-N	M	25	690	714	Claim Number of E1, E6
Birth_dt , Injured Worker	10	Date	M	8	715	722	Format: MMDDCCYY
SSN, Injured Worker	60A,08	A-N	M	9	723	731	Format 999999999
Employer_id (FEIN)	Insurer	A-N	M	9	732	740	Format: 999999999
Insurer_fein	Insurer	A-N	M	9	741	749	Format: 999999999
Payer	50A	A-N	M	30	750	779	
Bill-type	4	A-N	M	3	780	782	Valid Code =111,115,117 121,125,127 851,855,857
Discharge Status	17	A-N	C	2	783	784	Codes: 01,02,04,05,06, 07,08,20, 30, 40,41,42 43,50,51,62, 63, 65,
Admission_type	14	A-N	M	1	785	785	Codes: 1,2,3,4,5,9
Admission_Source	15	A-N	M	1	786	786	Codes: 1-9, A
Date_paid	Insurer	Date	M	8	787	794	Format: MMDDCCYY
Medical Record No	03,b	A-N	C	20	795	814	
Hospital_FEIN	5	A-N	M	9	815	823	Format: 999999999

**New Mexico Workers' Compensation**

**Inpatient Data Collection Instructions**

Field Name	UB-04 Loc.	Type	NM Req.	Length	Begin	End	Notes
Date of Occurrence	31,b	Date	M	8	824	831	Format: MMDDCCYY
Occurrence_cd	31,a	A-N	M	2	832	833	See Notes in Table A
Hospital -NPI	56	A-N	M	15	834	848	
ECI_cd (External Injury Code)	72,a	A-N	C	8	849	856	
Worker's Last Name	08,b	A-N	M	30	857	886	

