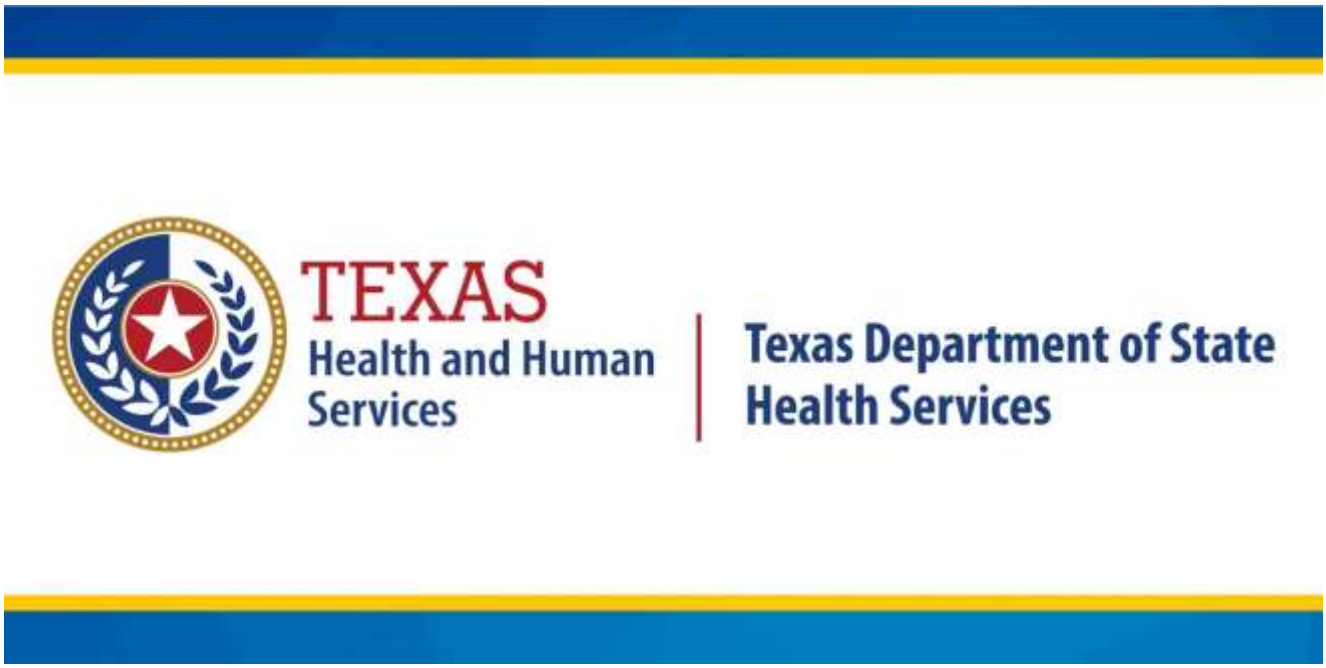

5010 Outpatient THCIC 837 Technical Specifications

Version 11.3 **December 1, 2023**

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1 Introduction

The Texas Health Care Information Collection's (THCIC) primary charge is to collect data and report on the quality performance and differences in charges of healthcare facilities and health maintenance organizations operating in Texas. The goal is to provide information that will enable consumers to have an impact on the cost and quality of health care in Texas.

The agency's governing legislation, which includes collecting data regarding outpatient surgical and radiological procedures covered under specified revenue codes listed in Title 25 Texas Administrative Code 421.67(e) and the HCPCS codes from the service and procedure categories listed in Title 25 Texas Administrative Code 421.67(f) for hospitals, ambulatory surgical centers, and freestanding emergency medical care facilities, is contained within Chapter 108, Texas Health & Safety Code.

The Outpatient Procedures and Technical Specifications are available for download from the THCIC website at Outpatient Data Reporting Requirements.

This guide is written to be complementary to the Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers rules, Title 25 Texas Administrative Code 421.61 to 421.68, and the Collection and Release of Hospital Outpatient Emergency Room Data rules, Title 25 Texas Administrative Code 421.71 to 421.78:

TITLE - 25 Health Services
PART - 1 Department of State Health Services
CHAPTER - 421 Health Care Information
SUBCHAPTER D Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers
SUBCHAPTER E Collection and Release of Hospital Outpatient Emergency Room Data

Related links to the Texas Health & Safety Code and Texas Administrative Code can also be found on the THCIC Web Site.

2 General Information And Overview

THCIC's primary purpose is to provide data that will enable Texas consumers and health plan purchasers to make informed health care decisions.

2.1 General Overview

Submitters are required to use the Outpatient THCIC 837 Institutional claim format (modified ANSI ASC X12N 837 Institutional claim format or modified ANSI ASC X12N 837 Professional guide format) to submit data on patients that receive one or more of procedures covered by the specified revenue codes in Title 25 Texas Administrative Code 421.67(32).

System13, Inc. maintains the THCIC Health Care Data Collection System (HCDCS), hereafter referenced as "the system", "the System13/THCIC system", or similar variations. The system is accessed by providers via a website that allows providers to submit data files and manually enter, modify, delete, and report on data formatted using the requirements described in this document.

Submissions are acknowledged upon receipt into the system. When a file is received at THCIC's online system (receiver process), an email receipt notification will be sent to the submitter indicating if the file was accepted or rejected for further processing. For a file to be accepted for further processing, its THCIC ID, NPI and/or EIN and the first 15 characters of the facility's submission address for each facility reported in the file must match the provider information THCIC has on file.

The system pre-process checks for formatting compliance. Files failing the format audits will not be accepted into the system. If a file is not accepted for processing, the email notification includes information regarding the failed formatting audits.

The system pre-process determines if a file is a Test (T) file or a Production (P) file. Claims submitted and accepted into the system in either a Production or Test file will be subjected to THCIC data requirement audits. For claims submitted in a Production file, the results of the auditing process will be made available to the provider (facility) and the facility will be given an opportunity to correct the claims. Claims can be corrected by using the system's web portal claim correction function, using the batch deletion component of the online system, or submitting corrected claims via the file submission process using the claim bill frequency type for deletion/replacement as appropriate. For claims submitted in a test file, the result of the auditing process will be made available to the submitter.

For more detail on the file submission process as well as the use of the System13/THCIC System, please see:

DSHS THCIC Outpatient Data Reporting Requirements

2.2 Reference Information

The Outpatient THCIC 837 Institutional or Professional claim format draws from the specifications for the ANSI 837 Health Care Institutional and Professional claim formats from the American National Standards Institutes, Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional, 837, ASC X12N 837 (005010X223) and Professional, ASC X12N (005010X222), May 2006 version, and the addenda published by the Washington Publishing Company in October 2007 (ANSI 837 Institutional Guide, 005010X223A2 and ANSI 837 Professional Guide 005010X222A1,which can be purchased and downloaded from the following website: X12 Product Licensing Program)

The Department of State Health Services requested permission to reproduce portions of the ANSI 837 Institutional and ANSI 837 Professional Guides and has been granted conditional approval to reproduce or cite ASC X12 materials as presented.

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Only the sections required by THCIC or situational ANSI 837 Institutional and Professional Guide sections are reproduced in this manual.

2.3 The THCIC Business Associate - System13, Inc.

System13, Inc. provides a testing process to ensure that a hospital or vendor submits a HIPAA compatible ANSI 837 Institutional and Professional Guide formatted file with the additional required fields listed in this manual then that data file should pass the audits at System13, Inc. System13, Inc. (System13) located in Charlottesville, Virginia, is contracted to provide data collection, auditing, and warehousing of the data submitted by hospitals. System13, Inc. Contact Information:

E-mail	thcichelp@system13.com
Helpdesk Phone#	(888) 308-4953 Monday through Friday 8:00 a.m. to 5:00 p.m. (CT)
Fax	(434) 979-1047

Data Portal Web Site - https://thcic.system13.com/
This is for uploading data files and manually entering claims online (data submission), manual claim correction, and data reports.

2.4 THCIC Web Site

The THCIC web site contains the latest information about THCIC, the outpatient discharge data reporting process, and other THCIC activities and publications. The site contains information about legislative mandates, instructions concerning the data reporting process, and THCIC staff contact information.

3 Definitions And Acronyms

Accurate and Consistent Data	Data that has been edited by DSHS and subjected to provider validation and certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(1)
Ambulatory Surgical Care Data	Data for events associated with facility services, which require surgery to be performed in an operating room on an anesthetized patient. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(2)
Ambulatory surgical center	An establishment licensed as an ambulatory surgical center under the Health and Safety Code, Chapter 243 Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(3)
Anesthetized patient	For the purposes Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(4) of this subchapter, an outpatient who receives an anesthetic (a substance that reduces sensitivity, feeling, or awareness to pain or bodily sensations or renders the patient unconscious) prior to surgical services from a hospital or ambulatory surgical center
ANSI 837 Institutional Guide	American National Standards Institute, Accrediting Standards Committee electronic claims format for billing health care services [specifications can be obtained via the Internet at Washington Publishing Company and Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(5)
ANSI 837 Professional Guide	American National Standards Institute, Accrediting Standards Committee electronic claims format for billing health care services [specifications can be obtained via the Internet at: Washington Publishing Company and Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(6)
APC	Ambulatory Payment Classification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(7)
APG	Ambulatory Patient Group - A prospective payment system (PPS) for hospital-based outpatient care developed by 3M. APGs provide information regarding the kinds and amounts of resources utilized in an outpatient visit and classify patients with similar clinical characteristics. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(8)
ASC	Ambulatory Surgical Center (ASC) - A facility that primarily provides surgical services to patients who do not require overnight hospitalization or extensive recovery, convalescent time or observation. Title 25 Texas Administrative Code, Chapter 135, Rule 135.2(5)
Audit	An electronic standardized process developed and implemented by DSHS to identify potential errors and mistakes in file structure format or data element content by reviewing data fields for the presence or absence of data and the accuracy and appropriateness of data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(9)

Certification File	One or more electronic files (may include reports concerning the data and its compilation process) compiled by DSHS that contain one record for each patient event which has at least one procedure covered in the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title (relating to Event Files--Records, Data Fields and Codes) submitted for each facility under this subchapter during the reporting quarter and may contain one record for any patient event occurring during one prior reporting quarter for whom additional event claims have been received. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(10)
Certification Process	The process by which a provider confirms the accuracy and completeness of the certification file required to produce the public use data file as specified in Title 25 Texas Administrative Code, Chapter 421, Rule 421.66 of this title (relating to Certification of Compiled Event Data). Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(11)
Charge	The amount billed by a provider for specific procedures or services provided to a patient before any adjustment for contractual allowances, government mandated fee schedules or write offs for charity care, bad debt or administrative courtesy. The term does not include co-payments charged to health maintenance organization enrollees by providers paid by capitation or salary in a health maintenance organization. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(12)
Clinical Classifications Software	A classification system that groups diagnoses and procedures into a limited number of clinically meaningful categories developed at the United States Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ). Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(13)
CRG	Clinical Risk Grouping software which classifies individuals into mutually exclusive categories and, using claims data, assigns the patient to a severity level if they have a chronic health condition. Developed by 3M™ Corporation. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(14)
Comments	The notes or explanations submitted by the facilities, physicians or other health professionals concerning the provider quality reports or the encounter data for public use as described in the Texas Health and Safety Code, §108.010(c) and (e) and §108.011(g) respectively. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(15)
Data format	The sequence or location of data elements in an electronic record according to prescribed specifications. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(16)
DSHS	Department of State Health Services, the successor state agency to the Texas Health Care Information Council and the Texas Department of Health. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(17)

EDI	Electronic Data Interchange--A method of sending data electronically from one computer to another. EDI helps providers and payers maintain a flow of vital information by enabling the transmission of claims and managed care transactions. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(18)
Edit	An electronic standardized process developed and implemented by the THCIC to identify potential errors and mistakes in data elements by reviewing data fields for the presence or absence of data, and the accuracy and appropriateness of data. (§108.002(8) Health and Safety Code) For the purposes of this manual: **1.** To make changes to a data file. **2.** The process of adding, deleting, or changing data. The THCIC edits the public use data file to protect the confidentiality of patients and physicians.
Electronic Filing	The submission of computer records in machine readable form by modem transfer from one computer to another (EDI) or by recording the records on a nine - track magnetic tape, computer diskette or other magnetic media acceptable to DSHS. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(19)
EMC	Electronic Media Claims (National Standard Format)
Emergency Department	Department or room within a hospital as determined by federal or state law for the provision of emergency health care. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(20)
Emergency Department Data	Events associated with hospital services in an emergency department or emergency room. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(21)
Encounter	An electronic record that contains information on all services rendered for a patient episode of care (admission through discharge) by a provider in a patient care setting (e.g., hospital, out-patient clinic, doctor's office).
Error	Data submitted on an event file which are not consistent with the format and data standards contained in this subchapter or with auditing criteria established by DSHS. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(22)
Ethnicity	The status of patients relative to Hispanic background. Facilities shall report this data element according to the following ethnic types: Hispanic or Non- Hispanic. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(23)
Event	The medical screening examination, triage, observation, diagnosis or treatment of a patient within the authority of a facility. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(24)
Event claim	A set of computer records as specified in §421.67 of this title relating to a specific patient. "Event claim" corresponds to the ANSI 837 Institutional Guide and ANSI 837 Professional Guide term, "Transaction set." Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(25)

Event file	A computer file as defined in §421.67(d), (e) of this title periodically submitted on or on behalf of a facility in compliance with the provisions of this subchapter. "Event File" corresponds to the ANSI 837 Institutional Guide and ANSI 837 Professional Guide terms, "Communication Envelope" or "Interchange Envelope." Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(26)
Facility	For the purposes of this subchapter a facility is a hospital or ambulatory surgical center, required to report under the Health and Safety Code, Chapter 108 and this subchapter. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(27)
Facility Type Indicators	An indicator that provides information to the data user as to the type of facility or the primary health services delivered at that hospital (e.g., Hospital based ambulatory surgical unit and hospitals with an emergency department or emergency room) and ambulatory surgical centers. A facility may have more than one indicator. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(28)
Geographic identifiers	A set of codes indicating the health service region and county in which the patient resides. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(29)
HCDCS	Health Care Data Collection System.
HCPCS	Healthcare Common Procedure Coding System of the Centers for Medicare and Medicaid Services. This includes the "Current Procedural Terminology" (CPT) codes (maintained by the "American Medical Association" (AMA)), which are "Level 1" HCPCS codes. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(30)
HIPPS	Health Insurance Prospective Payment System. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(31)
Hospital	A public, for-profit, or nonprofit institution licensed as a general or special hospital (25 TAC §133.2(21)) of this title, or a hospital owned by the state. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(32)
ICD	International Classification of Disease. The *International Classification of Diseases, Clinical Modification* (ICD-CM) is a system used to code and classify mortality data from death certificates. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(33)
Insured	Services for which the provider expects payment from a third party insuring Payer (e.g., Medicare, Medicaid, Blue Cross).
Non-insured	Services for which the Provider cannot bill a third party insuring payer (e.g., self-pay, charity).
IRB	Institutional Review Board composed of DSHS' appointees or agents who have experience and expertise in ethics, patient confidentiality, and health care data who review and approve or disapprove requests for data or information other than the outpatient event public use data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(34)

Operating or Other Physician	The "physician" licensed by the Texas Medical Board or "other health professional" licensed by the State of Texas who performed the surgical or radiological procedure most closely related to the principal diagnosis. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(35)
Other health professional	A person licensed to provide health care services other than a physician. An individual other than a physician who provides diagnostic or therapeutic procedures to patients. The term encompasses persons licensed under various Texas practice statutes, such as psychologists, chiropractors, dentists, nurse practitioners, nurse midwives, and podiatrists who are authorized by the facilities to examine, observe or treat patients. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(36)
Other Provider	For the purposes of reporting on the modified ANSI 837 Institutional Guide, the physician, other health professional or facility as reported on a claim, who performed a secondary surgical or a primary or secondary radiological procedure on the patient for the event if they are not reported as the operating or other physician or the facility. In the case where a substitute provider (locum tenens) is used, that physician or other health professional shall be submitted as specified in this subchapter. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(37)
Outpatient or patient	For the purposes of this subchapter a patient who receives surgical or radiological services from an ambulatory surgical center or a patient who receives surgical or radiological services from a hospital and is not admitted to a hospital for inpatient services. Outpatients include patients who receive one or more services covered by the revenue codes or surgical and radiological categories that are specified in §421.67(f) or §421.67(g) of this title, which may occur in the emergency department, ambulatory care, radiological, imaging or other types of hospital units. Outpatient includes a patient who is transferred from an ambulatory surgical center to another facility or a hospital patient who is under observation and not admitted to the hospital. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(38)
Patient account number	A number assigned to each patient by the facility, which appears on each computer record in a patient event claim. This number is not consistent for a given patient from one facility to the next, or from one admission to the next in the same facility. DSHS will delete or encrypt this number to protect patient confidentiality prior to release of data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(39)
Payer	The organization that pays for medical services. Payers usually are contractually responsible for adjudication and payment of provider claims for health care services rendered.
Physician	An individual licensed under the laws of this state to practice medicine under the Medical Practice Act, Occupations Code, Chapter 151 et seq. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(40)
Provider	An individual licensed under the laws of this state to practice medicine under the Medical Practice Act, Occupations Code, Chapter 151. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(41)

Public use data file	For the purposes of this subchapter, a data file composed of event claims which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of data imposed by statute. 25 Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(42)
Race	A division of patients according, to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Facilities shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(43)
Radiological procedures	For the purposes of this subchapter, diagnostic procedures performed on a patient using radiant energy devices (Projection Radiology (for example - X-ray), Computed Tomography, or other ionizing radiation) or diagnostic radioactive material or other non-ionizing imaging devices (e.g., Magnetic Resonance Imaging, Nuclear Medicine devices (for example Positron Emission Tomography), Sound Imaging devices (for example Ultrasound or Echocardiography), Thermal imaging devices, Diagnostic Light imaging devices (for example - diagnostic photography, endoscopy, and fundoscopy) and other diagnostic imaging devices. 25 Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(44)
Rendering provider or rendering other health professional	For the purposes of reporting on the modified ANSI 837 Professional Guide, the physician or other health professional who performed the surgical or radiological procedure on the patient for the event. In the case where a substitute provider (locum tenens) is used, that physician or other health professional shall be submitted as specified in this subchapter. For purposes of this definition, the term "provider" is not limited to only a physician, or facility as defined in paragraphs (27), (37) and (41) of this subsection. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(45)
Required minimum data set	The list of data elements for which facilities may submit an event claim for each patient event occurring in the facility. The required minimum data sets are specified in §421.67(d) and (e) of this title. This list does not include all the data elements that are required by the modified ANSI 837 Institutional Guide or modified ANSI 837 Professional Guide to submit an acceptable event file. For example: Interchange Control Headers and Trailers, Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify or qualify subsequent data elements). 25 TAC §421.61(46)
Research data file	A customized data file, which may include the data elements in the public use file and may include data elements other than the required minimum data set submitted to DSHS, except those data elements that could reasonably identify a patient or physician. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(47)
Submission	The transfer of a set of computer records as specified in §421.67 of this title that constitutes the event file for one or more reporting hospitals under this subchapter. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(48)

Submitter	The person or organization, which physically prepares an event file for one or more facilities and submits them under this subchapter. A submitter may be a facility or an agent designated by a facility or its owner. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(49)
Surgical procedure	For the purposes of this subchapter, an invasive procedure that penetrates or breaks the skin or other patient tissue (in vivo) for the purpose diagnosing, evaluating, analyzing, monitoring or treating a patient. 25 TAC §421.61(50)
System13, Inc.	System13, Inc. is the contracting company for THCIC that collects, audits, and warehouses the inpatient and outpatient health care claim data.
THCIC	Texas Health Care Information Collection sub-unit in the Department of State Health Services, Center for Health Statistics.
THCIC Identification Number	A string of 6 characters assigned by DSHS to identify facilities for reporting and tracking purposes. For a facility operating multiple facility locations under one license number and duplicating services at those locations, the department will assign a distinguishable identifier for each separate facility location under one license number. The relationship of the identifier to the name and license number of the facility is public information. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(51)
Uniform patient identifier	A unique identifier assigned by DSHS to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across facilities and patient events. The relationship of the identifier to the patient-specific data elements used to assign it is confidential. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(52)
Uniform physician identifier	A unique identifier assigned by DSHS to a physician or other health professional who is reported as operating, rendering or other provider providing health care services or treating a patient in a facility and which remains constant across facilities. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(53)
User	For the purposes of this manual, Hospital or Submitter.
Validation	The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(54)

4 Technical Requirements Summary

4.1 Patient Inclusion Requirements

Hospitals and ASCs must submit the required data elements for all patient events in which the patient received one or more of the surgical procedures or radiological services covered by the revenue codes specified in Title 25 Texas Administrative Code, Chapter 421, Rule 421.67(f) from the hospitals or ambulatory surgical centers (see Title 25 Texas Administrative Code, Chapter 421, Rule 421.62). Additionally, all hospital or freestanding emergency medical care facility are required to report all patient emergency medical care visits (see Title 25 Texas Administrative Code, Chapter 421, Rule 421.72). These include patients for which the hospital may not generate an electronic claim, such as self-pay and charity.

4.2 Communications Requirements

4.2.1 Data Submission

In order to facilitate the implementation and operation of the Department of State Health Services data reporting programs under Chapter 108, Texas Health & Safety Code, it is necessary for each reporting health facility to provide the name and contact information for its designated THCIC contact person or liaison.

System13 accepts data from providers or from their submitting agents using transmission methods and protocols specified in this manual as authorized by THCIC Title 25 Texas Administrative Code, Chapter 421, Rule 421.4.

Prior to submitting electronic claims to System13, Inc. the submitter (Facility or facility's designee, corporate office or contact vendor) must register with System13, Inc. and complete the enrollment process. For enrollment information, please visit:

System13 Enrollments

For more information, please see document:

THCIC Submitter and Provider Enrollment Guide

4.2.2 Data Corrections

Providers that receive error or warning codes and messages can submit corrections either by making the corrections using Claim Correction (see Claim Correction at DSHS THCIC Outpatient Data Reporting Requirements) or by resubmitting claims to System13, Inc. Claims can be corrected in one of the following ways:

1. **Replacement of Erroneous Claim Data –**

   Submit "Replacement claims" (XX7) to System13, Inc.

   "Replacement claims" are required to have the following data elements match exactly to replace the claim data from System13, Inc:

   a. Patient Control Number (PCN) (can be changed in the THCIC System WebCorrect/Claims Correction [online])
   b. Medical Record Number (MRN)
   c. Statement Covers Period From Date

2. **Void or Cancel Erroneous Claim Data and Resubmit -**

   Submit "Void/Cancel claims" (XX8) to System13, then resubmit original bill type codes (XX0, XX1, XX5 or XX6) with the corrected data included.

   "Void/Cancel claims" are required to have the following data elements match exactly to delete the claim data from System13:

   a. Patient Control Number (PCN) (can be changed in the THCIC System WebCorrect/Claims Correction [online])
   b. Medical Record Number (MRN)
   c. Statement Covers Period From Date
   d. Statement Covers Period Through Date

3. **Delete Erroneous Claim Data and Resubmit**:

   a. The designated Facility "Data Administrator" may log into the secure website and delete errant or duplicate batches or claims using the "Batches" tab or "Data Mgmt" tab.
   b. Contact System13, Inc. and request that they delete the claims/batches with errors (a charge is associated with this process), and then resubmit original bill type codes (XX0, XX1, XX2, XX3, XX4 or XX5) with the corrected data.

Contact the System13, Inc. Help Desk:

E-mail thcichelp@system13.com
Helpdesk Phone# (888) 308-4953 Monday through Friday 8:00 a.m. to 5:00 p.m. (CT)
Fax# (434) 979-1047

4.3 Required Data File Formats And Data Elements

4.3.1 Data File Specifications

Claims data must be submitted in the THCIC 837 (modified ANSI X12N 837, version 5010 Institutional Claim) format. See Section 5 "THCIC 837 File Specifications" of this document.

4.3.2 State Required Data Elements

THCIC ANSI 837 Institutional Guide Data Elements

The following data elements must be submitted for each outpatient visit.

(1) Patient Name:
  (A) Patient Last Name
  (B) Patient First Name
  (C) Patient Middle Initial
(2) Patient Address:
  (A) Patient Address Line 1
  (B) Patient Address Line 2 (if applicable)
  (C) Patient City
  (D) Patient State
  (E) Patient ZIP
  (F) Patient Country (if address is not in United States of America or one of its territories)
(3) Patient Birth Date
(4) Patient Sex
(5) Patient Race
(6) Patient Ethnicity
(7) Patient Social Security Number
(8) Patient Account Number
(9) Patient Medical Record Number
(10) Claim Filing Indicator Code (Payer Source - primary and secondary, if applicable)
(11) Payer Name - Primary and secondary (if applicable, for both)
(12) National Plan Identifier - for primary and secondary (if applicable) payers (National Health Plan Identification number, if applicable and when assigned by the federal government)
(13) Type of Bill (Facility Type Code plus Claim Frequency Code)
(14) Statement Dates
(15) Principal Diagnosis
(16) Patient's Reason for Visit
(17) External Cause of Injury (E-Code) up to 10 occurrences (if applicable)
(18) Other Diagnosis Codes - up to 24 occurrences (if applicable)
(19) Occurrence Span Code – up to 4 occurrences (if applicable)
(20) Occurrence Span Associated Dates – up to 4 occurrences (if applicable)
(21) Occurrence Code - up to 12 occurrences (if applicable)
(22) Occurrence Code Associated Date - up to 12 occurrences (if applicable)
(23) Value Code - up to 12 occurrences (if applicable)
(24) Value Code Associated Amount - up to 12 occurrences (if applicable)
(25) Condition Code - up to 8 occurrences (if applicable)
(26) Other Provider or Other Health Professional Name (if applicable):
  (A) Other Provider or Other Health Professional - Last Name
  (B) Other Provider or Other Health Professional - First Name
  (C) Other Provider or Other Health Professional - Middle Initial

(27) Other Provider or Other Health Professional Primary Identifier (National Provider Identifier)
(28) Other Provider or Other Health Professional Secondary Identifier (Texas State Provider Identifier)
(29) Operating Physician or Other operating health professional Name
(30) Operating Physician or other Health Professional Primary Identifier (National Provider Identifier)
(31) Operating Physician or Other Health Professional Secondary Identifier (Texas state license number)
(32) Total Claim Charges
  (A) Revenue Code
  (B) Procedure Code
  (C) HCPCS Procedure Modifier 1
  (D) HCPCS Procedure Modifier 2
  (E) HCPCS Procedure Modifier 3
  (F) HCPCS Procedure Modifier 4
  (G) Charge Amount
  (H) Unit Code
  (I) Unit Quantity
  (J) Unit Rate
  (K) Non-covered Charge Amount
(33) Service Line Date
(34) Service Provider
(35) Service Provider Primary Identifier – Provider Federal Tax ID(EIN) or National Identifier
(36) Service Provider Address:
  (A) Service Provider Address Line 1
  (B) Service Provider Address Line 2 (if applicable)
  (C) Service Provider City
  (D) Service Provider State
  (E) Service Provider ZIP and
(37) Service Provider Secondary Identifier - THCIC 6-digit facility ID assigned to each facility
(38) Attending Physician or Attending Practitioner Name
  (A) Attending Practitioner Last Name
  (B) Attending Practitioner First Name
  (C) Attending Practitioner Middle Initial
(39) Attending Practitioner Primary Identifier (National Provider Identifier, when HIPAA rule is implemented)
(40) Attending Practitioner Secondary Identifier (Texas state license number)
(41) Point of Origin (Source of Admission) (Emergency Department Visits only)
(42) Patient Status (Emergency Department Visits only)

THCIC ANSI 837 Professional Data Elements

Facilities shall submit the following required minimum data set in the following modified ANSI 837 Professional Guide format for all patients for which an event claim is required by a third-party payer to be in the ANSI 837 Professional Guide format or CMS-1500 format and required to be submitted under this subchapter. The required minimum data set for the modified (as specified in subsection (c) of this section) ANSI 837 Professional Guide format includes the following data elements as listed in this subsection:

(1) Patient Name:
  (A) Patient Last Name
  (B) Patient First Name
  (C) Patient Middle Initial
(2) Patient Address:
  (A) Patient Address Line 1
  (B) Patient Address Line 2 (if applicable)
  (C) Patient City
  (D) Patient State
  (E) Patient ZIP
  (F) Patient Country (if address is not in United States of America or one of its territories)
(3) Patient Birth Date
(4) Patient Sex
(5) Patient Race
(6) Patient Ethnicity
(7) Patient Social Security Number
(8) Patient Account Number
(9) Patient Medical Record Number (if applicable)
(10) Claim Filing Indicator Code (Payer Source - primary and secondary, if applicable)
(11) Payer Name - Primary and secondary (if applicable, for both)
(12) National Plan Identifier - for primary and secondary (if applicable) payers (National Health Plan Identification number, if applicable and when assigned by the federal government)
(13) Type of Bill (Facility Type Code plus Claim Frequency Code)
(14) Service Dates
(15) Principal Diagnosis
(16) Other Diagnosis Codes - up to 24 occurrences (all applicable)
(17) Related Cause Code - up to 3 occurrences (if applicable)
(18) Procedure Codes - up to 50 occurrences (all applicable):
  (A) HCPCS Procedure Modifier 1 (applicable to each submitted Procedure code)
  (B) HCPCS Procedure Modifier 2 (applicable to each submitted Procedure code)
  (C) HCPCS Procedure Modifier 3 (applicable to each submitted Procedure code)
  (D) HCPCS Procedure Modifier 4 (applicable to each submitted Procedure code)
  (E) Charge Amount
  (F) Unit Code
  (G) Unit Quantity

(19) Rendering Provider or Rendering Other Health Professional Name (Up to 2 occurrences):
  (A) Rendering Provider or Rendering Other Health Professional Last Name
  (B) Rendering Provider or Rendering Other Health Professional First Name
  (C) Rendering Provider or Rendering Other Health Professional Middle Initial

(20) Rendering Provider or Rendering Other Health Professional Primary Identifier (National Provider Identifier) (Up to 2 occurrences)

(21) Rendering Provider or Rendering Other Health Professional Secondary Identifier (Texas state license number) (if primary identifier not available) (Up to 2 occurrences)

(22) Total Claim Charges

(23) Service Provider Name

(24) Service Provider Primary Identifier -- Provider Federal Tax ID (EIN) or National Provider Identifier

(25) Service Provider Address:
  (A) Service Provider Address Line 1
  (B) Service Provider Address Line 2 (if applicable)
  (C) Service Provider City
  (D) Service Provider State
  (E) Service Provider ZIP

(26) Service Provider Secondary Identifier--THCIC 6-digit Hospital ID assigned to each facility

4.3.3 Revenue Codes

Facilities shall submit the required minimum data set to DSHS for each patient who has *one or more* of the following revenue codes for services rendered to the patient in the facility.

