THCIC Data Collection

Healthcare Facility Procedures
and
Technical Specifications

Inpatient and Outpatient Appendices

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CHANGES FROM LAST VERSION

1. New Appendices Manual for Inpatient and Outpatient requirements.

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APPENDIX - A1
VALID COUNTRY CODES

Codes are from the ISO 3166 Country Code List obtained from http://www.iso.org/iso/en/prods-services/iso3166ma/02iso-3166-code-lists/list-en1.html

CODE	COUNTRY NAME
AF	AFGHANISTAN
AL	ALBANIA
DZ	ALGERIA
AS	AMERICAN SAMOA
AD	ANDORRA
AO	ANGOLA
AI	ANGUILLA
AQ	ANTARCTICA
AG	ANTIGUA AND BARBUDA
AR	ARGENTINA
AM	ARMENIA
AW	ARUBA
AU	AUSTRALIA
AT	AUSTRIA
AZ	AZERBAIJAN
BS	BAHAMAS
BH	BAHRAIN
BD	BANGLADESH
BB	BARBADOS
BY	BELARUS
BE	BELGIUM
BZ	BELIZE
BJ	BENIN
BM	BERMUDA
BT	BHUTAN
BO	BOLIVIA
BA	BOSNIA AND HERZEGOVINA
BW	BOTSWANA
BV	BOUVET ISLAND
BR	BRAZIL
IO	BRITISH INDIAN OCEAN TERRITORY
BN	BRUNEI DARUSSALAM
BG	BULGARIA
BF	BURKINA FASO
BI	BURUNDI
KH	CAMBODIA
CM	CAMEROON

CODE	COUNTRY NAME
CA	CANADA
CV	CAPE VERDE
KY	CAYMAN ISLANDS
CF	CENTRAL AFRICAN REPUBLIC
TD	CHAD
CL	CHILE
CN	CHINA
CX	CHRISTMAS ISLAND
CC	COCOS (KEELING) ISLANDS
CO	COLOMBIA
KM	COMOROS
CG	CONGO
CD	CONGO, THE DEMOCRATIC REPUBLIC OF THE
CK	COOK ISLANDS
CR	COSTA RICA
CI	CÔTE D'IVOIRE
HR	CROATIA
CU	CUBA
CY	CYPRUS
CZ	CZECH REPUBLIC
DK	DENMARK
DJ	DJIBOUTI
DM	DOMINICA
DO	DOMINICAN REPUBLIC
EC	ECUADOR
EG	EGYPT
SV	EL SALVADOR
GQ	EQUATORIAL GUINEA
ER	ERITREA
EE	ESTONIA
ET	ETHIOPIA
FK	FALKLAND ISLANDS (MALVINAS)
FO	FAROE ISLANDS
FJ	FIJI
FI	FINLAND
FR	FRANCE

CODE	COUNTRY NAME
GF	FRENCH GUIANA
PF	FRENCH POLYNESIA
TF	FRENCH SOUTHERN TERRITORIES
GA	GABON
GM	GAMBIA
GE	GEORGIA
DE	GERMANY
GH	GHANA
GI	GIBRALTAR
GR	GREECE
GL	GREENLAND
GD	GRENADA
GP	GUADELOUPE
GU	GUAM
GT	GUATEMALA
GN	GUINEA
GW	GUINEA-BISSAU
GY	GUYANA
HT	HAITI
HM	HEARD ISLAND AND MCDONALD ISLANDS
VA	HOLY SEE (VATICAN CITY STATE)
HN	HONDURAS
HK	HONG KONG
HU	HUNGARY
IS	ICELAND
IN	INDIA
ID	INDONESIA
IR	IRAN, ISLAMIC REPUBLIC OF
IQ	IRAQ
IE	IRELAND
IL	ISRAEL
IT	ITALY
JM	JAMAICA
JP	JAPAN
JO	JORDAN
KZ	KAZAKHSTAN
KE	KENYA
KI	KIRIBATI
KP	KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF
KR	KOREA, REPUBLIC OF
KW	KUWAIT
KG	KYRGYZSTAN
LA	LAO PEOPLE'S DEMOCRATIC REPUBLIC
LV	LATVIA
LB	LEBANON
LS	LESOTHO
LR	LIBERIA
LY	LIBYAN ARAB JAMAHIRIYA
LI	LIECHTENSTEIN
LT	LITHUANIA
LU	LUXEMBOURG
MO	MACAO
MK	MACEDONIA, THE FORMER YUGOSLAV REPUBLIC OF
MG	MADAGASCAR
MW	MALAWI
MY	MALAYSIA
MV	MALDIVES
ML	MALI
MT	MALTA
MH	MARSHALL ISLANDS
MQ	MARTINIQUE
MR	MAURITANIA
MU	MAURITIUS
YT	MAYOTTE
MX	MEXICO
FM	MICRONESIA, FEDERATED STATES OF
MD	MOLDOVA, REPUBLIC OF
MC	MONACO
MN	MONGOLIA
MS	MONTSERRAT
MA	MOROCCO
MZ	MOZAMBIQUE
MM	MYANMAR
NA	NAMIBIA
NR	NAURU
NP	NEPAL
NL	NETHERLANDS
AN	NETHERLANDS ANTILLES
NC	NEW CALEDONIA
NZ	NEW ZEALAND
NI	NICARAGUA
NE	NIGER
NG	NIGERIA
NU	NIUE
NF	NORFOLK ISLAND
MP	NORTHERN MARIANA ISLANDS

CODE	COUNTRY NAME
NO	NORWAY
OM	OMAN
PK	PAKISTAN
PW	PALAU
PS	PALESTINIAN TERRITORY, OCCUPIED
PA	PANAMA
PG	PAPUA NEW GUINEA
PY	PARAGUAY
PE	PERU
PH	PHILIPPINES
PN	PITCAIRN
PL	POLAND
PT	PORTUGAL
PR	PUERTO RICO
QA	QATAR
RE	RÉUNION
RO	ROMANIA
RU	RUSSIAN FEDERATION
RW	RWANDA
SH	SAINT HELENA
KN	SAINT KITTS AND NEVIS
LC	SAINT LUCIA
PM	SAINT PIERRE AND MIQUELON
VC	SAINT VINCENT AND THE GRENADINES
WS	SAMOA
SM	SAN MARINO
ST	SAO TOME AND PRINCIPE
SA	SAUDI ARABIA
SN	SENEGAL
CS	SERBIA AND MONTENEGRO
SC	SEYCHELLES
SL	SIERRA LEONE
SG	SINGAPORE
SK	SLOVAKIA
SI	SLOVENIA
SB	SOLOMON ISLANDS
SO	SOMALIA
ZA	SOUTH AFRICA
GS	SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS
ES	SPAIN
LK	SRI LANKA
SD	SUDAN
SR	SURINAME