\*\*37: State Requirement on UB-04

**TABLE C**

**HEADER RECORD**

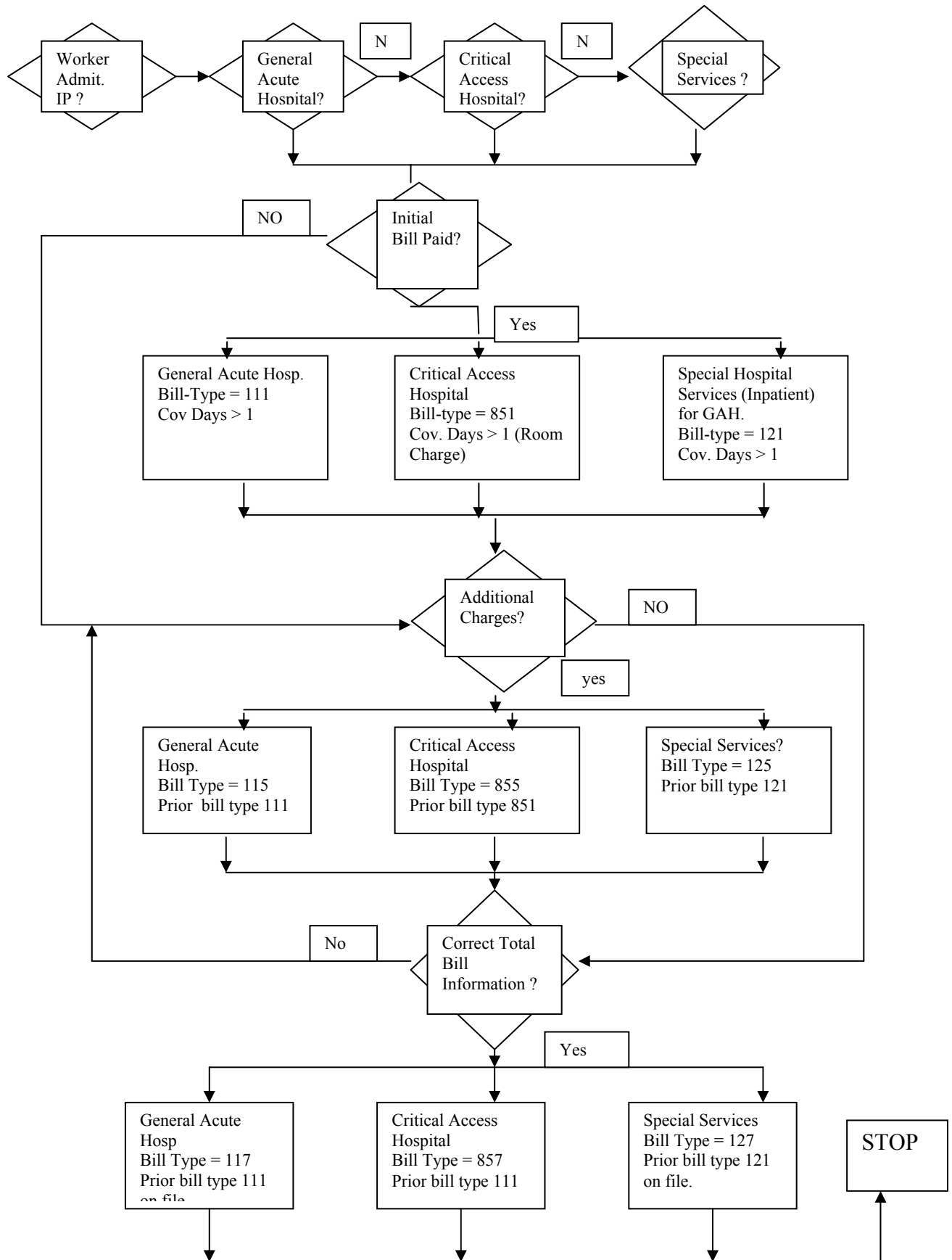
Field Name	Values	Req.	Length	Format	Column Position	
					Begin	End
Header ID	HIP	M	3	Text	1	3
Sender Name		M	25	Text	4	28
Sender FEIN	999999999	M	9	Text	29	37
Date Transmission	MMDDCCYY	M	8	Date	38	45
Test File Indicator	P, T	M	1	Text	46	46

**P = Production, T = Test. For Test Files Data will be discarded after test.**

**TRAILER RECORD**

Field Name	Values	Req.	Length	Format	Column Position	
					Begin	End
Trailer ID	TRP	M	3	Text	1	3
Detail Record Count	99999	M	5	Num	4	8