	Rev. Code	Revenue Code Description
1	0320	Radiology - Diagnostic General Classification
2	0321	Radiology - Diagnostic Angiocardiology
3	0322	Radiology - Diagnostic Arthrography
4	0323	Radiology - Diagnostic Arteriography
5	0329	Radiology - Diagnostic Other Radiology – Diagnostic
6	0330	Radiology - Therapeutic General Classification
7	0333	Radiology - Therapeutic Radiation Therapy
8	0339	Radiology - Therapeutic Other Radiology – Therapeutic
9	0340	Nuclear Medicine General Classification
10	0341	Nuclear Medicine Diagnostic
11	0342	Nuclear Medicine Therapeutic
12	0343	Nuclear Medicine Diagnostic Pharmaceuticals
13	0344	Nuclear Medicine Therapeutic Pharmaceuticals
14	0349	Nuclear Medicine Other Nuclear Medicine
15	0350	Computed Tomography (CT) Scan General Classification
16	0351	Computed Tomography (CT) - Head Scan
17	0352	Computed Tomography (CT) - Body Scan
18	0359	Computed Tomography (CT) - Other
19	0360	Operating Room Services General Classification
20	0361	Operating Room Services Minor Surgery
21	0369	Operating Room Services Other Operating Room Services
22	0400	Other Imaging Services General Classification
23	0401	Other Imaging Services Diagnostic Mammography
24	0403	Other Imaging Services Screening Mammography
25	0404	Other Imaging Services Positron Emission Tomography (PET)
26	0409	Other Imaging Services Other Imaging Services
27	0481	Cardiology Cardiac Catheterization Lab
28	0483	Cardiology Echocardiology
29	0489	Cardiology Other Cardiology Services
30	0490	Ambulatory Surgical Care General Classification
31	0499	Ambulatory Surgical Care Other Ambulatory Surgical
32	0500	Outpatient Services General Classification
33	0509	Outpatient Services Other Outpatient
34	0610	Magnetic Resonance Technology General Classification
35	0611	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Brain/Brainstem
36	0612	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Spinal Cord/Spine
37	0614	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Other

	Rev. Code	Revenue Code Description
38	0615	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Head and Neck
39	0616	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Lower Extremities
40	0618	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Other
41	0619	Magnetic Resonance Technology Other Magnetic Resonance Technology
42	0760	Specialty Room – Treatment/Observation Room General Classification
43	0761	Specialty Room – Treatment Room
44	0762	Specialty Room – Observation Room
45	0769	Specialty Room – Other Specialty Room
46	0450	ER -- General Classification
47	0451	ER -- Emergency Medical Screening – EMTALA
48	0452	ER -- Beyond EMTALA
49	0456	ER -- Urgent Care
50	0459	ER -- Other

4.3.4 Service and procedure categories

The web link to the list of outpatient Service and Procedure (HCPCS/CPT) codes that correspond to the AHRQ CCS list are posted our the THCIC website on the outpatient requirements webpage.

DSHS THCIC Hospital Reporting Requirements

What, how and when to report

Final rules for the collection and release of patient level data relating to patients that have surgical or radiological procedures (under specified revenue codes) performed in Texas hospitals (as an outpatient service including in the emergency department) or ambulatory surgical centers have been adopted and can be found in Chapter 421 of Title 25, Part 1 of the Texas Administrative Code. Title 25 Texas Administrative Code Chapter 421.

- Facilities are required to report data on patients who had surgical or radiological procedures that are covered by specific **revenue codes**.
- **Services and procedures categories** with associated outpatient procedure codes that are required for submission.
- For help with data submission or various help topics, contact the THCIC Help Desk at 1-888-308-4953. If there is no representative available to assist, a message can be left for a return call.

4.3.5 Data Elements by THCIC 837 Institutional Location

DATA ELEMENT LOCATION THCIC 837 INSTITUTIONAL	Loop	Ref. Des.
Patient Last Name	2010BA or 2010CA	NM103
Patient First Name	2010BA or 2010CA	NM104
Patient Middle Initial	2010BA or 2010CA	NM105
Patient Street Address	2010BA or 2010CA	N301
Patient City	2010BA or 2010CA	N401
Patient State	2010BA or 2010CA	N402
Patient Zip	2010BA or 2010CA	N403
Patient Country Code	2010BA or 2010CA	N404
Patient Birth Date	2010BA or 2010CA	DMG02
Patient Sex	2010BA or 2010CA	DMG03
Patient Race	2300	K301
Patient Ethnicity	2300	K301
Subscriber/Patient Social Security Number	2010BA	REF02
Patient Social Security Number	2300	K301
Patient Control Number/Patient Account Number	2300	CLM01
Medical Record Number	2300	REF02
Source of Payment Code (Standard)/ Claim Filing Indicator Code	2000B or 2320	SBR09
Payer Name	2010BB (and 2330B, if secondary payer)	NM103
National Plan Identifier (when implemented by Federal Government)	2010BB (and 2330B, if secondary payer)	NM109
Type of Bill (Facility Type Code plus Claim Frequency Code)	2300	CLM05
Statement Dates	2300	DTP03
Principal Diagnosis Code	2300	HI01
Patient's Reason for Visit	2300	HI01
External Cause of Injury (if applicable)	2300	HI03-2 thru HI12-2 *or Any HI segment with a "BN" qualifying code (HIxx-1)*
Other Diagnosis Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01-HI12
Occurrence Span Code (Up to 4 codes)	2300	HInn-2
Occurrence Span Associated Dates (Up to 4 codes)	2300	HInn-4
Occurrence Code (Up to 12 codes)	2300	HInn-2
Occurrence Code Associated Dates (Up to 12 codes)	2300	HInn-4
Value Code (Up to 12 codes)	2300	HInn-2
Value Code Associated Amount (Up to 12 codes)	2300	HInn-5
Condition Code (Up to 8 codes)	2300	HInn-2
Attending Physician Name	2310A	NM103, NM104, and NM105
Attending Physician Number	2310A	NM109 (NPI) or REF02 (State License)

DATA ELEMENT LOCATION THCIC 837 INSTITUTIONAL	Loop	Ref. Des.
Operating or Other Physician Name	2310B	NM103, NM104, and NM105
Operating or Other Physician Number	2310B	NM109 (NPI) or REF02 (State License)
Other Provider Name	2310C	NM103, NM104, and NM105
Other Provider Number	2310C	NM109 (NPI) or REF02 (State License)
Total Claim Charges	2300	CLM02
Accommodations Revenue Codes or Revenue Codes	2400	SV201
Outpatient Ancillary Revenue Code or HCPCS/HIPPS Procedure Codes	2400	SV202-2
HCPCS/HIPPS Procedure Code Modifiers	2400	SV202-3 to SV202-6
Accommodation Total Charges or Charge Amount	2400	SV203
Ancillary Charges Total or Charge Amount	2400	SV203
Unit Code	2400	SV204
Accommodations Days or Unit Quantity	2400	SV205
Units of Service or Unit Quantity	2400	SV205
Accommodations Rate or Unit Rate	2400	SV206
Service Line Date	2400	DTP03
Provider Name	2010AA or 2310E	NM103
Provider Address	2010AA or 2310E	N301
Provider City	2010AA or 2310E	N401
Provider ZIP Code	2010AA or 2310E	N403
Provider National Provider Identification Number (NPI)	2010AA or 2310E	NM109
Provider Tax Identification (EIN)	2010AA or 2310E	REF02
Provider THCIC ID Identification (6 Digit) number assigned by THCIC	2010AA or 2310E or 2310E	REF02
Point of Origin	2300	CL102
Patient Status	2300	CL103

4.3.6 Data Elements by THCIC 837 Professional Location

DATA ELEMENT THCIC 837 PROFESSIONAL	Loop	Ref. Des.
Patient Last Name	2010BA or 2010CA	NM103
Patient First Name	2010BA or 2010CA	NM104
Patient Middle Initial	2010BA or 2010CA	NM105
Patient Street Address	2010BA or 2010CA	N301
Patient City	2010BA or 2010CA	N401
Patient State	2010BA or 2010CA	N402
Patient Zip	2010BA or 2010CA	N403
Patient Country Code	2010BA or 2010CA	N404
Patient Birth Date	2010BA or 2010CA	DMG02
Patient Sex	2010BA or 2010CA	DMG03
Patient Race	2300	K301
Patient Ethnicity	2300	K301
Subscriber/Patient Social Security Number	2010BA	REF02
Patient Social Security Number	2300	K301
Patient Control Number/Patient Account Number	2300	CLM01
Medical Record Number	2300	REF02
Source of Payment Code (Standard)/ Claim Filing Indicator Code	2000B or 2320	SBR09
Payer Name	2010BB (and 2330B, if secondary payer)	NM103
National Plan Identifier (when implemented by Federal Government)	2010BB (and 2330B, if secondary payer)	NM109
Type of Bill (Facility Type Code plus Claim Frequency Code)	2300	CLM05
Principal Diagnosis Code	2300	HI01
External Cause of Injury (if applicable)	2300	HI03-2 thru HI12-2 *or Any HI segment with a "BN" qualifying code (HIxx-1)*
Other Diagnosis Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01-HI12
Principal Surgical Procedure Code (If applicable)	2300	HI01
Principal Surgical Procedure Date (If applicable)	2300	HI01
Other Surgical Procedure Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01-HI12
Other Surgical Procedure Dates (If applicable)	2300	HI01-HI12, plus a second segment HI01-HI12
Procedure Coding Method Used/ Code List Qualifier Code	2300	HInn – 1
Rendering Physician Name	2310B or 2420A	NM103, NM104, and NM105
Rendering Physician Number	2310B or 2420A	NM109 (NPI) or REF02 (State License
Total Claim Charges	2300	CLM02

DATA ELEMENT THCIC 837 PROFESSIONAL	Loop	Ref. Des.
Outpatient Ancillary Revenue Code or HCPCS Procedure Codes	2400	SV101-2
HCPCS Procedure Code Modifiers	2400	SV101-3 thru SV101-6
Monetary Amount	2400	SV102
Unit Code	2400	SV103
Unit Quantity	2400	SV104
Facility Code Value (if different from CLM05)	2400	SV105
Diagnosis Code Pointer	2400	SV107-1 thru SV107-4
Date – Service Date	2400	DTP
Provider Name	2010AA or 2010AB or 2310C	NM103
Provider Address	2010AA or 2010AB or 2310C	N301
Provider City	2010AA or 2010AB or 2310C	N401
Provider ZIP Code	2010AA or 2010AB or 2310C	N403
Provider National Provider Identification Number (NPI)	2010AA or 2310C	NM109
Provider Tax Identification (EIN)	2010AA or 2310E	REF02
Provider THCIC Identification 6 Digit) number assigned by THCIC	2010AA or 2010BB or 2310C	REF02

4.4 Billing Claims Validation and Acceptance

All submitted claims are audited and validated for adherence to the Outpatient THCIC 837 Institutional and Professional Guide specifications prior to being accepted for processing by System13, Inc. Audits required for validation include, at a minimum, those audits specified in the Appendices document. Audits will be applied at the data element level or record level and without regard to other billing claim records previously received for a provider or a patient.

4.5 System Resources and Availability

The system is available to collect and accept data from submitters seven (7) days a week, twenty-four (24) hours a day.

Secured electronic system for notification is available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information

1. ach billing claims submission must contain at least one valid file, including valid file header /trailer records.
2. A file/Transaction Set must contain one valid claim for the file/Transaction Set to be accepted.
3. Claim file numbers may not be reused within six months of acceptance of the first use of the batch number.
4. Claim detail charges and claim counts must balance with batch and file totals.
5. Claims submission may contain only valid record types/Data segments as defined in the ANSI 837 specifications.
6. All fields defined as number must contain numerical data.
7. All fields designated as required date fields must contain valid dates. Dates must be submitted in CCYYMMDD format including the patient's birth date. All other date fields may contain a valid date or may be blank or zero filled.

4.6 Auditing of Data by System13, Inc.

Audits are listed on the THCIC website at: Hospital Reporting Requirements

5010 Inpatient and Outpatient, Latest Version
Contains default codes, payer source codes, audit list, race/ethnicity documents, and other helpful information.

On page 19, we have available for your convenience:

APPENDIX - A5 INPATIENT & OUTPATIENT AUDIT ID'S THCIC

Table A Pre-Processing Audits (Format Check) (Example)

Audit MSG. ID	Audit Description
Example:	**Example:**
RJ001 - Missing/Invalid ISA Interchange Control Header Segment.	RJ001 - The first three characters in all 837 files are 'ISA'. This file does not start with 'ISA'. Our system has stopped processing this file.

Audit MSG. ID	Audit Description
RJ002 - ISA06 (Interchange Sender ID) contains invalid Submitter _ID='SUB999'.	RJ002 - Submitter Id's are six characters long, begin with 'SUB', and are followed by three numbers (e.g. SUB999). Do not put 'TH' in front of your Submitter Id. THSUB999 is a login, SUB999 is a Submitter Id.

And on page 28, we have available for your convenience:

Table B Claim Level Audit's (Example)

Audit Id	Status	Audit Message	Audit Description	Audit Severity
600	I	Missing Principal Procedure Date	If the Principal Procedure exists, the Principal Procedure Date must exist and contain a valid date of the format ccyymmdd.	Error

5 THCIC 837 File Specifications

5.1 Reference Information

The Outpatient THCIC 837 claim format draws from the specifications for the ANSI 837 health care claim format from the American National Standards Institutes, Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional, 837, ASC X12N 837 (005010X223), May 2006 version, and the addenda published by the Washington Publishing Company in October 2007 (ANSI 837 Institutional Guide, 005010X223A1) or the American National Standards Institutes, Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional, 837, ASC X12N 837 (005010X222), May 2006 version, and the addenda published by the Washington Publishing Company in October 2007 (**ANSI 837 Institutional Guide**, 005010X223A2 and **ANSI 837 Professional Guide** 005010X222A1, which can be purchased and downloaded from the following website

X12 Product Licensing Program

The Department of State Health Services requested permission to reproduce portions of the ANSI 837 Institutional and ANSI 837 Professional Guides and has been granted conditional to approval reproduce or cite ASC X12 materials as presented.

This document is published under the following copyright statement:

Only the sections required by THCIC or situational ANSI 837 Institutional Guide or ANSI 837 Professional Guide sections are reproduced in this manual. Following is a table of the data elements, which have been modified from the ANSI 837 Institutional Guide or ANSI 837 Professional Guide to meet the THCIC requirements for data submission.

A rule of thumb: If a hospital or vendor submits a HIPAA compliant ANSI 837 Institutional Guide or ANSI 837 Professional Guide formatted file with the additional required fields listed below, then that data file should pass the audits at System13.

5.2 Data Elements with Requirements Different than the ANSI 837 Guide

Data elements listed as "Situational" or "Not Used" in the ANSI 837 Institutional Guide or ANSI 837 Professional Guide, but **REQUIRED** by THCIC, are listed below:

Table 1: THCIC Data Elements where usage differs from ANSI 837 Institutional and Professional Guide

Data Elements	Loop	Ref. Des.	Difference
National Provider Identification Number (**NPI) *(INST and PROF.)***	2010AA[1] or 2310C* (P) or 2310E*(I)	NM109	The Name segments in Loop 2310C and 2310E are dependent upon who renders the service.
Provider Tax Identification **(EIN)**	2010AA* or 2310E*(Inst.)	REF02 (or NM109)	The REF segment in Loop 2010AA and 2310E are SITUATIONAL and would be required if the NPI is submitted in NM109 of the same loop.
Claim Filing Indicator Code **(INST and PROF.)**	2000B or 2320	SBR09	SBR09 (Required for Primary and Secondary Payers)
Provider THCIC Identification **(INST and PROF.)**	2010AA[2] or 2010BB* or 2310C* (P) or 2310E*(I)	REF02	REF Segment is marked situational for all loops. Though one loop will be required and is dependent upon which Loop indicates the facility that renders the service to patient.
Subscriber\Patient Social Security Number ***(INST and PROF.)***	2010BA[3]	REF02	REF segment (Required, not required for subscriber if they are not the patient). SSN moves to 3rd -11th characters with change to new contract in response to HB 2641 84th Texas Legislature).
Patient Social Security Number ***(INST and PROF.)***	2300	K301	K3 segment (Required, if patient is not listed as the subscriber and SSN reported in 2010BA | REF02.
Patient Ethnicity ***(INST and PROF.)***	2300	K301	K3 segment first character with change to new contract in response to HB 2641 84th Texas Legislature)
Patient Race *(**INST and PROF.**)*	2300	K301	(Required)(K3 segment second character with change to new contract in response to HB 2641 84th Texas Legislature)
Principal Diagnosis *(**INST and PROF.**)*	2300	HI01	Bill Type 4XX and 5XX in the addenda were provided exemptions in the ANSI 837 Institutional Guide or ANSI 837 Professional Guide. (Required)
Medical Record Number (***INST and PROF.**)*	2300	REF02	REF segment (Required)
Other Provider Name (***INST**)*	2310C	NM1 and REF Segments	Segments are required for Outpatient claims data
Diagnosis Code Pointer ***(PROF.)***	2400	SV107	SV107 is required per ANSI requirement (Required)

Data Elements	Loop	Ref. Des.	Difference
Service Line Date ***(INST)***	2400	DTP Segment	Segment required for revenue and procedure codes in SV2 segment.
Required by THCIC if Applicable			
Subscriber Name ***(INST and (PROF.)***	2010BA[4]	NM103-Last NM104-First NM105-MI	Segment is situational for THCIC submissions, only required if Subscriber is Patient.
Health Care Diagnosis Code **(PROF.)**	2300	HI09 – HI12	Data fields are Situational for THCIC, but are marked Not Used by ANSI 837 Professional Guide.
External Cause of Injury[5] **(INST)**	2300	HI03-2 HI12-2 **(INST)**	HI03-HI12 are marked situational (Inst) Requires "BN" or "ABN" qualifier code in HInn-1 to identify following code is E- Code.
External Cause of Injury[6] **(PROF.)**	2300	Any HI02-2- HI12-2 **(PROF.)**	THCIC will accept "BN" or "ABN" as qualifier code in HInn-1 for E-codes.
Service Facility Name and Identification Numbers	2310E **(*INST.*)** 2310C (***PROF.***)	NM108, NM109, REF01, and REF02	THCIC requires Facility Identification information for rendering facility
Other Subscriber Information **(INST)**	2320	SBR09	THCIC requires secondary payer Claim Filing Indicator Code.

1 Dependent on which facility is indicated as rendering the services to the patient.
2 Dependent on which facility is indicated as rendering the services to the patient.
3 Dependent on whether the subscriber is the patient.
4 Dependent on whether the subscriber is the patient.
5 Allows for 9 additional E-codes (10 total)
6 Allows for 9 additional E-codes (10 total)

Not required by THCIC but Required or Situational by ANSI Guide			
Data Elements	**Loop**	**Ref. Des.**	**Difference**
Subscriber Reference Identification, Name, and Insurance Type Code ***(INST and PROF.)***	2000B	SBR03, SBR04 SBR05 *(P)*	"Not used" by THCIC, Situational for ANSI 837 Claims.
Subscriber Identification Qualifier and Code ***(INST and PROF.)***	2010BA	NM108, NM109	"Not used" by THCIC, Situational for ANSI 837 Claims.
Patient Identification Qualifier and Code ***(INST and PROF.)***	2010CA	NM108, NM109	"Not used" by THCIC, Situational for ANSI 837 Claims.
Yes/No Condition or Response Code ***(PROF.)***	2300	CLM06, CLM08, CLM13, CLM15, CLM18	Not used" by THCIC, Required or Situational for ANSI 837 Professional Claims.
Provider Accept Assignment Code	2300	CLM07	Not used" by THCIC, Required for ANSI 837 Professional Claims.
Release of Information Code	2300	CLM09	Not used" by THCIC, Required for ANSI 837 Professional Claims.
Patient Signature Source Code	2300	CLM10	Not used" by THCIC, Situational for ANSI 837 Professional Claims.
State or Province Code and Country Code (Related Cause) ***(PROF.)***	2300	CLM11 - 4, CLM11 - 5	Not used" by THCIC, Situational for ANSI 837 Professional Claims.
Special Program Code	2300	CLM12	Not used" by THCIC, Situational for ANSI 837 Professional Claims.
Provider Agreement Code	2300	CLM16	Not used" by THCIC, Situational for ANSI 837 Professional Claims.
Delay Reason Code	2300	CLM20	Not used" by THCIC, Situational for ANSI 837 Professional Claims.
Occurrence Span Information ***(INST)***	2300	HI05 - HI12	Not used" by THCIC, Situational for ANSI 837 Institutional Claims.
Condition Information *(**INST and PROF.**)*	2300	HI09 - HI12	Not used" by THCIC on outpatient claims. Situational for ANSI 837 Institutional Claims.
Other Provider Specialty Information ***(INST and PROF.)***	2310C	PRV segment	"Not Used" or collected by THCIC. Not listed in this manual.

Data Elements	Loop	Ref. Des.	Difference
Other Subscriber Information ***(INST)***	2320	SBR02, SBR03, SBR04,	Not used" by THCIC, Required or Situational for ANSI 837 Institutional Claims.
Yes/No Condition or Response Code ***(PROF.)***	2400	SV109, SV111, SV112	"Not Used" or collected by THCIC.
Copay Status Code ***(PROF.)***	2400	SV115	"Not Used" or collected by THCIC.

5.3 Basic Structure

The X12 standards define commonly used business transactions in a formal, structured manner called transaction sets. A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of: a unique segment ID; one or more logically related simple data elements or composite data structures, or both, each proceeded by a data element separator; and a segment terminator.

Composite data structures are composed of one or more logically related component data elements. Each composite data structure is followed by a component element separator with the exception of the last one element. The data segment directory entry referenced by the data segment ID defines the sequence of simple data elements and composite data structures in the segment, and any interdependencies that may exist. The composite data structure directory entry referenced by the composite data structure number defines the sequence of component data elements in the composite data structure.

A data element in the transaction set header identifies the type of transaction set. A functional group contains one or more related transaction sets preceded by a functional group header control segment and terminated by a functional group trailer control segment.

5.4 ANSI Terminology

The following terms are particularly key to understanding and using this section.

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.
Control Segment, Interchange Control Segments	The Interchange Control Header (ISA) is used to denote the start and end of Functional Groups (GS). Each element on the line is in a fixed position. It defines what characters are used for segment, element, and other control characters. The ISA has an associate Interchange Control Trailer (IEA) to end the interchange group.
Control Segment, Functional Group Segments	The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets. It also provides control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.
Control Segment, Transaction Set Segments	The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer defines the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.
Control Segment, Hierarchical Level Segments	Hierarchical Level segments denote the start of a group of information. The information may be about a provider of date, about the insured person, or about a patient claim. It ends when another Hierarchical Loop occurs, or when a transaction trailer (SE) is received.
Control Segment, Relations among Control Segments	The control segments of this standard must have a nested relationship, as shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments. ISA Interchange Control Header GS Functional Group Header, starts a group of related Transaction sets. ST Transaction Set Header, starts a transaction set. HL Hierarchical Level, starts a bounded loop of data segments. SE Transaction Set Trailer, ends a transaction set. GE Functional Group Trailer, ends a group of related transaction sets. IEA Interchange Control Trailer

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.
	More than one ST/SE pair, each representing a transaction set, may be used within one functional group. More than one GS/GE pair, each representing a Functional Group, may be used within one ISA/IEA pair.
Data Element	The data element is the smallest unit of information in the X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinal positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.
Data Element, Numeric	A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data. The data element dictionary defines the number of implied decimal positions. The representation for this data element type is Nn where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point. If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of numeric type data elements does not include the optional sign. FOR EXAMPLE: Value is "-123.4". Numeric type is "N2" where the "2" indicates an implied decimal placement two positions from the right. The data stream value is "- 12340". The length is 5 (note padded zero).
Data Element, Decimal Number	A decimal data element contains an explicit decimal point and is used for numeric values that have a varying number of decimal positions. The representation for this data element type is "R." The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.
	prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point
Data Element, Identifier	An identifier data element always contains a value from a predefined list of values. Trailing spaces should be suppressed unless necessary to satisfy minimum length. The representation for this data element type is "ID."
Data Element, String	A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified and shall be space filled. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy minimum length. The representation for this data element type is "AN."
Data Element, Date	A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the century or first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is "DT." Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.
Data Element, Time	A time data element is used to express the ISO standard time HHMMSSdd format in which HH is the hour for a 24-hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is "TM."
Data Element, Length	Length: Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements
Data Element, *Reference Number*	Data elements are assigned a unique reference number to locate them in the data dictionary. For each data element, the dictionary specifies the name, description, type, minimum length, and maximum length. For ID data elements, the dictionary lists all code values and their descriptions or references where the valid code list can be obtained.
Data Element Type	The following types of data elements appear in the dictionary.

