



THCIC Data Collection

5010 Outpatient THCIC 837 Technical Specifications

Version 9

December 18, 2013

UPDATE CHANGE DESCRIPTIONS

Changes are from the 5010 Format specification that is in THCIC Data Collection

Outpatient THCIC 837 Technical Specifications 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. HI_{nn}-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. HI_{nn}-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. HI_{nn}-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. HI_{nn}-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. HI_{nn}-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. HI_{nn}-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. HI_{nn}-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 data submitted to THCIC.”
 - iii. HI_{nn}-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 example is 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”.

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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 (hospitals, ambulatory surgical centers, chemical dependency treatment facilities, renal dialysis facilities, birthing centers, rural health clinics, federally qualified health centers and free-standing imaging centers) 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 25 TAC §421.67(e) and the HCPCS codes from the service and procedure categories listed in 25 TAC §421.67(f) for hospitals and ambulatory surgical centers for approximately ~550 Texas hospitals and ~370 Ambulatory Surgical Centers, is contained within Chapter 108, Texas Health & Safety Code.

The Outpatient Procedures and Technical Specifications Institutional and Professional Guides are available for download from the THCIC website at www.dshs.state.tx.us/thcic/ . 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 [25 TAC §421.61-4211.68](http://www.dshs.state.tx.us/thcic/), which can be found on the THCIC Web site www.dshs.state.tx.us/thcic/ and on the Secretary of State's Web site (<http://www.sos.state.tx.us/>) under the Texas Administrative Code: [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=421](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=421)

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.

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 or Professional 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 [25 TAC §421.67\(f\)](#).

Submissions are acknowledged upon receipt into the system. Once 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/rejected for further processing. In order 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. Once accepted for further processing the file is checked for formatting compliance. Files failing the format (preprocessor) audits will not be accepted into the system. The submitter contact person will be notified via email if the file has been accepted/not-accepted into the system. The non-acceptance notification includes information regarding the failed formatting/preprocessor audits. The system (receiver process) also determines if a file is a Test (T) file or a Production (P) file. Claims submitted in either a Production or Test file accepted into the system, 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 a web based software system (WebCorrect) provided by System13, Inc. or by 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:

<https://thcic.system13.com/help>

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:

<http://www.wpc-edi.com/content/view/533/377/>

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.

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

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.

2.3 THE THCIC BUSINESS ASSOCIATE

2.3.1 SYSTEM13, INC.

System13, Incorporated (System13), located in Charlottesville, Virginia, is contracted to provide data collection, auditing, and warehousing of the data submitted by hospitals. SYSTEM13 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/user_session/new (*This is for Data Submission{uploading data}, and for any web system issues.*)

2.4 THCIC WEB SITE.

The THCIC Web site at www.dshs.state.tx.us/thcic/ contains the latest information about THCIC, the hospital discharge data reporting process, and other THCIC activities and publications. The site contains information about legislative mandates, instructions concerning the data reporting process, and phone/fax numbers for contacting THCIC staff.

3 DEFINITIONS AND ACRONYMS

Anesthetized patient	For the purposes of 25 TAC §§421.61 - 421.68 , 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	American National Standards Institute,
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 http://www.wpc-edi.com/content/view/533/377/]. 25 TAC §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 http://www.wpc-edi.com/content/view/533/377/]. 25 TAC §421.61(6)
APC	Ambulatory Payment Classification.
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.
ASC	Ambulatory Surgical Center licensed under Health and Safety Code, Chapter 24.
Audit	<i>For the purposes of this manual</i> A methodological examination and review of data. <i>Audits are performed during data collection to identify errors or potential errors (warnings).</i>
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 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. 25 TAC §421.61(12)
CHS	Texas Department of State Health Services, Center for Health Statistics.
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).
CPT	Current Procedural Terminology – HCPCS Level 1 procedure codes
CRG	Clinical Risk Grouping software -- 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.

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. 25 TAC §421.61(18)
Edit	<p>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)</p> <p><i>For the purposes of this manual</i></p> <ol style="list-style-type: none"> 1. To make changes to a data file. 2. The process of adding, deleting, or changing data. <p><i>The THCIC edits the public use data file to protect the confidentiality of patients and physicians.</i></p>
EMC	Electronic Media Claims (National Standard Format).
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 in a discharge data file, which are not consistent with the format, data standards, or auditing criteria established by the director of CHS, or the failure to submit required data. 25 TAC §421.61(22)
Event	The medical screening examination, triage, observation, diagnosis or treatment of a patient within the authority of a facility. 25 TAC §421.61(24)
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 facility (e.g. Teaching, Acute Care, Rehabilitation, Psychiatric, Pediatric, Cancer, Skilled Nursing, or other Long Term Care Facility). A facility may have more than one indicator. Hospitals may request updates to this field. 25 TAC §421.61(19)
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.
Hospital	A public, for-profit, or nonprofit institution licensed or owned by this state that is a general or special hospital, private mental hospital, chronic disease hospital, or other type of hospital. 25 TAC §421.61(32)
ICD	International Classification of Disease. The <i>International Classification of Diseases, Clinical Modification</i> (ICD-CM) is a system used to code and classify mortality data from death certificates.

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).
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 primary procedure or performed the surgical or radiological procedure most closely related to the principal diagnosis. 25 TAC §421.61(36)
Other Health Professional	A person licensed to provide health care services other than a physician. An individual other than a physician who admits patients to hospitals, or who provides diagnostic or therapeutic procedures to inpatients or outpatients. 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 admit or treat patients. 25 TAC §421.61(37)
Other Provider	For the purposes of reporting on the modified ANSI 837 Institutional Guide or Professional Guide, the physician or other health professional who performed the principal surgical or radiological procedure on the patient for the event if they are not reported as the operating physician or other physician. In the case where a substitute provider (locum tenans) is used, that physician or other health professional shall be submitted as specified in 25 TAC §§421.61 - 421.68 .
Outpatient	For the purposes of subchapter 25 TAC §§421.61-421.68 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 that are specified in §421.67(f) 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.
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. 25 TAC §421.61(31)
Provider	A hospital, physician, or other health professional that provides health care services to patients.

Public use data file	For the purposes of 25 TAC §§421.61 - 421.68 , 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.
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 tenans) is used, that physician or other health professional shall be submitted as specified in 25 TAC §§421.61 – 421.68 . 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 §421.61.
Required minimum data set	Required minimum data set--The list of data elements for which <u>facilities</u> may submit an event claim for each patient event occurring in the facility. The required minimum data sets are specified in 25 TAC §421.67 (d) and §421.67(e). 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).
Submitter	The person or organization, which physically prepares discharge reports for one or more hospitals and submits them to the THCIC. A submitter may be a hospital or an agent designated by a hospital or its owner. 25 TAC §421.61 (44)
Submitting agent	An organization authorized by a health care provider to submit billing claims on behalf of the provider.
SYSTEM13	System13, Inc. is the contractor 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 six characters assigned by THCIC to identify health care facilities for reporting and tracking purposes. 25 TAC §421.61 (50)
Uniform Patient Identifier	A unique identifier assigned by the THCIC to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across hospitals and patient events. The relationship of the identifier to the patient-specific data elements used to assign it is confidential. 25 TAC §421.61 (51)

Uniform Physician Identifier 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. [25 TAC §421.61](#)(52)

User For the purposes of this manual, Hospital or Submitter.

4 TECHICAL REQUIREMENTS SUMMARY

4.1 GENERAL REQUIREMENTS

4.1.1 REQUIRED PATIENTS

Hospitals 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 [25 TAC §421.67\(f\)](#)** from the hospitals or ambulatory surgical centers. This includes patients for which the hospital may not generate an electronic claim, such as self-pay and charity. (See [25 TAC 421.62](#))

4.2 COMMUNICATIONS REQUIREMENTS

4.2.1 DATA SUBMISSION

SYSTEM13 accepts data from providers or from their submitting agents using transmission methods and protocols specified in this manual as authorized by THCIC [[25 TAC §421.64](#)].