CODE	COUNTRY NAME
SJ	SVALBARD AND JAN MAYEN
SZ	SWAZILAND
SE	SWEDEN
CH	SWITZERLAND
SY	SYRIAN ARAB REPUBLIC
TW	TAIWAN, PROVINCE OF CHINA
TJ	TAJIKISTAN
TZ	TANZANIA, UNITED REPUBLIC OF
TH	THAILAND
TL	TIMOR-LESTE
TG	TOGO
TK	TOKELAU
TO	TONGA
TT	TRINIDAD AND TOBAGO
TN	TUNISIA
TR	TURKEY
TM	TURKMENISTAN
TC	TURKS AND CAICOS ISLANDS
TV	TUVALU
UG	UGANDA
UA	UKRAINE
AE	UNITED ARAB EMIRATES
GB	UNITED KINGDOM
US	UNITED STATES
UM	UNITED STATES MINOR OUTLYING ISLANDS
UY	URUGUAY
UZ	UZBEKISTAN
VU	VANUATU
VE	VENEZUELA
VN	VIET NAM
VG	VIRGIN ISLANDS, BRITISH
VI	VIRGIN ISLANDS, U.S.
WF	WALLIS AND FUTUNA
EH	WESTERN SAHARA
YE	YEMEN
ZM	ZAMBIA
ZW	ZIMBABWE

APPENDIX - A2
DEFAULT OR MISSING DATA VALUES

Unknown Patient Address:
If the address of the patient is unknown, use the following:

ANSI Loop.Data Segment	
2010AA or 2310E.N301 (Patient Address Line-1) =	Healthcare Facility's street address
2010AA or 2310E.N302 (Patient Address Line-2) =	"Unknown"
2010AA or 2310E.N401 (Patient City) =	Healthcare facility's city name
2010AA or 2310E.N402 (Patient State) =	TX
2010AA or 2310E.N403 (Patient ZIP) =	Healthcare facility's ZIP code

Patient Address in a Foreign Country (other than Canada):
If the address of the patient is in unknown, use the following:

UB92 - Record.Field / ANSI Loop.Data Segment	
2010BA or 201CA.N404 (Patient State) =	XX
2010BA or 201CA.N402 (Patient ZIP) =	Spaces

Unknown Social Security Number:
If a healthcare facility's system requires a SSN entry and one does not exist:

UB92 - Record.Field / ANSI Loop.Data Segment	
2010BA or 201CA.REF02 (Patient Social Security Number) =	999999999

If a SSN could not be obtained:

2010BA or 201CA.REF02 (Patient Social Security Number) =	Spaces, or 999999999 (if system requires an entry)

Unknown Date of Birth:
If a patient's date of birth is not known:
UB92 - Record.Field / ANSI Loop.Data Segment
201CA.DMG02(Patient Birth Date) = 19010101 = 01/01/1901

Unknown ZIP Code:
If patient's ZIP code is unknown:
UB92 - Record.Field / ANSI Loop.Data Segment
2010BA or 201CA.N403(Patient ZIP) = XXXXX OR

00000

Temporary Licenses
If a practitioner does not have a state license or UPIN, use the following:
UB92 - Record.Field / ANSI Loop.Data Segment
2310A or 2310B.REF02 (Attending or Operating Physicians, respectively) =

TXTEMP
OTHnnn
RESnnn
TEMPnn

Where "n" = a number (0-9) assigned by the healthcare facility

Alcohol, Drug Use or HIV Conditions
Patients covered by 42 USC 290dd-2 or 42 CFR Part 2.1
If a patient has an alcohol or drug use or HIV condition, the following mask must be applied to protect the identity of the patient:

Data Element	Loop	Data Element	Action and Default Value
Patient Control Number	2300	CLM01	Retain. Unique to institution and episode of care. Will be used by healthcare facility to review and certify data. This data element is not included in the public use data file.
Patient Last Name	2010BA or 2010CA	NM103	Remove. Replace with "Doe"
Patient First Name	2010BA or 2010CA	NM104	Remove. Replace with "Jane" if female, or "John" if male, can include a sequential number, e.g., John1, John2, John3.
Patient Middle Initial	2010BA or 2010CA	NM105	Remove. Leave blank.
Patient Date of Birth	2010BA or 2010CA	DMG02	Retain. DOB will not be provided in the public use data file and it will be transformed to age (in years).

Data Element	Loop	Data Element	Action and Default Value
Patient Address	2010BA or 2010CA	N301	Remove. Replace with healthcare facility street address.
Patient City	2010BA or 2010CA	N401	Retain.
Patient State	2010BA or 2010CA	N402	Retain.
Patient Zip Code	2010BA or 2010CA	N403	Retain.
Patient Country Code	2010CA	N404	Retain.
Medical Record Number	2300	REF02	Remove. Replace with 99999.
Patient SSN	2010BA or 2010CA	REF02	Remove. Replace with default value of 999999999.

Records submitted for substance abuse patients containing personal identifiers should include the specified default values in the identifier fields. The healthcare facility patient control number is normally considered to be a personal identifier. *However, in order to provide a means to correct records that do not pass THCIC audits, we are requesting that the patient control number be submitted with each record in the healthcare facility's data.*

APPENDIX - A3
RACE AND ETHNICITY QUESTIONNAIRE DOCUMENTS

The Texas Health Care Information Collection Subunit has created two documents (English and Spanish) that healthcare facility staff can use to obtain the ethnicity and race information required to be collected on healthcare facility inpatients, by Texas State law [Texas Health & Safety Code, §108.009(k), and administrative rules found at 25 TAC §421.9(c)(1) and (2) or §421.67(c)(1) and (2)]. The rules specify that the patient should self-report, and that if the patient cannot (for example, comatose, severely injured, or died shortly after admission) or refuses, the healthcare facility staff shall use their best judgment to identify the patient's ethnic and racial background.

An instruction sheet follows this page that the healthcare facility may provide it to its personnel to use as a guide for administering collection of this information. Followed by the English and Spanish versions of the questions to be presented to the patient. Use of these documents is optional, though the collection and submission of the data is required; the healthcare facility can modify the documents formatting, but not the content. Also, you may translate the document into other languages, as appropriate.

If you have questions regarding the documents and the requirements, please contact Bruce Burns, D.C. at (512) 458-7261.

INSTRUCTIONS FOR STATE ETHNICITY AND RACE QUESTIONNAIRE

(For Healthcare Facility Use Only)

For Healthcare Facility Staff Use in collecting and reporting Ethnicity and Race

RECOMMENDED PROCEDURE

I. Present Questionnaire to the patient, parents or the legal guardian of the patient and say, "The State of Texas requires this information".

If the patient, parent or legal guardian of the patient asks "Why?" Tell them that is required by state law and either read or refer them to the top of the page under "Background Information".

II. If the patient cannot read. A person elected by the patient or healthcare facility personnel should read the questions to the patient and record the responses.

III. If the patient refuses or cannot respond to the question (for example, comatose, severely injured, deceased), then healthcare facility personnel should select the most appropriate choice (with available information) in the Ethnicity and Race categories.

A. If the ethnicity choice cannot be determined by appearance or last name, mark the patient as "non-Hispanic".

B. If the race choice cannot be determined by appearance or last name, mark the patient as "Other".

Note: *Hispanics should be marked "White" for their race unless there is evidence they are of a different race (Black, Asian or Pacific Islander, or American Indian/Eskimo/Aleut). For example, many persons from the Caribbean Islands such as the Dominican Republic are of a "Hispanic" ethnicity and "Black" race.*

STATE REQUIRED ETHNICITY AND RACE QUESTIONS

BACKGROUND INFORMATION

Texas law requires the Texas Health Care Information Collection Subunit to collect information on the race/ethnic backgrounds of healthcare facility patients. Healthcare facilities are required to ask patients to identify their own race and ethnic backgrounds.