Type	Symbol

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.	
	Numeric Decimal Identifier String Date Time	NN R ID AN DT TM
Data Segment	The data segment is used primarily to convey user information while the control segment is used primarily to convey control information and for grouping data segments. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each proceeded by a data element separator, and a segment terminator.	
Data Segment, Identifier	Each data segment has a unique two- or three-position identifier. This identifier serves as a label for the data segment.	
Data Segment, Data Elements in a Segment	In defining a segment, each simple data element or composite data structure within the data segment is further characterized by a reference designator and a data element reference number or composite data structure reference identifier. Simple data elements and composite data elements may have additional attributes, including a condition designator and a semantic note designator.	
Data Segment Data Element	Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two- digit number that defines the position of the simple data element or composite data structure in that segment. For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is a two-digit number, prefixed with a hyphen that defines the position of the component data element in the composite data structure. For example: The first simple element of the SVC segment would be identified as SVC01 because the position count does not include the segment identifier, which is a label. If the second position in the SVC segment were occupied by a composite data structure that contained three component data elements, the reference designator for the second component data element would be SVC02-02.	

<table>
<tr><td>Control Segment</td><td colspan="2">A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.</td></tr>
<tr><td>Data Segment, Condition Designator</td><td colspan="2">Data element conditions are of three types: mandatory, optional, and relational; they define the circumstances under which a data element may be required to be present or not present in a particular segment.</td></tr>
<tr><td>Data Segment, Mandatory Condition</td><td colspan="2">The designation of mandatory data element is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. Mandatory conditions are specified by condition code "M".</td></tr>
<tr><td></td><td>Condition</td><td>Requirement</td></tr>
<tr><td></td><td>(M) Mandatory</td><td>The designated simple data element or composite data structure must be present in the segment (presence means a data element or composite structure must not be empty). If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.</td></tr>
<tr><td>Data Segment, Optional Condition</td><td colspan="2">The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. Optional conditions are specified by condition code "O".</td></tr>
<tr><td></td><td>Condition</td><td>Requirement</td></tr>
<tr><td></td><td>(O) Optional</td><td>The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.</td></tr>
<tr><td>Data Segment, Relational Conditions</td><td colspan="2">Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code and the identity of the subject elements. A data element may be subject to more than one relational condition.

The definitions for each of the <condition code> values are:</td></tr>
<tr><td></td><td>(P) Paired or Multiple</td><td>If any element specified in the relational condition is present, then all of the elements specified must be present.</td></tr>
<tr><td></td><td>(R) Required</td><td>At least one of the elements specified in the condition must be present.</td></tr>
<tr><td></td><td>(E) Exclusion</td><td>Not more than one of the elements specified in the condition may be present.</td></tr>
<tr><td></td><td>(C) Conditional</td><td>If the first element specified in the condition is present, then all other elements must be</td></tr>
</table>

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.	
		present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
	(L) List Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
Data Segment, Semantic Note Designator	Simple data elements or composite data structures may have a designation that indicates the existence of a semantic note. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements. Semantic notes are considered part of the relevant transaction set standard. Semantic Note (Z) A semantic note is referenced in the segment directory for this data element with respect to its use in this data segment.	
Data Segment, Absence of Data	Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order, to maintain the element's or structure's position as defined in the data segment.	
Delimiter	A delimiter is a character used to separate two data elements (or sub elements) or to terminate a segment. The delimiters are an integral part of the data.	

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.
	Delimiters are specified in the interchange header segment, ISA and are not to be used in a data element value elsewhere in the interchange. These delimiters can be visualized on the printed page. They also display each segment on a separate line, adding human readability to the transaction set. Due to potential conflicts with either the data elements or with the special needs of transmission and device control, the historically used delimiters have caused problems.
Dependent	In the hierarchical loop coding, the dependent code **23** indicates the use of the patient hierarchical loop (Loop ID-2000C).
Destination Payer	The destination payer is the payer who is specified in the Subscriber/Payer loop (Loop ID-2010BB)
Functional Group	A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group.
Patient	The term "patient" is intended to convey the case where the Patient loop (Loop ID- 2000C) is used. In that case, the patient is not the same person as the subscriber, and the patient is a person (e.g., spouse, children, others) who is covered by the subscriber's insurance plan. However, it also happens that the patient is sometimes the same person as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 2.3.2.1, HL Segment, (ANSI 837 Institutional and Professional Guides) for further details. Every effort has been made to ensure that the meaning of the word "patient" is clear in its specific context.
Provider	In a generic sense, the provider is the entity that originally submitted the claim/encounter. A provider may also have provided or participated in some aspect of the health care service described in the transaction. Specific types of providers are identified in this implementation section (e.g., billing provider, other provider, operating physician, rendering provider).
Secondary Payer	The term "secondary payer" indicates any payer, who is not the primary payer. The secondary payer may be the secondary, tertiary, or even quaternary payer.

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.
Subscriber	The subscriber is the person whose name is listed in the health insurance policy. Other synonymous terms include "member" and/or "insured." In some cases, the subscriber is the same person as the patient. See the definition of patient, In Section 1.4.3.2.2.1 Hierarchical Level, HL Segment, (ANSI 837 Institutional) and for (ANSI 837 Professional) see Section B.1.1.4.3 in Appendix B contains a general description of HL structures Guides) for further details.
Transaction Set	The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment.
Transaction Set, Header and Trailer	The transaction set header and trailer segments are constructed as follows: Transaction Set Header(ST) Data Segment Group Transaction Set Trailer (SE) The transaction set identifier, uniquely identifies the transaction set. This identifier is the first data element of the transaction set header segment. The value for the transaction set control number, in the header and trailer control segments must be identical for any given transaction. The value for the number of included segments is the total number of segments in the transaction set including the ST and SE segments.
Transaction Set, Data Segment Groups	The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.
Transaction Set, Repeated Occurrences of Single Data Segments	When a single data segment is allowed, to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is ">1".
Transaction Set, Loops of Data Segments	Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded
Transaction Set, Unbounded Loops.	In order, to establish the iteration of a loop, the first data segment in the loop shall appear Unbounded once and only once in each iteration. Loops may have a specified maximum number of Loops repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions ">1". There is a specified sequence of segments in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is

<table>
<tr><td>Control Segment</td><td>A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.</td></tr>
<tr><td></td><td>required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop.

If unbounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop shall not start with the same segment as its immediate outer loop. For any segment that occurs in a loop and in the parent structure of that loop, that segment must occur prior to that loop in the parent structure or subsequent, to an intervening mandatory segment in the parent structure (parent structure is composed of all segments at the same level of nesting as the beginning segment of the loop).</td></tr>
<tr><td>Transaction Set, Bounded Loops</td><td>The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start segment to appear before the first
occurrence and a loop end segment to appear after the last occurrence of the loop. If the loop does not occur, the segments shall be suppressed. The requirement designator on the segments must match the requirement designator of the beginning segment of the loop.
A bounded loop may contain only one loop structure at the level bracketed by the segments. Subordinate loops are permissible. If bounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop must end before or on the same segment as its immediate outer loop.</td></tr>
<tr><td>Transaction Set, Data Segment in a Transaction Set</td><td>When data segments are combined to form a transaction set, three characteristics are applied to each data segment: A requirement designator, a position in the transaction set, and a maximum occurrence.</td></tr>
<tr><td>Transaction Set, Data Segment Requirement Designators</td><td>A data segment, or loop, has one of the following requirement designators for health care Data Segment and insurance transaction sets, indicating its appearance in the data stream of a Requirement transmission. These requirement designators are represented by a single character code.
<table>
<tr><th>Designator</th><th>Requirement</th></tr>
<tr><td>(M) Mandatory</td><td>This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)</td></tr>
</table></td></tr>
</table>

Control Segment	A control segment has the same structure as a data segment, but is used for transferring control information rather than application information.	
	(O) Optional	The presence of this data segment is the option of the sending party. .
Transaction Set, Data Segment Position	The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.	
Transaction Set, Data Segment Occurrence	A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number.	
Transmission Intermediary	A transmission intermediary is any entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term "intermediary" is not used to convey a specific Medicare contractor type.	

5.5 Interchange Control Structure Overview

The transmission of data proceeds according, to very strict format rules in order, to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a "transaction". For instance, a group of health insurance claims sent from one provider to a Medicare Intermediary or a remittance advice returned by that Intermediary could each be considered a transaction.

Each transaction contains groups of logically related data in units called "segments". For instance, the "N4" segment used in the transaction conveys the city, state, zip code, and other geographic information. A transaction contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. Using an analogy, the transaction would be like a freight train, and the segments would be the train's cars, and each segment could contain several data "elements" the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12N standard, as well as the sequence of segments within the transaction. In a more conventional computing environment, the segments would be equivalent to "records", and the elements equivalent to "fields".

Similar transactions, called "functional groups", are sent together within a transmission. Each functional group is prefaced by a "group start" segment, and a functional group is terminated by a "group end" segment. One or more functional groups are prefaced by an "interchange header" and followed by an "interchange trailer". This is illustrated below:

```
ISA   (Interchange Header)
  GS  (Functional group Start)
    ST  (Transaction Start)
....    (Transaction Segments)
    N4  * City * State * Zip Code of the sender
...     (Transaction Segments)
    N4  * City * State * Zip Code of another party
...     (Transaction segments)
    SE  (Transaction End)
    ST  (Transaction Start)
...     (Transaction segments)
    SE  (Transaction End)
    ST  (Transaction Start)
...     (Transaction segments)
    SE  (Transaction End)
  GE    (Functional Group End)
  GS    (Functional group Start)
    ST  (Transaction Start)
...     (Transaction Segments)
    SE  (Transaction End)
  GE    (Functional Group End)
IEA   (Interchange End)
```

The interchange header and trailer segments envelope one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminators,
2. Identify the sender and receiver,
3. Provide control information for the interchange, and
4. Allow for authorization and security information.

5.6 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

5.7 Delimeters

A delimiter (from Section B.1.1.2.5 of ANSI 837 Institutional and ANSI 837 Professional Guides) is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered in implementations compliant with this guide to be a 105-byte fixed length record, followed by a segment terminator. The data element separator is byte number 4; the repetition separator is byte number 83; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown below in Delimiters Table, in all examples of EDI transmissions.

Delimiter Examples

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element will result in errors in translation. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

5.8 Element Attributes

Attributes for each element include a Requirement Designator, Data Type, and Minimum Length/Maximum Length.

Requirement Designator

M = Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O = Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X = Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty).

Data Type

AN	Alphanumeric
ID	Identifier
DT	Date
NO	Number
R	Decimal
TM	Time

5.9 Control Segment Elements Breakout

IMPLEMENTATION

INTERCHANGE CONTROL HEADER (*INST. and PROF.*)

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Notes: 1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange.

Spaces in the example are represented by "." for clarity.

Example - **ISA*00*.....*01*SECRET...*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*030101*1253*^*00501*000000905*1*T*:~**

Fixed Length Begin and end

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT NAME	ATTRIBUTES
Begin-5, End -6 REQUIRED	**ISA01**	**I01 Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**

THCIC WILL ACCEPT EITHER CODE

CODE	DEFINITION
00	**NO AUTHORIZATION INFORMATION PRESENT**
03	**ADDITIONAL DATA IDENTIFICATION**

USAGE	REF. DES.	DATA ELEMENT NAME	ATTRIBUTES
Begin - 8, End – 17 REQUIRED	**ISA02**	**I02 Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M AN 10/10**
Begin 19, End – 20 REQUIRED	**ISA03**	**I03 Security Information Qualifier** Code to identify the type of information in the Security Information	**M ID 2/2**

THCIC WILL ACCEPT EITHER CODE

CODE	DEFINITION
00	**NO SECURITY INFORMATION PRESENT**
01	**PASSWORD**

Begin 22,

End – 31 **REQUIRED** **ISA04 I04 Security Information** **M AN 10/10**

This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

Begin 33,
End – 34 **REQUIRED** **ISA05 I05 Interchange ID Qualifier** **M ID 2/2**

Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

THIS ID QUALIFIES THE SENDER IN ISA06.

CODE	DEFINITION
ZZ	MUTUALLY DEFINED

Begin – 36,
End – 50 **REQUIRED** **ISA06 I06 Interchange Sender ID** **M AN 15/15**

Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

CODE	DEFINITION
SUBNNN	SYSTEM13, INC. SUBMITTER ID NUMBER (MUST BE OBTAINED FROM SYSTEM13, INC.)

Begin 52,
End – 53 **REQUIRED** **ISA07 I05 Interchange ID Qualifier** **M ID 2/2**

Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

THIS ID QUALIFIES THE RECEIVER IN ISA08.

CODE	DEFINITION
ZZ	MUTUALLY DEFINED

Begin 55,
End – 69 **REQUIRED** **ISA08 I07Interchange Receiver ID** **M AN 15/15**

Identification code published by the receiver of the data When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them.

CODE	DEFINITION
YTH837	Required for 837 claim submission

Begin 71,
End – 76 **REQUIRED** **ISA09 I08 Interchange Date** **M DT 6/6**

Date of the interchange

The date format is YYMMDD.

Begin 78,

End – 81 **REQUIRED** **ISA10 I09 Interchange Time** **M TM 4/4**

Time of the interchange

The time format is HHMM.

Begin 83,
End – 83 **REQUIRED** **ISA11 I10 Repetition Separator** **M ID 1/1**

Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator.

CODE	DEFINITION
^	REPETITION SEPARATOR (CARAT – THCIC RECOMMENDED)

Begin 85,
End – 89 **REQUIRED** **ISA12 I11 Interchange Control Version Number** **M ID 5/5**

This version number covers the interchange control segments

CODE	DEFINITION
00501	APPROVED VERSION

Begin 91,
End – 99 **REQUIRED** **ISA13 I12 Interchange Control Number** **M N0 9/9**

A control number assigned by the interchange sender

The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.

Begin101,
End – 101 **REQUIRED** **ISA14 I13 Acknowledgment Requested** **M ID 1/1**

Code sent by the sender to request an interchange acknowledgment (TA1)

THCIC WILL ACCEPT EITHER CODE

CODE	DEFINITION
0	NO ACKNOWLEDGMENT REQUESTED
1	INTERCHANGE ACKNOWLEDGMENT REQUESTED

SUBMITTERS WILL RECEIVE AN ACKNOWLEDGEMENT AND A CLAIM ACCEPTANCE RESPONSE REPORT, REGARDLESS OF WHICH CODE IS SUBMITTED.

Begin103,

End – 103 **REQUIRED** **ISA15 I14 Usage Indicator** **M ID 1/1**

Code to indicate whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	PRODUCTION DATA SUBMITTERS MUST BE ON THE APPROVED SUBMITTER LIST AT SYSTEM13 PRIOR TO SUBMITTING PRODUCTION DATA
T	TEST DATA SUBMITTER MUST SUBMIT TEST TO SYSTEM13 AND RECEIVE APPROVAL PRIOR TO SUBMITTING PRODUCTION DATA.

Begin105,
End – 105 **REQUIRED** **ISA16 I15 Component Element Separator** **M** **1/1**

Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

RECOMMENDED CODE SEPARATORS

*** - STAR**

: - COLON

~ - TILDE

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER (INST. and PROF.)

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Example: **IEA*1*000000905~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups**	**M**	**N0 1/5**
A count of the number of functional groups included in an interchange					
REQUIRED	**IEA02**	**I12**	**Interchange Control Number**	**M**	**N0 9/9**
A control number assigned by the interchange sender					

NUMBER MUST MATCH NUMBER IN ISA13

IMPLEMENTATION

FUNCTIONAL GROUP HEADER (*INST. and PROF.*)

Purpose: To indicate the beginning of a functional group and to provide control information

Example: **INST:**

GS*HC*SUBnnn*YTH837*20110130*0802*1*X*005010X223A2~

PROF:

GS*HC*SUBnnn*YTH837*20110130*0802*1*X*005010X222A1~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **CODE DEFINITION** **HC HEALTH CARE CLAIM (837)**	**M ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **CODE DEFINITION** **SUBNNN SYSTEM13 SUBMITTER ID NUMBER** This is the same ID as in ISA06. The Submitter ID must be obtained from Commonwealth	**M AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners **CODE DEFINITION** **YTH837 REQUIRED FOR THCIC**	**M AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD SEMANTIC: GS04 is the group date. Use this date for the functional group creation date	**M DT 8/8**
REQUIRED	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **SEMANTIC:** GS05 is the group time. **Use this time for the creation time. The recommended format is HHMM.**	**M TM 4/8**

REQUIRED	**GS06**	**28**	**Group Control Number**	**M**	**N0**	**1/9**

Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

REQUIRED	**GS07**	**455**	**Responsible Agency Code**	**M**	**ID**	**1/2**

Code used in conjunction with Data Element 480 to identify the issuer of the standard

CODE	DEFINITION
X	**ACCREDITED STANDARDS COMMITTEE X12N**

REQUIRED	**GS08**	**480**	**Version / Release / Industry Identifier Code**	**M**	**AN**	**1/12**

Code indicating the version, release, sub release, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and sub release, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE	DEFINITION
005010X223A2	**ADDENDUM A2 FOR RELEASE 00501 (INST.)**
005010X222A1	**ADDENDUM A1 FOR RELEASE 00501 (PROF.)**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER (*INST. and PROF.*)

Purpose: To indicate the end of a functional group and to provide control information Example: **GE*1*1~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M N0 1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender SEMANTIC: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06. **MUST MATCH THE NUMBER IN GS06**	**M N0 1/9**

OVERALL DATA ARCHITECTURE FOR ANSI FORM 837

Two formats, or views, are used to present the transaction set - the implementation view and the standard view. The implementation view of the transaction set is presented in this section and in Section 2.1, Overall Data Architecture of the ANSI 837 Institutional and Professional Guides. See figure 1, 837 Transaction Set Listing, for the implementation view (ANSI 837 Institutional and Professional Guide). The standard view, which is presented in Section 6.8 (Section 3 of ANSI 837 Institutional and Professional Guides), Transaction Set, displays all segments available within the transaction set and their assigned ASC X12 names.

The intent of the implementation view is to clarify the segments' purpose and use by restricting the view to display only those segments used with their assigned health care names.

5.10 Loop Labeling, Sequence and Use

The 837 transaction uses two naming conventions for loops. Loops are labeled with a descriptive name as well as with a shorthand label. Loop ID-2000A BILLING PROVIDER contains information about the billing provider, pay-to address and pay-to plan. The descriptive name -- BILLING PROVIDER -- informs the user of the overall focus of the loop. The Loop ID is a short-hand name, for example 2000A, that gives, at a glance, the position of the loop within the overall transaction. Loop ID-2010AA BILLING PROVIDER NAME is a sub-loop of Loop ID-2000A. When a loop is used more than once, a letter is appended to its numeric portion to allow the user to distinguish the various iterations of that loop when using the shorthand name of the loop. For example, loop 2000 has three possible iterations: Billing Provider Hierarchical Level (HL), Subscriber HL and Patient HL. These loops are labeled 2000A, 2000B and 2000C respectively. As the 2000 level loops define the hierarchical structure, they are required to be used in the order shown in the implementation guide.

The order of multiple sub-loops that do not involve hierarchical structure and that do have the same numeric position within the transaction is less important. Such sub-loops do not need to be sent in the same order in which they appear in this implementation guide. For such sub loops in this transaction, the numeric portion of the loop ID does not end in 00. For example, Loop ID-2010 has two possibilities within Loop ID-2000B (Loop ID-2010BA Subscriber Name and Loop ID-2010BB Payer Name). Each of these 2010 loops is at the same numeric position in the transaction. Since they do not specify an HL, it is not necessary to use them in any particular order. However, it is not acceptable to send sub loop 2330B before loop 2310 because these are not equivalent sub-loops.

In a similar manner, if a single loop has multiple iterations (repetitions) of a particular segment the sequence of those segments within a transaction is not important and is not required to follow the same order in which they appear in this implementation guide. For example, there are many DTP segments in the 2300 loop. It is not required that Initial Treatment Date be sent before Last Seen Date. However, it is required that the DTP segment in the 2300 loop come after the CLM segment because it is carried in a different position within the 2300 loop.

5.11 Required and Situational Loops

Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction.

The usage designator of a loop's beginning segment indicates the usage of the loop. If a loop is used, the first segment (initial segments) of that loop is required even if it is marked Situational.

If the usage of the first segment in a loop is marked “Required”, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the required initial segment of a nested loop will indicate dependency on the higher-level loop.

If the first segment is Situational, there will be a segment note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used.

5.12 Use of Data Segments and Elements Marked Situational

Institutional and Professional claims span an enormous variety of health care institutional and professional specialties and payment situations. Because of this, it is difficult to set a single list of data elements that are required for all types of institutional and professional health care claims. To meet the divergent needs of institutional and professional claim submitters, many data segments and elements included in this implementation section are marked "situational." Wherever possible, notes have been added to this implementation section to clarify when to use a particular situational segment or element. For example, a data element may be marked "situational," but the note attached to the element may explain that under certain circumstances the element is "required." If there is not an explanatory note, interpret "situational" to mean, "If the information is available and applicable to the claim, the developers of this implementation section recommend that the information be sent."

5.13 Limitations to the Size of a Claim/Encounter (837) Transaction

Receiving trading partners may have system limitations regarding the size of the transmission they can receive. Some submitters may have the capability and the desire to transmit enormous 837 transactions with thousands of claims contained in them. The developers of this implementation section recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. Willing trading partners can agree to set CLM limits higher. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

5.14 THCIC Transaction Set

Table 1 Header (INSTITUTIONAL)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
0050	ST	Transaction Set Header	R	1	
0100	BHT	Beginning of Hierarchical Transaction	R	1	
		LOOP ID – 1000A SUBMITTER NAME	R		1
0200	NM1	Submitter Name	R	1	
		LOOP ID – 1000B RECEIVER NAME	R		1
0200	NM1	Receiver Name	R	1	

Table 2 Detail – Billing Provider Hierarchical Level(INST)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000A Billing Provider HIERARCHICAL LEVEL	R		>1
0010	HL	Billing/ Provider Hierarchical Level	R	1	
		LOOP ID – 2010AA BILLING PROVIDER NAME	R		1
0150	NM1	Billing Provider Name	R	1	
0250	N3	Billing Provider Address	R	1	
0300	N4	Billing Provider City/State/ZIP Code	R	1	
0350	REF	Billing Provider Tax Identification	R	1	
0400	REF	Billing Provider THCIC Identification	S	2	
		LOOP ID – 2010AB PAY-TO PROVIDER NAME	S		1
0150	NM1	Pay-To Provider Name	S	1	
0250	N3	Pay-To Provider Address	R	1	
0300	N4	Pay-To Provider City/State/ZIP Code	R	1	
0350	REF	Pay-To Provider Tax Identification	R	8	
0350	REF	Pay-To Provider THCIC Identification	R	1	

Table 2 Detail – Subscriber Hierarchical Level (INST)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL	R		>1
0010	HL	Subscriber Hierarchical Level	R	1	
0050	SBR	Subscriber Information	R	1	
		LOOP ID – 2010BA SUBSCRIBER NAME	S		1
		"Required" if the "Subscriber" is the "Patient" otherwise "Not Used"			
0150	NM1	Subscriber Name	R/N	1	
0250	N3	Subscriber Address	R/N	1	
0300	N4	Subscriber City/State/ZIP Code	R/N	1	
0320	DMG	Subscriber Demographic Information	R/N	1	
0350	REF	Subscriber Secondary Identification	R/N	1	
		LOOP ID - 2010BB PAYER NAME	R		1
0150	NM1	Payer Name	R	1	
0350	REF	Billing Provider Secondary Identification	S	1	

Table 2 Detail – Patient Hierarchical Level (INST.)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000C PATIENT HIERARCHICAL LEVEL	**S**		**>1**
0010	**HL**	Patient Hierarchical Level	**S**	1	
0070	**PAT**	Patient Information	**R**	1	
		LOOP ID – 2010CA PATIENT NAME	**S**		**1**
		"Not-Used" if "Subscriber" is the "Patient" otherwise "Required"			
0150	**NM1**	Patient Name	**R/N**	**1**	
0250	**N3**	Patient Address	**R/N**	**1**	
0300	**N4**	Patient City/State/ZIP Code	**R/N**	**1**	
0320	**DMG**	Patient Demographic Information	**R/N**	**1**	
		LOOP ID – 2300 CLAIM INFORMATION	**R**		**100**
1300	**CLM**	Claim Information	**R**	**1**	
1350	**DTP**	Statement Dates	**R**	**1**	
1400	**CL1**	Institutional Claim Code	**R**	**1**	
1800	**REF**	Medical Record Number	**R**	**1**	
1850	**K3**	File Information (Patient Social Security Number if Subscriber is not Patient) (Patient Ethnicity and Race Codes to be added here in future with next contract) **"Not-Used" if "Subscriber" is the "Patient" otherwise "Required"**	**R**	**10**	
1900	**NTE**	Claim Note (*Patient Ethnicity*) (Patient Ethnicity will move to K3 with next contract)	**R**	**10**	
2310	**HI**	Principal, E-Codes and Patient Reason For Visit Diagnosis Information	**R**	**1**	
2310	**HI**	Other Diagnosis Information	**S**	**2**	
2310	**HI**	Occurrence Span Information	**S**	**1**	
2310	**HI**	Occurrence Information	**S**	**1**	
2310	**HI**	Value Information	**S**	**2**	
2310	**HI**	Condition Information	**S**	**2**	
		LOOP ID - 2310A ATTENDING PHYSICIAN NAME	**S**		**1**
2500	**NM1**	Attending Physician Name	**R**	**1**	
2710	**REF**	Attending Physician Secondary Identification	**R**	**4**	
		LOOP ID - 2310B OPERATING PHYSICIAN NAME	**S**		**1**
2500	**NM1**	Operating Physician Name	**R**	**1**	
2710	**REF**	Operating Physician Secondary Identification	**S**	**4**	
		LOOP ID – 2310C OTHER PROVIDER NAME	**S**		**1**
2500	**NM1**	Other Provider Name	**R**	**1**	
2710	**REF**	Other Provider Secondary Identification	**S**	**5**	
		LOOP ID – 2310E SERVICE FACILITY NAME	**S**		**1**
2500	**NM1**	Service Facility Name	**S**	**1**	
2650	**N3**	Service Facility Address	**R**	**1**	
2700	**N4**	Service Facility City/State/Zip Code	**R**	**1**	
2710	**REF**	Service Facility Secondary Identification	**S**	**3**	
		LOOP ID 2320 OTHER SUBSCRIBER INFORMATION	**S**		**10**
2900	**SBR**	Other subscriber Information	**S**	**1**	
		LOOP ID – 2330B OTHER PAYER NAME			
3250	**NMI**	Other Payer Name	**S**	**1**	**1**
		LOOP ID 2400 SERVICE LINE NUMBER	**R**		**999**
3650	**LX**	Service Line Number	**R**	**1**	
3750	**SV2**	Institutional Service Line(Inst.)	**R**	**1**	

4550	**DTP**	Service Line Date	**S**	**1**	
5550	**SE**	Transaction Trailer	**R**	**1**	