SYSTEM13 accepts file transfers using hypertext transfer protocol over a Secure Sockets Layer (https) connection so that is encrypted at 128-bits in transit.

Requirements:

- SYSTEM13 will provide for one or more secure submitter system logins and associated passwords to submit data files and separate provider system logins and associated passwords to retrieve data files and reports (Error reports, correction files, certification reports and certification files).
- You will continue to use your existing SYSTEM13 Submitter/Logon ID and password.
- For Dial-up transmission, SYSTEM13 accepts dial-up modem data change with transmission protocols/speeds that include V.34-28.8 kbps, V.42 - 14.4 kbps and V.32 -9.6 kbps transmission protocols.

Prior to submitting electronic claims to SYSTEM13, the submitter must complete trading partner documentation. Upon receipt of the documentation, SYSTEM13 will assign each submitter a secure (electronic) system login and associated password for submission of billing claims and retrieval of error files, confirmations and other files.

SYSTEM13 uses secure electronic messages through the secure login and password system to communicate billing claims receipt and acceptance reports to Submitters. The secure electronic system is scheduled to be available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information.

Files may be compressed using industry accepted compression software (such as WinZip, ZipFree, PKZIP), prior to submitting the files to SYSTEM13.

SYSTEM13 provides access for providers to a web-based data entry software product, WebClaim, as a mechanism to enter new claims information into the data system.

4.2.2 DATA CORRECTIONS

Facilities that receive error or warning codes and messages can submit corrections either by making the corrections using the data correction tool (WebCorrect) (See https://thcic.system13.com/static/show/webcorrect_help) or by resubmitting claims to SYSTEM13. Claims can be corrected in one of the following ways::

1. Replacement of Erroneous Claim Data -

- a. ANSI 837 Institutional - Submit “Replacement claims” (XX7) to SYSTEM13.
“Replacement claims” are required to have the following data elements match exactly to replace the claim data from SYSTEM13:
 - i. Patient Control Number (PCN) (*can be changed in the $THCIC_{System}$ WebCorrect/Claims Correction[online]*).
 - ii. Medical Record Number (MRN)
 - iii. Date of Birth
 - iv. Statement Date/s - Statement Covers Period From Date
- b. ANSI 837 Professional – Submit Corrected Claims which have the following
 - i. Patient Control Number (PCN) (*can be changed in the $THCIC_{System}$ WebCorrect/Claims Correction [online]*).
 - ii. Medical Record Number (MRN)
 - iii. Date of Birth
 - iv. Service Date – First Date

2. Void or Cancel Erroneous Claim Data and Resubmit –

- a. ANSI 837 Institutional - Submit “Void/Cancel claims” (XX8) to SYSTEM13, then resubmit original bill type codes (XX0, XX1 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:
 - i. Patient Control Number (PCN)
 - ii. Medical Record Number (MRN)
 - iii. Date of Birth
 - iv. Statement Date/s - Statement Covers Period From Date
- b. ANSI 837 Professional – Submit Void/Cancel Claims which have the following:
 - i. Patient Control Number (PCN)
 - ii. Medical Record Number (MRN)
 - iii. Date of Birth
 - iv. Service Date – First Date

3. **Delete Erroneous Claim Data and Resubmit-** Login to the $THCIC_{System}$ [online] and mark erroneous claims or batches of data for deletion and continue with the deletion process for those data or contact SYSTEM13 and request that they delete the claims/batches with errors (*a charge is associated with this process*), and then resubmit original claims with the corrected data.

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

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

4.3.2.1 THCIC ANSI 837 INSTITUTIONAL GUIDE DATA ELEMENTS

- (1) Patient Name:
 - (A) Patient Last Name;
 - (B) Patient First Name; and
 - (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; and
 - (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 (primary and secondary);

- (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 Date/s;

- (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 (all applicable);
- (19) Occurrence Code - up to 24 occurrences (if applicable);
- (20) Occurrence Code Associated Date - up to 24 occurrences (if applicable);
- (21) Value Code - up to 24 occurrences (if applicable);
- (22) Value Code Associated Amount - up to 24 occurrences (if applicable);
- (23) Condition Code - up to 24 occurrences (if applicable);
- (24) Related Cause Code - up to 3 occurrences (if applicable);
- (25) Other Provider or other health professional Name:
 - (A) Other Provider or other health professional - Last Name;
 - (B) Other Provider or other health professional - First Name; and
 - (C) Other Provider or other health professional - Middle Initial.
- (26) Other Provider or other health professional Primary Identifier (National Provider Identifier);
- (27) Other Provider or other health professional Secondary Identifier (Texas state license number);
- (28) Operating Physician or Other operating health professional Name:
 - (A) Operating Physician or Other health professional - Last Name;
 - (B) Operating Physician or Other health professional - First Name; and
 - (C) Operating Physician or Other health professional - Middle Initial.
- (29) Operating Physician or Other health professional Primary Identifier (National Provider Identifier);
- (30) Operating Physician or Other health professional Secondary Identifier (Texas state license number);
- (31) Total Claim Charges;
- (32) Revenue Service Line Details (up to 999 service lines) (all applicable);
 - (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; and
- (K) Non-covered Charge Amount.

(33) Service Provider Name;

(34) Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier (when HIPAA rule is implemented);

(35) 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; and
- (E) Service Provider ZIP; and

(36) Service Provider Secondary Identifier - THCIC 6-digit facility ID assigned to each facility;

4.3.2.2 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 for secondary payer source));
- (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 7 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;
 - (B) HCPCS Procedure Modifier 2;
 - (C) HCPCS Procedure Modifier 3;
 - (D) HCPCS Procedure Modifier 4;
 - (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; and
 - (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; and
 - (E) Service Provider ZIP;
- (26) Service Provider Secondary Identifier--THCIC 6-digit Hospital ID assigned to each facility.

4.3.2.3 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;
38	0615	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Head and Neck;

	Rev. Code	Revenue Code Description
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; and
45	0769	Specialty Room – Other Specialty Room

4.3.2.4 SERVICE AND PROCEDURE CATEGORIES

Agency for Healthcare Research and Quality’s Clinical Classification Software listing of service and procedure categories is referenced in the rules to standardize the list of required outpatient services and procedures. The weblink to the listing of the AHRQ CCS home page is <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>.

The weblink 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 <http://www.dshs.state.tx.us/thcic/OutpatientFacilities/OutpatientReportingRequirements.shtm>

The list is updated by September 1 of the previous year.

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.

- 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.

Data Elements by THCIC 837 Institutional Location

Below is a list of the data elements and their respective locations in the approved formats.