**INPATIENT DATA TRANSACTIONS**



**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**

**Inpatient Medical Data Provider Partner Profile**

ATTN: STATISTICS  
 PO BOX 27198  
 ALBUQUERQUE, NM 87125-7198

Email Address: mark.llewellyn@state.nm.us  
 Phone Number: (505) 841-6044

PLEASE PRINT IN BLACK INK OR TYPE

<b>Reporting Purpose Code</b>	<b>PARTNER TYPE:</b>		
	<b>TPA</b> <input type="checkbox"/>	<b>Carrier</b> <input type="checkbox"/>	<b>Medical Bill Review Company</b> <input type="checkbox"/>
	<b>Employer</b> <input type="checkbox"/>	<b>Other</b> <input type="checkbox"/>	<b>Sender Administrator</b> <input type="checkbox"/>
<b>DATA PROVIDER PARTNER: (SENDER)</b>			
<b>Name:</b>		<b>FEIN:</b>	
<b>Mail/Address:</b>			
<b>City:</b>		<b>State:</b>	
<b>Postal Code:</b>			
<b>Contact Person:</b>		<b>Phone:</b>	
<b>Fax #:</b>		<b>Email Address:</b>	
<b>FILE TRANSMISSION:</b>		<b>FILE TYPE:</b>	
Medical Hosp. <input type="checkbox"/>	Medical Opt <input type="checkbox"/>	Other <input type="checkbox"/>	
		ANSI <input type="checkbox"/>	Flat File <input type="checkbox"/> (ASCII)
		EXCEL <input type="checkbox"/>	UB-04 (Paper) <input type="checkbox"/>
<b>FREQUENCY OF REPORTING:</b>			<b>DAY OF WEEK:</b>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Semi-Annually <input type="checkbox"/>	Sat. <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/>
Daily <input type="checkbox"/>	Bi-weekly <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Annually <input type="checkbox"/>
			Tue. <input type="checkbox"/> Wed. <input type="checkbox"/> Thur. <input type="checkbox"/> Fri. <input type="checkbox"/>
<b>NETWORK:</b>			
MAIL BOX ACCT. _____	<b>Production</b> <input type="checkbox"/> <b>Start Date</b> _____		
USER ID: _____	<b>Test</b> <input type="checkbox"/> <b>Start Date</b> _____		
MESSAGE CLASS: _____	<b>Email File</b> <input type="checkbox"/>		
<b>ORGANIZATIONS REPORTING UNDER SENDER ADMINISTRATOR:</b>			
<b>Insurer Name</b>	<b>FEIN</b>	<b>Type (Carrier or Self-Insured)</b>	<b>Postal Code, Phone Number</b>
Agreement Person	Title	Signature	Date

E9 (12/15/2006)

**Mail:** UB-04 with Supplement to  
 NM Workers' Compensation Adm.  
 P.O. Box 27198  
 Albuquerque, NM 87125-7198  
 Attention: Statistics Unit

OR

**FAX:** UB-04 with supplement to  
 (505) 841-6883

**Questions:** call (505)-841-6000, ask for  
 Statistics Unit

Please Print

(1) <b>Injured Worker's Last Name:</b>		(2) Sender's Name	(3) <b>Sender's FEIN</b>
(4) Insurer's Name:			(5) <b>Insurer's FEIN:</b>
(6) Employer's Name:			(7) <b>Employer's FEIN:</b>
(8) <b>Insurer's Claim Number:</b>			(9) <b>Date of Payment of Billed Amt.:</b>
(10) Date of Submission:	(11) Number of Attached Pages:	(12) <b>Total Amount Paid on Bill</b>	
(13) <b>DRG if not in Block 37</b>	(14) TPA FEIN	(15) TPA Name	

**INSTRUCTIONS:** Please provide the supplemental form for each inpatient bill (UB-04) submitted to the WCA through the mail or by FAX. Insurers or insurer representatives must file a UB-04 with the supplemental form (E10-1) within 10 to 90 days from the date of payment.

**DEFINITIONS:**

- (1) Injured Worker's Last Name: This block of information is required by the supplemental form to insure that the information corresponds to the UB-04 in case that the form and Billing information gets separated.
- (2) Sender's Name: Name of the company representing the insurer submitting the UB-04 information to the WCA.
- (3) Sender FEIN: Federal Tax Identification Number of the company representing the insurer submitting UB-04 data.
- (4) Insurer Name: Name of the company financially responsible for Workers' Compensation claim.
- (5) Insurer FEIN: Federal Tax Id number of insurer.
- (6) Employers' Name: Name of the company employing injured worker.
- (7) Employer FEIN: Federal Tax Id number of employer.
- (8) Insurer's Claim Number: The Claim Administrator's Claim Number associated with the E1.2 and E6.1 filed with the WCA.
- (9) Date of Payment: Date of the payment of the inpatient bill submitted to the insurer for this claim.
- (10) Date of Submission: The date the UB-04 is faxed or mailed to the WCA.
- (11) Number of Attached Pages: The number of pages faxed or mailed to the WCA for this Bill.
- (12) Total Amount Paid: The total amount paid to the hospital for the billed charges submitted on the UB-04
- (13) DRG Code: The Diagnosis-Related Group code is based on the patient's primary and secondary diagnosis and the procedures performed during an inpatient stay.