Table 1 Header (*PROFESSIONAL*)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
0050	**ST**	Transaction Set Header	**R**	**1**	
0100	**BHT**	Beginning of Hierarchical Transaction	**R**	**1**	
		LOOP ID – 1000A SUBMITTER NAME	**R**		**1**
0200	**NM1**	Submitter Name	**R**	**1**	
		LOOP ID – 1000B RECEIVER NAME	**R**		**1**
0200	**NM1**	Receiver Name	**R**	**1**	

Table 2 Detail – Billing Hierarchical Level (PROF)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000A Billing Provider HIERARCHICAL LEVEL	**R**		**>1**
0010	**HL**	Billing Provider Hierarchical Level	**R**	**1**	
		LOOP ID – 2010AA BILLING PROVIDER NAME	**R**		**1**
0150	**NM1**	Billing Provider Name	**R**	**1**	
0250	**N3**	Billing Provider Address	**R**	**1**	
0300	**N4**	Billing Provider City/State/ZIP Code	**R**	**1**	
0350	**REF**	Billing Provider THCIC Identification	**S**	**1**	

Table 2 Detail – Subscriber Hierarchical Level (PROF)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL	**R**		**>1**
0010	**HL**	Subscriber Hierarchical Level	**R**	**1**	
0050	**SBR**	Subscriber Information	**R**	**1**	
		LOOP ID – 2010BA SUBSCRIBER NAME	**S**		**1**
		"N3", "N4" Required" if "Subscriber" is the "Patient", otherwise "Not Used".			
0150	**NM1**	Subscriber Name	**N/R**	**1**	
0250	**N3**	Subscriber Address	**N/R**	**1**	
0300	**N4**	Subscriber City/State/ZIP Code	**N/R**	**1**	
0320	**DMG**	Subscriber Demographic Information	**S**	**1**	
0350	**REF**	Subscriber Secondary Identification	**S**	**1**	
		LOOP ID - 2010BB PAYER NAME	**R**		**1**
0150	**NM1**	Payer Name	**R**	**1**	
0350	**REF**	Billing Provider Secondary Identification	**S**	**1**	

Table 2 Detail – Patient Hierarchical Level (*PROF.*)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000C PATIENT HIERARCHICAL LEVEL	**S**		**>1**
0010	**HL**	Patient Hierarchical Level	**S**	**1**	
0070	**PAT**	Patient Information	**R**	**1**	
		LOOP ID – 2010CA PATIENT NAME	**S**		**1**
		"N3", "N4" "Not-Used" if "Subscriber" is the "Patient", otherwise "Required".			
0150	**NM1**	Patient Name	**N/R**	**1**	
0250	**N3**	Patient Address	**N/R**	**1**	
0300	**N4**	Patient City/State/ZIP Code	**N/R**	**1**	
0320	**DMG**	Patient Demographic Information	**N/R**	**1**	
		LOOP ID – 2300 CLAIM INFORMATION	**R**		**100**
1300	**CLM**	Claim Information	**R**	**1**	
1800	**REF**	Medical Record Number	**R**	**1**	
1850	**K3**	File Information (*Patient Social Security Number if Subscriber is not Patient*) **"Not-Used" if "Subscriber" is the "Patient" otherwise "Required"**	**R**	**10**	
1900	**NTE**	Claim Note (*Patient Ethnicity*)	**S**	**1**	
2310	**HI**	Health Care Diagnosis Code	**R**	**1**	
		LOOP ID - 2310B RENDERING PROVIDER NAME	**S**		**1**
2500	**NM1**	Operating Physician Name	**R**	**1**	
2710	**REF**	Operating Physician Secondary Identification	**S**	**4**	
		LOOP ID - 2310C SERVICE FACILITY LOCATION	**S**		**1**
2500	**NM1**	Service Facility Location Name	**S**	**1**	
2650	**N3**	Service Facility Location Address	**R**	**1**	
2700	**N4**	Service Facility Location City/State/Zip Code	**R**	**1**	
2710	**CREF**	Service Facility Location Secondary Identification	**S**	**3**	
		LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION	**S**		**10**
2900	**SBR**	Other subscriber Information	**S**	**1**	
		LOOP ID – 2330B OTHER PAYER NAME	**S**		**1**
3250	**NM1**	Other Payer Name	**R**	**1**	
		LOOP ID 2400 SERVICE LINE NUMBER	**R**		**50**
3650	**LX**	Service Line Number	**R**	**1**	
3700	**SV1**	Professional Service (PROF.)	**R**	**1**	
4550	**DTP**	Date - Service Date	**R**	**1**	
		LOOP ID – 2420A RENDERING PROVIDER NAME	**S**		**1**
	NM1	Operating Physician Name	**R**	**1**	
5250	**REF**	Operating Physician Secondary Identification	**R**	**5**	
5550	**SE**	Transaction Set Trailer	**R**	**1**	

5.15 Segment ID Breakout

IMPLEMENTATION

ST - TRANSACTION SET HEADER (*INST. and PROF.*)

Usage: REQUIRED

Repeat:

Example **ST*837*987654*005010X223A2~ (INST)**
ST*837*987654*005010X223A1~ (PROF)

ELEMENT SUMMARY

USAGE	REF.DES	DATAELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **CODE DEFINITION** **837 HEALTH CARE CLAIM**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Number in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could be sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.**	**M AN 4/9**
REQUIRED	**ST03**	**1705**	**Implementation Convention Reference** **Reference assigned to identify Implementation Convention** **SEMANTIC: The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.** IMPLEMENTATION NAME: Implementation Guide Version Name This element must be populated with the guide identifier named in Section 1.2. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (ST-SE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is used at translation time.	**O AN 1/35**

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION (*INST. and PROF.*)

Usage: REQUIRED

Repeat: 1

Example **BHT*0019*00*0123*19960618*0932*CH~**

BHT Beginning of Hierarchical Transaction

ELEMENT SUMMARY

USAGE	REF.DES	DATAELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set **CODE DEFINITION** **0019 INFORMATION SOURCE, SUBSCRIBER, DEPENDENT**	**M ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST- SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. **THCIC will accept either code and will treat both as an original submission.** **CODE DEFINITION** **00 ORIGINAL** **18 REISSUE**	**M ID 2/2**
REQUIRED	**BHT03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Originator Application Transaction Identifier SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system. **Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.** **The Reference Identification must not be duplicated or reused within 12Months**	**O AN 1/50**
REQUIRED	**BHT04**	**373**	**Date** Date expressed as CCYYMMDD INDUSTRY: Transaction Set Creation Date SEMANTIC: BHT04 is the date the transaction was created within the business application system. Use this date to identify the date on which the submitter created the file.	**O DT 8/8**

REQUIRED **BHT05** **337** **Time** **O TM 4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD= decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

INDUSTRY: Transaction Set Creation Time

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

Use this time to identify the time of day that the submitter created the file.

REQUIRED **BHT06** **640** **Transaction Type Code** **O ID 2/2**

Code specifying the type of transaction

INDUSTRY: Claim or Encounter Identifier ALIAS: Claim or Encounter Indicator

All codes accepted by THCIC

CODE	DEFINITION
CH	**CHARGEABLE**
RP	**REPORTING**
31	**SUBROGATION DEMAND- THE SUBROGATION DEMAND CODE IS ONLY FOR USE BY STATE MEDICAID AGENCIES PERFORMING POST PAYMENT RECOVERY CLAIMING WITH WILLING TRADING PARTNERS.**

NOTE: AT THE TIME OF THIS WRITING, SUBROGATION DEMAND IS NOT A HIPAA MANDATED USE OF THE 837 TRANSACTION.

IMPLEMENTATION

SUBMITTER NAME (*INST. and PROF.*)

Loop: 1000A — SUBMITTER NAME Repeat: 1

Usage: REQUIRED

Repeat: 1

Notes: 1. See ANSI 837 Institutional Claim Guide Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000.

Example: **NM1*41*2*ABC Submitter*****46*SUB###~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF.DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **CODE DEFINITION** **41 SUBMITTER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Submitter Last or Organization Name ALIAS: Submitter Name	**O AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Submitter First Name ALIAS: Submitter Name **Required if NM102=1 (person).**	**O AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Submitter Middle Name ALIAS: Submitter Name **Required if NM102=1 and the middle name/initial of the person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**
			CODE DEFINITION **46 ELECTRONIC TRANSMITTER IDENTIFICATION NUMBER (ETIN) ESTABLISHED BY A TRADING PARTNER AGREEMENT**			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Submitter Identifier ALIAS: Submitter Primary Identification Number **CODE DEFINITION** **SUBNNN SYSTEM13 SUBMITTER ID NUMBER** **This must match ISA06 and GS02**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organizational Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

RECEIVER NAME (*INST. and PROF.*)

Loop: 1000B — RECEIVER NAME Repeat: 1

Usage: REQUIRED

Repeat: 1

Notes: 1. See ANSI 837 Institutional Claim Guide Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000.

Example: **NM1*40*2*THCIC*****46*YTH837~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an Individual **CODE DEFINITION** **40 RECEIVER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Receiver Name **CODE DEFINITION** **THCIC IDENTIFIES THCIC AS THE RECEIVER**	**X AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) INDUSTRY: Information Receiver Identification Number **CODE DEFINITION** **46 ELECTRONIC TRANSMITTER IDENTIFICATION NUMBER (ETIN)**	**X ID 1/2**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Receiver Primary Identifier ALIAS: Receiver Primary Identification Number	**X**	**AN**	**2/80**
			CODE DEFINITION **YTH837 RECEIVER CODE FOR THCIC**			
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

BILLING PROVIDER HIERARCHICAL LEVEL (*INST. and PROF.*)

Loop: 2000A - BILLING PROVIDER HIERARCHICAL LEVEL Repeat: >1

Usage: REQUIRED

Repeat:

Notes:

1. Use the Billing Provider HL to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in Loop ID- 2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.

2. The Billing Provider Hierarchical Level may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.

3. If the Service Facility Provider is the same entity as the Billing or the Pay-to Provider, then do not use 2310E (INST.) or Loop 2310C (PROF.).

4. If the Billing or Pay-to Provider is also the Service Facility Provider and Loop ID 2310E (INST.) or Loop 2310C (PROF.) is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Service Facility Provider.

5. THCIC uses the provider HLs as a base for batching claim submissions. Each set of claims for a provider HL results in one set of reports. Multiple provider HLs will result in multiple sets of reports. Thus, the number of provider HLs should be minimized where possible, to reduce the numbers of reports that must be reviewed.

Example: **HL*1**20*1~**

HL Hierarchical Level

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **The first HL01 each ST-SE envelope must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.**	**M AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. **CODE DEFINITION** **20 INFORMATION SOURCE**	**M ID 1/2**
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. **The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).** **CODE DEFINITION** **1 ADDITIONAL SUBORDINATE HL DATA SEGMENT IN THIS HIERARCHICAL STRUCTURE.**	**O ID 1/1**

IMPLEMENTATION

BILLING PROVIDER NAME (*INST. and PROF.*)

Loop: 2010AA — BILLING PROVIDER NAME Repeat: 1 Usage: REQUIRED

Repeat: 1

Notes: 1. Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.

Example: **NM1*85*2*JONES HOSPITAL*****XX*45609312~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF.DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **CODE DEFINITION** **85 BILLING PROVIDER** **USE THIS CODE**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON** **2 NON-PERSON ENTITY (THCIC RECOMMENDS USING THIS CODE)**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name This is the name of the facility as reported to Bureau of Facility Licensing, Texas Department of Health INDUSTRY: Billing Provider Last or Organizational Name ALIAS: Billing Provider Name	**X AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**

Code designating the system/method of code structure used for Identification Code (67)

If "XX - NPI" is used, then either the Employer's Identification Number of the provider must be carried in the REF segment in this loop.

CODE	DEFINITION
XX	**CMS NATIONAL PROVIDER IDENTIFIER (RECOMMENDED BY THCIC)**

SITUATIONAL	**NM109**	**67**	**Identification Code**	**X**	**AN**	**2/80**

Code identifying a party or other code

INDUSTRY: Billing Provider Identifier ALIAS: Billing Provider Primary ID

This data element is REQUIRED by THCIC and shall be submitted here unless another facility is rendering the services in which case the information will be submitted in Loop 2310E NM109.

This data element is used in conjunction with the THCIC ID, and the 1st 15 characters of the address to identify the facility's data. The information in this field must be provided and on file with THCIC for data submissions to be identified

CODE	DEFINITION
XXXXXXXXXX	**NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) (RECOMMENDED BY THCIC)**
NNNNNNNNN	**EMPLOYER IDENTIFICATION NUMBER - THCIC WILL ALLOW FOR EIN TO BE SUBMITTED HERE FOR FACILITY IDENTIFICATION PURPOSES, DATA MUST MATCH PROVIDER REFERENCE INFORMATION MAINTAINED BY THCIC.**

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

BILLING PROVIDER ADDRESS (*INST. and PROF.*)

Loop: 2010AA — BILLING PROVIDER NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. The first 15 characters of N301 are used to validate the billing provider.

Example: **N3*225 MAIN STREET BARKLEY BUILDING~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF.DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information **No Post Office Box numbers are allowed** INDUSTRY: Billing Provider Address Line	**M AN 1/40**
SITUATIONAL	**N302**	**166**	**Address Information** Address information **No Post Office Box numbers are allowed** INDUSTRY: Billing Provider Address Line **Required if a second address line exists**	**O AN 1/25**

IMPLEMENTATION

BILLING PROVIDER CITY/STATE/ZIP CODE (*INST.*and PROF.)

Loop: 2010AA — BILLING PROVIDER NAME

Usage: REQUIRED

Repeat: 1

Example: **N4*CENTERVILLE*PA*17111~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name**	**O AN 2/20**
REQUIRED	**N402**	**156**	**Free-form text for city name** INDUSTRY: Billing Provider City Name State or Province Code Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Billing Provider State or Province Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (ZIP code for United States) INDUSTRY: Billing Provider Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code	**O ID 3/9**
NOT USED	**N404**	**26**	**Country Code**	**X ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**

IMPLEMENTATION

BILLING PROVIDER TAX IDENTIFICATION (INST. and PROF.)

Loop: 2010AA — BILLING PROVIDER NAME

Usage: REQUIRED

Segment Repeat: 1

Notes:
1. This is the tax identification number (TIN) of the entity to be paid for the submitted services.

2. This is used as part of facility identification, if NPI is not provided in NM109 of this segment (2010AA – Billing Provider Name).

Example: **REF*EI*123456789~**

REF Reference

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **EI EMPLOYER'S IDENTIFICATION NUMBER** The Employer's Identification Number must be a string of exactly nine numbers with no separators. For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **CODE DEFINITION** **NNNNNNNNNN EMPLOYER'S IDENTIFICATION NUMBER**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

BILLING PROVIDER THCIC IDENTIFICATION(INST. and PROF.)

Loop: 2010AA — BILLING PROVIDER NAME

Usage: SITUATIONAL

Repeat: 1 - (THCIC will allow a second REF segment, not allowed for billing translators)

Notes:

1. THCIC requires that the THCIC ID (6-digit number assigned by THCIC) and either the National Provider Identifier (in Loop 2010AA | NM109) or the Employer Identification Number (EIN/ Tax ID, in Loop 2010AA | REF02) and the 1st 15 characters of street address (Loop 2010AA | N301) be submitted to identify those facilities. *If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310E (Inst.) or Loop 2310C(Prof).*

2. ANSI X12N removed the other seven (7) REF segments in the ANSI X12N 837 5010 Institutional Guide and moved the Billing Provider Secondary Identification to Loop 2010BB (Payer Name) in the Subscriber Hierarchical Level. THCIC allows for either location to be used.

Example: **REF*1J*000116~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **1J FACILITY ID NUMBER;**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Billing Provider Additional Identifier SYNTAX: R0203 **CODE DEFINITION** **NNNNNN THCIC ID NUMBER** **(6-DIGIT NUMBER ASSIGNED BY THCIC)**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

SUBSCRIBER HIERARCHICAL LEVEL (*INST. and PROF.*)

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL

Repeat: >1

Usage: REQUIRED

Repeat: 1

Notes: **1.** If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.

2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA).

Example: **HL*124*123*22*1~**

HL Hierarchical Level

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. **CODE DEFINITION** **22 SUBSCRIBER**	**M ID 1/2**

REQUIRED HL04 736 Hierarchical Child Code O ID 1/1

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 =0) or when HL04 has subordinate levels indicated (HL04 = 1).

In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims. The second case (HL04 = 1) happens when claims/encounters for a dependent is being sent under the same billing provider HL (e.g., a father has insurance and son is in an automobile accident).

CODE	DEFINITION
0	NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL STRUCTURE.
1	ADDITIONAL SUBORDINATE (DEPENDENT) HL DATA SEGMENT IN THIS HIERARCHICAL STRUCTURE.

IMPLEMENTATION

SUBSCRIBER INFORMATION (*INST. and PROF.*)

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL

Usage: REQUIRED

Repeat: 1

Notes: THCIC requires only the Primary and one Secondary Payer types.

Example: **SBR*P**GRP01020102******CI~**

SBR Subscriber Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01** 1/1	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim **CODE DEFINITION** **P PRIMARY** **S SECONDARY** **U UNKNOWN** **THIS CODE MAY ONLY BE USED IN PAYER TO PAYER COB CLAIMS WHEN THE ORIGINAL PAYER DETERMINED THE PRESENCE OF THIS COVERAGE FROM ELIGIBILITY FILES RECEIVED FROM THIS PAYER OR WHEN THE ORIGINAL CLAIM DID NOT PROVIDE THE RESPONSIBILITY SEQUENCE FOR THIS PAYER.**	**M ID**
SITUATIONAL	**SBR02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities ALIAS: Patients Relationship to Insured SEMANTIC: SBR02 specifies the relationship to the person insured. **Use this code only when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element.** **CODE DEFINITION** **18 SELF**	**O ID 2/2**
NOT USED	**SBR03**	**127**	**Reference Identification**	**O AN 1/50**
NOT USED	**SBR04**	**93**	**Name**	**O AN 1/60**
NOT USED	**SBR05**	**1336**	**Insurance Type Code**	**O ID 1/3**
NOT USED	**SBR06**	**1143**	**Coordination of Benefits Code**	**O ID 1/1**
NOT USED	**SBR07**	**1073**	**Yes/No Condition or Response Code**	**O ID 1/1**
NOT USED	**SBR08**	**584**	**Employment Status Code**	**O ID 2/2**

REQUIRED SBR09 1032 Claim Filing Indicator Code O ID 2/2

Code identifying type of claim

CODE	DEFINITION
11	OTHER NON-FEDERAL PROGRAMS
12	PREFERRED PROVIDER ORGANIZATION (PPO)
13	POINT OF SERVICE (POS)
14	EXCLUSIVE PROVIDER ORGANIZATION (EPO)
15	INDEMNITY INSURANCE
16	HEALTH MAINTENANCE ORGANIZATION (HMO) MEDICARE RISK
17	DENTAL MAINTENANCE ORGANIZATION
AM	AUTOMOBILE MEDICAL
BL	BLUE CROSS/BLUE SHIELD
CH	CHAMPUS
CI	COMMERCIAL INSURANCE CO.
DS	DISABILITY
FI	FEDERAL EMPLOYEES PROGRAM
HM	HEALTH MAINTENANCE ORGANIZATION
LM	LIABILITY MEDICAL
MA	MEDICARE PART A
MB	MEDICARE PART B
MC	MEDICAID
OF	OTHER FEDERAL PROGRAM USE CODE OF WHEN SUBMITTING MEDICARE PART D CLAIMS OR HEALTH EXCHANGE INSURANCE PLANS (UNTIL OTHERWISE DIRECTED)
TV	TITLE V
VA	VETERAN ADMINISTRATION PLAN
WC	WORKERS' COMPENSATION HEALTH CLAIM
ZZ	MUTUALLY DEFINED, OR SELF PAY OR UNKNOWN, OR CHARITY, USE CODE ZZ WHEN THE PAYMENT IS SELF-PAY OR CHARITY OR TYPE OF INSURANCE IS NOT KNOWN AT THE TIME THE DATA IS SUBMITTED TO THCIC.

IMPLEMENTATION

SUBSCRIBER NAME (*INST. and PROF.*)

Loop: 2010BA — SUBSCRIBER NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes: **1. REQUIRED if the "Subscriber" is the "Patient".** Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient.

Example: **NM1*IL*1*DOE*JOHN*T***MI*739004273~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **IL INSURED OR SUBSCRIBER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Subscriber Last Name For patients that are covered by 42 USC 290dd-2 or 42 CFR Part 2: Use the following last name: DOE.	**O AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **For patients that are covered by 42 USC 290dd-2 or 42 CFR Part 2: Use one of the following names: "Jane" if female, or "John" if male. Hospitals may include a sequential number, e.g., John1, John2, John3.** INDUSTRY: Subscriber First Name This data element is required when NM102 equals one (1).	**O AN 1/35**

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Subscriber Middle Name ALIAS: Subscriber's Middle Initial **This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SUBSCRIBER ADDRESS (*INST. and PROF.*)

Loop: 2010BA — SUBSCRIBER NAME Repeat: 1

Usage: SITUATIONAL

Notes: **1.** This segment is required when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B | SBR02 =18 (self)).

2. REQUIRED if the "Subscriber" is the "Patient". Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient.

Example: **N3*125 CITY AVENUE~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Subscriber Address Line	**M AN 1/40**
SITUATIONAL	**N302**	**166**	**Address Information** Address information INDUSTRY: Subscriber Address Line Required if a second address line exists.	**O AN 1/25**

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP CODE (*INST. and PROF.*)

Loop: 2010BA — SUBSCRIBER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** This segment is required when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B | SBR02 =18 (self)).

2. REQUIRED if the "Subscriber" is the "Patient". Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient.

Example: **N4*CENTERVILLE*PA*17111~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name INDUSTRY: Subscriber City Name	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defin0ed by appropriate government agency INDUSTRY: Subscriber State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Subscriber Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code	**O ID 3/9**

THCIC: If the subscriber is the patient and the subscriber address and city are not in the U.S.A. or a Territory of U.S.A. the following codes should be used. Also, the Country Code in N404 will be required.

CODE	DEFINITION
00000	**FOREIGN COUNTRY DEFAULT THCIC RECOMMENDED CODE**
XXXXX	**FOREIGN COUNTRY DEFAULT**

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country CODE SOURCE 5: Countries, Currencies and Funds	**O**	**ID**	**2/3**
	THIS DATA ELEMENT IS REQUIRED WHEN THE ADDRESS IS OUTSIDE OF THE U.S. See 5010 Inpatient and Outpatient Appendices					
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**ID**	**1/3**

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION (*INST. and PROF.*)

Loop: 2010BA — SUBSCRIBER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** This segment is required when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B | SBR02 = 18 (self)).

Example: **DMG*D8*19780730*M**5****~**

DMG Demographic Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X ID 2/3**
REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Subscriber Birth Date ALIAS: Date of Birth – Patient	**X AN 8/8**

REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual INDUSTRY: Subscriber Gender Code ALIAS: Gender - Patient	**O**	**ID**	**1/1**

CODE	DEFINITION
F	**FEMALE**
M	**MALE**
U	**UNKNOWN**

NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race Code**	**X**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X**	**ID**	**1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

IMPLEMENTATION

SUBSCRIBER SECONDARY IDENTIFICATION (*INST. and PROF.*)

Loop: 2010BA — SUBSCRIBER NAME

Usage: SITUATIONAL

Repeat: 4

Notes: **1.** Required by THCIC when the subscriber is the patient (Loop ID 2000B | SBR02=18 (self))

2. REQUIRED if the "Subscriber" is the "Patient". Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient.

Example: **REF*SY*030385074~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **SY SOCIAL SECURITY NUMBER**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **CODE DEFINITION** **NNNNNNNNN SOCIAL SECURITY NUMBER** **999999999 REQUIRED FOR:** **1. NEWBORNS THAT HAVE NO SOCIAL SECURITY NUMBER** **2. FOREIGNERS WHO DO NOT HAVE A SOCIAL SECURITY NUMBER** **3. PATIENTS WHO CANNOT OR REFUSE TO PROVIDE A SOCIAL SECURITY NUMBER.** INDUSTRY: Subscriber Supplemental Identifier	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

PAYER NAME (INST. and PROF.)

Loop: 2010BB — PAYER NAME Repeat: 1

Usage: REQUIRED

Repeat: 1

Notes:
1. This is the primary payer or only payer
2. This is the destination payer.
3. For the purposes of this implementation the term payer is synonymous with several other terms, such as, reprise and third party administrator.

Example: **NM1*PR*2*UNION MUTUAL OF TEXAS*****PI*43140~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **PR PAYER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Payer Name **CODE DEFINITION** **SELF-PAY USE FOR SELF PAY CLAIMS (LOOP 2000B | SBR09= ZZ).** **CHARITY USE FOR CHARITY CLAIMS (LOOP 2000B SBR09 = ZZ).** **UNKNOWN USE WHEN THE PAY SOURCE IS UNKNOWN (LOOP 2000B | SBR09 =ZZ).**	**O AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**

Code designating the system/method of code structure used for Identification Code (67)

CODE	DEFINITION
PI	**PAYER IDENTIFICATION** **USE FOR PAYER IDENTIFICATION CODES OTHER THAN SELF, CHARITY AND UNKNOWN**
XV	**HEALTH CARE FINANCING ADMINISTRATION NATIONAL PLAN ID** **REQUIRED WHEN THE NATIONAL PLAN ID IS IMPLEMENTED**
ZY	**TEMPORARY IDENTIFICATION NUMBER,** **USE FOR SELF PAY, CHARITY, OR UNKNOWN PAYER CLAIMS**

SITUATIONAL	**NM109**	**67**	**Identification Code**	**X**	**AN**	**2/80**

Code identifying a party or other code

INDUSTRY: Payer Identifier ALIAS: Primary Payer ID

Situational Rule: The Identification Code is required when the payer is "Self Pay", "Charity Care" or "Unknown" at the time of data submission to THCIC.

CODE	DEFINITION
NNNNNNNNNN	**NATIONAL PLAN IDENTIFIER (WHEN IMPLEMENTED) (CMS CURRENTLY HAS DELAYED THE IMPLEMENTATION DATE FOR ALL PLANS AND PROVIDERS UNTIL FURTHER NOTICE)**
SELF	**SELF-PAY CLAIMS** **(LOOP 2000B | SBR09 = ZZ)**
CHARITY	**CHARITY CARE CLAIMS** **(LOOP 2000B | SBR09 = ZZ)**
UNKNOWN	**PAYER SOURCE IS UNKNOWN** **(LOOP 2000B | SBR09 = ZZ)**

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

BILLING PROVIDER SECONDARY IDENTIFICATION (*INST. and PROF.*)

Loop: 2010BB — BILLING PROVIDER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** If the THCIC ID is not submitted in a 2010AA REF segment REF01 (with qualifier "1J" in the REF02), then it is required to be submitted here. THCIC requires that the THCIC ID (6-digit number assigned by THCIC) and NPI or whatever is submitted in in Loop 2010AA | NM109) and the 1st 15 characters of street address (Loop 2010AA | N301) be submitted to identify those facilities. *If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310E (Inst.) or Loop 2310C(Prof).*

Example: **REF*1J*000116~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **1J FACILITY ID NUMBER;**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Billing Provider Additional Identifier **CODE DEFINITION** **NNNNNN THCIC ID NUMBER (6-DIGIT NUMBER ASSIGNED BY THCIC)**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

PATIENT HIERARCHICAL LEVEL (*INST. and PROF.*)

Loop: 2000C — PATIENT HIERARCHICAL LEVEL Repeat: >1

Usage: SITUATIONAL

Repeat: 1

Notes: 1. This HL is required when the patient is a different person than the subscriber. There is no HL's subordinate to the Patient HL.
2. If a patient is a dependent of a subscriber and can be uniquely identified to the payer by a unique Identification Number, then the patient is considered the subscriber and is to be identified in the Subscriber Level.