DATA ELEMENT	THCIC 837 INSTITUTIONAL LOCATION	
	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	2010BA or 2010CA	DMG05
Patient Ethnicity	2300	NTE02
Patient Social Security Number	2010BA or 2300	REF02 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 Covers Period From	2300	DTP03
Statement Covers Period Through	2300	DTP03
Principal Diagnosis Code	2300	HI01
Patient's Reasons for Visit	2300	HI02
External Cause of Injury (if applicable)	2300	HI03-2 thru HI12-2 <i>or</i> <i>Any HI segment with a</i> <i>"BN" qualifying code</i> <i>(HIxx-1)</i>
Other Diagnosis Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01- HI12
Occurrence Span Code (Up to 4 codes will be used)	2300	HIInn-2
Occurrence Span Code Associated Dates (up to 4 will be collected)	2300	HIInn-4
Occurrence Code (Up to 12 codes will be used)	2300	HIInn-2

DATA ELEMENT	THCIC 837 INSTITUTIONAL LOCATION	
	Loop	Ref. Des.
Occurrence Code Associated Dates (Up to 12 codes will be used)	2300	HIInn-4
Value Code (Up to 12 codes will be used)	2300	HIInn-2
Value Code Associated Amount (Up to 12 codes will be used)	2300	HIInn-5
Condition Code (Up to 8 codes will be used)	2300	HIInn-2
Related Cause Code	2300	CLM11-1
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/HOPPS Procedure Codes	2400	SV202-2
HCPCS/HOPPS 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 Identification (6 Digit) number assigned by THCIC	2010AA or 2010BB or 2310E	REF02

4.3.2.5 DATA ELEMENTS BY THCIC 837 PROFESSIONAL LOCATION

DATA ELEMENT	THCIC 837 PROFESSIONAL LOCATION	
	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	2010BA or 2010CA	DMG05
Patient Ethnicity	2300	NTE02
Patient Social Security Number	2010BA or 2300	REF02 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 <i>Any HI segment with a "BN" qualifying code (HIxx-1)</i>
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	HI _{nn} - 1

DATA ELEMENT	THCIC 837 PROFESSIONAL LOCATION	
	Loop	Ref. Des.
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
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. 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 are available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information.

4.6 SYSTEM13 TECHNICAL REQUIREMENTS – ENROLLMENT AND SUBMISSION

4.6.1 PROVIDER ENROLLMENT / SIGNATURE REQUIREMENTS

See the “[THCIC Facility Provider Enrollment Manual](#)”

4.6.2 SUBMISSION VALIDATIONS AND AUDITS SUMMARY

Format, syntax, and validation audits are performed on all claims data submitted to THCIC for processing. These audits and validations are summarized below. A list of the audits codes and descriptions of the codes can be found in the Appendices document. In general the audits support the following rules:

1. Each 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.

4.7 AUDITING OF DATA BY SYSTEM13

Audits are listed on the THCIC website at <http://www.dshs.state.tx.us/thcic/hospitals/THCIC-Inpat-Output-Audit-Comparison--7.xls>

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: <http://www.wpc-edi.com/content/view/533/377/>

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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.

There are a few data elements that are required beyond the ANSI 837 Institutional Guide and the ANSIS 837 Professional Guide (the guide lists these as “Situational” or “Not Used”) and those are specified in this manual.

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:

Data Elements	Loop	Ref. Des.	Difference from ANSI 837 Institutional and Professional Guides
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Data Elements	Loop	Ref. Des.	Difference from ANSI 837 Institutional and Professional Guides
National Provider Identification Number (NPI) (<i>INST and PROF</i>)	2010AA* 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 (<i>INST and PROF</i>)	2000B or 2320	SBR09	SBR09 (Required for Primary and Secondary Payers)
Provider THCIC Identification (<i>INST and PROF</i>)	2010AA [†] 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.
Patient Social Security Number (<i>INST and PROF</i>)	2010BA [‡] or	REF02	REF segment (Required, not required for subscriber if they are not the patient)
	2300	K301	K3 segment (Required, if patient is not listed as the subscriber and SSN reported in 2010BA REF02.
Patient Race (<i>INST and PROF</i>)	2010BA [†] or 2010CA [†]	DMG05	DMG05 (Required)
Principal Diagnosis (<i>INST and PROF</i>)	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)
Patient Ethnicity (<i>INST and PROF</i>)	2300	NTE02	NTE (Required)
Medical Record Number (<i>INST and PROF</i>)	2300	REF02	REF segment (Required)

* Dependent on which facility is indicated as rendering the services to the patient

[†] Dependent on which facility is indicated as rendering the services to the patient

[‡] Dependent on whether the subscriber is the patient.

Data Elements	Loop	Ref. Des.	Difference from ANSI 837 Institutional and Professional Guides
Other Provider Name (<i>INST</i>)	2310C	NM1 and REF Segments	Segments are required for Outpatient claims data
Diagnosis Code Pointer (<i>PROF</i>)	2400	SV107	SV107 is required per ANSI requirement (Required)
Service Line Date (<i>INST</i>)	2400	DTP Segment	Segment required for revenue and procedure codes in SV2 segment.

Required by THCIC if applicable

Subscriber Name (<i>INST and PROF</i>)	2010BA [§]	NM103-Last NM104-First NM105-MI .	Segment is situational for THCIC submissions, only required if Subscriber is Patient.
Health Care Diagnosis Code (<i>PROF.</i>)	2300	HI09 – HI12	Data fields are Situational for THCIC, but are marked Not Used by ANSI 837 Professional Guide.
External Cause of Injury ^{**} (<i>INST</i>)	2300	HI03-2 – HI12-2 (INST)	HI03-HI12 are marked situational (Inst) Requires “BN” qualifier code in HInn-1 to identify following code is E-Code.
External Cause of Injury ^{††} (<i>PROF.</i>)	2300	Any HI02-2 - HI12-2 (<i>PROF.</i>)	THCIC will accept “BN” or “BF ” as qualifier code in HInn-1 for E-codes.
Service Facility Name and Identification Numbers	2310E (<i>INST.</i>) 2310C (<i>PROF.</i>)	NM108, NM109, REF01, and REF02	THCIC requires Facility Identification information for rendering facility.
Other Subscriber Information (<i>INST</i>)	2320	SBR09	THCIC requires secondary payer Claim Filing Indicator Code.

Not required by THCIC but Required or Situational by ANSI Guide

Subscriber Reference Identification, Name, and Insurance Type Code (<i>INST and PROF</i>)	2000B	SBR03, SBR04 SBR05 (<i>P</i>)	“Not used” by THCIC, Situational for ANSI 837 Claims.
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[§] Dependent on whether the subscriber is the patient.

^{**} Allows for 9 additional E-codes (10 total)

^{††} Allows for 9 additional E-codes (10 total)

Data Elements	Loop	Ref. Des.	Difference from ANSI 837 Institutional and Professional Guides
Subscriber Identification Qualifier and Code (<i>INST and PROF</i>)	2010BA	NM108, NM109	“Not used” by THCIC, Situational for ANSI 837 Claims.
Patient Identification Qualifier and Code (<i>INST and PROF</i>)	2010CA	NM108, NM109	“Not used” by THCIC, Situational for ANSI 837 Claims.
Yes/No Condition or Response Code (<i>PROF.</i>)	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) (<i>PROF.</i>)	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 (<i>INST</i>)	2300	HI05 – HI12	Not used” by THCIC, Situational for ANSI 837 Institutional Claims.
Condition Information (<i>INST and PROF</i>)	2300	HI09 – HI12	Not used” by THCIC on outpatient claims. Situational for ANSI 837 Institutional Claims.
Other Provider Specialty Information (<i>INST and PROF</i>)	2310C	PRV segment	“Not Used” or collected by THCIC. Not listed in this manual.

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

5.2 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 preceded 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.

5.3 ANSI TERMINOLOGY

Certain terms have been defined to have a specific meaning within this section. 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.

A control segment has the same structure as a data segment; the distinction is in the usage.

Control Segment, Loop Control Segments Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments, and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop.

Control Segment, Transaction Set Control 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, Functional Group Control 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 a 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, 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.

GS Functional Group Header, starts a group of related transaction sets.

ST Transaction Set Header, starts a transaction set.

LS Loop Header, starts a bounded loop of data segments but is not part of the loop.

LS Loop Header, starts an inner, nested, bounded loop.

LE Loop Trailer, ends an inner, nested, bounded loop.

LE Loop Trailer, ends a bounded loop of data segments but is not part of the loop.