**FOR INTERNAL USE**

SSN	DOI	WCA#	Date Received

## DETAIL ACKNOWLEDGMENT

Table D

Segment Type	Group	Data Name	Values	Tech Req.	Length	Format	Begin	End
One record at beginning of file	HEADER	Transaction Set-Id	HIP	M	3	A/N	1	3
		Sender FEIN		M	9	A/N	5	13
		Process date		M	8	Date	16	23
		Transaction date		M	8	Date	26	33
		Test indicator	T, P	M	1	A/N	36	36
		Acknowledgment ID	AK1	M	3	A/N	39	41
Variable based on number of records submitted	Acknowledgement	Ack-trans-set-Id	INP	M	3	A/N	1	3
		Record-Sequence		M	9	Numeric	5	13
		Process Time		M	6	Time	16	21
		Insurer FEIN		M	9	A/N	24	32
		Clm-Admin Claim Number		M	25	A/N	34	58
		Ack- transaction Cd	TA, TR	M	2	A/N	60	61
		Number of errors		M	2	Numeric	63	64
Variable	Error	Element number		C	4	A/N	66	**
		Element error number		C	3	A/N	**	156
One Record	TRAILER	Trailer-id	TRP	M	3	A/N	1	3
		Detail Record Count		M	7	Numeric	5	13

\*\* Note depends on the number of errors found

Error Matrix Table #1

<b>Message Number</b>	<b>Edit Description</b>	<b><u>Dn 4</u></b>	<b><u>DN 6</u></b>	<b><u>DN 10</u></b>	<b><u>DN 12</u></b>	<b><u>DN 14</u></b>	<b><u>DN 15</u></b>	<b><u>DN 17</u></b>	<b><u>DN 31.02</u></b>	<b><u>DN 42.01</u></b>
001	Bill number out of sequence or wrong billing number	X								
002	Invalid or missing Admissions Type code					X				
003	Invalid or missing Source Code						X			
004	Missing Principle Diagnosis code									
005	Missing Diagnosis Related Group code									
006	Missing Revenue Code									X
007	Missing Mandatory Date				X				X	
008	Missing or invalid total charge data									
009	Missing Mandatory Field	X		X		X	X			
010	Invalid or missing Insurer/Emp FEIN									
011	Missing Principle Procedure code									
012	Invalid Discharge Status							X		
013	Admissions date < Date of Occurrence				X				X	
014	Admissions date > Discharge Date		X		X					
015	Discharge date < Date of Occurrence								X	
016	PPC Date < Admissions date				X					
017	Duplicate (111) for same admin & SSN	X								
018	Admissions date < Birthdate			X	X					
019	Date Occurrence < Birthdate			X					X	
020	PPC date > date paid									
021	Invalid or missing Sender FEIN									

Table #2

<b>Message Number</b>	<b>Edit Description</b>	<b><u>DN 47.00</u></b>	<b><u>DN 47.01</u></b>	<b><u>DN 42.XX</u></b>	<b><u>DN 50</u></b>	<b><u>DN 55.01</u></b>	<b><u>DN 55.02</u></b>	<b><u>DN 37</u></b>	<b><u>DN 60</u></b>
001	Bill number out of sequence or wrong billing number								
002	Invalid or missing Admissions Type code								
003	Invalid or missing Source Code								
004	Missing Principle Diagnosis code								
005	Missing Diagnosis Related Group code								X
006	Missing Revenue Code			X					
007	Missing Mandatory Date						X		
008	Missing or invalid total charge data	X	X						
009	Missing Mandatory Field	X	X			X			X
010	Invalid or missing Insurer/Emp FEIN				X				
011	Missing Principle Procedure code								
012	Invalid Discharge Status								
013	Admissions date < Date of Occurrence								