Situational Rule: Required when the patient is a dependent of the subscriber identified in Loop ID-2000B and cannot be uniquely identified to the payer using the subscriber's identifier in the Subscriber Level. If not required by this implementation guide, do not send.

Example: **HL*125*124*23*0~**

HL Hierarchical Level

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to. COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. **CODE DEFINITION** **23 DEPENDENT**	**M ID 1/2**

REQUIRED	**HL04**	**736**	**Hierarchical Child Code**	**O ID**	**1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).

CODE	DEFINITION
0	**NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL STRUCTURE**

IMPLEMENTATION

PATIENT INFORMATION (*INST. and PROF.*)

Loop: 2000C — PATIENT HIERARCHICAL LEVEL

Usage: SITUATIONAL

Repeat: 1

Note: 1. **Required by THCIC when the Patient is a different person than the Subscriber.**

Example: **PAT*19******01*145~**

PAT Patient Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PAT01**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities ALIAS: Patients Relationship to Insured **Use this code to specify the patient's relationship to the person insured.**	**O ID 2/2**

CODE	DEFINITION
01	SPOUSE
18	SELF
19	CHILD
20	EMPLOYEE
21	UNKNOWN
39	ORGAN DONOR
40	CADAVER DONOR
53	LIFE PARTNER
G8	OTHER RELATIONSHIP

NOT USED	**PAT02**	**1384**	**Patient Location Code**	**O ID 1/1**
NOT USED	**PAT03**	**584**	**Employment Status Code**	**O ID 2/2**
NOT USED	**PAT04**	**1220**	**Student Status Code**	**O ID 1/1**
NOT USED	**PAT05**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**PAT06**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**PAT07**	**355**	**Unit or Basis for Measurement Code**	**X ID 2/2**
NOT USED	**PAT08**	**81**	**Weight**	**X R 1/10**
NOT USED	**PAT09**	**1073**	**Yes/No Condition or Response Code**	**O ID 1/1**

IMPLEMENTATION

PATIENT NAME (*INST. and PROF.*)

Loop: 2010CA — PATIENT NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Note: 1. **REQUIRED by THCIC when the Patient is a different person than the Subscribe**r. "Not Used" if Subscriber is the Patient

2. Required if the "Subscriber" **is not** the "Patient".

Example: **NM1*QC*1*DOE*SALLY****MI*123456789~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **QC PATIENT**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Patient Last Name **FOR PATIENTS THAT ARE covered by 42 USC 290dd-2 or 42 CFR Part 2: Use the following last name: DOE.**	**O AN 1/60**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Patient First Name **FOR PATIENTS THAT ARE COVERED BY 42 USC 290dd-2 OR 42 CFR Part 2:** **Use one of the following names: "Jane" if female, or "John" if male. Sequential numbers, e.g., John1, John2, John3, may be used.**	**O AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Patient Middle Name **This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X ID 1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X AN 2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X ID 2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O ID 2/3**

NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

PATIENT ADDRESS (*INST. and PROF.*)

Loop: 2010CA — PATIENT NAME

Usage: SITUATIONAL

Repeat: 1

Note:
1. **REQUIRED by THCIC when the Patient is a different person than the Subscriber.** "Not Used" if Subscriber is the Patient
2. Required if the "Subscriber" **is not** the "Patient".

Example: **N3*RFD 10*100 COUNTRY LANE~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Patient Address Line	**M AN 1/40**
SITUATIONAL	**N302**	**166**	**Address Information** Address information INDUSTRY: Patient Address Line Required if a second address line exists	**O AN 1/25**

IMPLEMENTATION

PATIENT CITY/STATE/ZIP CODE (*INST. and PROF.*)

Loop: 2010CA — PATIENT NAME

Usage: SITUATIONAL

Repeat: 1

Note: **1. REQUIRED by THCIC when the Patient is a different person than the Subscriber**. "Not Used" if Subscriber is the Patient
2. Required if the "Subscriber" **is not** the "Patient".

Example: **N4*CORNFIELD TOWNSHIP*IA*99999~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name INDUSTRY: Patient City Name	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Patient State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **CODE DEFINITION** **AA US STATE OR CANADIAN PROVINCE CODE** **FC FOREIGN COUNTRY DEFAULT** **XX FOREIGN COUNTRY DEFAULT (THCIC RECOMMENDED)** THCIC will recognize either foreign country codes.	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Patient Postal Zone or ZIP Code CODE SOURCE **51:** ZIP Code **If the subscriber is the patient and the subscriber address and city are not in the U.S.A. or a Territory of U.S.A. the following codes should be used. Also, the Country Code in N404 will be required.** **CODE DEFINITION** **00000 FOREIGN COUNTRY DEFAULT (THCIC RECOMMENDED CODE)** **XXXXX FOREIGN COUNTRY DEFAULT**	**O ID 3/9**

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country CODE SOURCE 5: Countries, Currencies, and Funds **This data element is required when the address is outside of the U.S.** **See Appendices for Country Codes.**	**X**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**ID**	**1/3**

IMPLEMENTATION

PATIENT DEMOGRAPHIC INFORMATION (*INST.* and PROF.)

Loop: 2010CA — PATIENT NAME

Usage: SITUATIONAL

Repeat: 1

Note: REQUIRED by THCIC when the Patient is a different person than the Subscriber.

Example: **DMG*D8*19870730*M**5****~**

DMG Demographic Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X ID 2/3**
REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Patient Birth Date	**X AN 8/8**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual INDUSTRY: Patient Gender Code **CODE DEFINITION** **F FEMALE** **M MALE** **U UNKNOWN**	**O ID 1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O ID 1/1**
NOT USED	**DMG05**	**C056**	**Race Code**	**X ID 1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O ID 1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O ID 2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O ID 1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O R 1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X ID 1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X AN 1/30**

IMPLEMENTATION

CLAIM INFORMATION *(INST.)*

Loop: 2300 — CLAIM INFORMATION Repeat: 100

Usage: REQUIRED

Repeat: 1

Notes: 1. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BB in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent.

Example: **CLM*01319300001*500***11:A:1*Y*A*Y*Y***02******N~**

CLM Health Claim

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CLM01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment INDUSTRY: Patient Account Number ALIAS: Patient Control Number	**M AN 1/38**
REQUIRED	**CLM02**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Total Claim Charge Amount SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim. This amount is the total of the charges in the SV2 segments. **Zero may be a valid amount.**	**O R 1/18**
NOT USED	**CLM03**	**1032**	**Claim Filing Indicator Code**	**O ID 1/2**
NOT USED	**CLM04**	**1343**	**Non-Institutional Claim Type Code**	**O ID 1/2**
REQUIRED	**CLM05**	**C023**	**HEALTH CARE SERVICE LOCATION INFORMATION** To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered ALIAS: Type of Bill	**O**

REQUIRED **CLM05-1** **1331** **Facility Code Value** **M** **AN** **1/2**

Code identifying the type of facility where services were performed. These are the first and second digits of the Uniform Billing Claim Form Bill Type.

The ANSI 837 Institutional Guide Code Set for Facility Codes is different than the ANSI 837 Professional Guide Code Set

INDUSTRY: Facility Type Code

CODE	DEFINITION
12	HOSPITAL INPATIENT (MEDICARE PART B ONLY)
13	HOSPITAL OUTPATIENT
14	HOSPITAL LABORATORY SERVICES PROVIDED TO NON-PATIENTS
22	SKILLED NURSING-INPATIENT (MEDICARE PART B ONLY)
23	SKILLED NURSING FACILITY OUTPATIENT
43	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS-OUTPATIENT SERVICES
78	LICENSED FREESTANDING EMERGENCY MEDICAL FACILITY
82	SPECIAL FACILITY – HOSPICE (HOSPITAL BASED)
83	SPECIAL FACILITY – AMBULATORY SURGICAL CENTER
85	SPECIAL FACILITY - CRITICAL ACCESS HOSPITAL
89	SPECIAL FACILITY OTHER

NOT USED **CLM05 - 2** **1332** **Facility Code Qualifier** **O** **ID** **1/2**

Code identifying the type of facility referenced

CODE	DEFINITION
A	UNIFORM BILLING CLAIM FORM BILL TYPE

CODE SOURCE **236:** Uniform Billing Claim Form Bill Type

REQUIRED **CLM05 - 3** **1325** **Claim Frequency Type Code** **O** **ID** **1/1**

Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.

INDUSTRY: Claim Frequency Code

CODE	DEFINITION
0	NON-PAYMENT/ZERO CLAIM
1	ADMIT THROUGH DISCHARGE CLAIM
2	INTERIM - FIRST CLAIM
3	INTERIM - CONTINUING CLAIM
4	INTERIM - LAST CLAIM
5	LATE CHARGE ONLY
7	REPLACEMENT OF PRIOR CLAIM
8	VOID (VOID/CANCEL OF PRIOR CLAIM)

NOT USED	CLM06	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	CLM07	1359	Provider Accept Assignment Code	O	ID	1/1
NOT USED	CLM08	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	CLM09	1363	Release of Information Code	O	ID	1/1
NOT USED	CLM10	1351	Patient Signature Source Code	O	ID	1/1
NOT USED	CLM11	C024	RELATED CAUSES INFORMATION	O		
NOT USED	CLM12	1366	Special Program Code	O	ID	2/3
NOT USED	CLM13	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	CLM14	1338	Level of Service Code	O	ID	1/3
NOT USED	CLM15	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	CLM16	1360	Provider Agreement Code	O	ID	1/1
NOT USED	CLM17	1029	Claim Status Code	O	ID	1/2
NOT USED	CLM18	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	CLM19	1383	Claim Submission Reason Code	O	ID	2/2
NOT USED	CLM20	1514	Delay Reason Code	O	ID	1/2

IMPLEMENTATION

CLAIM INFORMATION (PROF.)

Loop: 2300 — CLAIM INFORMATION Repeat: 100

Usage: REQUIRED

Repeat: 1

Notes: **1.** For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BB in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent.

Example: **CLM*01319300001*500***11:A:1*Y*A*Y*Y***02******N~**

CLM Health Claim

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CLM01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment INDUSTRY: Patient Account Number ALIAS: Patient Control Number	**M AN 1/38**
REQUIRED	**CLM02**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Total Claim Charge Amount SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim. **This amount is the total of the charges in the SV2 segments. Zero may be a valid amount.**	**O R 1/18**
NOT USED	**CLM03**	**1032**	**Claim Filing Indicator Code**	**O ID 1/2**
NOT USED	**CLM04**	**1343**	**Non-Institutional Claim Type Code**	**O ID 1/2**
REQUIRED	**CLM05**	**C023**	**HEALTH CARE SERVICE LOCATION INFORMATION** To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered ALIAS: Type of Bill	**O**

REQUIRED **CLM05-1** **1331** **Facility Code Value** **M AN 1/2**

Code identifying the type of facility where services were performed. These are the first and second digits of the Uniform Billing Claim Form Bill Type.

INDUSTRY: Facility Type Code

CODE	DEFINITION
22	OUTPATIENT HOSPITAL
23	EMERGENCY ROOM HOSPITAL
24	AMBULATORY SURGICAL CENTER
31	SKILLED NURSING FACILITY
32	NURSING FACILITY
34	HOSPICE
50	FEDERALLY QUALIFIED HEALTH CENTER
62	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
99	OTHER UNLISTED FACILITY

NOT USED **CLM05 - 2** **1332** **Facility Code Qualifier** **O ID 1/2**

REQUIRED **CLM05 - 3** **1325** **Claim Frequency Type Code** **O ID 1/1**

Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.

INDUSTRY: Claim Frequency Code

CODE	DEFINITION
0	NON-PAYMENT/ZERO CLAIM (THCIC WILL ALLOW THIS CODE)
1	ORIGINAL (ADMIT THROUGH DISCHARGE CLAIM)
2	INTERIM - FIRST CLAIM
3	INTERIM - CONTINUING CLAIM
4	INTERIM - LAST CLAIM
6	CORRECTED (ADJUSTMENT OF PRIOR CLAIM) (CORRECTION CAN BE DONE ONLINE)
7	REPLACEMENT (REPLACEMENT OF PRIOR CLAIM)
8	VOID (VOID/CANCEL OF PRIOR CLAIM)

NOT USED **CLM05 - 4** **156** **State or Province Code** **O ID 2/2**

NOT USED **CLM05 - 5** **26** **Country Code** **O ID 2/3**

NOT USED **CLM06** **1073** **Yes/No Condition or Response Code** **O ID 1/1**

NOT USED **CLM07** **1359** **Provider Accept Assignment Code** **O ID 1/1**

NOT USED **CLM08** **1073** **Yes/No Condition or Response Code** **O ID 1/1**

NOT USED **CLM09** **1363** **Release of Information Code** **O ID 1/1**

NOT USED **CLM10** **1351** **Patient Signature Source Code** **O ID 1/1**

SITUATIONAL CLM11 C024 RELATED CAUSES INFORMATION O

To identify one or more related causes and associated state or country information

ALIAS: Accident/Employment/Related Causes

CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0.

If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.

REQUIRED CLM11 - 1 1362 Related-Causes Code M ID 2/3

Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: Related Causes Code

CODE	DEFINITION
AA	AUTO ACCIDENT
AB	ABUSE
AP	ANOTHER PARTY RESPONSIBLE
EM	EMPLOYMENT
OA	OTHER ACCIDENT

SITUATIONAL CLM11 - 2 1362 Related-Causes Code O ID 2/3

Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: Related Causes Code

Used if more than one code applies.

CODE	DEFINITION
AA	AUTO ACCIDENT
AB	ABUSE
AP	ANOTHER PARTY RESPONSIBLE
EM	EMPLOYMENT
OA	OTHER ACCIDENT

SITUATIONAL CLM11 - 3 1362 Related-Causes Code O ID 2/3

Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: Related Causes Code

Used if more than one code applies.

CODE	DEFINITION
AA	AUTO ACCIDENT
AB	ABUSE
AP	ANOTHER PARTY RESPONSIBLE
EM	EMPLOYMENT

			OA OTHER ACCIDENT			
NOT USED	**CLM11 - 4**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**CLM11 - 5**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**CLM12**	**1366**	**Special Program Code**	**O**	**ID**	**2/3**
NOT USED	**CLM13**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM14**	**1338**	**Level of Service Code**	**O**	**ID**	**1/3**
NOT USED	**CLM15**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM16**	**1360**	**Provider Agreement Code**	**O**	**ID**	**1/1**
NOT USED	**CLM17**	**1029**	**Claim Status Code**	**O**	**ID**	**1/2**
NOT USED	**CLM18**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM19**	**1383**	**Claim Submission Reason Code**	**O**	**ID**	**2/2**
NOT USED	**CLM20**	**1514**	**Delay Reason Code**	**O**	**ID**	**1/2**

IMPLEMENTATION

STATEMENT DATES (*INST.*)

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

Example: **DTP*434*RD8*20101214-20101214~**

DTP Date or Time or Period

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier **CODE DEFINITION** **434 STATEMENT**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **CODE DEFINITION** **RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD** USE RD8 TO INDICATE THE FROM AND THROUGH DATE OF THE STATEMENT. WHEN THE STATEMENT IS FOR A SINGLE DATE OF SERVICE, THE FROM AND THROUGH DATE ARE THE SAME.	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Statement From and To Dates	**M AN 1/35**

IMPLEMENTATION

CL1 - INSTITUTIONAL CLAIM CODE (*INST.*)

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED for Emergency Department Visits

Only Segment Repeat: 1

Example: **CL1*1*7*30~**

CL1 Admission

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	**CL101**	**1315**	**Admission Type Code**	**O ID 1/1**
SITUATIONAL	**CL102**	**1314**	**Admission Source Code** Code indicating the source of this admission **SITUATIONAL RULE Required for Emergency Department Visits with Rev Codes 0450, 0451, 0452, 0456, and 0459** CODE SOURCE: Point of Origin for Admission or Visit, National Uniform Billing Committee UB –04 Manual.	**O ID 1/1**
SITUATIONAL	**CL103**	**1352**	**Patient Status Code** Code indicating patient status as of the "statement covers through date" **SITUATIONAL RULE Required for Emergency Department Visits with Rev Codes 0450, 0451, 0452, 0456, and 0459** **CODE SOURCE 239:** Patient Status Code	**O ID 1/2**
NOT USED	**CL104**	**1345**	**Nursing Home Residential Status Code**	**O ID 1/1**

IMPLEMENTATION

MEDICAL RECORD NUMBER (*INST. and PROF.*)

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

Example: **REF*EA*1230484376R~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **EA MEDICAL RECORD IDENTIFICATION NUMBER**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Medical Record Number	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

K3 – STATE REQUIRED DATA ELEMENTS

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 10

Notes:

1. Required to report PATIENT SOCIAL SECURITY NUMBER, if the subscriber is not the patient and Social Security Number is not submitted in Loop 2010BA REF02.

2. THCIC requires that the Patient's Social Security Number be submitted to be used in conjunction with other submitted data elements to generate the uniform patient identification for longitudinal studies and epidemiological studies.

3. Per the requirements of Texas Government Code, Title 4, Section 531.0162, to meet national standard reporting requirements, the "Patient Ethnicity" and "Patient Race" is collected in the K3 segment. The adopted location for "Patient Ethnicity" is the 1st character of the K301 data field, the "Patient Race" is the 2nd character, and the "Patient's Social Security Number" is in the 3rd through 11th character slots.

ANSI 837 Committee removed the Patient Secondary Identification segment for the 5010 version of the ANSI 837 Institutional and Professional Guides.

Example:

K3*25999999999
Example of a "Non- Hispanic/Latino" and "Other or multiple race", with no known SSN.
K3*14999999999
Example of "Hispanic/Latino" of "White" race, with no known SSN.

Required Rule:

1. This is a REQUIRED segment to collect the Ethnicity and Race codes.
2. Required to report ETHNICITY code (Patient or Subscriber).
3. Required to report RACE code (Patient or Subscriber).
4. THCIC requires that the patient's Social Security Number (SSN) be submitted to be used in conjunction with other submitted data elements to generate the uniform patient identification for longitudinal studies and epidemiological studies.
5. Situational to report patient SSN, "Not Used" if Subscriber is the patient, since the SSN would be submitted in REF02 of the Subscriber Loop 2010BA.

K3 State Required Data Elements

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**K301**	**449**	**Fixed Format Information** A free-form description to clarify the related data elements and their content Per requirements of House Bill (HB) 2641 (84th Texas Legislature) to meet national standard reporting requirements the "Patient Ethnicity" and "Patient Race" will be collected on the K3 segment. The adopted location for "Patient Ethnicity" is the first character and "Patient Race" will be the second character of the K301 data field with the "Patient's Social Security Number" being located in the 3rd through 11th character slots. This will be implemented under the next contract, which is anticipated to begin January 1, 2020. **ETHNICITY CODE — POSITION (1)** **CODE DEFINITION** **1 HISPANIC OR LATINO** **2 NOT HISPANIC OR LATINO** **RACE CODE — POSITION (2)** **CODE DEFINITION** **1 AMERICAN INDIAN/ESKIMO/ALEUT** **2 ASIAN OR NATIVE HAWAIIAN OR PACIFIC ISLANDER** **3 BLACK OR AFRICAN AMERICAN** **4 WHITE** **5 OTHER Race** **SOCIAL SECURITY NUMBER — POSITIONS (3 - 11)** **CODE DEFINITION** **NNNNNNNNN SOCIAL SECURITY NUMBER** **999999999 1. Newborn that have no social security number** **2. Foreigners who do not have a social security number** **3. Patients who cannot or refuse to provide a social security number**	**M AN 1/80**
NOT USED	**K302**	**1333**	**Record Format Code**	**O ID 1/2**
NOT USED	**K303**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**

IMPLEMENTATION

THE PRINCIPAL DIAGNOSIS (INST.)

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

Notes: **1.** The Principal Diagnosis is required on all outpatient claims.

Do not transmit the decimal point for ICD codes. The decimal point is Implied

Example: **HI*ABK:S93334A~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **ABK INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) PRINCIPAL DIAGNOSIS**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list CODE SOURCE **131:** International Classification of Diseases Clinical Modification (ICD-9-CM)	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
NOT USED	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**

IMPLEMENTATION

HI – PATIENT'S REASON FOR VISIT (*INST.*)

Loop: 2300 - CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when claim involves outpatient visits. If not required by this implementation guide, do not send.

Notes: **1.** Do not transmit the decimal point for ICD codes. The decimal point is implied.

Example: **HI*APR:S93334A~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **APR INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) PRINCIPAL DIAGNOSIS**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **IMPLEMENTATION NAME: Patient Reason For Visit**	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities **SITUATIONAL RULE: Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. If not required by this implementation guide, do not send.**	**O**

REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			APR INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) PRINCIPAL DIAGNOSIS			
REQUIRED	**HI02 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			IMPLEMENTATION NAME: Patient Reason For Visit			
NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**		
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**	**ID**	**1/1**
			To send health care codes and their associated dates, amounts and quantities			
			SITUATIONAL RULE: Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. If not required by this implementation guide, do not send.			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			APR INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) PRINCIPAL DIAGNOSIS			
REQUIRED	**HI03 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			IMPLEMENTATION NAME: Patient Reason For Visit.			
NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

IMPLEMENTATION

HEALTH CARE DIAGNOSIS CODE (PROF.)

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

Notes: 1. THCIC REQUIRES a "Principal Diagnosis Code/Health Care Diagnosis Code". "External Cause of Injury/Morbidity Codes (Ecodes)" and "Other Diagnosis Codes" are required if applicable, therefore are "Situational". In ICD-10, the External Cause of Morbidity codes are in the range of V00-Y99.

2. Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.

Example: **HI*ABK:T23151A*ABF:T23152A*ABN:X0820XA~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **ABK INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) PRINCIPAL DIAGNOSIS** **ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)** IMPLEMENTATION NAME: Diagnosis Type Code	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Principal Diagnosis INDUSTRY: External Cause of Injury Code [E-code]	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**

To send health care codes and their associated dates, amounts, and quantities

Required for all unscheduled outpatient visits or upon the patient's admission to the hospital

REQUIRED HI02 - 1 1270 Code List Qualifier Code M ID 1/3

Code identifying a specific industry code list

ZZ used to indicate the "Patient Reason For Visit."

CODE	DEFINITION
ZZ	**MUTUALLY DEFINED**

USE ALSO TO INDICATE THE "PATIENT REASON FOR VISIT." (ALLOWED BY THCIC)

ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED HI02 - 2 1271 Industry Code M AN 1/30

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL HI03 C022 HEALTH CARE CODE INFORMATION O

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED HI03 - 1 1270 Code List Qualifier Code M ID 1/3

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED HI03 - 2 1271 Industry Code M AN 1/30

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI04 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI05 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**

NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI06 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

Industry: External Cause of Injury Code [E-code] INDUSTRY: Other Diagnosis

NOT USED	**HI06 – 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI07 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI08 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI09 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI09 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**

NOT USED	**HI09 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI10 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI10 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI11 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI11 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**

IMPLEMENTATION NAME: Diagnosis Type Code

REQUIRED	**HI12 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

HI - ANESTHESIA RELATED PROCEDURE (PROF.)

Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required on claims where anesthesiology services are being billed or reported when the provider knows the surgical code and knows the adjudication of the claim will depend on provision of the surgical code. If not required by this implementation guide, do not send.

Example: **HI*BP:0481~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BP HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM PRINCIPAL PROCEDURE** CODE SOURCE 130: Healthcare Common Procedural Coding System	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list IMPLEMENTATION NAME: Anesthesia Related Surgical Procedure	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 – 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities SITUATIONAL RULE: Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.	**O**

REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BO HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM** CODE SOURCE 130: Healthcare Common Procedural Coding System	**M**	**ID**	**1/3**
REQUIRED	**HI02 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

IMPLEMENTATION

OTHER DIAGNOSIS INFORMATION (*INST.*)

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 2

Notes: **1. Required when other condition(s) co-exists with the principal diagnosis**, co-exists at the time of admission or develop subsequently during the patient's treatment.

Example: **HI*ABF:T23121A~ HI*ABN:X0820XA~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS** **ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis INDUSTRY: External Cause of Injury Code [E-code]	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 – 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 – 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 – 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**

REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI02 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
			INDUSTRY: External Cause of Injury Code [E-code]			
NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 – 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI03 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
			INDUSTRY: External Cause of Injury Code [E-code]			
NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 – 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS
ABN	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)

REQUIRED	**HI04 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS
ABN	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)

REQUIRED	**HI05 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

INDUSTRY: External Cause of Injury Code [E-code]

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI06 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis INDUSTRY: External Cause of Injury Code [E-code]			
NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI07 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis INDUSTRY: External Cause of Injury Code [E-code]			
NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI08 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
NOT USED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
			INDUSTRY: External Cause of Injury Code [E-code]			
REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI09 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
			INDUSTRY: External Cause of Injury Code [E-code]			
NOT USED	**HI09 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI10 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
NOT USED	**HI10 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
			ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)			
REQUIRED	**HI11 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
			INDUSTRY: External Cause of Injury Code [E-code]			
NOT USED	**HI11 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS** **ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF MORBIDITY CODE (E-CODES)**	**M**	**ID**	**1/3**
REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis INDUSTRY: External Cause of Injury Code [E-code]	**M**	**AN**	**1/30**
NOT USED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

OCCURRENCE SPAN INFORMATION (*INST.*)

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 2

Notes: **1.** Required when occurrence span information applies to the claim or encounter.

2. THCIC will collect a maximum of 4 occurrences.

Example: **HI*BI:70:RD8:19981202-19981212~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BI OCCURRENCE SPAN**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
REQUIRED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD- CCYYMMDD**	**X ID 2/3**
REQUIRED	**HI01 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence or Occurrence Span Code Associated Date	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 – 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 – 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**

SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**		**O**	
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			BI OCCURRENCE SPAN			
REQUIRED	**HI02 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code			
			CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format			
			CODE DEFINITION			
			RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD			
REQUIRED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times			
			INDUSTRY: Occurrence or Occurrence Span Code Associated Date			
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**		**O**	
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			BI OCCURRENCE SPAN			
REQUIRED	**HI03 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code			
			CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format			
			CODE DEFINITION			
			RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD			

REQUIRED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence or Occurrence Span Code Associated Date			
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			TO SEND HEALTH CARE CODES AND THEIR ASSOCIATED DATES, AMOUNTS, AND QUANTITIES			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BI OCCURRENCE SPAN**	**M**	**ID**	**1/3**
REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI04 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence or Occurrence Span Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			TO SEND HEALTH CARE CODES AND THEIR ASSOCIATED DATES, AMOUNTS, AND QUANTITIES			
			USED WHEN NECESSARY TO REPORT MULTIPLE ADDITIONAL CO-EXISTING CONDITIONS			
NOT USED	**HI05 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI05 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**

NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

TO SEND HEALTH CARE CODES AND THEIR ASSOCIATED DATES, AMOUNTS, AND QUANTITIES

USED WHEN NECESSARY TO REPORT MULTIPLE ADDITIONAL CO-EXISTING CONDITIONS

NOT USED	**HI06 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI06 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI07 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI08 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 – 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**		**O**	

TO SEND HEALTH CARE CODES AND THEIR ASSOCIATED DATES, AMOUNTS, AND QUANTITIES

USED WHEN NECESSARY TO REPORT MULTIPLE ADDITIONAL CO-EXISTING CONDITIONS

NOT USED	**HI09 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI09 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09- 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

NOT USED	HI09 – 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION TO SEND HEALTH CARE CODES AND THEIR ASSOCIATED DATES, AMOUNTS, AND QUANTITIES USED WHEN NECESSARY TO REPORT MULTIPLE ADDITIONAL CO-EXISTING CONDITIONS	O		
NOT USED	HI10 - 1	1270	Code List Qualifier Code	M	ID	1/3
NOT USED	HI10 - 2	1271	Industry Code	M	AN	1/30
NOT USED	HI10 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI10- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI10 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI10 - 6	380	Quantity	O	R	1/15
NOT USED	HI10 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI10 – 8	1271	Industry Code	X	AN	1/30
NOT USED	HI10 – 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION TO SEND HEALTH CARE CODES AND THEIR ASSOCIATED DATES, AMOUNTS, AND QUANTITIES USED WHEN NECESSARY TO REPORT MULTIPLE ADDITIONAL CO-EXISTING CONDITIONS	O		
NOT USED	HI11 - 1	1270	Code List Qualifier Code	M	ID	1/3
NOT USED	HI11 - 2	1271	Industry Code	M	AN	1/30
NOT USED	HI11 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI11- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI11 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI11 - 6	380	Quantity	O	R	1/15
NOT USED	HI11 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI11 – 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11 – 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION TO SEND HEALTH CARE CODES AND THEIR ASSOCIATED DATES, AMOUNTS, AND QUANTITIES USED WHEN NECESSARY TO REPORT MULTIPLE ADDITIONAL CO-EXISTING CONDITIONS	O		
NOT USED	HI12 - 1	1270	Code List Qualifier Code	M	ID	1/3
NOT USED	HI12 - 2	1271	Industry Code	M	AN	1/30
NOT USED	HI12 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI12- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI12 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI12 - 6	380	Quantity	O	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

IMPLEMENTATION

OCCURRENCE INFORMATION (*INST.*)

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when occurrence information applies to the claim or encounter.