SE Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also, more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

Data Element The data element is the smallest named unit of information in the X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinal 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	<p>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.</p> <p>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.</p> <p>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 do not include the optional sign.</p> <p>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).</p>
Data Element, Decimal Number	<p>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."</p> <p>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.</p> <p>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 prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.</p>
Data Element, Identifier	<p>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."</p>
Data Element, String	<p>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."</p>

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 HHMMSSd.d 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 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
Numeric	Nn
Decimal	R
Identifier	ID
String	AN
Date	DT
Time	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 preceded 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, Reference Designator	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.				
Data Segment, Condition Designator	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.				
Data Segment, Mandatory Condition	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".				
	<table border="0"> <tr> <td style="padding-right: 20px;">Condition</td> <td>Requirement</td> </tr> <tr> <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> </table>	Condition	Requirement	(M) Mandatory	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.
Condition	Requirement				
(M) Mandatory	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.				
Data Segment, Optional Condition	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".				
	<table border="0"> <tr> <td style="padding-right: 20px;">Condition</td> <td>Requirement</td> </tr> <tr> <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> </table>	Condition	Requirement	(O) Optional	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.
Condition	Requirement				
(O) Optional	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.				

Data Segment,
Relational
Conditions

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:

Condition	Requirement
(P) Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
(R) Required	At least one of the elements specified in the condition must be present.
(E) Exclusion	Not more than one of the elements specified in the condition may be present.
(C) Conditional	If the first element specified in the condition is present, then all other 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.
(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	<p>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.</p> <p>Delimiters are specified in the interchange header segment, ISA and are not to be used in a data element value elsewhere in the interchange.</p> <p>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.</p> <p>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.</p>
Dependent	In the hierarchical loop coding, the Dependent code 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.
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, and see Section 2.3.2.1, HL Segment, (ANSI 837 Institutional and Professional 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,	<p>The transaction set header and trailer segments are constructed as follows:</p> <p style="margin-left: 40px;">Transaction Set Header (ST) Data Segment Group Transaction Set Trailer (SE)</p> <p>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.</p>
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 once and only once in each iteration. Loops may have a specified maximum number of 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 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).

Transaction Set,
Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start (LS) segment to appear before the first occurrence and a loop end (LE) segment to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments shall be suppressed. The requirement designator on the LS and LE 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 LS and LE 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.

Transaction Set,
Data Segments in
a Transaction Set

When data segments are combined to form a transaction set, three characteristics are to be applied to a data segment in that usage: a requirement designator, a position in the transaction set, and a maximum occurrence.

Transaction Set,
Data Segment
Requirement
Designators

A data segment shall have one of the following requirement designators indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

Designator	Requirement
-------------------	--------------------

(M) Mandatory 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.)

(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 and floating 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, or a finite number greater than one, or an unlimited number.

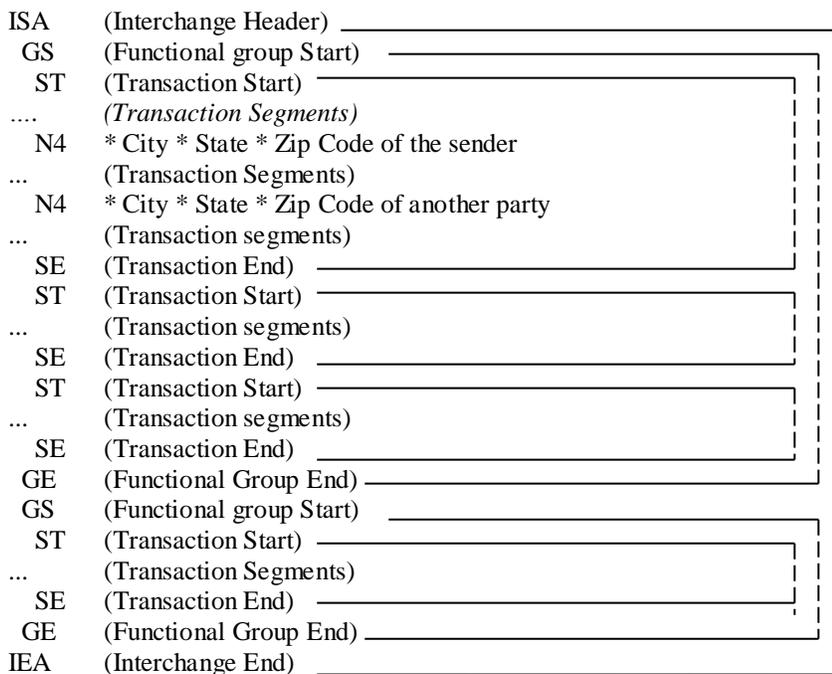
Transmission Intermediary A transmission intermediary is any entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term "intermediary" is not used to convey a specific Medicare contractor type.

5.4 INTERCHANGE OVERVIEW

The transmission of data proceeds according to very strict format rules in order to insure 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, 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:



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.

5.5 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.

Delimiters (*From Section B.1.1.2.5 of ANSI 837 Institutional and ANSI 837 Professional Guides*)

A delimiter 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 (see Appendix C, ISA Segment Note 1) 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.

Delimiters

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.

5.5.1 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...* 930602* 1253* ^* 00501* 000000905* 1* T* :~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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Fixed Length
Begin and end

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

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
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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 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)	M AN 10/10
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Begin - 33,
End - 34

REQUIRED	ISA05	I05	Interchange ID Qualifier Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified	M ID 2/2
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THIS ID QUALIFIES THE SENDER IN ISA06.

CODE	DEFINITION
ZZ	MUTUALLY DEFINED

Begin - 36,
End - 50

REQUIRED	ISA06	I06	Interchange Sender ID 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	M AN 15/15
----------	-------	-----	--	------------

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

Begin - 52,
End - 53

REQUIRED	ISA07	I05	Interchange ID Qualifier Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified	M ID 2/2
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THIS ID QUALIFIES THE RECEIVER IN ISA08.

CODE	DEFINITION
ZZ	MUTUALLY DEFINED

Begin - 55,
End - 69

REQUIRED	ISA08	I07	Interchange Receiver ID 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.	M AN 15/15
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CODE	DEFINITION
YTH837	REQUIRED FOR 837 CLAIM SUBMISSION

Begin - 71,
End - 76

REQUIRED	ISA09	I08	Interchange Date Date of the interchange	M DT 6/6
----------	-------	-----	--	----------

The date format is YYMMDD.

Begin - 78, End - 81	REQUIRED	ISA10	I09	Interchange Time Time of the interchange The time format is HHMM.	M TM 4/4
Begin - 83, End - 83	REQUIRED	ISA11	I10	Repetition Separator 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	M ID 1/1
Begin - 85, End - 89	REQUIRED	ISA12	I11	Interchange Control Version Number This version number covers the interchange control segments CODE DEFINITION 00501 APPROVED VERSION 5010	M ID 5/5
Begin - 91, End - 99	REQUIRED	ISA13	I12	Interchange Control Number A control number assigned by the interchange sender The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.	M N0 9/9
Begin - 101 End - 101	REQUIRED	ISA14	I13	Acknowledgment Requested 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.	M ID 1/1
Begin - 103, End - 103	REQUIRED	ISA15	I14	Interchange Usage Indicator 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.	M ID 1/1
Begin - 105, End - 105	REQUIRED	ISA16	I15	Component Element Separator 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	M 1/1

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 A count of the number of functional groups included in an interchange	M N0 1/5
REQUIRED	IEA02	I12	Interchange Control Number A control number assigned by the interchange sender NUMBER MUST MATCH NUMBER IN ISA13	M N0 9/9

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	M ID 2/2
			CODE DEFINITION	
			HC HEALTH CARE CLAIM (837)	
REQUIRED	GS02	142	Application Sender's Code Code identifying party sending transmission; codes agreed to by trading partners	M AN 2/15
			CODE DEFINITION	
			SUBNNN SYSTEM13 SUBMITTER ID NUMBER	
			This is the same ID as in ISA06. The Submitter ID must be obtained from Commonwealth	
REQUIRED	GS03	124	Application Receiver's Code Code identifying party receiving transmission. Codes agreed to by trading partners	M AN 2/15
			CODE DEFINITION	
			YTH837 REQUIRED FOR THCIC	
REQUIRED	GS04	373	Date Date expressed as CCYYMMDD SEMANTIC: GS04 is the group date.	M DT 8/8
			Use this date for the functional group creation date.	
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.	M TM 4/8
			Use this time for the creation time. The recommended format is HHMM.	
REQUIRED	GS06	28	Group Control Number 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 .	M N0 1/9
REQUIRED	GS07	455	Responsible Agency Code Code used in conjunction with Data Element 480 to identify the issuer of the standard	M ID 1/2
			CODE DEFINITION	
			X ACCREDITED STANDARDS COMMITTEE X12	
REQUIRED	GS08	480	Version / Release / Industry Identifier Code 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	M AN 1/12
			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.	M N0 1/9

MUST MATCH THE NUMBER IN GS06

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.