**New Mexico Workers' Compensation**

**Inpatient Data Collection Instructions**

<u>Message Number</u>	<u>Edit Description</u>	<u>DN 47.00</u>	<u>DN 47.01</u>	<u>DN 42.XX</u>	<u>DN 50</u>	<u>DN 55.01</u>	<u>DN 55.02</u>	<u>DN 37</u>	<u>DN 60</u>
001	Bill number out of sequence or wrong billing number								
014	Admissions date > Discharge Date								
015	Discharge date < Date of Occurrence								
016	PPC Date < Admissions date								
017	Duplicate (111) for same admin & SSN								
018	Admissions date < Birth-date								
019	Date Occurrence < Birth-date								
020	PPC date > date paid								
021	Invalid or missing Sender FEIN								

Table #3

<u>Message Number</u>	<u>Edit Description</u>	<u>DN 61</u>	<u>DN 62</u>	<u>DN 65</u>	<u>DN 67</u>	<u>DN 80.01</u>	<u>DN 80.02</u>	<u>DN 100</u>	<u>DN 31.01</u>	<u>DN 56</u>	<u>DN 08</u>
001	Bill number out of sequence or wrong billing number										
002	Invalid or missing Admissions Type code										
003	Invalid or missing Source Code										
004	Missing Principle Diagnosis code				X						
005	Missing Diagnosis Related Group code										
006	Missing Revenue Code										
007	Missing Mandatory Date						X				
008	Missing or invalid total charge data										
009	Missing Mandatory Field	X							X	X	X
010	Invalid or missing Insurer/Emp FEIN		X	X							
011	Missing Principle Procedure code					X					
012	Invalid Discharge Status										
013	Admissions date < Date of Occurrence										
014	Admissions date > Discharge Date										
015	Discharge date < Date of Occurrence										
016	PPC Date < Admissions date										
017	Duplicate (111) for same admin & SSN										
018	Admissions date < Birthdate										
019	Date Occurrence < Birthdate										
020	PPC date > date paid										
021	Invalid or missing Sender FEIN		X					X			

TABLE 4 (DATA MATRIX)

Field Name	UB-04 Data #	Field Name	Data Num	Field Name	Data Num	Field Name	Data Num
		Bill-type	04	RC-1 HCPCS Rate	44.01	RC-10 Total Charges	47.10
Hospital_FEIN	05	RC-2 HCPCS Rate	44.02	RC-11 Total Charges	47.11	3 <sup>rd</sup> Procedure Code	81.02
Discharge_dt	06	RC-3 HCPCS Rate	44.03	RC-12 Total Charges	47.12	4 <sup>th</sup> Procedure Code	81.03
Birth_dt , Injured Worker	10	RC-4 HCPCS Rate	44.04	RC-13 Total Charges	47.13	5 <sup>th</sup> Procedure Code	81.04
Admissions_dt	12	RC-5 HCPCS Rate	44.05	RC-14 Total Charges	47.14	6 <sup>th</sup> Procedure Code	81.05
Admission_type	14	RC-6 HCPCS Rate	44.06	RC-15 Total Charges	47.15	Sender FEIN	100
Admission_Source	15	RC-7 HCPCS Rate	44.07	RC-16 Total Charges	47.16	Occurrence Code	31.01
Discharge Status	17	RC-8 HCPCS Rate	44.08	RC-17 Total Charges	47.17	Hospital NPI	56
Medical Record No	03	RC-9 HCPCS Rate	44.09	RC-18 Total Charges	47.18	Worker Last Name	08
Date of Occurrence	31.02	RC-10 HCPCS Rate	44.10	RC-19 Total Charges	47.19		
Revenue Code 1 (RC-1)	42.01	RC-11 HCPCS Rate	44.11	RC-20 Total Charges	47.20		
Revenue Code 2 (RC-2)	42.02	RC-12 HCPCS Rate	44.12	RC-21 Total Charges	47.21		
Revenue Code 3 (RC-3)	42.03	RC-13 HCPCS Rate	44.13	RC-22 Total Charges	47.22		
Revenue Code 4 (RC-4)	42.04	RC-14 HCPCS Rate	44.14	RC-23 Total Charges	47.23		
Revenue Code 5 (RC-5)	42.05	RC-15 HCPCS Rate	44.15	Payer	50		