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care.

If patients fail to identify their own race and ethnic backgrounds, healthcare facility staff will use its best judgment in making the identification.

QUESTIONS

Question #1: Ethnic Background

(mark the box that the patient believes most accurately identifies his/her ethnic background)

Is the patient . . .?

- ❑ **(1) Hispanic/Latino** (21352)
- ❑ **(2) Not Hispanic/Latino** (21865)

Question #2: Race

(mark the box that the patient believes most accurately identifies his/her race)

Is the patient . . .?

- ❑ **(1) American Indian/Eskimo/Aleut** (10025)
- ❑ **(2) Asian or Pacific Islander** (20289)
- ❑ **(3) Black** (20545)
- ❑ **(4) White** (21063)
- ❑ **(5) Other** *Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category.* (21311)

Preguntas sobre el origen étnico y la raza exigidas por el estado

LOS ANTECEDENTES

La ley de Texas exige a la Subunidad de Recogida de Información Sanitaria de Texas que reúna información sobre la raza y el origen étnico de los pacientes en centros de salud. Se exige a los centros de salud que pidan a los pacientes que identifiquen su propia raza y origen étnico.

Los datos obtenidos por medio de este proceso se usarán para ayudar a que los investigadores determinen si todos los ciudadanos de Texas reciben acceso a una atención de salud adecuada.

Si los pacientes no identifican su propia raza y origen étnico, el personal del centro de salud hará la identificación a su juicio.

PREGUNTAS

Pregunta #1: origen étnico

(Marque la casilla que el paciente cree que más fielmente identifica su origen étnico)

¿Qué es el paciente?

- ❑ **(1) Hispano/latino** (21352)
- ❑ **(2) No hispano/latino** (21865)

Pregunta #2: raza

(Marque la casilla que el paciente cree que más fielmente identifica su raza)

¿Qué es el paciente?

- ❑ **(1) Indio americano, esquimal o aleutiano** (10025)
- ❑ **(2) Asiático o isleño del Pacífico** (20289)
- ❑ **(3) Negro** (20545)
- ❑ **(4) Blanco** (21063)
- ❑ **(5) Otro.** *Se incluyen todas las otras respuestas no listadas arriba. Los pacientes que se consideran a sí mismos multirraciales o mixtos deben elegir esta categoría.* (21311)

APPENDIX - A4
REVENUE CODE GROUPINGS FOR ENCOUNTER FILE AND PUDF

Codes are a subset of the list from the Centers for Medicare and Medicaid's "EXPANDED MODIFIED MEDICARE PROVIDER ANALYSIS AND REVIEW (MEDPAR) RECORD -- FROM CMS DATA DICTIONARY"

	Category	Type	Revenue Codes
1	Accommodation	Private Room Days & Charges	011x, 014x
2	Accommodation	Semi-private Room Days & Charges	010x, 012x, 013x, 016x, 017x, 018x, 019x
3	Accommodation	Ward Days & Charges	015x
4	Accommodation	Intensive Care Days & Charges	020x
5	Accommodation	Coronary Care Days & Charges	021x
1	Ancillary	Other Charges	0002-0099, 022x, 023x, 024x, 052x, 053x, 055x, 056x, 057x, 058x, 059x, 060x, 064x, 065x, 066x, 067x, 068x, 069x, 070x, 076x, 077x, 078x, 090x, 091x, 092x, 093x, 094x, 095x, 099x, 210x, 310x
2	Ancillary	Pharmacy Charges	025x, 026x, 063x
3	Ancillary	Medical/Surgical Supply Charges	027x, 062x
4	Ancillary	Durable Medical Equipment Charges	0290, 0291, 0292, 0294-0299
5	Ancillary	Used Durable Medical Equipment Charges	0293
6	Ancillary	Physical Therapy Charges	042x
7	Ancillary	Occupational Therapy Charges	043x
8	Ancillary	Speech Pathology Charges	044x, 047x
9	Ancillary	Inhalation Therapy Charges	041x, 046x
10	Ancillary	Blood Charges	038x

	Category	Type	Revenue Codes
11	Ancillary	Blood Administration Charges	039x
12	Ancillary	Operating Room Charges	036x, 071x, 072x
13	Ancillary	Lithotripsy Charges	079x
14	Ancillary	Cardiology Charges	048x, 073x
15	Ancillary	Anesthesia Charges	037x
16	Ancillary	Laboratory Charges	030x, 031x, 074x, 075x,
17	Ancillary	Radiology Charges	028x, 032x, 033x, 034x, 035x, 040x
18	Ancillary	MRI Charges	061x
19	Ancillary	Outpatient Services Charges	049x, 050x
20	Ancillary	Emergency Room Charges	045x
21	Ancillary	Ambulance Charges	054x
22	Ancillary	Professional Fees Charges	096x, 097x, 098x
23	Ancillary	Organ Acquisition Charges	081x, 089x
24	Ancillary	ESRD Revenue Setting Charges	080x, 082x, 083x, 084x, 085x, 086x, 087x, 088x
25	Ancillary	Clinic Visit Charges	051x

APPENDIX - A5
INPATIENT AUDIT ID'S AND AUDIT MESSAGES

Table A – Pre-Processing Audits (Format Check)		
Audit Msg ID	**Audit Message**	**Audit Description**
RJ001	Missing Interchange Control Header (ISA Segment)	An Interchange Control Header was expected but not found. The ISA segment must be the first segment of a submission
RJ002	Invalid value in segment ISA, data element ISA06 (Submitter ID)	ISA06 must contain the Submitter ID assigned by THCIC. This must be the same value as in GS02.
RJ003	Invalid value in segment ISA, data element ISA08 (Interchange Receiver ID).	ISA08 contains the THCIC Receiver ID. For claims submissions in 2003, the value is "YTHCIC". For claims submissions beginning with 1st quarter 2004, the value is "YTH837". Failure to use the correct code may result in the claim data being mistranslated. This must be the same value as in GS03.
RJ004	Invalid value in segment ISA, data element ISA13 (Interchange Control Number)	ISA13 (Interchange Control Version Number) must contain a value > 0. This will be the same value as in IEA02. This number is used to ensure submission integrity.
RJ005	Invalid value in segment ISA, data element ISA15 (Usage Indicator)	ISA15 (Usage Indicator) must contain a valid value of "P" or "T".
RJ006	ISA segment character 4 must contain a non-blank value.	Character position 4 of the ISA segment denotes the value that will be used as the element separator for the submission. This must be a non-blank value.
RJ007	Invalid value in segment ISA, data element ISA16 (Component Element Separator)	ISA16 (Component Element Separator) must contain a non-blank value. Preferred values are "*", ":", and "~".
RJ008	ISA char position 106 must contain a non-blank value.	ISA character position 106 contains the value to be used as the segment terminator for the submission. The value must be non-blank.