5.6 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, Loop ID-2010AB PAY-TO ADDRESS NAME, and Loop ID-2010AC PAY-TO PLAN NAME are subloops 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 subloops that do not involve hierarchical structure and that do have the same numeric position within the transaction is less important. Such subloops do not need to be sent in the same order in which they appear in this implementation guide. For such subloops 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 subloop 2330 before loop 2310 because these are not equivalent subloops.

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.

5.7 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. An example of this is Loop ID-2330A - Other Subscriber Name. Loop 2330A is required only when Loop ID-2320 - Other Subscriber Information is used, i.e., if the claim involves coordination of benefits information. A parallel situation exists with the Loop ID-2330B - Other Payer Name. 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.

5.8 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."

5.9 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.

5.10 THCIC TRANSACTION SET

Table 1 Header (INSTITUTIONAL)

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

Table 2 Detail – Billing/Pay to Provider Hierarchical Level

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
LOOP ID – 2000A Billing Provider HIERARCHICAL LEVEL			R		>1
001	HL	Billing Provider Hierarchical Level	R	1	
LOOP ID – 2010AA BILLING PROVIDER NAME					
015	NM1	Billing Provider Name	R	1	1
025	N3	Billing Provider Address	R	1	
030	N4	Billing Provider City/State/ZIP Code	R	1	
035	REF	Billing Provider Secondary Identification	S	8	
LOOP ID – 2010AB PAY-TO ADDRESS NAME					
015	NM1	Pay-To Address Name	S	1	1
025	N3	Pay-To Address – ADDRESS	S	1	
030	N4	Pay-To Address City/State/ZIP Code	S	1	

Table 2 Detail – Subscriber Hierarchical Level

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL			R		>1
001	HL	Subscriber Hierarchical Level	R	1	
005	SBR	Subscriber Information	R	1	
LOOP ID – 2010BA SUBSCRIBER NAME					
015	NM1	Subscriber Name	R/N	1	1
025	N3	Subscriber Address	R/N	1	
030	N4	Subscriber City/State/ZIP Code	R/N	1	
032	DMG	Subscriber Demographic Information	R/N	1	
035	REF	Subscriber Secondary Identification	R/N	1	
LOOP ID - 2010BB PAYER NAME					
015	NM1	Payer Name	R	1	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
001	HL	Patient Hierarchical Level	S		1	
007	PAT	Patient Information	S		1	
LOOP ID – 2010CA PATIENT NAME			S			1
015	NM1	Patient Name	N/R		1	
025	N3	Patient Address	N/R		1	
030	N4	Patient City/State/ZIP Code	N/R		1	
032	DMG	Patient Demographic Information	N/R		1	
LOOP ID – 2300 CLAIM INFORMATION			R			100
130	CLM	Claim Information	R		1	
135	DTP	Statement Dates	R		1	
180	REF	Medical Record Number	R		1	
1850	K3	File Information (<i>Patient Social Security Number if Subscriber is not Patient</i>)	N/R		10	
190	NTE	Claim Note (<i>Patient Ethnicity</i>)	R		10	
231	HI	Principal, E-Codes and Patient Reason For Visit Diagnosis Information	R		1	
231	HI	Other Diagnosis Information	S		2	
231	HI	Occurrence Span Information	S		2	
231	HI	Occurrence Information	S		2	
231	HI	Value Information	S		2	
231	HI	Condition Information	S		2	
LOOP ID - 2310B OPERATING PHYSICIAN NAME			S			1
250	NM1	Operating Physician Name	R		1	
271	REF	Operating Physician Secondary Identification	S		5	
LOOP ID – 2310C OTHER PROVIDER NAME			S			1
250	NM1	Other Provider Name	R		1	
271	REF	Other Provider Secondary Identification	S		5	
LOOP ID - 2310E SERVICE FACILITY NAME			S			1
250	NM1	Service Facility Name	S		1	
265	N3	Service Facility Address	S		1	
270	N4	Service Facility City/State/Zip Code	S		1	
271	REF	Service Facility Secondary Identification	S		5	
LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			S			10
290	SBR	Other subscriber Information	S		1	
LOOP ID – 2330B OTHER PAYER NAME			S			1
325	NM1	Other Payer Name	S		1	
LOOP ID 2400 SERVICE LINE NUMBER			R			999
365	LX	Service Line Number	R		1	
375	SV2	Institutional Service Line (Inst)	R		1	
455	DTP	Service Line Date	S		1	
555	SE	Transaction Trailer	R		1	

“Not Used” if “Subscriber” is the “Patient”, otherwise “Required”.

“Not Used” if “Subscriber” is the “Patient”, otherwise “Required”.

Table 1 Header (PROFESSIONAL)

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

Table 2 Detail – Billing Hierarchical Level

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
LOOP ID – 2000A Billing Provider HIERARCHICAL LEVEL			R		>1
001	HL	Billing Provider Hierarchical Level	R	1	
LOOP ID – 2010AA BILLING PROVIDER NAME			R		1
015	NM1	Billing Provider Name	R	1	
025	N3	Billing Provider Address	R	1	
030	N4	Billing Provider City/State/ZIP Code	R	1	
035	REF	Billing Provider Secondary Identification	S	8	
LOOP ID – 2010AB PAY-TO ADDRESS NAME			S		1
015	NM1	Pay-To Address Name	S	1	
025	N3	Pay-To Provider Address - ADDRESS	S	1	
030	N4	Pay-To Address City/State/ZIP Code	S	1	

Table 2 Detail – Subscriber Hierarchical Level

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL			R		>1
001	HL	Subscriber Hierarchical Level	R	1	
005	SBR	Subscriber Information	R	1	
LOOP ID – 2010BA SUBSCRIBER NAME			S		1
015	NM1	Subscriber Name	R/N	1	
025	N3	Subscriber Address	R/N	1	
030	N4	Subscriber City/State/ZIP Code	R/N	1	
032	DMG	Subscriber Demographic Information	S	1	
035	REF	Subscriber Secondary Identification	S	1	
LOOP ID - 2010BB PAYER NAME			R		1
015	NM1	Payer Name	R	1	
0350	REF	Billing Provider Secondary Identification	S	1	

“Required” if “Subscriber” is the “Patient”, otherwise “Not Used”.

Table 2 Detail – Patient Hierarchical Level (PROF.)

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
LOOP ID – 2000C PATIENT HIERARCHICAL LEVEL			S		>1
001	HL	Patient Hierarchical Level	S	1	
007	PAT	Patient Information	S	1	
LOOP ID – 2010CA PATIENT NAME			S		1
015	NM1	Patient Name	N/R	1	
025	N3	Patient Address	N/R	1	

“Not Used” if “Subscriber” is the “Patient”, otherwise “Required”.