Field Name	UB-04 Data #	Field Name	Data Num	Field Name	Data Num	Field Name	Data Num
Revenue Code 6 (RC-6)	42.06	RC-16 HCPCS Rate	44.16	Total Paid Amount	55.01		
Revenue Code 7 (RC-7)	42.07	RC-17 HCPCS Rate	44.17	Date_paid	55.02		
Revenue Code 8 (RC-8)	42.08	RC-18 HCPCS Rate	44.18	Diagnosis Related Group code (DRG)	37		
Revenue Code 9 (RC-9)	42.09	RC-19 HCPCS Rate	44.19	SSN, Injured Worker	60		
Revenue Code 10 (RC-10)	42.10	RC-20 HCPCS Rate	44.20	Clm-Admin Claim Number	61		
Revenue Code 11 (RC-11)	42.11	RC-21 HCPCS Rate	44.21	Insurer_fein	62		
Revenue Code 12 (RC-12)	42.12	RC-22 HCPCS Rate	44.22	Employer_id (FEIN)	65		
Revenue Code 13 (RC-13)	42.13	RC-23 HCPCS Rate	44.23	Principle Diagnosis Code (PDC)	67		
Revenue Code 14 (RC-14)	42.14	TOTAL GROSS CHARGES	47.00	2 <sup>nd</sup> Diagnosis code	68		
Revenue Code 15 (RC-15)	42.15	RC-1 Total Charge	47.01	3 <sup>rd</sup> Diagnosis code	69		
Revenue Code 16 (RC-16)	42.16	RC-2 Total Charge	47.02	4 <sup>th</sup> Diagnosis code	70		
Revenue Code 17 (RC-17)	42.17	RC-3 Total Charge	47.03	5 <sup>th</sup> Diagnosis code	71		
Revenue Code 18 (RC-18)	42.18	RC-4 Total Charges	47.04	6 <sup>th</sup> Diagnosis code	72		
Revenue Code 19 (RC-19)	42.19	RC-5 Total Charges	47.05	7 <sup>th</sup> Diagnosis code	73		

Field Name	UB-04 Data #	Field Name	Data Num	Field Name	Data Num	Field Name	Data Num
Revenue Code 20 (RC-20)	42.20	RC-6 Total Charges	47.06	8 <sup>th</sup> Diagnosis code	74		
Revenue Code 21 (RC-21)	42.21	RC-7 Total Charges	47.07	9 <sup>th</sup> Diagnosis code	75		
Revenue Code 22 (RC-22)	42.22	RC-8 Total Charges	47.08	Principle Procedure Code (PPC)	80.01		
Revenue Code 23 (RC-23)	42.23	RC-9 Total Charges	47.09	PPC Date	80.02		

**NOTES:**

The following are our latest changes to the manual since January 18<sup>th</sup> 2006:

- (1) Header record does not include insurer FEIN number. We are allowing multiple FEIN for insurers to be filed per sender file.
- (2) We are adding the field Date of Occurrence to the data record. We are noticing that a number of records are not comparable to the 148 or A49 record submitted for the worker and the date of injury is not the same.
- (3) Several typographical errors were corrected.

April 13, 2006

A change in special processing for Paper was added to the instructions to deal with partial payments. See page 7

August 15, 2006

- Formatting Clarification for no decimals in money amounts. Addition to Error Matrix and acknowledgement record

December 15, 2006

- Changes to formatting of record due to UB-04 Changes included DRG moving to block 37, Hospital NPI was added, Patient Last Name was added to record.
- Error Matrix Data Numbers changed to reflect UB04 changes.
- New Acknowledgement Record Format updated.

May 1, 2007

- Changes made to Acknowledgement Record Format. The record now includes the insurer's claim number and insurer's fein.