Table A – Pre-Processing Audits (Format Check)		
Audit Msg ID	**Audit Message**	**Audit Description**
RJ009	ISA segment must contain three non-blank distinct values for element separator, component element separator and segment terminator.	ISA segment character positions 4, 105 and 106 must contain non-blank distinct values.
RJ010	Missing Functional Group Header (GS segment)	A Functional Group Header was expected but not found. The segment immediately after the ISA segment (beginning in position 107) must be the GS segment.
RJ011	Invalid value in segment GS, data element GS06 (Group Control Number)	GS06 (Group Control Number) must contain a value > zero. This is the same value as in GE02.
RJ012	Invalid value in segment GS, data element 08 (Version Identifier Code)	GS08 (Version Identifier Code) must contain a value of "004010X096A1", which is the current version accepted by THCIC.
RJ013	Missing Transaction Set Header (ST segment)	The Transaction Set Header was expected but not found. The first two characters of the segment must contain 'ST'.
RJ014	Invalid value in segment ST, data element ST01 (Transaction Set Identifier Code)	ST01 (Transaction Set Identifier Code) must contain a value of "837".
RJ015	Invalid value in segment ST, data element ST02 (Transaction Set Control Number)	ST02 (Transaction Set Control Number) must contain a non-blank value. This is the same value as in SE02. This value must be a unique number within a specific GS-GE group and ISA-IEA interchange.
RJ016	Missing Beginning of Hierarchical Transaction (BHT segment)	The BHT segment was expected but not found.
RJ017	Invalid value in segment BHT, data element BHT03 (Originator Application Transaction ID)	BHT03 (Originator Application Transaction ID) must contain a value other than spaces.
RJ018	Invalid date in segment BHT, data element BHT04 (Transaction Set Create Date).	BHT04 (Transaction Set Create Date) must contain a valid date in the format CCYYMMDD.

Table A – Pre-Processing Audits (Format Check)		
Audit Msg ID	**Audit Message**	**Audit Description**
RJ019	Missing or invalid Billing/Pay-To Provider Hierarchical Level (HL segment)	The Billing/Pay-To Provider Hierarchical Level is missing or invalid.
RJ020	Invalid value in segment HL for Billing/Pay-To Provider, data element HL01 (Hierarchical ID Number)	HL01 (Hierarchical ID Number) must contain a number > 0. If the HL is the first HL segment in the transaction, the value must be 1.
RJ021	Invalid value in segment HL for Billing/Pay-To Provider, data element HL04 (Hierarchical Child Code)	HL04 (Hierarchical Child Code) must contain a value of "1".
RJ022	Missing Subscriber Hierarchical Level.	A Subscriber Hierarchical Level segment was expected but not found.
RJ023	Invalid value in segment HL for Subscriber, data element HL01 (Hierarchical ID Number)	HL01 (Hierarchical ID Number) must contain a value > 1.
RJ024	Invalid value in segment HL for Subscriber, data element HL02 (Hierarchical Parent ID Number)	HL02 (Hierarchical Parent ID Number) must contain a value > 0 and less than the value in HL01.
RJ025	Missing Patient Hierarchical Level.	A Patient Hierarchical Level segment was expected but not found.
RJ026	Invalid value in Patient HL segment, data element HL01 (Hierarchical ID Number)	HL01 (Hierarchical ID Number) must contain a value > 2.
RJ027	Invalid value in segment HL for Patient, data element HL02 (Hierarchical Parent ID Number)	HL02 (Hierarchical Parent ID Number) must contain a value < HL01.
RJ028	Missing Transaction Set Trailer (SE segment)	A Transaction Set Trailer segment was expected but not found.
RJ029	Invalid Included Number of Segments in Transaction Set Trailer (SE segment)	The Included Number of Segments (SE01) did not = the actual number of segments in the transaction set.