030	N4	Patient City/State/ZIP Code	N/R	1
032	DMG	Patient Demographic Information	N/R	1
LOOP ID - 2300 CLAIM INFORMATION			R	100
130	CLM	Claim Information	R	1
180	REF	Medical Record Number	R	1
1850	K3	File Information (<i>Patient Social Security Number if Subscriber is not Patient</i>)	N/R	1
190	NTE	Claim Note (<i>Patient Ethnicity</i>)	S	1
231	HI	Health Care Diagnosis Code	R	1
LOOP ID - 2310B RENDERING PROVIDER NAME			S	1
250	NM1	Operating Physician Name	R	1
271	REF	Operating Physician Secondary Identification	S	5
LOOP ID - 2310C SERVICE FACILITY LOCATION			S	1
250	NM1	Service Facility Location	S	1
265	N3	Service Facility Location Address	S	1
270	N4	Service Facility Location City/State/Zip Code	S	1
271	REF	Service Facility Location Secondary Identification	S	5
LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			S	10
290	SBR	Other subscriber Information	S	1
LOOP ID - 2330B OTHER PAYER NAME			S	1
325	NM1	Other Payer Name	S	1
LOOP ID 2400 SERVICE LINE NUMBER			R	50
365	LX	Service Line Number	R	1
375	SV1	Professional Service (PROF.)	R	1
455	DTP	Date - Service Date	R	1
4800	NTE	Line Note (<i>Patient Ethnicity</i>)	S	1
4850	NTE	Third Party Organization Notes (<i>Patient Ethnicity</i>)	S	1
LOOP ID - 2420A RENDERING PROVIDER NAME			S	1
500	NM1	Operating Physician Name	R	1
525	REF	Operating Physician Secondary Identification	R	5
555	SE	Transaction Trailer	R	1

“Not Used” if “Subscriber” is the “Patient”, otherwise “Required”.

5.11 SEGMENT ID BREAKOUT

IMPLEMENTATION

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

Usage: REQUIRED

Repeat:

Example ST*837*987654*005010X223A2~ (INST)
ST*837*987654*005010X222A1~ (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).	M ID 3/3				
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>837</td> <td>HEALTH CARE CLAIM</td> </tr> </tbody> </table>					CODE	DEFINITION	837	HEALTH CARE CLAIM
CODE	DEFINITION							
837	HEALTH CARE CLAIM							
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 (STSE) 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	M ID 4/4						
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>0019</td> <td>INFORMATION SOURCE, SUBSCRIBER, DEPENDENT</td> </tr> </tbody> </table>					CODE	DEFINITION	0019	INFORMATION SOURCE, SUBSCRIBER, DEPENDENT		
CODE	DEFINITION									
0019	INFORMATION SOURCE, SUBSCRIBER, DEPENDENT									
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.	M ID 2/2						
<p>THCIC will accept either code and will treat both as an original submission.</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>ORIGINAL</td> </tr> <tr> <td>18</td> <td>REISSUE</td> </tr> </tbody> </table>					CODE	DEFINITION	00	ORIGINAL	18	REISSUE
CODE	DEFINITION									
00	ORIGINAL									
18	REISSUE									
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.	O AN 1/50						
<p>Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.</p> <p>The Reference Identification must not be duplicated or reused within 12 months.</p>										
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 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.	O TM 4/8						
<p>Use this time to identify the time of day that the submitter created the file.</p>										
REQUIRED	BHT06	640	Transaction Type Code	O ID 2/2						

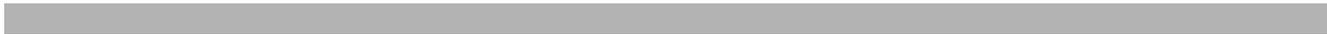
Code specifying the type of transaction

INDUSTRY: Claim or Encounter Identifier

ALIAS: Claim or Encounter Indicator

All codes accepted by THCIC

CODE	DEFINITION
CH	CHARGEABLE
RP	REPORTING
31	SUBROGATION DEMAND



IMPLEMENTATION

SUBMITTER NAME (*INST. and PROF.*)

Loop: 1000A — SUBMITTER NAME Repeat: 1
 Usage: REQUIRED
 Repeat: 1
 Notes: 1. See ANSI 837 Institutional or Professional 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	M ID 2/3
			CODE DEFINITION	
			41 SUBMITTER	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			1 PERSON	
			2 NON-PERSON ENTITY	
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	X AN 2/80

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

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

RECEIVER NAME (INST. and PROF.)

Loop: 1000B — RECEIVER NAME Repeat: 1
 Usage: REQUIRED
 Repeat: 1
 Notes: 1. See ANSI 837 Institutional or Professional 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	O AN 5/5
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 CODE DEFINITION YTH837 RECEIVER CODE FOR THCIC	X AN 6/6
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

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

- Loop: 2000A - BILLING PROVIDER HIERARCHICAL LEVEL Repeat: >1
- Usage: REQUIRED
- Repeat: 1
- 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 HL 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 Loop 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 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 within 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.	M ID 1/2
		CODE	DEFINITION	
		20	INFORMATION SOURCE	

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
------	------------

1	ADDITIONAL SUBORDINATE HL DATA SEGMENT IN THIS HIERARCHICAL STRUCTURE.
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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	M ID 2/3
			CODE DEFINITION 85 BILLING PROVIDER USE THIS CODE TO INDICATE BILLING PROVIDER.	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION 1 PERSON 2 NON-PERSON ENTITY (THCIC RECOMMENDS USING THIS CODE)	
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	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) 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.	X ID 1/2
			CODE DEFINITION XX CMS NATIONAL PROVIDER IDENTIFIER (RECOMMENDED BY THCIC)	
REQUIRED	NM109	67	Identification Code 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.	X AN 2/80

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) <i>(RECOMMENDED BY THCIC)</i>
nnnnnnnnnn	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.	DATAELEMENT	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 Free-form text for city name INDUSTRY: Billing Provider City Name	O AN 2/20
REQUIRED	N402	156	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.	O 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 Code identifying the country CODE SOURCE 5: Countries, Currencies and Funds	O 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	M ID 2/3
			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.	
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/50
			Code DEFINITION	
			NNNNNNNNNN Employer Identification Number.	
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	M ID 2/3
			CODE DEFINITION	
			1J FACILITY ID NUMBER;	
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/50
			INDUSTRY: Billing Provider Additional Identifier SYNTAX: R0203	
			CODE DEFINITION	
			NNNNN THCIC ID NUMBER (6-DIGIT NUMBER ASSIGNED BY THCIC)	
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.	M ID 1/2						
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>22</td> <td>SUBSCRIBER</td> </tr> </tbody> </table>	CODE	DEFINITION	22	SUBSCRIBER			
CODE	DEFINITION									
22	SUBSCRIBER									
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 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).	O ID 1/1						
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL STRUCTURE.</td> </tr> <tr> <td>1</td> <td>ADDITIONAL SUBORDINATE (DEPENDENT) HL DATA SEGMENT IN THIS HIERARCHICAL STRUCTURE.</td> </tr> </tbody> </table>	CODE	DEFINITION	0	NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL STRUCTURE.	1	ADDITIONAL SUBORDINATE (DEPENDENT) HL DATA SEGMENT IN THIS HIERARCHICAL STRUCTURE.	
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	1138	Payer Responsibility Sequence Number Code Code identifying the insurance carrier's level of responsibility for a payment of a claim	M ID 1/1
			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.	
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.	O ID 2/2
			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	
NOT USED	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 ALIAS: Group Number	O AN 150
			Use this element to carry the subscriber's group number, but not the number that uniquely identifies the subscriber. The subscriber's number should be carried in NM109. Using code IL in NM101 identifies the number in NM109 as the insured's Identification Number.	
NOT USED	SBR04	93	Name Free-form name INDUSTRY: Insured Group Name ALIAS: Plan Name (Group Name)	O AN 1/60
			Used only when no group number is reported in SBR03.	
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.
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	M ID 2/3
			CODE DEFINITION	
			IL INSURED OR SUBSCRIBER	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			1 PERSON	
			2 NON-PERSON ENTITY	
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name INDUSTRY: Subscriber Last Name	O AN 1/60
			For patients that are covered by 42 USC 290dd-2 or 42 CFR Part 2: Use the following last name: DOE.	
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	O AN 1/35
			This data element is required when NM102 equals one (1).	
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial INDUSTRY: Subscriber Middle Name ALIAS: Subscriber’s Middle Initial	O AN 1/25
			This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.	
NOT USED	NM106	1038	Name Prefix	O AN 1/10
NOT USED	NM107	1039	Name Suffix Suffix to individual name INDUSTRY: Subscriber Name Suffix	O AN 1/10

This data element is required when the NM102 equals one (1) and the name suffix is known.
 Examples: I, II, III, IV, Jr, Sr.