2. THCIC will collect a maximum of 12 occurrences.

Example: **HI*BH:42:D8:20161208~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
REQUIRED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X ID 2/3**
REQUIRED	**HI01 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 – 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**

SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI02 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI02 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI03 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**

REQUIRED	**HI03 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION** **To send health care codes and their associated dates, amounts, and quantities** **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI04 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION** **To send health care codes and their associated dates, amounts, and quantities** **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**

REQUIRED	**HI05 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI05 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION** **To send health care codes and their associated dates, amounts, and quantities** **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI06 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI07 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI08 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
D8	**DATE EXPRESSED IN FORMAT CCYYMMDD**

REQUIRED	**HI08 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: Occurrence Code Associated Date

REQUIRED	**HI09 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Occurrence Code

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

CODE	DEFINITION
BH	**OCCURRENCE**

REQUIRED	**HI09 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**

Code indicating the date format, time format, or date and time format

CODE	DEFINITION
D8	**DATE EXPRESSED IN FORMAT CCYYMMDD**

REQUIRED	**HI09 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: Occurrence Code Associated Date

NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
BH	**OCCURRENCE**

REQUIRED	**HI10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI10 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI10 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** **To send health care codes and their associated dates, amounts, and quantities** **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI11 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI11 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI12 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

VALUE INFORMATION (*INST.*)

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** Required when value information applies to the claim or encounter.

2. THCIC will collect a maximum of 12 occurrences.

Example: **HI*BE:08:::1740~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
REQUIRED	**HI01 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M ID 1/3**

REQUIRED	**HI02 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI02 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI03 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI03 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**

REQUIRED	**HI04 - 2**	**1271**	**Industry Code** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**M**	**AN**	**1/30**
NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI04 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI05 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI05 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**

REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI06 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI07 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI08 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code	**M**	**AN**	**1/30**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

NOT USED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI08 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI09 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI09 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI10 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

REQUIRED	**HI10 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI11 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI11 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE VALUE**	**M**	**ID**	**1/3**
REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

REQUIRED	**HI12 - 5**	**782**	**Monetary Amount** Monetary amount INDUSTRY: Value Code Associated Amount	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

CONDITION INFORMATION (INST.)

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** Required when condition information applies to the claim or encounter.

2. THCIC will collect a maximum of 8 occurrences.

Example: **HI*BG:17*BG:67~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M ID 1/3**

REQUIRED	**HI02 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
NOT USED	**HI02 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**			
REQUIRED	**HI03 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**			
REQUIRED	**HI04 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
NOT USED	**HI04 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**

NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
BG	**CONDITION**

REQUIRED	**HI05 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Condition Code

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts, and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
BG	**CONDITION**

REQUIRED	**HI06 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**

Code indicating a code from a specific industry code list

INDUSTRY: Condition Code

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	**HI07 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
NOT USED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	**HI08 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
NOT USED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI09 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI10 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**

REQUIRED	**HI11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI11 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

ATTENDING PHYSICIAN NAME

Loop: 2310A — ATTENDING PHYSICIAN NAME

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** Emergency Department Visit Use Only.

Example: **NM1*71*1*JONES*JOHN****XX*1234567890~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** **CODE DEFINITION** **71 ATTENDING PHYSICIAN**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **INDUSTRY**: Attending Physician Last Name	**O AN 1/35**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name **INDUSTRY**: Attending Physician First Name **Required if NM102=1 (person).**	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **INDUSTRY**: Attending Physician Middle Name **Required if NM102=1 and the middle name/initial of the person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name **INDUSTRY:** Attending Physician Name Suffix **Required if known.**	**O AN 1/10**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE DEFINITION** **XX CMS NATIONAL PROVIDER IDENTIFIER** **Required if NO State License Number Submitted in 2310A REF02**	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **INDUSTRY:** Attending Physician Primary Identifier	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ATTENDING PHYSICIAN SECONDARY IDENTIFICATION (INST.)

Loop: 2310A — ATTENDING PHYSICIAN NAME

Usage: SITUATIONAL

Repeat: 5

Notes: 1. Emergency Department Visit Use Only

2. REQUIRED by THCIC to report the Practitioner's state license if the National Provider Identification Number is NOT submitted in Loop 2310A NM109.

Example: **REF*0B*A12345~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			REQUIRED IF NATIONAL PROVIDER IDENTIFIER IS NOT SUBMITTED IN LOOP 2310A, NM109	
			CODE DEFINITION	
			0B STATE LICENSE NUMBER	
SITUATIONAL	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **INDUSTRY**: Attending Physician Secondary Identifier	**X AN 1/50**
			REQUIRED IF NATIONAL PROVIDER IDENTIFIER IS NOT SUBMITTED IN LOOP 2310A, NM109	
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

OPERATING PHYSICIAN NAME (*INST.*)

Loop: 2310B — OPERATING PHYSICIAN NAME

Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required by THCIC when any surgical procedure code is listed on this claim.

2. For THCIC reporting, the operating physician name is that of the individual that performed the principal procedure.

Example: **NM1*72*1*MEYERS*JANE****XX*1234567890~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an Individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** **CODE DEFINITION** **72 OPERATING PHYSICIAN**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Operating Physician Last Name	**X AN 160**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Operating Physician First Name	**O AN 135**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Operating Physician Middle Name **This data element is required when NM102 equals one (1) and the Middle Name or Initial of the person is known by the provider.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name INDUSTRY: Operating Physician Name Suffix **Required if known**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE DEFINITION** **XX CMS NATIONAL PROVIDER IDENTIFIER (THCIC RECOMMENDED)** **REQUIRED IF NO STATE LICENSE NUMBER IS SUBMITTED WHEN APPLICABLE IN LOOP 2310B REF02**	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Operating Physician Primary Identifier	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

OPERATING PHYSICIAN SECONDARY IDENTIFICATION (*INST.*)

Loop: 2310B — OPERATING PHYSICIAN NAME

Usage: SITUATIONAL

Repeat: 4

Notes: **1. REQUIRED by THCIC to report the Operating Practitioner's state license, if the National Provider Identification Number is NOT submitted in Loop 2310B NM109.**

2. Required if National Provider Identifier Number is not submitted and if surgical procedure covered under one of the revenue codes from 25 TAC 421.67(f) is performed by the provider.

Example: **REF*0B*A12345~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Required by THCIC to report if the National Provider Identification Number is NOT submitted in Loop 2310B NM109** **CODE DEFINITION** **0B STATE LICENSE NUMBER**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Operating Physician Secondary Identifier **Required by THCIC to report if the National Provider Identification Number is NOT submitted in Loop 2310B NM109**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

RENDERING PROVIDER NAME (*PROF.*)

Loop: 2310B — RENDERING PROVIDER NAME Repeat: 1 Usage: SITUATIONAL

Repeat: 1

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules (ANSI 837 Institutional or Professional Guides).

3. Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.

4. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.

Example: **NM1*82*1*BEATTY*GARY*C***SR*XX*1234567890~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual The entity identifier in NM101 applies to all segments in this Loop ID-2310. **CODE DEFINITION** **82 RENDERING PROVIDER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Rendering Provider Last or Organization Name ALIAS: Rendering Provider Last Name NSF Reference: FB1-14.0	**O AN 1/60**

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Rendering Provider First Name NSF Reference: FB1-15.0	**O**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Rendering Provider Middle Name NSF Reference: FB1-16.0 **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name INDUSTRY: Rendering Provider Name Suffix ALIAS: Rendering Provider Generation	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 NSF Reference: FA0-57.0 FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims. **CODE DEFINITION** **XX HEALTH CARE FINANCING ADMINISTRATION NATIONAL PROVIDER IDENTIFIER** **REQUIRED VALUE IF THE NATIONAL PROVIDER ID IS MANDATED FOR USE. OTHERWISE, ONE OF THE OTHER LISTED CODES MAY BE USED.**	**X**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Rendering Provider Identifier ALIAS: Rendering Provider Primary Identifier SYNTAX: P0809 NSF Reference: FA0-23.0, FA0-58.0 FA0-58.0 crosswalk is only used in Medicare COB payer-to-payer claims.	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

RENDERING PROVIDER SECONDARY IDENTIFICATION (*PROF.*)

Loop: 2310B — RENDERING PROVIDER NAME

Usage: SITUATIONAL

Repeat: 4

Notes: 1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

2. REQUIRED by THCIC to report the Operating Practitioner's state license, if the National Provider Identification Number is NOT submitted in Loop 2310B NM109.

Example: **REF*0B*A12345~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification NSF Reference: FA0-57.0 **CODE DEFINITION** **OB STATE LICENSE NUMBER** **REQUIRED IF NPI NOT SUBMITTED IN 2310B | NM109**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Rendering Provider Secondary Identifier SYNTAX: R0203 NSF Reference: FA0-58.0	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

OTHER PROVIDER NAME (*INST.*)

Loop: 2310C — OTHER PROVIDER NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.

2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature (ANSI 837 Institutional or Professional Guides).

3. Required on all outpatient claims/encounters to indicate the person or organization who rendered the care or radiological imaging procedure covered by the specified revenue codes in 25 TAC §421.67(f). In the case where a substitute provider (locum tenens) was used, that person should be entered here. Required when the Other Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider in the 2010AA/AB loops.

Example: **NM1*73*1*DOE*JOHN*A***XX*1234567890~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** **CODE DEFINITION** **73 OTHER PROVIDER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Other Provider Last Name	**O AN 1/60**

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Other Provider First Name **Required if NM102=1 (person).**	**O**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Other Provider Middle Name **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name INDUSTRY: Other Provider Name Suffix **Required if known.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE DEFINITION** **XX CMS NATIONAL PROVIDER IDENTIFIER (THCIC RECOMMENDED)** **REQUIRED IF NO STATE LICENSE NUMBER SUBMITTED IN 2310C REF02 .**	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Other Provider Primary Identifier **CMS National Provider Identifier Required if NO State License Number Submitted in 2310C REF02.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

OTHER PROVIDER SECONDARY IDENTIFICATION (*INST.*)

Loop: 2310C — OTHER PROVIDER NAME

Usage: SITUATIONAL

Repeat: 4

Notes: 1. REQUIRED by THCIC to report the Physician or Other Health Professional's state license, if the National Provider Identification Number is NOT submitted in Loop 2310C NM109.

Example: REF*0B*A12345~

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Required if National Provider Identifier is NOT Submitted in Loop 2310C, NM109** **CODE DEFINITION** **0B STATE LICENSE NUMBER**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Other Provider Secondary Identifier **Required if National Provider Identifier is NOT Submitted In Loop 2310C, NM109**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIE**	**O**

IMPLEMENTATION

SERVICE FACILITY LOCATION (*PROF.*)

Loop: 2310C — SERVICE FACILITY LOCATION Repeat: 1 Usage: SITUATIONAL

Repeat: 1

Notes:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules (ANSI 837 Institutional or Professional Guides).

3. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) loop.

4. Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address.

5. The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05-1 should indicate that the service occurred in the patient's home.

6. THCIC requires this if the Billing Provider (2010AA) are not indicated as the Facility providing the services.

Example: **NM1*77*2*A-OK RADIOLOGICAL CENTER*****24*11122333~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT NAME	ATTRIBUTES
REQUIRED	**NM101**	**98 Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **CODE DEFINITION** **77 SERVICE LOCATION** **USE WHEN OTHER CODES IN THIS ELEMENT DO NOT APPLY.**	**M ID 2/3**
REQUIRED	**NM102**	**1065 Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Laboratory or Facility Name ALIAS: Laboratory/Facility Name NSF Reference: EA0-39.0 **Required except when service was rendered in the patient's home.**	**O**	**AN**	**1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**AN**	**1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known** **CODE DEFINITION** **XX HEALTH CARE FINANCING ADMINISTRATION NATIONAL PROVIDER IDENTIFIER** **REQUIRED VALUE IF THE NATIONAL PROVIDER ID IS MANDATED FOR USE. OTHERWISE, ONE OF THE OTHER LISTED CODES MAY BE USED.**	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier ALIAS: Laboratory/Facility Primary Identifier SYNTAX: P0809 NSF Reference: EA1-04.0, EA0-53.0 **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SERVICE FACILITY LOCATION ADDRESS (*PROF.*)

Loop: 2310C — SERVICE FACILITY LOCATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".)

2. THCIC REQUIRES if Billing Provider are not indicated as the facility providing the services.

Example: **N3*123 MAIN STREET~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Laboratory or Facility Address Line ALIAS: Laboratory/Facility Address 1 NSF Reference: EA1-06.0	**M AN 1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information INDUSTRY: Laboratory or Facility Address Line ALIAS: Laboratory/Facility Address 2 NSF Reference: EA1-07.0 **Required if a second address line exists**	**O AN 1/55**

IMPLEMENTATION

SERVICE FACILITY LOCATION CITY/STATE/ZIP (*PROF.*)

Loop: 2310C — SERVICE FACILITY LOCATION

Usage: REQUIRED

Repeat: 1

Notes: 1. If service facility location is in an area where there are no street addresses, enter the name of the nearest town, state and zip of where the service was rendered.

2. THCIC REQUIRES if Billing Provider are not indicated as the facility providing the services.

Example: **N4*ANY TOWN*TX*75123~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name INDUSTRY: Laboratory or Facility City Name ALIAS: Laboratory/Facility City COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. NSF Reference: EA1-08.0	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Laboratory or Facility State or Province Code ALIAS: Laboratory/Facility State COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S. NSF Reference: EA1-09.0	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Laboratory or Facility Postal Zone or ZIP Code ALIAS: Laboratory/Facility Zip Code CODE SOURCE 51: ZIP Code NSF Reference: EA1-10.0	**O ID 3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country ALIAS: Laboratory/Facility Country Code CODE SOURCE 5: Countries, Currencies and Funds Required if the address is out of the U.S.	**X ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**

NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**ID**	**1/3**

IMPLEMENTATION

SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION (*PROF.*)

Loop: 2310C — SERVICE FACILITY LOCATION

Usage: SITUATIONAL

Repeat: 3

Notes: 1.Required by THCIC if the Service Facility Provider is different than the Billing Provider.

2.THCIC REQUIRES if Billing Provider are not indicated as the facility providing the services.

Example: **REF*1D*A12345~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **1J FACILITY ID NUMBER (THCIC ID)**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Laboratory or Facility Secondary Identifier ALIAS: Laboratory/Facility Secondary Identification Number SYNTAX: R0203 NSF Reference: EA1-04.0, EA0-53.0 **CODE DEFINITION** **NNNNNN THCIC ID NUMBER (ASSIGNED BY THCIC)**	**X AN 1/50**

IMPLEMENTATION

SERVICE FACILITY LOCATION NAME (*INST.*)

Loop: 2310E — SERVICE FACILITY LOCATION NAME
Repeat: 1 Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required by THCIC when the Service Facility Provider is different than the Billing Provider (2010AA).

This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.

Situational Rule: Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider). If not required by this implementation guide, do not send.

Example: **NM1*FA*2*Rehab Facility*****XX*1234567890~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **FA FACILITY**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Laboratory or Facility Name	**O AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE DEFINITION** **24 EMPLOYER'S IDENTIFICATION NUMBER** **XX HEALTH CARE FINANCING ADMINISTRATION NATIONAL PROVIDER IDENTIFIER**	**X ID 1/2**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier **CODE DEFINITION** **NNNNNNNNN EMPLOYER IDENTIFICATION NUMBER** **XXXXXXXXXX NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) RECOMMENDED BY THCIC**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SERVICE FACILITY ADDRESS (*INST.*)

Loop: 2310E — SERVICE FACILITY NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required by THCIC if the Service Facility Provider is different than the Billing Provider or the Pay-To Provider.

2. Required if Service Facility Name segment is used.

3. If the Service Facility is used, THCIC requires that the THCIC ID (Loop2310E| REF01), the Employer Identification Number (EIN/ Tax ID, in Loop 2310E | NM109) and the 1st 15 characters of street address (Loop 2310E N301) be submitted to identify those facilities.

Situational Rule: Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider). If not required by this implementation guide, do not send.

Example: **N3*123 MAIN STREET~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Laboratory or Facility Address Line **DO NOT USE PO BOX**	**M AN 1/ 55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information INDUSTRY: Laboratory or Facility Address Line **DO NOT USE PO BOX** **REQUIRED IF A SECOND ADDRESS LINE EXISTS**	**O AN 1/55**

IMPLEMENTATION

SERVICE FACILITY CITY/STATE/ZIP CODE (*INST.*)

Loop: 2310E — SERVICE FACILITY NAME

Usage: SITUATIONAL

Repeat: 1

Notes: Required by THCIC if the Service Facility Provider is different than the Billing Provider or the Pay-To Provider.

Situational Rule: Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider). If not required by this implementation guide, do not send.

Example: **N4*ANY TOWN*TX*75123~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Laboratory or Facility State or Province Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (ZIP code for United States) INDUSTRY: Laboratory or Facility Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**X ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**
SITUATIONAL	**N407**	**1715**	**Country Subdivision Code** Code identifying the country subdivision	**X ID 1/3**

IMPLEMENTATION

SERVICE FACILITY SECONDARY IDENTIFICATION (*INST.*)

Loop: 2310E — SERVICE FACILITY NAME

Usage: SITUATIONAL

Repeat: 3

Notes: Required by THCIC if the Service Facility Provider is different than the Billing Provider (2010AA) or the Pay-To Provider (2010AB).

Situational Rule: Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider). If not required by this implementation guide, do not send.

Example: **REF*1J*000116~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **1J FACILITY ID NUMBER**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Laboratory or Facility Secondary Identifier **CODE DEFINITION** **NNNNNN THCIC ID NUMBER *(ASSIGNED BY THCIC)***	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

OTHER SUBSCRIBER INFORMATION (*INST. and PROF.*)

Loop: 2320 — OTHER SUBSCRIBER INFORMATION

Repeat: 10

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required if other payers are known to potentially be involved in paying on this claim.

2. THCIC collects secondary payer data for only the first secondary payer reported.

3. All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is reported, run the 2320 Loop again with its respective 2330 Loops.

Example: **SBR*S*01*GR00786**MC****OF~**

SBR Subscriber Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01 1/1**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim **CODE DEFINITION** **S SECONDARY** **U UNKNOWN** **THIS CODE MAY ONLY BE USED IN PAYER TO PAYER COB CLAIMS WHEN THE ORIGINAL PAYER DETERMINED THE PRESENCE OF THIS COVERAGE FROM ELIGIBILITY FILES RECEIVED FROM THIS PAYER OR WHEN THE ORIGINAL CLAIM DID NOT PROVIDE THE RESPONSIBILITY SEQUENCE FOR THIS PAYER.**	**M ID**
REQUIRED	**SBR02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities SEMANTIC: SBR02 specifies the relationship to the person insured.	**O ID 2/2**
SITUATIONAL	**SBR03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Insured Group or Policy Number SEMANTIC: SBR03 is policy or group number.	**O AN 1/50**

SITUATIONAL	**SBR04**	**93**	**Name** Free-form name INDUSTRY: Other Insured Group Name SEMANTIC: SBR04 is plan name.	**O**	**AN**	**1/60**
SITUATIONAL	**SBR05**	**1336**	**Insurance Type Code**	**O**	**ID**	**1/3**
NOT USED	**SBR06**	**1143**	**Coordination of Benefits Code**	**O**	**ID**	**1/1**
NOT USED	**SBR07**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SBR08**	**584**	**Employment Status Code**	**O**	**ID**	**2/2**
REQUIRED	**SBR09**	**1032**	**Claim Filing Indicator Code** Code identifying type of claim	**O**	**ID**	**1/2**

CODE	DEFINITION
11	OTHER NON-FEDERAL PROGRAMS
12	PREFERRED PROVIDER ORGANIZATION (PPO)
13	POINT OF SERVICE (POS)
14	EXCLUSIVE PROVIDER ORGANIZATION (EPO)
15	INDEMNITY INSURANCE
16	HEALTH MAINTENANCE ORGANIZATION (HMO) MEDICARE RISK
17	DENTAL MAINTENANCE ORGANIZATION
AM	AUTOMOBILE MEDICAL
BL	BLUE CROSS/BLUE SHIELD
CH	CHAMPUS
CI	COMMERCIAL INSURANCE CO.
DS	DISABILITY
FI	FEDERAL EMPLOYEES PROGRAM
HM	HEALTH MAINTENANCE ORGANIZATION
LM	LIABILITY MEDICAL
MA	MEDICARE PART A
MB	MEDICARE PART B
MC	MEDICAID
OF	OTHER FEDERAL PROGRAM USE CODE OF WHEN SUBMITTING MEDICARE PART D CLAIMS OR HEALTH EXCHANGE INSURANCE PLANS (UNTIL OTHERWISE DIRECTED)
TV	TITLE V
VA	VETERAN ADMINISTRATION PLAN
WC	WORKERS' COMPENSATION HEALTH CLAIM
ZZ	MUTUALLY DEFINED, OR SELF PAY OR UNKNOWN, OR CHARITY, USE CODE ZZ WHEN THE PAYMENT IS SELF-PAY OR CHARITY OR TYPE OF INSURANCE IS NOT KNOWN AT THE TIME THE DATA IS SUBMITTED TO THCIC.

IMPLEMENTATION

OTHER PAYER NAME (*INST. and PROF.*)

Loop: 2330B — OTHER PAYER NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when more than one payer is paying on claim.

2. Submitters are required to send all known information on other payers in this Loop ID - 2330.

Example: **NM1*PR*2*MUTUAL OF TEXAS*****PI*43140~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **PR PAYER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Other Payer Last or Organization Name ALIAS: Payer Name **CODE DEFINITION** **SELF PAY USE FOR SELF PAY CLAIMS (LOOP 2320 | SBR09 = ZZ).** **CHARITY USE FOR CHARITY CLAIMS (LOOP 2320 | SBR09 = ZZ).** **UNKNOWN USE FOR UNKNOWN CLAIMS (LOOP 2320 | SBR09 = ZZ).**	**O AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**
			Code designating the system/method of code structure used for Identification Code (67)				
			Activated when the National Plan Identification Number is implemented by CMS				
			CODE DEFINITION				
			PI PAYER IDENTIFICATION				
			XV HCFA NATIONAL PLAN ID **REQUIRED WHEN THE NATIONAL PLAN ID IS IMPLEMENTED**				
			ZY TEMPORARY IDENTIFICATION NUMBER OR CHARITY OR UNKNOWN OR SELF- PAY CLAIMS				
			CODE SOURCE 540: Health Care Financing Administration National Plan ID				
SITUATIONAL	**NM109**	**67**	**Identification Code**	**X**	**AN**	**2/80**
			Code identifying a party or other code INDUSTRY: Other Payer Primary Identifier				
			ALIAS: Payer Primary ID				
			CODE DEFINITION				
			XXXXXXXXXX NATIONAL PLAN IDENTIFIER (WHEN IMPLEMENTED)				
			SELF PAY SELF-PAY CLAIMS, (LOOP 2320 | SBR09 = "ZZ")				
			CHARITY CHARITY CARE CLAIMS (LOOP 2320 | SBR09= "ZZ")				
			UNKNOWN PAYER SOURCE IS UNKNOWN (LOOP 2320 | SBR09 = "ZZ")				
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**160**

IMPLEMENTATION

SERVICE LINE NUMBER (*INST.*)

Loop: 2400 — SERVICE LINE NUMBER Repeat: 200

Usage: REQUIRED

Repeat: 1

Notes: **1.** The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.

Example: **LX*1~**

LX Assigned Number

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LX01**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set	**M N0 1/6**
			This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.	

IMPLEMENTATION

SERVICE LINE (*PROF.*)

Loop: 2400 — SERVICE LINE Repeat: 50

Usage: REQUIRED

Repeat: 1

Notes: 1. The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.

2. The datum in the LX is not usually returned in the 835 (Remittance Advice) transaction. LX01 may be used as a line item control number by the payer in the 835 if a line item control number has not been submitted on the service line. See that REF for more information (ANSI 837 Institutional or Professional Guides). LX01 is used to indicate bundling/unbundling in SVC06. See Section 1.4.3 for more information on bundling and unbundling (ANSI 837 Institutional or Professional Guides).

3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules (ANSI 837 Institutional or Professional Guides).

Example: **LX*1~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LX01**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set ALIAS: **Line Counter** NSF Reference: FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0 **The service line number incremented by 1 for each service line**	**M N0 1/6**

IMPLEMENTATION

PROFESSIONAL SERVICE (*PROF.*)

Loop: 2400 — SERVICE LINE

Usage: REQUIRED

Repeat: 1

Example: **SV1*HC:99211:25*12.25*UN*1*11**1:2:3Y~**

SV1 Professional Service

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SV101**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**M**
			To identify a medical procedure by its standardized codes and applicable modifiers	
			ALIAS: Procedure identifier	
REQUIRED	**SV101 - 1**	**235**	**Product/Service ID Qualifier**	**M ID 2/2**
			Code identifying the type/source of the descriptive number used in Product/Service ID (234)	
			INDUSTRY: Product or Service ID Qualifier	
			CODE DEFINITION	
			HC HEALTH CARE COMMON PROCEDURAL CODING SYSTEM (HCPCS) CODES	
			BECAUSE THE AMA'S CPT CODES ARE ALSO LEVEL 1 HCPCS CODES, THEY ARE REPORTED UNDER " HC"	
			CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	
REQUIRED	**SV101 - 2**	**234**	**Product/Service ID**	**M AN 1/48**
			Identifying number for a product or service	
			INDUSTRY: Procedure Code	
			NSF Reference: FA0-09.0, FB0-15.0, GU0-07.0	
SITUATIONAL	**SV101 - 3**	**1339**	**Procedure Modifier**	**O AN 2/2**
			This identifies special circumstances related to the performance of the service, as defined by trading partners	
			ALIAS: Procedure Modifier 1	
			NSF Reference: FA0-10.0, GU0-08.0	
			Use this modifier for the first procedure code modifier.	
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code	

SITUATIONAL	**SV101 - 4**	**1339**	**Procedure Modifier**	**O**	**AN**	**2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: Procedure Modifier 1

NSF Reference: FA0-10.0, GU0-08.0

Use this modifier for the first procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code

SITUATIONAL	**SV101 - 5**	**1339**	**Procedure Modifier**	**O**	**AN**	**2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: Procedure Modifier 1

NSF Reference: FA0-10.0, GU0-08.0

Use this modifier for the first procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code

SITUATIONAL	**SV101 - 6**	**1339**	**Procedure Modifier**	**O**	**AN**	**2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: Procedure Modifier 1

NSF Reference: FA0-10.0, GU0-08.0

Use this modifier for the first procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code

NOT USED	**SV101 - 7**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**SV101 - 8**	**234**	**Product/Service ID**	**O**	**AN**	**1/48**
REQUIRED	**SV102**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

Monetary amount

INDUSTRY: Line Item Charge Amount

ALIAS: Submitted charge amount

SEMANTIC: SV102 is the submitted charge amount. NSF Reference: FA0-13.0

For encounter transmissions, zero (0) may be a valid amount.

