

TO: Hospitals - Chief Executive Officer
Home Health Agencies (Hospital-Based and
Community-Based)

ROUTING TO: MIS Department or Software Vendor,

SUBJECT: Optical Character Recognition (OCR) Specifications

EFFECTIVE: Immediately

BACKGROUND: The Division of Medical Assistance and Health Services and
claim forms.

PURPOSE: To notify hospitals and home health agencies of the benefits
completing OCR forms.

ACTION: The introduction of OCR will perform the following:

- 1) Increase the volume of claims processed daily;
- 2) Improve the overall quality of the work;
- 3) Reduce data entry errors; and
- 4) Provide a more rapid response to submitted claims.

The OCR equipment will scan specified fields on the claim form and transmit the data directly into the computer system. This will eliminate the need for manual keying of claim forms. (Currently, all paper claims submitted to Unisys for processing are keyed by data entry operators.)

Please read carefully the items on the following list and make the necessary corrections to the forms.

1. The claim form must be the revised UB-92, HCFA-1450 ORIGINAL claim form printed in red "drop-out" ink. (The OCR Copy 1 is not acceptable.)
2. All data must be typed or computer generated in black ink. Computer generated ink must be clear and dark. A faulty ribbon or light ink will cause data not to be read. This, in turn, will cause the claim to be denied by the OCR Scanner.
3. The print size must be consistent throughout the claim form.
4. The preferred pitch is 10. The block style font is best suited for the scanning equipment. Do not use compressed or script print.
5. The OCR Scanner will reject OCR claims if one of the pins in the printhead is missing or the ribbon is too light when using a dot matrix printer.
6. The use of liquid paper (white out) or correction tape anywhere on the claim form will cause the claim to be rejected by the OCR Scanner.
7. Claims must be both horizontally and vertically aligned to ensure that the data is correctly transmitted to the system. Printing in the dark red areas (description of Form Locators) will cause the claim to be rejected by the OCR Scanner.
8. All data must be contained within the specified block. If not, critical data may be read incorrectly or assumed to be information from another block, thus delaying the processing of your claim.
9. Do NOT use ANY special characters such as ditto marks, hyphens, periods, dollar signs, or slashes (/), etc.
10. Handwritten fields will cause the claim to be rejected by the OCR Scanner.
11. Do not use numeric 0 for alpha o in names. Do not use the alpha o for the numeric 0 in numeric fields.
12. Any internal use of a stamp (i.e., SECOND REQUEST, MEDICAID, CHARITY or DATE STAMP) in any portion of the claim form other than the remarks section will be rejected by the OCR Scanner.
13. Mail OCR claims flat (not folded), in a 9" x 13" envelope.

14. The recommended size for attachments is 8 1/2" x 11" paper.
15. If the provider's MIS Department or programming staff have specific programming questions they may direct their call to the:
- EMC Department
 Claire Ringel (609) 588-6031, or
 Cindy Scofield (609) 588-6088

16. The mailing address for OCR claims is as follows:

Unisys Corporation
 P.O. Box 4815
 Trenton, NJ 08650-4815

Please be reminded that OCR is only available to providers who produce computer generated or typewritten claim forms. All other claims that do not qualify for scanning will continue to be processed in the normal manner.

The following items are correct/incorrect samples of data elements and how they should appear in the appropriate Form Locators of the UB-92 in order to process New Jersey Medicaid claims utilizing the OCR Scanner:

<u>FORM LOCATOR</u>	<u>CORRECT</u>	<u>INCORRECT</u>
IP-FL 2	0001000000040000	OR 0001 0000 0004 0000 0001-0000-0004-0000
OP-FL 2	leave blank	
FL 3	1122334455667788	112-233-4455667788
IP-FL 4	121	1 21
OP-FL 4	131	1 31
IP-FL 6	061494 062094	06-14-94 06/20/94
OP-FL 6	061494 061494	06-14-94 06/14/94
FL 7	5	05, 0005
FL 8	0	000 0000
FL 9	0	000, 0000

<u>FORM LOCATOR</u>	<u>CORRECT</u>	<u>INCORRECT</u>
FL 10	0	(BLANK OR SPACES)
FL 11	1111444499	1111 4444 99
FL 12	DOE, JANE A	OR GSHP 11114444-99 Jane A. Doe
FL 14	04021953	04 02 53, OR 04/02/53, OR 04-02-53
FL 17	061494	06 14 94, OR 06/14/94, OR 06-14-94
FL 18	01	1:00 OR 1
FL 19	3	03
FL 20	1	Dr. J 01
FL 22	01	1
FL 32a 35b	A3 061494	OR 01061494 01 06/14/94 OR 1 061494
FL 39A 41d	A1 120 00	A1 00012000
IP-FL 42-1	092	0092
IP-FL 42-2	121	0121
IP-FL 42-3	131	0131
IP-FL 42-4	001	TOT
IP-FL 46-1	15	0015
IP-FL 46-2	1	01
IP-FL 46-3	10	010
IP-FL 47-1	2600 00	02600.00
IP-FL 47-2	875 00	875.00
IP-FL 47-3	1005 00	10050.00
IP-FL 47-4	4480 00	4480.00
OP-FL 42-1	301	0301
OP-FL 42-2	450	450
OP-FL 42-3	001	TOT

<u>FORM</u>	<u>CORRECT</u>		<u>INCORRECT</u>
<u>LOCATOR</u>			
OP-FL 43-1	061494061494		06/14/94-06/14/94
OP-FL 43-2	061494061494 00	OR	0614940614942
FL 43-3	(BLANK OR SPACES)		(NON-BLANK)
OP-FL 44-1	83970		Handwritten
FL 44-2	(BLANK OR SPACES)		(NON-BLANK)
FL 44-3	(BLANK OR SPACES)		(NON-BLANK)
OP-FL 46-1	15		0015
OP-FL 46-2	1		001
OP-FL 47-1	385 00		000385.00
OP-FL 47-2	15 00		00015.00
OP-FL 47-3	400 00		000400.00
FL 50-A	015 MEDICARE PART B		Medicare Part B 015
FL 50-B	012 MEDICAID		NJ Medicaid 012
			Handwritten 012
FL 51-A	310099		Medicare not
FL 51-B	4139999		Handwritten
FL 54	559 65	OR	000559.65
			Handwritten
FL 57	10 00		00010.00
FL 60-A	190009999		Medicare ID not
FL 60-B	111144449901		1111444499-01
FL 63	1234567880		MEDICAID
FL 67-77	V1234		V123.4
		OR	V123 4

FORM
LOCATOR

CORRECT

INCORRECT

FL 78	312		Must be 3 digit for
FL 80-81	6901 061494		690.1 06-14-94
FL 82-82	4281303		EN48208 Dr. Joe NJ Medicaid 4281303
FL 85	Prov Rep Signature	OR	No signature Signature outside of
FL 86	061494	OR	06-14-94 Handwritten

*NOTE: |Symbol indicates beginning of Form Locator or cents

Attachments: OCR Inpatient Claim Sample (UB-92)
OCR Outpatient Claim Sample (UB-92)

RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")