NOT USED	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67)	X ID 1/2
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This data element is required when NM102 equals one (1).

MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in REF02.

CODE	DEFINITION
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G	PAYEE IDENTIFICATION NUMBER
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MI	MEMBER IDENTIFICATION NUMBER
-----------	-------------------------------------

ZZ	MUTUALLY DEFINED
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NOT USED	NM109	67	Identification Code Code identifying a party or other code INDUSTRY: Subscriber Primary Identifier	X AN 2/80
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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 defined 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.	O 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						
<p>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.</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>00000</td> <td>FOREIGN COUNTRY DEFAULT THCIC RECOMMENDED CODE</td> </tr> <tr> <td>XXXXX</td> <td>FOREIGN COUNTRY DEFAULT</td> </tr> </tbody> </table>					CODE	DEFINITION	00000	FOREIGN COUNTRY DEFAULT THCIC RECOMMENDED CODE	XXXXX	FOREIGN COUNTRY DEFAULT
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 THIS DATA ELEMENT IS REQUIRED WHEN THE ADDRESS IS OUTSIDE OF THE U.S. See Appendices for Country Codes.	O 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

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)).
 2. THCIC requires that the code that corresponds to the race, and the code that corresponds to the ethnicity be reported. Example: Multi racial without Hispanic origin would be reported as a race code of 5 and an ethnicity code of 2. A black Hispanic would be reported as a race code of 3 and an ethnicity code of 1.
 3. **REQUIRED if the “Subscriber” is the “Patient”.** Subscriber Name data segment is “Not Used” if Subscriber is NOT the Patient.
 Example: DMG*D8*19290730*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	X ID 2/3
			CODE DEFINITION	
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD	
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
REQUIRED	DMG05	1109	Race Code To send general and detailed information on race or ethnicity THCIC rules requires the code that corresponds to the race be reported in DMG05 and the code that corresponds to the ethnicity in Loop 2300 NTE02. Examples: Multi racial without Hispanic origin person would be reported as 5, then on Loop 2300, NTE02= 2. A black Hispanic would be reported as 3, then on Loop 2300 NTE02=1.	X ID 1/1
			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

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	M ID 2/3
			CODE DEFINITION	
			SY SOCIAL SECURITY NUMBER	
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/50
			CODE DEFINITION	
			NNNNNNNN SOCIAL SECURITY NUMBER	
			99999999 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	
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, repricer 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	M ID 2/3
			CODE DEFINITION	
			PR PAYER	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			2 NON-PERSON ENTITY	
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name INDUSTRY: Payer Name	O AN 1/60
			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).	
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)	X ID 1/2
			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 Code identifying a party or other code.	X AN 2/80

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
NNNNNNNNN	NATIONAL PLAN IDENTIFIER (WHEN IMPLEMENTED)
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	M ID 2/3				
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>1J</td> <td>FACILITY ID NUMBER;</td> </tr> </tbody> </table>	CODE	DEFINITION	1J	FACILITY ID NUMBER;	
CODE	DEFINITION							
1J	FACILITY ID NUMBER;							
REQUIRED	REF02	27	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/50				
			INDUSTRY: Billing Provider Additional Identifier					
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>nnnnnn</td> <td>THCIC ID NUMBER (6-digit number assigned by THCIC)</td> </tr> </tbody> </table>	CODE	DEFINITION	nnnnnn	THCIC ID NUMBER (6-digit number assigned by THCIC)	
CODE	DEFINITION							
nnnnnn	THCIC ID NUMBER (6-digit number assigned by THCIC)							
NOT USED	REF03	352	Description	X AN 1/80				
NOT USED	REF04	C040	REFERENCE IDENTIFIER					

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 are 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. <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>23</td> <td>DEPENDENT</td> </tr> </tbody> </table>	CODE	DEFINITION	23	DEPENDENT	M ID 1/2
CODE	DEFINITION							
23	DEPENDENT							
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. <div style="background-color: #e0e0e0; padding: 2px;">The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).</div> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL STRUCTURE.</td> </tr> </tbody> </table>	CODE	DEFINITION	0	NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL STRUCTURE.	O ID 1/1
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	
			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 **Subscriber**. “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	M ID 2/3
			CODE DEFINITION	
			QC PATIENT	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			1 PERSON	
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name INDUSTRY: Patient Last Name	O AN 1/60
			FOR PATIENTS THAT ARE covered by 42 USC 290dd-2 or 42 CFR Part 2: Use the following last name: DOE.	
REQUIRED	NM104	1036	Name First Individual first name INDUSTRY: Patient First Name	O AN 1/35
			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.	
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial INDUSTRY: Patient Middle Name	O AN 1/25
			This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.	
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. <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>AA</td> <td>US STATE OR CANADIAN PROVINCE CODE</td> </tr> <tr> <td>FC</td> <td>FOREIGN COUNTRY DEFAULT</td> </tr> <tr> <td>XX</td> <td>FOREIGN COUNTRY DEFAULT (THCIC RECOMMENDED)</td> </tr> </tbody> </table> THCIC will recognize either foreign country codes.	CODE	DEFINITION	AA	US STATE OR CANADIAN PROVINCE CODE	FC	FOREIGN COUNTRY DEFAULT	XX	FOREIGN COUNTRY DEFAULT (THCIC RECOMMENDED)	O ID 2/2
CODE	DEFINITION											
AA	US STATE OR CANADIAN PROVINCE CODE											
FC	FOREIGN COUNTRY DEFAULT											
XX	FOREIGN COUNTRY DEFAULT (THCIC RECOMMENDED)											
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 <p>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.</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>0000</td> <td>FOREIGN COUNTRY DEFAULT (THCIC RECOMMENDED CODE)</td> </tr> <tr> <td>XXXXX</td> <td>FOREIGN COUNTRY DEFAULT</td> </tr> </tbody> </table>	CODE	DEFINITION	0000	FOREIGN COUNTRY DEFAULT (THCIC RECOMMENDED CODE)	XXXXX	FOREIGN COUNTRY DEFAULT	O ID 3/9		
CODE	DEFINITION											
0000	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 This data element is required when the address is outside of the U.S. See Appendices for Country Codes.	O 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: 1. **REQUIRED by THCIC when the Patient is a different person than the Subscriber.** “Not Used” if Subscriber is the Patient
 2. THCIC requires that the code that corresponds to the race, and the code that corresponds to the ethnicity be reported. Example: Multi racial without Hispanic origin would be reported as a race code of 5 and an ethnicity code of 2. A black Hispanic would be reported as a race code of 3 and an ethnicity code of 1.
 3. Required if the “Subscriber” **is not** the “Patient”.