Table A – Pre-Processing Audits (Format Check)		
Audit Msg ID	**Audit Message**	**Audit Description**
RJ030	Invalid Transaction Set Control Number in Transaction Set Trailer (SE segment)	The Transaction Set Control Number (SE02) in the Transaction Set Trailer must = the Transaction Set Control Number (ST02) in the Transaction Set Header (ST segment).
RJ031	Missing Functional Group Trailer (GE segment)	A Functional Group Trailer segment was expected but not found.
RJ032	Invalid Number of Transaction Sets Included in Functional Group Trailer (GE segment)	The Number of Transaction Sets Included (GE01) did not = the actual number of transaction sets in the group.
RJ033	Invalid Group Control Number in Functional Group Trailer (GE segment)	The Group Control Number (GE02) in the Functional Group Trailer must = the Group Control Number (GS06) in the Functional Group Header (GS segment).
RJ034	Missing Interchange Control Trailer (GE segment)	An Interchange Control Trailer segment was expected but not found.
RJ035	Invalid Number of Included Functional Groups in Interchange Control Trailer (IEA segment)	The Number of Included Functional Groups (IEA01) did not = the actual number of functional groups in the Interchange
RJ036	Invalid Interchange Control Number in Functional Group Trailer (GE segment)	The Interchange Control Number (IEA02) in the Interchange Control Trailer must = the Interchange Control Number (ISA13) in the Interchange Control Header (ISA segment).
RJ037	Missing Billing Provider	The Billing Provider was identified in the 2000A PRV segment as also being the service provider but the Billing Provider Identifier Code was not found.
RJ038	Missing Pay-To Provider	The Pay-To Provider was identified in the 2000A PRV segment as also being the service provider but the Pay-To Provider Identifier Code was not found.
RJ038	Subscriber is Patient But No Primary Payer Source	The subscriber is the patient but there is no SBR segment with a primary payer source.
RJ039	Service Provider Not Identified	Neither the 2000A PRV segment or the 2310E segment exists. One of the two segments must exist.
RJ040	Subscriber is primary and not self-patient and subscriber hierarchy child code not = 1.	The SBR segment shows the subscriber not to be the patient but the HL segment immediately proceeding does not indicate that there is a subordinate HL segment. This is a programming problem and not a data entry issue.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
600	Missing Principal Procedure Date	If the Principal Procedure exists, the Principal Procedure Date must exist and contain a valid date of the format CCYYMMDD.
601	Principal Procedure not reported when Other Procedure(s) reported	The Principal Procedure is not reported or blank or zeroes and Other Procedure(s) are reported.
602	Invalid Principal Procedure	The Principal Procedure field does not contain a valid ICD, CPT or HCPCS code. The Principal Procedure code must be valid for the time period covering the discharge date.
603	Duplicate Diagnosis Codes	The same ICD diagnosis code is reported more than once on the same claim.
604	Patient Gender not consistent with Other Diagnosis	The gender of patient does not agree with a gender specific Other Diagnosis.
605	Invalid Other Diagnosis	If reported, the Other Diagnosis Code field must contain a valid ICD code.
606	Invalid E-Code	If an E-Code field is reported, it must contain a valid value.
607	Invalid Principal Diagnosis	Principal Diagnosis is a required field and must contain a valid ICD code.
608	Missing Principal Diagnosis	Principal Diagnosis is a required field.
609	Invalid Principal Procedure Date	If the Principal Procedure exists, the Principal Procedure Date must contain a valid date of the format ccyymmdd.
610	Duplicate E-Codes	The same ICD E-code value is reported more than once in the same record.
611	Invalid External Cause of Injury	The Principal E-Code field (External Cause of Injury) does not contain a valid value.
612	Principal Procedure Date before 1971	The Principal Procedure Date field must contain a date after 1970.
613	Invalid Value Code	The Value Code field does not contain a valid value.
614	Invalid Occurrence Span Code	If reported, the Occurrence Span Code field must contain a valid values
615	Invalid Admitting Diagnosis	Admitting Diagnosis is a required field and must contain a valid ICD code.
616	Age > 1 day and Principal Diagnosis = newborn before admission	The age, at admission, of an infant not born in the hospital is greater than 1 day.
617	Other Procedure Date earlier than three days before Admission Date or after Statement Thru Date	The Other Procedure Date must be on or after the third day before Admission Date and on or before the Statement Thru Date.
618	Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date.	The Principal Procedure Date must be on or after the third day before the Admission Date and on or before the Statement Thru Date.
619	Other Procedure Date before 1971	The Other Procedure Date field must contain a date after 1970.
620	Invalid Other Procedure Date	The Other Procedure Date field must contain a valid date of the format ccyymmdd.
621	Procedure Date missing for Other Procedure	An Other Procedure Date is required when a corresponding Other Procedure is present.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
622	Patient Gender not consistent with Other Procedure	Patient Gender is not consistent with a gender related Other Procedure.
623	Invalid Other Procedure	If reported, an Other Procedure field must contain valid ICD, CPT or HCPCS code. The Other Procedure code also must be valid for the discharge date of the claim.
624	Invalid Condition Code	The Condition Code field must contain a valid value.
625	Patient Gender not consistent with the Principal Diagnosis	The patient gender does not agree with a gender specific principal diagnosis.
626	Missing Patient State	The Patient State field is required.
627	Missing Patient ZIP	The ZIP code of the patient address is a required field.
628	Invalid Patient Country	The Patient Country field of the patient address contains an invalid value.
629	Missing Patient Country	The Patient State indicates a foreign country but the Country field of the patient address is invalid or missing. The Country is required when a patient's address is not in the US or a US territory.
630	Missing Patient Birth Date	Patient Birth Date is a required field and must contain a valid date of format CCYYMMDD.
631	Patient age > 115 years or < zero years	The value in the Patient Birth Date field indicates that the patient is older than 115 years or has not yet been born.
632	Patient Birth Date > Admission Date and Admission Type not newborn	The patient's birth date is after the admission date but the admission type is not for a newborn (4). The patient birth date cannot be later than the admission date, unless the admission type is newborn.
633	Missing Patient Gender	Patient Gender is a required field and must contain M, F or U.
634	Missing Patient Race	Patient Race is a required field.
635	Missing Patient Ethnicity	Patient Ethnicity is a required field and must contain 1 or 2.
636	Patient SSN not 9 numeric characters	Patient Social Security Number is a required field and must contain 9 numeric characters.
637	Invalid Patient SSN	The Patient Social Security Number field contains a number is that is not the confidentiality default (999999999) and is not a valid number recognized by the Social Security Administration. Possible errors include the following: 1) first 8 positions are zeros, 2) all characters are the same (but not the confidentiality default), 3) first 3 characters are >= 800, 4) the last four characters are 0000, and 5) the number is 078-05-1120.
638	Missing Patient Medical Record Number	The Medical Record Number field is required and cannot contain spaces or all zeroes.
639	Missing Facility Type Code	Facility Type Code field is required field. The Facility Type Code is the first two characters of the claim's bill type.
640	Missing Claim Frequency Type Code	Claim Frequency Type Code is a required field. The Claim Frequency Type Code is the third character of the claim's bill type.
641	Statement From Date after Statement Thru Date	The Statement From Date must be on or before the Statement Thru Date.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
642	Statement From Date before Patient Birth Date	The Statement From Date must be on or after the Patient Birth Date.
643	Admission Date before 1971	The patient admission date must be after 1970.
644	Admission Date after Statement Thru Date	The patient admission date must be on or before the statement thru date.
645	Missing Admission Type	Admission Type field is required.
646	Missing Admission Source	Admission Source is a required field.
647	Missing Patient Discharge Status	Patient Discharge Status is a required field.
648	Missing Admitting Diagnosis	Admitting Diagnosis is a required field.
649	Invalid Occurrence Code	If an Occurrence Code field exists, the field must contain a valid value.
650	Date of Birth not = Admission Date and Admission Type = Newborn	The Patient Birth Date is not equal to the Admission Date yet the Admission Type is newborn.
651	Newborn with birth date not within 3 days (+/-) of the Admission Date and newborn diagnosis present	If the Admission Type indicates a newborn, then the date of birth must be within 3 days of the admission date and a newborn diagnosis must be present.
652	Admission Type = Newborn and Principal Diagnosis Not = Newborn	The admission type code indicates newborn, but the principal diagnosis is not for a newborn.
653	Patient Birth Date Not = Admission Date and (Principal Diagnosis = Newborn or Admission Type = Newborn)	The Principal Diagnosis or the Admission Type indicates newborn in this hospital, but the Patient Birth Date and Admission Date are not the same.
654	Missing 019x Revenue Code for Bill Type 17x	If Bill Type 17x is reported, then one Revenue Code field must contain 019x.
655	Invalid Admission Source	The Admission Source Code is a required field and must contain a valid value .
656	Invalid Admission Type	The Admission Type field is required and must contain a valid value.
657	Invalid Facility Type Code	The Facility Type Code field contains an invalid value. The Facility Type Code is the first two characters of the claim's bill type.
658	Invalid Claim Frequency Type Code	The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type.
659	Invalid Patient Birth Date	Patient Birth Date is a required field and must contain a valid date of format ccyymmdd.
660	Invalid Patient Ethnicity	The Patient Ethnicity field contains an invalid value. Patient Ethnicity is a required field and must contain 1 or 2.
661	Invalid Patient Gender	Patient Gender is a required field and must contain M, F or U.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
662	Invalid Patient State	The value in the Patient State field of the patient address is not valid.
663	Invalid Patient ZIP	The ZIP Code of the patient address must be at least 5 numeric characters in length and must contain XXXXX's or 00000's or a valid ZIP Code (USPS ZIP Code table).
664	Invalid Patient Race	Patient Race is a required field and must contain a valid code value for the THCIC 837.
665	Missing Patient Social Security Number	Patient Social Security Number is a required field and must contain 9 numeric characters.
666	Invalid Patient Discharge Status	The Patient Discharge Status is a required field and must contain one of the following two character values: 01, 02, 03, 04, 05, 06, 07, 08, 09, 20, 30, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, 65.
667	Missing Total Claim Charges	Total Claim Charges field is a required field and must contain a numeric value.
668	Total Claim Charges not = sum of Service Lines Charges	The Total Claim Charges must equal the sum of all Service Line Charges.
669	Non-numeric Value Code Associated Amount	If the Value Code exists, the Value Code Associated Amount must exist and contain a numeric value.
670	Revenue Code in first service line detail is missing	At least one revenue code is required.
671	Invalid Revenue Code	The Revenue Code field must contain a valid revenue code (per NUBC Manual).
672	Invalid Revenue Procedure Code	If it exists, the Revenue Procedure Code field must contain a valid HCPCS code.
673	Charges not present for Revenue Code	The Charge Amount field is required when a corresponding service line Revenue Code is present.
674	Service Line Charge not numeric	The Service Line Charge Amount must be numeric if a corresponding Revenue Code is present.
675	Invalid Unit Code	Unit Code field must contain “DA” or “UN” or "F2".
676	Missing or Invalid Unit Quantity	A Unit Quantity field is required when corresponding a revenue code is present and must contain a numeric value greater than zero.
677	Invalid Unit Rate	The Unit Rate field must contain a numeric value > 0.
678	Non-numeric Non-Covered Charge Amount	When present, a service line Non-Covered Charge Amount field must contain a numeric value.
679	Charges present but no corresponding Revenue Code	Service Line Charges exists but there is no corresponding Revenue Code.
680	Questionable Revenue Procedure Modifier 1	The HCPCS/HIPPS Revenue Procedure Modifier Code 1 field contains a value not recognized by Medicare.
681	Questionable Revenue Procedure Modifier 2	The HCPCS/HIPPS Revenue Procedure Modifier Code 2 field contains a value not recognized by Medicare.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
682	Questionable Revenue Procedure Modifier 3	The HCPCS/HIPPS Revenue Procedure Modifier Code 3 field contains a value not recognized by Medicare.
683	Questionable Revenue Procedure Modifier 4	The HCPCS/HIPPS Revenue Procedure Modifier Code 4 field contains a value not recognized by Medicare.
684	Invalid Total Claim Charges	Total Claim Charges field is a required field and must contain a numeric value not less than zero.
685	Missing Unit Code	A Revenue Code field exists but there is not a corresponding Unit Code field.
686	Invalid product service ID qualifier	The qualifier for the productions service ID must contain a valid code.
687	Missing Value Code Associated Amount	If the Value Code is reported, the Value Code Associated Amount must exist and be numeric.
688	Invalid Attending Practitioner Secondary Identifier Qualifier	The Attending Practitioner Secondary Identifier Qualifier field identifies the type of license contained in the Primary Practitioner Identifier field and the field must contain "0B" or "1G". The Secondary Identifier has not been audited and should be verified prior to resubmission of the claim.
689	Missing Attending Practitioner Secondary Identifier	The Attending Practitioner Secondary Identifier field is required. The Attending Practitioner Secondary Identifier field must contain the practitioner's state license number or UPIN.
690	Invalid Attending Practitioner Secondary Identifier	The Attending Practitioner Secondary Identifier field does not contain a valid state license number or UPIN (number does not match THCIC Practitioner Reference File) and isn't a recognized temporary number ("TXTnnn"-,"OTHnnn", "RESnnn","TEMnnn").
691	Missing Attending Practitioner Last Name	Attending Practitioner Last Name is a required field.
692	Invalid Operating Practitioner Secondary Identifier Qualifier	The Operating Practitioner Secondary Identifier Qualifier field identifies the type of license contained in the Secondary Practitioner Identifier field and the field must contain "0B" or "1G". The Secondary Identifier has not been audited and should be verified prior to resubmission of the claim.
693	Invalid Operating Practitioner Secondary Identifier	The Operating Practitioner Secondary Identifier does not contain a valid state license number or UPIN (number does not match THCIC Practitioner Reference File) or one the following temporary numbers: "TXTEMP", "OTHnnn", "RESnnn", or "TEMPnn" (where n may be numbers, that the healthcare facility can identify the practitioner).
694	Missing Attending Practitioner First Name	Attending Practitioner First Name is a required field.
695	Invalid Attending Practitioner Name Match	The 1st three characters of the Attending Practitioner's Last Name field and the first character of the Attending Practitioner's First Name field does not match an entry in the THCIC Practitioner Reference File.
696	Invalid Operating Practitioner Name Match	The 1st three characters of the Operating Practitioner's Last Name field and the first character of the Operating Practitioner's First Name field does not match an entry in the THCIC Practitioner Reference File.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
697	Missing Claim Filing Indicator Code for Subscriber	Claim Filing Indicator Code for the subscriber is a required field and must contain the primary source of payment.
698	Invalid Claim Filing Indicator Code for Other Subscriber	The Claim Filing Indicator Code field for the Other Subscriber does not contain a valid value. The Claim Filing Indicator Code field in the Other Subscriber segment contains the Secondary Payer Source code.
699	Missing Primary Payer Plan ID	The Primary Payer Plan ID is required.
700	Invalid Claim Filing Indicator Code for Subscriber	The Claim Filing Indicator Code field for the Subscriber does not contain a valid value. The Claim Filing Indicator Code field in the Subscriber segment contains the Primary Payer Source code.
701	Primary Payer Name is required	The Primary Payer Name is required.
702	Missing Secondary Payer Name	The Secondary Payer Name is required when a Claim Filing Indicator Code containing the secondary payer source code exists for the Other Subscriber (secondary subscriber).
703	Missing Secondary Payer Plan ID	NOTE: This audit is suspended until the NPI rule is implemented. The Secondary Payer Plan ID field is required when a secondary source of payment is reported.
704	Missing Service Provider Primary Identifier (EIN)	Service Provider Primary Identifier is a required field and must contain the Service Provider's EIN.
705	Missing Service Provider Secondary Identifier (THCIC ID)	Service Provider Secondary Identifier is a required field and must contain the THCIC 6-digit ID.
706	Missing Service Provider Address	The first line of the Service Provider's street address is required.
707	Missing Operating Practitioner Secondary Identifier	If the operating practitioner is reported, the Secondary Identifier for the Operating Practitioner is required.
708	Missing Operating Practitioner First Name	The Operating Practitioner First Name is required if an operating practitioner is reported.
709	Invalid Length for Occurrence Span Associated Date	If the Occurrence Span Code Associated exists, then the Occurrence Span Associated Date field must contain 17 characters.
710	Invalid Service Provider Primary Identifier Qualifier	The qualifier for the Primary Provider Identifier which contains the service provider's Tax ID is required and must contain a value of "24" for employer identification number.
711	Invalid Provider Primary Identifier	The service provider's Employer Identification Number (Federal Tax ID) reported in the Provider Primary Identifier field does not match an entry in the THCIC Provider Table. The Provider Primary Identifier is a required field.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
712	Invalid Provider Secondary Identifier	The THCIC 6-digit healthcare facility identifier in the Service Provider Secondary Identifier field is not a valid THCIC Healthcare facility Identifier. The Provider Secondary Identifier is a required field.
713	Missing Occurrence Code Associated Date	If an Occurrence Code exists, then the Occurrence Date field must exist.
714	Patient Gender not consistent with the Principal Procedure	The patient gender does not agree with a gender specific principal procedure.
715	Invalid Occurrence Span From Date	If an Occurrence Span Code exists, then the Occurrence Span From Date must contain a valid date of format ccyymmdd. The Occurrence Span From Date is the first 8 characters of the Occurrence Span Associated Date field.
716	Invalid Occurrence Code Associated Date	If the Occurrence Code exists, the Occurrence Code Associated Date field must exist and contain a valid date of format ccyymmdd.
717	Invalid Occurrence Span Thru Date	If an Occurrence Span Code exists, then the Occurrence Span Thru Date must be a valid date of format ccyymmdd. The Occurrence Span Thru Date is the last 8 characters of the Occurrence Span Associated Date field.
718	Missing Occurrence Span Code Associated Date	If an Occurrence Span Code exists, then the Occurrence Span Code Associated Date field must exist. The Occurrence Span Code Associated Date field contains the Occurrence Span From Date and the Occurrence Span Thru Date and is of the format ccyymmdd-ccyymmdd.
719	Invalid Statement From Date	Statement From Date is a required field and must be a valid date. The Statement From Date is the first 8 characters of the Statement Dates field and is of format ccyymmdd.
720	Invalid Statement Thru Date	Statement Thru Date is a required field and must be a valid date. The Statement Thru Date is the last 8 characters of the Statement Dates field and of format ccyymmdd.
721	Invalid Admission Date	Admission Date is a required field. The admission date is taken from the Admission Date and Hour field. The first eight characters of the Admission Date and Hour field must be a valid date of the format ccyymmdd.
722	Invalid Admission Hour	Admission Hour is a required field. The admission hour is taken from the 9th and 10th characters of the Admission Date and Hour field. The Admission Hour field must contain one of (00-23).
723	Birth Date after Statement Thru Date or Procedure Date	The patient birth date is after one of the following dates: statement thru date, principal procedure date, other procedure date.
724	Missing Patient Discharge Hour	Patient Discharge Hour is a required field of format hhmm.
725	Missing Patient Address Line 1	The first line of the patient's address of residence is required.
726	Missing Patient Account Number	The Patient Account Number is required.
727	Missing Admission Date and Hour	Admission Date and Hour is a required field.
728	Invalid Discharge Hour	Discharge Hour is a required field and must contain a valid hour of 00 - 23.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
729	Missing Patient City	The city of the patient's address is required.
730	Missing Operating Practitioner Last Name	If the operating practitioner is reported, the Operating Practitioner Last Name field is required.
800	Encounter contains discharge claim but no admission claim	A discharge claim exists for an encounter but there is no matching admission claim.
801	Statement Thru Date not contiguous to Statement From Date on subsequent claim	The Statement Thru Date on this claim must be contiguous (one day before) the Statement From Date on a subsequent claim.
802	Claims for this encounter include more than one non-payment admission-thru-discharge claim	There are more than one non-payment admission thru discharge [type xx0] claim for this encounter. The claim submitted last will be used in the encounter.
803	Claims for this encounter include more than one admission-thru-discharge claim	There is more than one admission-thru-discharge [type xx1] claim for this encounter. The claim submitted last will be used in the encounter.
804	Encounter contains more than one admission claim	There is more than one admission claim (xx2) for this encounter. The admission claim submitted last will be used in the encounter.
805	Encounter contains more than one discharge claim	There is more than one discharge claim (xx4) for this encounter. The discharge claim submitted last will be used in the encounter.
806	Statement From Date overlaps previous claim's billing period	The Statement From Date on this claim falls within a previous claim's billing period
807	Statement Thru Date overlaps following claim's billing period	The Statement Thru Date on this claim falls within a following claim's billing period.
808	Principal Diagnosis at discharge not same as at admission	The Principal Diagnosis on the discharge claim (xx4) is not the same as on the admission claim (xx2). The Principal Diagnosis field in the discharge claim will be used in the encounter.
809	Encounter contains admission, and possibly continuing claims, but no discharge claim	Claim with admission bill type exists but no matching discharge claims exists. The encounter contains admission and possibly continuing claims. The claims will be held and no encounter will be created.
810	The Attending Practitioner Secondary Identifier in discharge claim not same as in admission / interim claim(s)	The Attending Practitioner Secondary Identifier in the discharge claim (XX4) is not same as in the admission / interim claim(s) (xx2 or xx3). The Identifier in the discharge claim will be used in the encounter.
811	Statement From Date not contiguous to Statement Thru Date on prior claim	The Statement From Date on this claim must be contiguous (one day after) the Statement Thru Date on the prior claim.