REQUIRED	**SV103**	**355**	**Unit or Basis for Measurement Code**	**X**	**ID**	**2/2**

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0304

NSF Reference: FA0-50.0

FA0-50.0 is only used in Medicare COB payer-to-payer situations.

CODE	DEFINITION
MJ	**MINUTES**
UN	**UNIT**

REQUIRED	**SV104**	**380**	**Quantity**	**X**	**R**	**1/15**

Numeric value of quantity

INDUSTRY: Service Unit Count

ALIAS: Units or Minutes

SYNTAX: P0304

Note: If a decimal is needed to report units, include it in this element, e.g., "15.6".

SITUATIONAL	**SV105**	**1331**	**Facility Code Value**	**O**	**AN**	**1/2**

Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format

INDUSTRY: Place of Service Code

ALIAS: Place of Service Code

SEMANTIC: SV105 is the place of service.

NSF Reference: FA0-07.0, GU0-05.0

Required if value is different than value carried in CLM05-1 in Loop ID-2300.

CODE	DEFINITION
22	OUTPATIENT HOSPITAL
23	EMERGENCY ROOM - HOSPITAL
24	AMBULATORY SURGICAL CENTER
31	SKILLED NURSING FACILITY
32	NURSING FACILITY
34	HOSPICE
50	FEDERALLY QUALIFIED HEALTH CENTER
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
62	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
99	OTHER UNLISTED FACILITY

NOT USED	**SV106**	**1365**	**Service Type Code**	**O**	**ID**	**1/2**
REQUIRED	**SV107**	**C004**	**COMPOSITE DIAGNOSIS CODE POINTER**	**O**		

To identify one or more diagnosis code pointers

ALIAS: Diagnosis Code Pointer

Required if HI segment in Loop ID-2300 is used

THCIC requires Health Care Diagnosis Code in 2300 HI segment.

REQUIRED	**SV107 - 1**	**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service NSF Reference: FA0-14.0 Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line). Use remaining diagnosis pointers in declining level of importance to service line. Acceptable values are 1 through 8, inclusive.	**M**	**N0**	**1/2**
SITUATIONAL	**SV107 - 2**	**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service NSF Reference: FA0-15.0 Use this pointer for the second diagnosis code pointer. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.	**O**	**N0**	**1/2**
SITUATIONAL	**SV107 - 3**	**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service NSF Reference: FA0-16.0 Use this pointer for the third diagnosis code pointer. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment Acceptable values are 1 through 8, inclusive.	**O**	**N0**	**½**
SITUATIONAL	**SV107 - 4**	**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service NSF Reference: FA0-17.0 Use this pointer for the fourth diagnosis code pointer. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment Acceptable values are 1 through 8, inclusive	**O**	**N0**	**1/2**
NOT USED	**SV108**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**SV109**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV110**	**1340**	**Multiple Procedure Code**	**O**	**ID**	**1/2**
NOT USED	**SV111**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV112**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV113**	**1364**	**Review Code**	**O**	**ID**	**1/2**
NOT USED	**SV114**	**1341**	**National or Local Assigned Review Value**	**O**	**AN**	**1/2**
NOT USED	**SV115**	**1327**	**Copay Status Code**	**O**	**ID**	**1/1**
NOT USED	**SV116**	**1334**	**Health Care Professional Shortage Area Code**	**O**	**ID**	**1/1**
NOT USED	**SV117**	**127**	**Reference Identification**	**O**	**AN**	**1/50**
NOT USED	**SV118**	**116**	**Postal Code**	**O**	**ID**	**3/15**
NOT USED	**SV119**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**SV120**	**1337**	**Level of Care Code**	**O**	**ID**	**1/1**
NOT USED	**SV121**	**1360**	**Provider Agreement Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

INSTITUTIONAL SERVICE LINE (*INST.*)

Loop: 2400 — SERVICE LINE NUMBER

Usage: REQUIRED

Repeat: 1

Notes: 1. This segment is required for outpatient claims that require procedure or drug information to be reported for claim adjudication.

Example: **SV2*0300*HC:80019*73.42*UN*1~**
Example: **SV2*0120**1500*DA*5*300~**

SV2 Institutional Service

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SV201**	**234**	**Product/Service ID** Identifying number for a product or service INDUSTRY: Service Line Revenue Code SEMANTIC: SV201 is the revenue code. **See National Uniform Billing Committee (NUBC) Codes.**	**X AN 1/48**
REQUIRED	**SV202**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers ALIAS: Service Line Procedure Code This data element is required for all Outpatient claims.	**X**
REQUIRED	**SV202 – 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) INDUSTRY: Product or Service ID Qualifier **CODE DEFINITION** **HC HCFA COMMON PROCEDURAL CODING SYSTEM (HCPCS) CODES** **(CPT CODES ARE REPORTED UNDER HC).** CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M ID 2/2**
REQUIRED	**SV202 - 2**	**234**	**Product/Service ID** Identifying number for a product or service INDUSTRY: Procedure Code ALIAS: HCPCS Procedure Code	**M AN 1/48**

SITUATIONAL SV202 - 3 1339 Procedure Modifier O AN 2/2

This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: HCPCS Modifier 1

Use this modifier for the first procedure code modifier.

This data element is required when the Provider needs to convey additional clarification for the associated procedure code.

CODE SOURCE 130: See NUBC UB04 manual or CMS website http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/02_HOPPSCodes.asp for valid HOPPS and https://www.cms.gov/medicare/coding/medhcpcsgeninfo/index.html for HCPCS modifiers

SITUATIONAL SV202 - 4 1339 Procedure Modifier O AN 2/2

This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: HCPCS Modifier 2

See SV202-3

SITUATIONAL SV202 - 5 1339 Procedure Modifier O AN 2/2

This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: HCPCS Modifier 3

See SV202-3

SITUATIONAL SV202 - 6 1339 Procedure Modifier O AN 2/2

This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: HCPCS Modifier 4

See SV202-3

NOT USED SV202 - 7 352 Description O AN 1/80

REQUIRED SV203 782 Monetary Amount O R 1/18

Negative charges must have a "minus" (-) leading the numbers.

INDUSTRY: Line Item Charge Amount

ALIAS: Service Line Charge Amount

SEMANTIC: SV203 is a submitted charge amount.

Use this amount to indicate the submitted charge amount.

Zero may be a valid amount.

REQUIRED	**SV204**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken **CODE DEFINITION** **DA DAYS** **F2 INTERNATIONAL UNIT** **DOSAGE AMOUNT IS ONLY USED FOR DRUG CLAIMS WHEN THE DOSAGE OF THE DRUG IS VARIABLE WITHIN A SINGLE NDC NUMBER (E.G. BLOOD FACTORS).** **UN UNIT**	**X**	**ID**	**2/2**
REQUIRED	**SV205**	**380**	**Quantity** Numeric value of quantity Negative amounts must have a "minus" (-) leading the numbers INDUSTRY: Service Unit Count ALIAS: Service Line Units	**X**	**R**	**1/15**
SITUATIONAL	**SV206**	**1371**	**Unit Rate** The rate per unit of associate revenue for hospital accommodation Negative charges must have a "minus" (-) leading the numbers INDUSTRY: Service Line Rate ALIAS: Service Line Rate Amount **ANSI changed the usage to NOT USED, THCIC has turned-off the audit for this data field. THCIC will calculate this field for the Certification Data and the Public Use Data File and Research Files by following formula (Monetary Amount (SV203) divided by Quantity (SV205)).**	**O**	**R**	**1/10**
SITUATIONAL	**SV207**	**782**	**Monetary Amount** Monetary amount Negative charges must have a "minus" (-) leading the numbers INDUSTRY: Line Item Denied Charge or Non-Covered Charge Amount ALIAS: Service Line Non-Covered Charge Amount SEMANTIC: SV207 is a non-covered charge amount. **Use this amount if needed to report line specific non-covered charge amount.**	**O**	**R**	**1/18**
NOT USED	**SV208**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV209**	**1345**	**Nursing Home Residential Status Code**	**O**	**ID**	**1/1**
NOT USED	**SV210**	**1337**	**Level of Care Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

SERVICE LINE DATE (*INST.*)

Loop: 2400 — SERVICE LINE NUMBER

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required on outpatient claims when revenue, procedure, HIEC or drug codes are reported in the SV2 segment.

2. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.

3. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

4. Assessment Date DTP is not used when this segment is present.

Example: **DTP*472*D8*19960819~**

SERVICE LINE DATE (*INST.*)

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier **CODE DEFINITION** **472 SERVICE** USE RD8 IN DTP02 TO INDICATE BEGIN/END OR FROM/TO DATES.	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD** **RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDDCCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Service Date	**M AN 1/35**

IMPLEMENTATION

DATE - SERVICE DATE (*PROF.*)

Loop: 2400 — SERVICE LINE

Usage: REQUIRED

Repeat: 1

Notes: 1. The total number of DTP segments in the 2400 loop cannot exceed 15.

2. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.

3. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

Example: **DTP*472*RD8*19970607-19970608~**

DATE - SERVICE DATE (*PROF.*)

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier **CODE DEFINITION** **472 SERVICE** Use RD8 in DTP02 to indicate begin/end or from/to dates.	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD** **RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD** **RD8 IS REQUIRED ONLY WHEN THE "TO AND FROM" DATES ARE DIFFERENT. HOWEVER, AT THE DISCRETION OF THE SUBMITTER, RD8 CAN ALSO BE USED WHEN THE "TO AND FROM" DATES ARE THE SAME.**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Service Date NSF Reference: FA0-05.0, FA0-06.0	**M AN 1/35**

IMPLEMENTATION

RENDERING PROVIDER NAME (*PROF.*)

Loop: 2420A — RENDERING PROVIDER NAME
Repeat: 1
Usage: SITUATIONAL
Repeat: 1
Notes: 1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.
See Appendix A for further details on ASC X12 syntax rules (ANSI 837 Institutional or Professional Guides).
2. Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this Particular service line has a different Rendering Provider that what is given in the 2010AA/AB loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.
3. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.
Situational Rule: Required when the Rendering Provider NM1 information is different than that carried in the Loop ID-2310B Rendering Provider.
OR
Required when Loop ID-2310B Rendering Provider is not used AND this particular line item has different Rendering Provider information than that which is carried in Loop ID-2010AA Billing Provider. If not required by this implementation guide, do not send.

Example: **NM1*82*1*SMITH*JUNE*L***XX*9876543210~**

RENDERING PROVIDER NAME (*PROF.*)

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in this iteration of Loop ID- 2420.** **CODE DEFINITION** **82 RENDERING PROVIDER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON** **2 NON-PERSON ENTITY**	**M ID 1/1**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: **Rendering Provider Last or Organization Name** ALIAS: **Rendering Provider Last Name** NSF Reference: FB1-14.0	**O**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: **Rendering Provider First Name** NSF Reference: FB1-15.0 **Required if NM102=1 (person).**	**O**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: **Rendering Provider Middle Name** NSF Reference: FB1-16.0 **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name INDUSTRY: **Rendering Provider Name Suffix** ALIAS: **Rendering Provider Generation** **Required if known**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 NSF Reference: FA0-57.0 **CODE DEFINITION** **XX HEALTH CARE FINANCING ADMINISTRATION NATIONAL PROVIDER IDENTIFIER** **REQUIRED VALUE IF THE NATIONAL PROVIDER ID IS MANDATED FOR USE. OTHERWISE, ONE OF THE OTHER LISTED CODES MAY BE USED.**	**X**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Rendering Provider Identifier ALIAS: Rendering Provider Primary Identifier SYNTAX: P0809 NSF Reference: FA0-23.0, FA0-58.0	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

RENDERING PROVIDER SECONDARY IDENTIFICATION (*PROF.*)

Loop: 2420A — RENDERING PROVIDER NAME

Usage: SITUATIONAL

Repeat: 20

Notes: 1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

2. Required by THCIC to report the Physician or Other Health Professional's state license, if the National Provider Identification Number is NOT submitted in Loop 2420A NM109.

Example: **REF*0B*A12345~**

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **0B STATE LICENSE NUMBER** **THCIC REQUIRES IF NPI NOT SUBMITTED IN 2420A | NM109**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: **Rendering Provider Secondary Identifier** SYNTAX: R0203	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

TRANSACTION SET TRAILER *(INST and PROF)*

Usage: REQUIRED

Repeat: 1

Example: **SE*1230*987654~**

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments INDUSTRY: Transaction Segment Count	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set SE02 must match ST02. **MUST MATCH NUMBER IN ST02**	**M AN 4/9**

6 Past Version Changes to this Document

6.1 Outpatient THCIC 837 Technical Specifications Updates of Versions

Outpatient THCIC 837 Technical Specifications Updates of Version 2 from Version 1

1. Table of Contents added, inadvertently deleted

2. Section 5.5.1 Interchange Control Header, ISA12 code is updated from 00401 to 00501.

3. Section 5.12 Loop 2300, Other Diagnosis Information added, inadvertently deleted.

Outpatient THCIC 837 Technical Specifications Updates of Version 3 from Version 2

1. Section 2.2 – Reference Information – Versions and dates are updated

2. Section 4.3.1 Data File Specifications – Version is updated

3. Section 4.3.2 State Required Data Elements (Table)

    a) Payer Name Loop is updated from 2010BC to 2010BB.

    b) National Plan Identifier is updated from 2010BC to 2010BB.

4. Section 5.1 Reference Information – Versions and dates are updated.

5. Section 5.7 Loop Labeling and Use – Loop 2010BC is deleted.

6. Section 5.11 THCIC Transaction Set – Table 2 Detail – Subscriber Hierarchical Level – Loop 2010BC changed to 2010BB.

7. Section 5.12 Segment ID Breakout

    a) 2000A Billing Provider Hierarchical Level – Note the Loop ID 2010BC is updated to 2010BB.

    b) 2300 External Cause of Injury – HInn-9 (nn = 01-12) Yes/No Condition or Response Code - Situational Rule is added.

    c) 2300 Other Diagnosis Information –

        i. Hinn-8 (nn – 01-12) – Industry Code is added

        ii. HInn-9 (nn – 01-12) - Yes/No Condition or Response Code is added

d) 2320 Other Subscriber Information – SBR09 codes update to match codes in Loop 2000B.

Outpatient THCIC 837 Technical Specifications Updates of Version 4 from Version 3

1. Section 5.5.1 Control Segment Elements Breakout – Interchange Control Header (Inst. and Prof.)
   a. Example – Version Code is updated to 00501 from 00401
   b. ISA12 - Interchange Control Version Number – code is changed to 00501 from 00401
2. Section 5.5.1 Control Segment Elements Breakout –
   a. 2010BB Payer Name - NM108 the usage is changed "Situational" from "Required".
   b. Loop 2300 Principal Diagnosis (Inst.) - HI01 – 9 - Yes/No Condition or Response Code (Present on Admission Indicator) the usage is changed to "Not Used" from "Situational".
   c. Loop 2300 Health Care Diagnosis Code (Prof.) - Data elements HInn – 9 (nn = 01 – 12) - Yes/No Condition or Response Code (Present on Admission Indicator) the usage is changed to "Not Used" from "Situational".
   d. Loop 2330 Other Payer Name (Inst. and Prof.) – NM108 the usage is changed "Situational" from "Required".

Outpatient THCIC 837 Technical Specifications Updates of Version 5 from Version 4

1. Section 2.2 Reference Information versions updated for ANSI 837 Institutional Claim
2. format to 005010X223A2 from 005010X223A1 and 837 Professional Claim format to 005010X222A1 from 005010X222.
3. Section 4.3.2.4 Table listing Data Elements by THCIC 837 Institutional Location
   a. Operating or Other Physician Number – NPI is reported in Loop 2310B, NM109 or State License is reported in Loop 2310B, REF02.
   b. Other Provider Number - NPI is reported in Loop 2310C, NM109 or State License is reported in Loop 2310C, REF02.
4. Section 5.1 Reference Information -First paragraph, last sentence the version is updated for ANSI 837 Institutional Claim format to 005010X223A2 from

005010X223A1 and 837 Professional Claim format to 005010X222A1 from 005010X222.

5. Section 5.5.1 Control Segment Elements Breakout - INTERCHANGE CONTROL HEADER (INST. and PROF.) Segment

   a. Note 1 – the phrase "fixed record length segment" is underlined.

   b. Boxes noting the fixed length record beginning and ending positions are added for each data element.

6. Section 5.2.1 Control Segment Elements Breakout – Functional Group Header (INST. and PROF.)

   a. INST Example is updated to 005010X223A2 from 005010X223A1.
   b. PROF Example is updated to 005010X222A1 from 005010X222.
   c. GS08 Version/Release/Industry Identifier Code is updated to 005010X223A2 from 005010X223A1 and description updated to A2 from A1.
   d. GS08 Version/Release/Industry Identifier Code is updated to 005010X222A1 from 005010X222 and description updated to Addendum A1 for Release 00501 (Prof.)

7. Section 5.10 THCIC Transaction Set – INSTITUTIONAL Table 2 Detail – Subscriber Hierarchical Level

   a. Loop ID 2010BA Subscriber Name – The "Usage" is changed to "R/N" for Subscriber Name, Subscriber Address, Subscriber City/State/ZIP Code, Subscriber Demographic Information and Subscriber Secondary Identification and boxed note added stating "Required" if "Subscriber" is the "Patient" otherwise "Not Used".

   b. Loop 2010BB Payer Name – REF Billing Provider Secondary Identification was added.

8. Section 5.10 THCIC Transaction Set – INSTITUTIONAL Table 2 Detail – Patient Hierarchical Level

   a. Loop ID 2010CA Patient Name – The "Usage" is changed to "N/R" for Patient Name, Patient Address, Patient City/State/ZIP Code and Patient Demographic Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".

   b. Loop ID 2300 Claim Information – K3 Segment

      i. Usage changed to N/R

      ii. Note added "Not Used" if "Subscriber" is the "Patient", otherwise "Required".

9. Section 5.10 THCIC Transaction Set – PROFESSIONAL Table 2 Detail – Subscriber Hierarchical Level

   a. Loop ID 2010BA Subscriber Name – The "Usage" is changed to "R/N" for Subscriber Name, Subscriber Address, Subscriber City/State/ZIP Code,

Subscriber Demographic Information and Subscriber Secondary Identification and boxed note added stating "Required" if "Subscriber" is the "Patient" otherwise "Not Used".

b. Loop 2010BB Payer Name – REF Billing Provider Secondary Identification was added.

10. Section 5.10 THCIC Transaction Set – PROFESSIONAL Table 2 Detail – Patient Hierarchical Level

    a. Loop ID 2010CA Patient Name – The "Usage" is changed to "N/R" for Patient Name, Patient Address, Patient City/State/ZIP Code and Patient Demographic Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".

    b. Loop ID 2300 Claim Information – K3 Segment

        i. Usage changed to N/R

        ii. Note added "Not Used" if "Subscriber" is the "Patient", otherwise "Required".

11. Section 5.10 Segment ID Breakout – ST Transaction Set Header – Examples changed

    a. Added ST*837*987654*005010X223A2~ (INST)

    b. Updated ST*837*987654*005010X222A1~ (PROF) from ST*837*987654~

12. Section 5.10 Segment ID Breakout – Loop 2010AA Billing Provider THCIC Identification (INST. and PROF.) – REF02 Reference Identification – Length changed to 50 from 30.

13. Section 5.10 Segment ID Breakout – Loop 2010BA Subscriber Name (INST. And PROF.) - Note changed to "The Subscriber Name is REQUIRED when the subscriber is the patient. Subscriber Name data segment is "NOT USED" if Subscriber is NOT the Patient."

14. Section 5.10 Segment ID Breakout – Loop 2010BA Subscriber Address (INST. And PROF.) – Note 2 the sentence "Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.

15. Section 5.10 Segment ID Breakout – Loop 2010BA Subscriber City/State/ZIP Code (INST. And PROF.) – Note 2 the sentence "Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.

16. Section 5.10 Segment ID Breakout – Loop 2010BA Subscriber Demographic Information (INST. And PROF.) – Note 3 the sentence "Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.

17. Section 5.10 Segment ID Breakout – Loop 2010BA Subscriber Secondary Identification (INST. And PROF.)

a. Note 2 the sentence "Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.

b. REF02 Reference Identification – Length changed to 50 from 30.

18. Section 5.10 Segment ID Breakout – Loop 2010BB Billing Provider Secondary Identification (INST. And PROF.) - REF02 Reference Identification – Length changed to 50 from 30.

19. Section 5.10 Segment ID Breakout – Loop 2010CA Patient Name (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

20. Section 5.10 Segment ID Breakout – Loop 2010CA Patient Address (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

21. Section 5.10 Segment ID Breakout – Loop 2010CA Patient City/State/ZIP Code (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

22. Section 5.10 Segment ID Breakout – Loop 2010CA Patient Demographic Information (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

23. Section 5.10 Segment ID Breakout – Loop 2300 Medical Record Number (INST. And PROF.) - REF02 Reference Identification – Length changed to 50 from 30.

24. Section 5.10 Segment ID Breakout – Loop 2300 State Required Data Elements – K3 Segment – Note 1 sentence added "Not Used" if "Subscriber" is the "Patient", otherwise "Required".

25. Section 5.10 Segment ID Breakout – Loop 2310B Operating Physician Secondary Identification (INST.) - REF02 Reference Identification – Length changed to 50 from 30.

26. Section 5.10 Segment ID Breakout – Loop 2310B Rendering Provider Secondary Identification (PROF.) - REF02 Reference Identification – Length changed to 50 from 30.

27. Section 5.10 Segment ID Breakout – Loop 2310C Other Provider Secondary Identification (INST.) - REF02 Reference Identification – Length changed to 50 from 30.

28. Section 5.10 Segment ID Breakout – Loop 2310C Service Facility Location Secondary Identification (PROF.) - REF02 Reference Identification – Length changed to 50 from 30.

29. Section 5.10 Segment ID Breakout – Loop 2310E Service Facility Location Secondary Identification (INST.) - REF02 Reference Identification – Length changed to 50 from 30.

30. Section 5.10 Segment ID Breakout – Loop 2310B Rendering Provider Secondary Identification (PROF.) - REF02 Reference Identification – Length changed to 50 from 30.

31. Section 5.10 Segment ID Breakout – Loop 2420A Rendering Provider Secondary Identification (PROF.) - REF02 Reference Identification – Length changed to 50 from

Outpatient THCIC 837 Technical Specifications Updates of Version 6 from Version 5

1. Section 2.1 General Overview – Second paragraph language is clarified regarding the submission process.

2. Section 2.2 Reference Information – Third paragraph is modified to state that the testing process checks for a HIPAA compatible file submission.

3. Section 2.3.1 – System13, Inc.

    a. Title is changed by removing reference to "Commonwealth Clinical Systems, Inc."

    b. Help Desk e-mail is updated to thcichelp@system13.com

    c. Help Desk hours change to 8:00 am to 5:00 pm Central Time

    d. Data Portal Web Site – description is changed to clarify that the link can be used to address any web system issues.

4. Section 3 Definitions and Acronyms

    a. CCS is deleted

    b. System13, Inc. – the reference to Commonwealth Clinical System, Inc. is removed and the definition is clarified that System13, Inc. collects inpatient and outpatient data on behalf of THCIC.

5. Section 4.2.2 Data Correction – The reference to the THCIC Hospital Data Corrections Manual and Data Corrections is removed and replaced with information about WebCorrect and the hyperlink for help about the WebCorrect components

6. Section 4.3.2 State Required Data Elements – Table listing Data Elements and Locations

    a. References to Loop 2010AB for Pay-To-Provider are removed from the following rows:

        i. Provider Name

        ii. Provider Address

        iii. Provider City

iv. Provider ZIP Code

b. "Diagnosis Present on Admission" is added.

c. "Provider National Provider Identification" was changed from "Provider Federal Tax ID/EIN/NPI"

d. Provider Tax Identification was added with associated loops and reference descriptors.

e. THCIC ID – Loop 2010BB replaces 2010AB.

7. Section 4.7 AUDITING OF DATA BY System13, INC. – Language is updated and hyperlink is updated to the audits on the website.

8. Section 5.1. Reference Information – THCIC DATA ELEMENTS WHERE USAGE DIFFERS FROM ANSI 837 INSTITUTIONAL GUIDE

   a. National Provider Identification Number (NPI)

      i. Employer Identification Number reference was deleted

      ii. Loop 2010AB references were deleted

   b. Employer Identification Number – Loop 2010AA- REF02 (or NM109) and the difference added

   c. Facility ID Number (THCIC ID#) - Loop 2010BB replaces 2010AB. Language added about usage change to "SITUATIONAL". Footnote added also for Loop 2010BB.

9. Section 5.2 – Control Segments – Information added about Delimiters.

10. Section 5.2.1 - CONTROL SEGMENT ELEMENTS BREAKOUT- Interchange Control Header

    a. Example is updated in ISA11.

    b. ISA11 Repetition Separator replaces Interchange Control Standards Identifier

11. Section 5.3 – THCIC Transaction Set table

    a. Table 2 Detail – Billing Provider Hierarchical Level

       i. Table Title was updated, removed "/Pay-to"

       ii. Loop Title Loop ID – 2000A Billing Provider title updated, removed "/Pay-to"

       iii. HL – Billing Provider Hierarchical segment name updated removed "/Pay-to"

       iv. PRV Billing Provider Specialty Information segment deleted

       v. REF – Billing Provider Tax Identification is added

vi. REF – Billing Provider THCIC Identification has name changed from Billing Provider Secondary Identification and the repeat level is changed to "1" from "8"

vii. REF – Pay-To Provider Secondary Information segment is deleted

b. Table 2 Detail – Subscriber Hierarchical Level - Loop 2010BB Payer Name – REF – Billing Provider Secondary Identification is added.

c. Table 2 Detail – Patient Hierarchical Level

i. Loop ID – 2300 Claim Information – K3 – State Required Data Elements (Patient SSN) File Information, "File Information" was added to refer to name in ANSI X12N 837 Institutional Guide.

ii. Loop ID 2310E Service Facility Name – REF – Service Facility Secondary Identification segment repeat was updated and reduced to "3".