Table B – Data Content Audits		
Audit Msg ID	Audit Message	Audit Description
812	Operating Practitioner Secondary Identifier in the discharge claim not same as in the admission / interim claim(s)	The Operating Practitioner at the time of discharge (XX4) is not same as in the matching claim components (Matching xx2 or xx3). The Operating Practitioner field in the discharge claim will be used in the encounter.
813	Claims for encounter have incompatible bill types	The encounter has two or more claims that have admission bill types and the admission bill types are different (xx0, xx1, xx2).
814	Encounter does not have admission claim	Claim(s) exists for an encounter but there is no claim with an admission bill type (xx0, xx1, or xx2).
815	Adjustment, replacement, or void claim exists, but no claim to change	A claim with a bill type of xx5, xx7, or xx8 exists, but there is no matching claim.
816	Claims for this encounter have different patient SSNs	Two (or more) claims for this encounter contain different values in the Patient Social Security Number field.
817	Claims for this encounter contain different codes for patient ethnicity	Two (or more) claims for this encounter contain different values in the Patient Ethnicity field. The ethnicity code reported on the discharge claim will be used in the encounter.
818	Claims for this encounter contain different values for patient race	Two (or more) claims for this encounter contain different values in the Patient Race field. The Patient Race field in the discharge claim will be used in the encounter.
819	Claims for this encounter contain different codes for patient gender	Two (or more) claims for this encounter contain different codes for patient gender. The Patient Gender field in the discharge claim will be used in the encounter.
820	The claims for this encounter contain different patient birth dates.	The patient birth date is different on the claims for this encounter. The Birth Date field in the discharge claim will be used in the encounter.
821	Claims for this encounter have different patient first names	Two (or more) claims for this encounter contain patient first names that are different. The Patient First Name field in the discharge claim will be used in the encounter.
822	Claims for this encounter have different patient last names	Two (or more) claims for this encounter contain patient last names that are different.
823	Principal Procedure at discharge not same as at admission	The Principal Procedure on the discharge claim (xx4) is not the same as on the admission claim (xx2). The Principal Procedure field in the discharge claim will be used in the encounter.
824	The claims for the encounter have different claim filing indicator codes for the subscriber.	The claims for this encounter do not have the same value in the subscriber Claim Filing Indicator Code field, which identifies the primary source of payment. The Claim Filing Indicator Code field in the discharge claim will be used in the encounter.