12. Section 5.4 Segment ID Breakout –

a. Loop 2010AA BILLING PROVIDER NAME - NM109

i. Notes are added regarding the requirement that this information must be on file with THCIC to have data submission properly identified.

ii. The EIN code was moved to the bottom and a note stating THCIC would allow EIN to be reported here.

b. Loop 2010AA BILLING PROVIDER THCIC IDENTIFICATION is added

c. Loop 2000B – SUBSCRIBER INFORMATION – SBR01 – All codes except "P" – Primary are removed.

d. Loop 2010BB - BILLING PROVIDER SECONDARY IDENTIFICATION

i. Usage was changed from REQUIRED to SITUATIONAL

ii. Note 1 the language was modified to explain that THCIC ID is required and if not submitted in the Loop 2010AA REF segment with the "1J" qualifier and the NPI or other identifier (that is on file with THCIC) in Loop 2010AA NM109 then the data cannot be identified properly. Removed reference to 2010AB Pay- to-Provider Loop.

e. LOOP 2310E – SERVICE FACILITY SECONDARY IDENTIFICATION

i. Repeat is reduced to "3" from "5"

ii. Note – reference to "Pay-to Provider is removed

f. LOOP 2320 - OTHER SUBSCRIBER INFORMATION – SBR09 – Code "LI" Liability was not previously removed.

g. Loop 2400 – INSTITUTIONAL SERVICE LINE – SV206 – Note of requirement removed. Note added stating the field will be calculated for the Certification Data and the Public Use Data File and Research Files by following formula (Monetary Amount (SV203) divided by Quantity (SV205)).

Outpatient THCIC 837 Technical Specifications Updates of Version 7 from Version 6

1. Section 2.2 Reference Information version updated to 005010X223A2 from 005010X223A1.
2. Section 4.3.2 State Required Data Elements – The list of the data elements and their respective locations in the approved formats
   a. Type of Admission text added to identify new UB-04 name "Priority (Type) of Admission".
   b. Source of Admission text added to identify new UB-04 name "Point of Origin for Admission or Visit".
3. Section 5.1 Reference Information
   a. First paragraph last sentence the version updated to 005010X223A2 from 005010X223A1.
   b. List of THCIC Data Elements Where Usage Differs From ANSI 837 Institutional Guide
      i. Type of Admission text added to identify new UB-04 name "Priority (Type) of Admission".
      ii. Source of Admission text added to identify new UB-04 name "Point of Origin for Admission or Visit".
4. Section 5.2.1 Control Segment Elements Breakout – Interchange Control Header
   a. Note 1 – the phrase "fixed record length segment" is underlined.
   b. Boxes noting the fixed length record beginning and ending positions are added for each data element.
   c. ISA14 – note referencing Section A.1.5.1 is removed.
5. Section 5.2.1 Control Segment Elements Breakout – Functional Group Header
   a. Example is updated to 005010X223A2 from 005010X223A1.
   b. GS08 Version/Release/Industry Identifier Code is updated to 005010X223A2 from 005010X223A1 and description updated to A2 from A1.
6. Section 5.3 THCIC Transaction Set – Table 2 Detail – Subscriber Hierarchical Level – Loop ID 2010BA Subscriber Name – The "Usage" is changed to "R/N" for Subscriber

Name, Subscriber Address, Subscriber City/State/ZIP Code, Subscriber Demographic Information and Subscriber Secondary Identification and boxed note added stating "Required" if "Subscriber" is the "Patient" otherwise "Not Used".

7. Section 5.3 THCIC Transaction Set – Table 2 Detail – Patient Hierarchical Level

   a. Loop ID 2010CA Patient Name – The "Usage" is changed to "N/R" for Patient Name, Patient Address, Patient City/State/ZIP Code and Patient Demographic Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".

   b. Loop ID 2300 K3 State Required Data Elements (Patient SSN) File Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".

8. Section 5.4 Segment ID Breakout – ST Transaction Set Header – Example changed to ST*837*987654*005010X223A2~ from ST*837*987654*005010X223~
9. Section 5.4 Segment ID Breakout – Loop 2010BA Subscriber Name – Note changed to "The Subscriber Name is REQUIRED when the subscriber is the patient. Subscriber Name data segment is "NOT USED" if Subscriber is NOT the Patient."

10. Section 5.4 Segment ID Breakout – Loop 2010BB Payer Name – NM103- SELF PAY code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).

11. Section 5.4 Segment ID Breakout – Loop 2010BB Billing Provider Secondary Identification – REF02 Reference Identification – Length changed to 50 from 30.

12. Section 5.4 Segment ID Breakout – Loop 2300 Institutional Claim Code

    c. Note is shortened to "This segment is REQUIRED when reporting hospital based admissions.

    d. CL102 - Code Source name changed to "Point of Origin for Admission or Visit, , National Uniform Billing Committee UB –04 Manual." from "Source of Referral for Admission or Visit, , National Uniform Billing Committee UB –04 Manual."

13. Section 5.4 Segment ID Breakout – Loop 2310A Attending Physician Secondary Identification – REF02 – Reference Identification - Length change to 50 from 30.

14. Section 5.4 Segment ID Breakout – Loop 2310B Operating Physician Secondary Identification – REF02 – Reference Identification - Length change to 50 from 30.

15. Section 5.4 Segment ID Breakout – Loop 2310E Service Facility Secondary Identification – REF02 – Reference Identification - Length change to 50 from 30.

16. Section 5.4 Segment ID Breakout – Loop 2330B Other Payer Name

    e. NM103- SELF PAY code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).

f. NM109- SELF code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).

Outpatient THCIC 837 Technical Specifications Updates of Version 9 from Version 8

1. Section 3 - Definitions – Other Health Professional – the phrase "or outpatients" is added to the end of the first sentence.
2. Section 4.2.2 – Data Corrections Item 2 (b) ANSI 837 Professional – the description is changed to "Submit Void/Cancel Claims which have the following:" to "Submit Corrected Claims which have the following:"
3. Section 4.3.2 – State Required Data Elements – The sentence below the title is change to "The following data elements must be submitted for each outpatient events" from "The following data elements must be submitted for each inpatient stay"
4. Section 5.11 Segment ID Breakout - Loop 2300 – Claim Information –
   a. CL1 – Institutional Claim Code (Inst) segment is added.
   b. HI - Principal Diagnosis – HI01-2 The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10.
   c. HI – Patient's Reason For Visit (INST.) –
      i. HInn-1 (nn = 01 through 03) the description under Code "PR" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
      ii. HInn-2 (nn = 01 through 03) The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
   d. HI – Health Care Diagnosis Code (PROF.) –
      i. HI01-1 the description under Code "BK" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
      ii. HI02-1 the description under Code "BF" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
      iii. HInn-1 (nn = 03 through 12) the description under Code "BF" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
      iv. HInn-1 (nn = 03 through 12) the description under Code "BN" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM E-Codes will be required on data submitted to THCIC."

v. HInn-2 (nn = 01 through 12) the description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E- Codes will be required on data submitted to THCIC."

e. HI – Other Diagnosis Information (INST.) -
   i. HInn-1 (nn = 03 through 12) the description under Code "BF" is amended by adding the phrase "Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
   ii. HInn-1 (nn = 03 through 12) the description under Code "BN" is amended by adding the phrase "Beginning October 1, 2014, ICD-10-CM E-Codes will be required on datasubmitted to THCIC."
   iii. HInn-2 (nn = 01 through 12) the description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC."

f. HI – Value Information (INST.) - Extraneous HI10-1 through HI10-7 that was between HI11 and HI12 were deleted.

5. Section 5.11 Segment ID Breakout - Loop 2310B Rendering Provider Name – Rendering Provider Secondary Identification (PROF.) the Gis changed to "REF*0B*A12345~" from "REF*1D*A12345~"
6. Section 5.11 Segment ID Breakout - Loop 2320 OTHER SUBSCRIBER INFORMATION - Other Subscriber Information (INST. and PROF.) – SBR01 Coed P- Primary is deleted from the list.
7. Section 5.11 Segment ID Breakout - Loop 2400 Service Line – Professional Service (PROF.) – SV101 – 6 Procedure Modifier - the "Alias" information was changed to "Procedure Modifier 4" from "Procedure Modifier 3".

Outpatient THCIC 837 Technical Specifications Updates of Version 10.1 from Version 10

1. Section 1 Introduction, 2nd Paragraph, the language has been added stating the reason for the guide and how to get the action Rule text. This guide is written to be complementary to the Hospital

   Discharge Data Collection and Release rules **25 TAC §421.61- §421.68**, which can be found at The Office of Secretary of State's Web site:
   http://www.sos.state.tx.us/texreg/index.shtml
   Or:
   http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=25&pt=1

   Select from the list CHAPTER 421 HEALTH CARE INFORMATION

2. Section 3 – Definition and Acronyms –
   a. The following terms, acronyms and descriptions were added: "Accurate and Consistent Data", "Certification Process", "Comments", "Discharge", "Discharge claim", "Discharge report" "DRG", "Electronic Filling", "Ethnicity",

"Geographic identifiers", "HCPCS--HCFA's", "Health care facility", "HIPPS", "Institutional Review Board", "Operating or Other Physician", "Other exempted provider", "Patient account number", "Present on admission (POA)", "Provider quality data", "Public use data file", "Race", "Research data file", "Risk adjustment", "Rural provider", "Submission", "Uniform facility identifier", and "Validation".

b. The following terms were modified: "Required minimum data set
c. Terms and definitions that are in the rules **25 TAC §§421.61- 421.68** are modified to be equivalent and note the words and terms, to the exact rule(s) section used in this document to follow the meaning of the context in which the legislation was written.

3. Section 4.2.1 – Data Submission
   i) Clarifying language (which is enclosed in parentheses) is added.
   ii) Website URL is updated. Old paragraph three and four delete and replaced by statement to see the THCIC Submitter and Provider Enrollment Guides document along with a hyperlink to the document
   iii) Old paragraph three and four delete and replaced by statement to see the THCIC Submitter and Provider Enrollment Guides document along with a hyperlink to the document
   iv) We have replaced the old documentation link with a new and the URL has been update

4. Section 4.2.2 – Data Correction Number 3 Delete Errant Claim Data and Resubmit two sub-sections were create, the first addressing that how the facilities "Data Administrator" (THCIC Liaison) can login to the System13, Inc. (THCIC) secure website and go the "User Management" tab to delete batches or individual claims from the system. Contact information to Helpdesk is provided for any assistance that may be needed. The previous option to contact System13, Inc. a contract with them to delete or modify a facilities data is moved to the second option.

5. Section 4.2.2 – Data Corrections- We made we few modifications:
   1. **Replacement of Errant Claim Data**

   Removed Date of Birth

   Removed Statement Date(s)
   And replace them with the following
   - *Admission Date*
     a. *Admission Hour*
     b. *Statement Covers Period From Date*
     c. *Statement Covers Period Through Date*

   And
   2. **Void or Cancel Errant Claim Data and Resubmit** we did the same:
      a. *Admission Date*
      b. *Admission Hour*
      c. *Statement Covers Period From Date*
      d. *Statement Covers Period Through Date*

6. Section 4.3.2 State Required Data Elements – language is added to the bottom of the list regarding the submission of diagnosis present on admission (POA) and which facilities are exempt from having to report the POA indicator.

7. Section 4.3.2.1 THCIC ANSI 837 INSTITUTIONAL GUIDE DATA ELEMENTS – the table is updated
   a) Service Line Date (was added and which had previously not been added)
   b) Point of Origin (Source of Admission) (Hospital Emergency Department Visits only) is added and will be effective for service beginning January 1, 2015.
   c) Patient Status (Hospital Emergency Department Visits only) is added and will be effective for service beginning January 1, 2015.

8. Section 4.3.2.3 Revenue Codes – We have added the following new Revenue Codes to the table for Emergency Room**:** 0450 ER — (General Classification), 0451 ER (Emergency Medical Screening - EMTALA), 0452 ER—(Beyond EMTALA), 0456 ER—(Urgent Care), 0459 ER – (Other), these become effective with services beginning January 1, 2015.

9. Section 4.3.2.5 DATA ELEMENTS BY THCIC 837 INSTITUTIONAL LOCATION –
   a) Numbering of the header was added back in, loss in a previous version.
   b) Table was updated
      i) Source of Admission (Point of Origin for Admission or Visit) (Hospital Emergency Department Visits only) is added
      ii) Patient Status (Hospital Emergency Department Visits only)

10. Section 4.3.2.6 DATA ELEMENTS BY THCIC 837 INSTITUTIONAL LOCATION – header numbering is updated

11. Section 4.6.1 Provider Enrollment / Signature Requirements – the document title and hyperlink are updated. "THCIC Submitter and Provider Enrollment Guide"

12. Section 4.7 - Auditing of Data by System13, Inc. The link to the website is updated and replaced. "5010_Inpatient_and_Outpatient_Appendices ver._3"

Outpatient THCIC 837 Technical Specifications Updates of Version 10.1 from Version 10

1. Section 5.10 THCIC Transaction Set – Table 2 Table 2 Detail – Patient Hierarchical Level (INST.) – the CL1 Data segment is added

2. Section 5.4 Segment ID Breakout – Loop 2300 – Claim Information HI – Health Care Diagnosis Code (PROF.) –
   a) CL1 - Institutional Claim Code (INST.) segment is added include the following situationally required data elements for Emergency Department visits
      i) CL102 – Admission Source Code (Point of Origin) includes note on requirement for Emergency Department Visits
      ii) CL103 – Patient Status Code - includes note on requirement for Emergency Department Visits
   b) HI - Principal Diagnosis – HI01-2 The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
   c) HI - HI – Patient's Reason for Visit (INST.) –

i) HInn-1 (nn = 01 through 03) the description under Code "PR" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."

ii) HInn-2 (nn = 01 through 03) The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."

3. HI01-1 the description under Code "BK" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."

Outpatient THCIC 837 Technical Specifications Updates of Version 10.1 from Version 10

1. H101-1 Code List Qualifier Code – Principal Diagnosis
   a. Code List Qualifier Code – Qualifying Code "ABK" is added for ICD-10-CM Principal Diagnosis and a noted about the implementation dates is added.
   b. Code List Qualifier Code – Qualifying Code "ABN" is added for ICD-10-CM External Cause of Injury and a note is added about the implementation dates is added.
   c. Qualifying Code "ABF" is added for ICD-10-CM Other Diagnosis Information and a note is added about the implementation dates is added.
   d. Phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."

2. Section 6 - PAST VERSION CHANGES THAT HAVE BEEN MADE TO THIS DOCUMENT - The listing of all past changes to the different Inpatient manual versions is added to the end of the document, under Section 6.

3. **Rider 93** specifically states that DSHS shall collect emergency room data as set forth in Chapter 108, Health and Safety Code. Chapter 108 does authorize the collection of data from hospitals but does not list or authorize the collection from free-standing emergency centers.

4. Collection and Release of Hospital Outpatient Emergency Room Data
   1. New §§421.71 - 421.78 The hospital outpatient emergency room data rules were drafted in conjunction with amendments regarding the repeal of rural provider exemptions in SB 7, (82nd First Called Session, section 7.07(b)) from the amendments to §§421.1, 421.2, 421.5 and 421.8, §§421.62, 421.67 and 421.68, concerning the collection and release of outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers. The new rules and the amendments were combined and proposed and published in the May 2, 2014, issue of the Texas Register (39 TexReg 3553) and were adopted and published in the September 19, 2014, issues of the Texas Register (39 TexReg 7582). Three organizations submitted comments on the proposed rules. One commenter requested physician assistants be added to the list of the definition of "Other Health Professional". The other two commenters

recommended staggering the implementation dates and for the department to be lenient on penalizing rural facilities that will be submitting for the first time.

Outpatient THCIC 837 Technical Specifications Updates of Version 10.2 from Version 10.1

1. The format of Tables, headings, section numbers, when uploaded to Adobe Acrobat format from a Word Document written in MS Word 2007 or 2010 of Version 10.1, we encounter compatibility issues. All have been verified and fixed. (Paragraph, style, breaks, fonts, tables, pages, alignment)

2. Modifications made to all the Texas administration rules 25 TAC §421.xx from the old link:
   http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1

   To the new link:
   http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1

Outpatient THCIC 837 Technical Specifications Updates of Version 10.2.1 from Version 10.2

1. CMS switched to the NPI and does not support UPIN any longer. There for THCIC has removed the references to UPIN. (page 171)
2. On Page 113 of this manual, we have changed the title to reflect the following: "THE PRINCIPAL DIAGNOSIS IS REQUIRED ON ALL OUTPATIENT CLAIMS"
3. On Page 118 of this manual, we have changed the title to reflect the following: "PRINCIPAL DIAGNOSIS CODE IS REQUIRED ON PROFESSIONAL CLAIMS"

Outpatient THCIC 837 Technical Specifications Updates of Version 11.0 from Version 10.2.1

1. Section 5.2 DATA ELEMENTS WITH REQUIREMENTS DIFFERENT THAN THE ANSI 837 GUIDE Table of Required Data Elements – Patient SSN, Patient Race and Patient Ethnicity language was added regarding change of location due to HB 2641 for next contract.
2. Section 5.12 SEGMENT ID BREAKOUT
   (a) Loop 2010BA – DMG Subscriber Demographic Information (INST and PROF):
      (i) Note 4 – Added language regarding change of Patient Race collection with new contract due to implementation of HB 2641.
      (ii) DMG05 – note added regarding change of Patient Race collection with new contract due to implementation of HB 2641.
   (b) Loop 2010BB Payer Name – NM109 – Note added to National Plan Identifier code regarding CMS delay of implementation.

(c) Loop 2010CA DMG Patient Demographic Information (INST. and PROF.):

(i) Note 4 – Added language regarding change of Patient Race collection with new contract due to implementation of HB 2641.

(ii) DMG05 – note added regarding change of Patient Race collection with new contract due to implementation of HB 2641.

(d) Loop 2300 K3 State Required Data Elements:

(i) Note 3 – Added language regarding change of Patient SSN, Patient Race, and Patient Ethnicity collection with new contract due to implementation of HB 2641.

(ii) K301 - Note 4 – Added language regarding change of Patient SSN, Patient Race, and Patient Ethnicity collection with new contract due to implementation of HB 2641.

(iii) Added CODE and DEFINATION to Loop200 K3 segment regarding Ethnicity, Race, and Social Security Number in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data Collection efforts.

(e) Loop 2300 NTE Claim Note (INST.)

(i) Note 3 – Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.

(ii) K301 - Note 4 – Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.

(f) Loop 2300 NTE Claim Note (PROF.)

(iii) Note 3 – Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.

(iv) K301 - Note 4 – Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.

(g) Loop 2300 HI PRINCIPAL DIAGNOSIS CODE - Segment Title was incorrect and was corrected to HEALTHCARE DIAGNOSIS Code (PROF.)

(h) Loop 2400 SV2 INSTITUTIONAL SERVICE LINE – SV206 the gray note is amended regarding THCIC turning off the audit for the Unit Rate.

3. Changed the examples for Principal Diagnosis code for ICD-9 and ICD-10.
4. Changed the examples for Principal Diagnosis code for ICD-9 and ICD-10.
5. Changed the examples for Reason for Visit Diagnosis code for ICD-9 and ICD-10.
6. Changed the examples for External Causes of Injury/Morbidity, for ICD-9 and ICD-10 codes. Modified the definition to describe ICD-10 code ranges of V00-Y99.
7. Changed the examples for Other Diagnosis code for ICD-9 and ICD-10.
8. Changed the example for Anesthesia Related Procedure code.
9. Changed the Condition Code example to use the asterisk.
10. Changed the Attending Physician example to have a 10-digit NPI number.
11. Changed the Operating Physician example to have a 10-digit NPI number.
12. Changed the Service Facility example to have a 10-digit NPI number
13. Changed the Service Facility Location and Service Facility Address examples to use the asterisk.
14. Changed the example in SV1 to use the asterisk.
15. Removed "IV", "ZZ", "HP", and "WK" as valid HCPCS qualifiers for segment SV1. The only valid value for the HCPCS qualifier is "HC".
16. Changed the example in segment SV2 to have 0300, not 300, and 0120, not 120, as the revenue codes. Modified the HCPCS example.

17. Removed "IV" and "ZZ" as valid HCPCS qualifiers for segment SV2. The only valid value for the HCPCS qualifier is "HC".
18. Inspected accessibility results and removed the errors.

Outpatient THCIC 837 Technical Specifications Updates of Version 11.1 from Version 11.0

1. DMG05 is changed to NOT USED from REQUIRED in loop 2010BA and 2010CA.
2. Removed Claim note and NTE segment completely.

Outpatient THCIC 837 Technical Specifications Updates of Version 11.1.1 from Version 11.

1. Loop 2400 SERVICE LINE NUMBER (INST.) the "Repeat" number is changed to "200" it was "50"
2. Removed Claim note and NTE segment completely.

Outpatient THCIC 837 Technical Specifications Updates of Version 11.2 from Version 11.1.1

1. Fixed incorrect and inconsistent spelling, grammar, capitalization, formatting and punctuation throughout document (did not affect implementation).
2. Removed "THCIC Hospital Discharge Data Collection" from document title.
3. Changed "WebCorrect" to "Claim Correction" for all occurrences.
4. Reworded website links to match destination page titles.
5. Updated section numbers so Introduction is section 1, General Information and Overview is section 2, and the rest of the sections renumbered appropriately.
6. Section 1 Introduction
   Updated the lists of provider types from whom we collect data.
7. Section 2 General Information and Overview
   (a) Renamed section Loop Labeling, Sequence and Use to General Overview.
   (b) Section 2.1 General Overview
      (i) Inserted 2nd paragraph describing the HCDCS.
      (ii) Changed "receiver process also" to "system pre-process" in 4th paragraph.
      (iii) Updated wording for clarity in the 5th paragraph.
   (c) Added subsection title "2.2 Reference Information".
   (d) Removed paragraph about System13 testing submitted files because it is described elsewhere.
8. Added "System13, Inc." to section title 2.3 The THCIC Business Associate, added System13 description, and changed the contact information formatting.
9. In 2.4 THCIC Web Site, changed the wording of the description for clarity.
10. Section 3 Definitions and Acronyms
   (a) Removed "We are providing this section to aid our audiences with accurate and consistent definitions and acronyms:"
   (b) Changed the definition of ASC.
11. Section 4 Technical Requirements
   (a) Changed section title 4.1.1 Required Patients to Patient Inclusion Requirements and added emergency department requirements.
   (b) In 4.2.1 Data Submission, added 1st paragraph concerning name and contact information requirement.
   (c) 4.2.2 Data Corrections
      (i) In 2.a., added "XX5" to the list of resubmitted original bill type codes.
      (ii) Added System13 contact information.

(d) 4.3.1 Data File Specifications
- (i) Institutional Data Elements
  1. Added "if applicable" to item (10).
  2. Added Occurrence Span Code as new item (19) and Occurrence Span Associated Dates as new item (20).
  3. Removed old item (24) Related Cause Code.
  4. Changed field numbering to account for one additional field item.
  5. Changed new items (21), (22), (23), (24), and (25) from 12 (or 8) occurrences to 24 occurrences.
- (ii) Professional Data Elements
  1. Added "if applicable" to item (10).
  2. Changed item (16) from 7 to 24 occurrences.
- (iii) Revenue Codes
  1. Removed "New Revenue Codes for Emergency Room (Effective for services beginning January 1, 2015)".
- (iv) Service and Procedure Categories
  1. Changed this section to match current processes.
- (v) Data Elements by THCIC 837 Institutional Location
  1. Change table to include complete list of fields.

(e) 4.7 Auditing of Data by System13, Inc

(f) Changed appendices description.

12. Section 5 THCIC 837 Technical Specifications

(a) In PATIENT DEMOGRAPHIC INFORMATION (INST. and PROF.), 2010CA – PATIENT NAME, removed Note item "Required if the "Subscriber" is not the "Patient." since it is a duplicate of another Note item.

(b) In CLAIM INFORMATION (INST.), 2300 — CLAIM INFORMATION, CLM05-1, data element 1331, added "78 LICENSED FREESTANDING EMERGENCY MEDICAL FACILITY", a value already collected by the THCIC System but not correctly documented.

(c) In CLAIM INFORMATION (PROF.), 2300 — CLAIM INFORMATION, CLM11 – 1, data element 1362, added values "AB ABUSE" and "AP ANOTHER PARTY RESPONSIBLE", values already collected by the THCIC System but not correctly documented.

(d) In CLAIM INFORMATION (PROF.), 2300 — CLAIM INFORMATION, changed CLM11 – 2 and 3 to match CLM11 – 1, values already collected by the THCIC System but not correctly documented.

(e) In THE PRINCIPAL DIAGNOSIS (INST.), 2300 — CLAIM INFORMATION, removed "IS REQUIRED ON ALL OUTPATIENT CLAIMS" from element name because it's in the Notes, and changed Note 1 from "inpatient" to "outpatient".

(f) In HEALTH CARE DIAGNOSIS CODE (PROF.), 2300 — CLAIM INFORMATION, removed "IS REQUIRED ON ALL PROFESSIONAL CLAIMS" from element name because it's in the Notes, and changed Note 1 from "Principal Diagnosis Code" to "Principal Diagnosis Code/Health Care Diagnosis Code".

(g) In OTHER DIAGNOSIS INFORMATION (INST.), 2300 — CLAIM INFORMATION, changed Example, removing "HI*BF:94425~" and adding "HI*ABN:X0820XA~".

(h) In CONDITION INFORMATION (INST. and PROF.), 2300 — CLAIM INFORMATION, removed "and PROF." from element name.

(i) In ATTENDING PHYSICIAN NAME, 2310A — ATTENDING PHYSICIAN NAME, NM102, data element 1065, removed "2 NON PERSON ENTITY" from list of values.

(j) In SERVICE FACILITY NAME (INST.), 2310E — SERVICE FACILITY LOCATION NAME, added "LOCATION" to Element and Loop names.

(k) In SERVICE LINE NUMBER (INST.), 2400 — SERVICE LINE NUMBER, changed Repeat from 50 to 200.

(l) In INSTITUTIONAL SERVICE LINE (INST.), 2400 — SERVICE LINE NUMBER, changed Notes from " This segment is required for inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication" to " This segment is required for outpatient claims that require procedure or drug information to be reported for claim adjudication."

Changes from Version 11.2 to 11.3 on 12/1/2023

1. Section 1 was assigned to Introduction. All other sections and section references were renumbered.
2. Section 2.2 Reference Information – updated X12 Product link.
3. Section 4.2.1 - updated link to THCIC Submitter and Provider Enrollment Guide.
4. Section 4.2.2 – updated matching formulas for Replacement of Erroneous Claim Data, Void or Cancel Erroneous Claim Data and Resubmit, and Delete Erroneous Claim Data and Resubmit.
5. Section 4.3.2 – removed semi-colons from data elements lists.
6. Section 4 – updated 5010 IP and OP Appendices link in multiple locations.
7. Section 5.1 – replaced Washington Publishing Company link with X12 Product link.
8. Section 5.2 – table titles, headers, and footnotes added, modified, or moved for clarity and better formatting.
9. Section 5.6 – first sentence of 5.7 moved here.
10. Section 5.7 – reference to Appendix C removed because it is not applicable to the current document.
11. Section 5.14 – In two tables, position 1850 K3 File Information usage changed from N/R to R. This makes it consistent with audit rules in the Appendix that have been enforced since K3 was implemented.
12. Section 5.15 – removed unnecessary details from NOT USED data elements including but not limited to references, codes, definitions, INDUSTRY name, SEMANTIC information, etc.
13. 2010BA – SUBSCRIBER NAME – removed Note 2 (details about how to complete Race are unnecessary due to Race collection in the K3 segment), Note 3 (rephrasing of Note 1), and Note 4 (describes the future of adoption of the K3 segment that has already happened).
14. 2010CA – PATIENT NAME – removed Note 2 (details about how to complete Race are unnecessary due to Race collection in the K3 segment) and Note 3 (describes the future of adoption of the K3 segment that has already happened).