APPENDIX - A6 OUTPATIENT AUDITS AND AUDIT MESSAGES

Outpatient Audits coming soon

APPENDIX - A7
PAYER SOURCE CODING GUIDE

(*Claim Filing Indicator Code*)

CATEGORY DESCRIPTIONS

09 Self pay
Payment responsibility is borne by the patient or another individual and not by a federal, state, local or private organization. Includes Medical or Health Savings Accounts.

If payment is made by the patient or an individual, use "SELF PAY" in Payer Organization Name field and use ""SELF" in Payer Identification field.

10 Central certification
Definition is unknown. Category is not used.

11 Other non-federal program
Payment is made by a state or local program and most likely funded by tax dollars. This could include claims for which application to a program has been made but eligibility has not been determined. Can include entities such as the Texas Rehabilitation Commission, Texas Kidney Foundation, non-federal incarceration and adoption agencies.

12 Preferred Provider Organization (PPO)
PPO is a type of managed care insurance. PPO plans combine some elements of the HMO plan with elements of the indemnity plan. Like HMOs, the PPO plans have contracts with a specific list of medical providers. The enrollees may go outside of the network, but will incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

13 Point of Service (POS)

POS is a type of managed care and the category is new with the THCIC 837. A POS is an HMO/PPO hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans.

14 Exclusive Provider Organization (EPO)

EPO is a type of managed care and the category is new with the THCIC 837. An EPO is a more restrictive type of preferred provider organization plan under which beneficiaries must use

providers from a specific network of physicians and healthcare facilities to receive coverage. In most cases, there is no coverage for care received from a non-network provider except in an emergency situation.

15 Indemnity Insurance
This is a fee-for-service health insurance plan that is not otherwise specified as a PPO, HMO, or EPO, whether group or individual. It includes individual insurance and an employer's self-funded insurance. An indemnity plan reimburses the patient and/or provider as expenses are incurred. Indemnity plans usually do not require beneficiaries to choose from a provider network for covered care.

16 Health Maintenance Organization – Medicare Risk
Medicare risk is a contractual relationship between CMS and HMO managed care plans where the plan provides specific health care benefits to beneficiaries in exchange for a prepaid fixed monthly amount from CMS. These benefits replace traditional Medicare benefits. Programs included in the Medicare managed care risk programs fall under the Medicare + Choice contract. These are called Coordinated Care Plans.

AM Automobile Medical
This category is new with the THCIC 837. Automobile medical or no-fault insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile.

BL Blue Cross (*THCIC recommends that this category not be used.*)
This category refers to a specific insurance company. Blue Cross provides many different plan options (PPO, HMO).

CH CHAMPUS

CHAMPUS is a health benefits program offered through the Military Health Services System of the Department of Defense of inactive military, their spouses, dependents and beneficiaries. CHAMPUS provides authorized in-patient and out-patient care from civilian sources, on a cost-sharing basis. Retired military are eligible, as well as dependents of active-duty, retired and deceased military. Also known as TRICARE.

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services

CI Commercial Insurance (*THCIC recommends that this category not be used.*)
This category is misinterpreted as being any insurance that can be purchased on the open market (commercially). However, there are other categories that provide more specific categorization.

DS Disability
Disability insurance pays benefits in the event that the policy holder becomes incapable of working. This does not include workers compensation insurance or other tax-funded programs.

Types of disability insurance include:

- Short-term disability: a disability not lasting longer than six months.
- Partial disability: Any condition, resulting from illness or injury, that keeps an insured from performing one or more occupation related activities.
- Total disability: A disability that prevents an insured from performing duties essential to his/her regular job.
- Permanent disability: An inability to work at any job.

HM Health Maintenance Organization (HMO)
An HMO is an organized system that arranges or provides a set of health care services to members in return for a prepaid or periodic charge paid by or on the behalf of the enrollees.

Membership in an HMO requires plan members to obtain their health services from doctors and healthcare facilities affiliated with the HMO. Members usually select a primary care physician who manages all of the health care and serves as a gatekeeper for specialty care.

LI Liability
Insurance which pays and renders service on behalf of an insured for loss arising out of his/her responsibility to others imposed by law or assumed by contract.

Types of liability insurance include homeowner's insurance, umbrella liability insurance for individuals and companies.

LM Liability Medical
Insurance which pays only for medical services on behalf of an insured for loss arising out of the insured's responsibility to others imposed by law or assumed by contract.

MA Medicare Part A
Federal insurance program for people aged 65 and older, people with disabilities, or people with End-Stage Renal Disease (ESRD). Medicare Part A covers in-hospital services.

MB Medicare Part B
Federal insurance program for people aged 65 and older, people with disabilities, or people with End-Stage Renal Disease (ESRD). Medicare Part B covers physician and other outpatient services.

MC Medicaid
Medicaid is a jointly funded, federal – state, health insurance program for low-income and needy people. Medicaid is run by the state and covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments. The state provides Medicaid eligibility to people eligible for Supplemental Security Income (SSI) benefits. This includes the CHIP/SCHIP programs.

OF Other Federal Program
Federal tax-funded programs, other than Medicare, Medicaid, CHAMPUS and Veteran's Administration, that pay for health services. Such programs include Indian Health Service, Federal incarceration, US Marshall's Office, and Crime Victims.

TV Title V
The Children with Special Health Care Needs (CSHCN) Services Program, funded through the Title V Block grant, provides services to children with extraordinary medical needs, disabilities, and chronic health conditions. The CSHCN Services Program's health care benefits include payments for medical care, family support services, and related services not covered by Medicaid, CHIP, private insurance, or other third party payors.

VA Veterans Administration Plan
The Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to its customers. Services are provided primarily in VHA facilities.

WC Workers Compensation Health Plan
Workers Compensation insurance covers the cost of medical care and rehabilitation for workers injured on the job. It also compensates them for lost wages and provides death benefits for their dependents if the workers are killed in work-related accidents, including terrorist attacks.

ZZ Charity or Unknown
This category is new with the THCIC 837. This category is used to report services that will not be paid for or reimbursed by a local, county, or state program or by private insurance. It is also used to report claims for which the payer source is unknown at the time that the claim is reported to THCIC.

If no payment is expected, enter "CHARITY" in Payer Organization Name and in Payer Identification fields.

If the payer is unknown at the time the claim is reported to THCIC, enter "UNKNOWN" in Payer Organization Name and in Payer Identification fields.

If an application has been made to Medicaid or another state or local program, "Program name Application" may be used in Payer Organization Name field.

Descending order of frequency

IF	Then Use	Code
Medicaid (including HMO, PPO, EPO, POS) or CHIP/SCHIP		MC
Medicare Health Maintenance Organization (HMO)		16
Medicare Part B or Medicare Outpatient		MB
Medicare Part A or Medicare (including PPO, EPO, POS, Indemnity)		MA
Preferred Provider Organization (PPO)		12
Health Maintenance Organization (HMO)		HM
Local or State Program (including county or hospital district indigent program)		11
Self/Private Pay		09
Unknown		ZZ
Healthcare facility charity		ZZ
CHAMPUS		CH
Veterans Administration Plan		VA
Exclusive Provider Organization (EPO)		14
Point of Service (POS)		13
Automobile Medical or No-Fault Insurance		AM
Liability		LI
Liability Medical		LM
Disability		DS
Other Federal Programs not listed above (including Indian Health Service, Federal incarceration, Crime victims, US Marshall's office)		OF
Workers Compensation Health Plan		WC
Title V Children with Special Health Care Needs (CSHCN) Services Program		TV
If none of the above, will be Indemnity		15

APPENDIX - B1
KEY DATA ELEMENTS FOR MATCHING INPATIENT CLAIMS

System 13 uses the following data elements to create a key for matching XX7 replacement, XX3 Intermediate Interim, XX4 Final Interim and XX8 Void/Cancel claims:

- THCIC Number [1]
- PCN/PAN - Patient Control Number or Patient Account Number
- MRN – Medical Record Number
- Admit Date
- Admit Hour
- Type of Bill.
- Statement Covers Period From Date

The use of these data elements maximizes the integrity of claim matching. However, it decreases the number of data elements that can be changed using the XX7 claim. To change any of the above data elements, the XX8 Void claim must be used and then an original claim type can be submitted.

[1] *UB92 claims this is generated from the six digit code (Record 10 Field 10) and Facility EIN, or Facility EIN, Medicare # and the Facility Address; 837 claims will use the required THCIC # (Loop 2010AA, 2010AB or 2310E|REF02)*

APPENDIX - B2
KEY DATA ELEMENTS FOR MATCHING OUTPATIENT CLAIMS

Key Data Elements to be added.