Example: DMG*D8*19290730*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	X ID 2/3
			CODE DEFINITION	
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD	
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 1/8
REQUIRED	DMG03	1068	Gender Code Code indicating the sex of the individual INDUSTRY: Patient Gender Code	O ID 1/1
			CODE DEFINITION	
			F FEMALE	
			M MALE	
			U UNKNOWN	
NOT USED	DMG04	1067	Marital Status Code	O ID 1/1
REQUIRED	DMG05	C056	Race Code This data element breakout is required if the patient is not the subscriber. THCIC rules requires the code that corresponds to the race be reported in DMG05 and the code that corresponds to the ethnicity in Loop 2300 NTE02. Examples: Multi racial without Hispanic origin person would be reported as 5, then on Loop 2300, NTE02= 2. A black Hispanic would be reported as 3, then on Loop 2300 NTE02=1.	X ID 1/1
			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

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 2010BD 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 1/20
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(Inst)	CLM05-1	1331	Facility Code Value 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	M AN 1/2
		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
82	SPECIAL FACILITY - HOSPICE (HOSPITAL BASED)
83	SPECIAL FACILITY – AMBULATORY SURGICAL CENTER
85	SPECIAL FACILITY – CRITICAL ACCESS HOSPITAL
89	SPECIAL FACILITY – OTHER

REQUIRED (Inst) **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/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 2010BD 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 1/20
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(Prof)	CLM05-1	1331	Facility Code Value 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	M AN 1/2
			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 (Prof) CLM05 - 2 1332 Facility Code Qualifier O ID 1/2

REQUIRED(Prof) 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 (Prof) 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 (Prof) 1362 Related-Causes Code M ID 2/3
Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: Related Causes Code

NSF Reference:

**EA0-05.0 - Auto Accident or Other Accident,
EA0-04.0 - Employment,
EA0-09.0 - Responsibility Indicator**

CODE	DEFINITION
AA	AUTO ACCIDENT
EM	EMPLOYMENT
OA	OTHER ACCIDENT

SITUATIONAL (Prof) 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

NSF Reference:

**EA0-05.0 - Auto Accident or Other Accident,
EA0-04.0 - Employment,
EA0-09.0 - Responsibility Indicator**

Used if more than one code applies.

CODE	DEFINITION
AA	AUTO ACCIDENT
EM	EMPLOYMENT
OA	OTHER ACCIDENT

NOT USED	CLM11 - 3	1362	Related-Causes Code	O	ID	2/3
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	M ID 3/3				
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>434</td> <td>STATEMENT</td> </tr> </tbody> </table>	CODE	DEFINITION	434	STATEMENT	
CODE	DEFINITION							
434	STATEMENT							
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.	M ID 2/3				
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>RD8</td> <td>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.</td> </tr> </tbody> </table>	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.	
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.							
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
 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 Code indicating the priority of this admission SITUATIONAL RULE: Required when patient is being admitted for inpatient services. If not required by this implementation guide, do not send. CODESOURCE 231: Admission Type Code	O ID 1/1
SITUATIONAL	CL102	1314	Admission Source Code Code indicating the source of this admission SITUATIONAL RULE: Required for all inpatient and outpatient services. If not required by this implementation guide, do not send. CODESOURCE 230: Admission Source Code	O ID 1/1
REQUIRED	CL103	1352	Patient Status Code Code indicating patient status as of the "statement covers through date" CODESOURCE 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	M ID 2/3
			CODE DEFINITION	
			EA MEDICAL RECORD IDENTIFICATION NUMBER	
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,** “Not Used” if Subscriber is the Patient
 2. THCIC requires that the Patient’s Social Security Number be submitted to be use in conjunction with other submitted data elements to generate the uniform patient identification for longitudinal studies and epidemiological studies.

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

Example: K3*12345678914

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	M AN 1/80
SOCIAL SECURITY NUMBER (1-9)				
		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.	
NOT USED	K302	1333	Record Format Code	O ID 1/2
NOT USED	K303	C001	COMPOSITE UNIT OF MEASURE	O

IMPLEMENTATION

CLAIM NOTE (INST.)

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 10 (Inst.)

Notes: **1. Required to report PATIENT ETHNICITY.**
 2. THCIC requires that the code that corresponds to the race, and the code that corresponds to the ethnicity be reported. Example: Multi racial without Hispanic origin would be reported as a race code of 5 and an ethnicity code of 2. A black Hispanic would be reported as a race code of 3 and an ethnicity code of 1.

Example: NTE*UPI*1~

NTE Note/Special Instruction

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NTE01	363	Note Reference Code Code identifying the functional area or purpose for which the note applies	O ID 3/3
			CODE DEFINITION	
			UPI UPDATED INFORMATION	
REQUIRED	NTE02	352	Description A free-form description to clarify the related data elements and their content	M AN 1/80
			THCIC requires that the code that corresponds to the “Ethnicity” of the patient be reported in NTE02 and the code that corresponds to the “Race” be reported in Loop 2010BA or 2010CA segment, element DMG05.	
			CODE DEFINITION	
			1 HISPANIC OR LATINO	
			2 NOT HISPANIC OR LATINO	

IMPLEMENTATION

CLAIM NOTE (*PROF.*)

Loop: 2300 — CLAIM INFORMATION
 Usage: SITUATIONAL for Prof. maybe submitted in Loop 2400 if 2300 Loop is used for other purposes)
 Repeat: 1 (Prof.)
 Notes: **1. Required to report PATIENT ETHNICITY.**
 2. THCIC requires that the code that corresponds to the race, and the code that corresponds to the ethnicity be reported. Example: Multi racial without Hispanic origin would be reported as a race code of 5 and an ethnicity code of 2. A black Hispanic would be reported as a race code of 3 and an ethnicity code of 1.
 Situational Rule: For Professional Claims. Required when Race code is not submitted in the Loop 2400 Line Note or the Loop 2400 Third Party Organization Notes segments
 Example: NTE*UPI*1~

NTE Note/Special Instruction

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NTE01	363	Note Reference Code Code identifying the functional area or purpose for which the note applies	O ID 3/3
			CODE DEFINITION	
			UPI UPDATED INFORMATION	
REQUIRED	NTE02	352	Description A free-form description to clarify the related data elements and their content	M AN 1/80
			THCIC requires that the code that corresponds to the “Ethnicity” of the patient be reported in NTE02 and the code that corresponds to the “Race” be reported in Loop 2010BA or 2010CA segment, element DMG05.	
			CODE DEFINITION	
			1 HISPANIC OR LATINO	
			2 NOT HISPANIC OR LATINO	

IMPLEMENTATION

PRINCIPAL DIAGNOSIS (INST.)

Loop: 2300 — CLAIM INFORMATION
 Usage: REQUIRED
 Repeat: 1
 Notes: 1. The Principal Diagnosis is required on all inpatient claims.

Example 1: HI*BK:9976~

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	M ID 1/3										
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>BK</td> <td>PRINCIPAL DIAGNOSIS</td> </tr> </tbody> </table>					CODE	DEFINITION	BK	PRINCIPAL DIAGNOSIS						
CODE	DEFINITION													
BK	PRINCIPAL DIAGNOSIS													
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). Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC.	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 IMPLEMENTATION NAME: Present on Admission Indicator	X ID 1/1										
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>NO</td> </tr> <tr> <td>U</td> <td>UNKNOWN</td> </tr> <tr> <td>W</td> <td>NOT APPLICABLE</td> </tr> <tr> <td>Y</td> <td>YES</td> </tr> </tbody> </table>					CODE	DEFINITION	N	NO	U	UNKNOWN	W	NOT APPLICABLE	Y	YES
CODE	DEFINITION													
N	NO													
U	UNKNOWN													
W	NOT APPLICABLE													
Y	YES													
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.
 TR3 Notes: 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.
 TR3 Example: HI.PR:78701~

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	M ID 1/3
CODE DEFINITION				
PR INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-9-CM) PATIENT’S REASON FOR VISIT. BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.				
CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC.				
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M AN 1/30
IMPLEMENTATION NAME: Patient Reason For Visit				
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	O
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	HI02 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M ID 1/3
CODE DEFINITION				
PR INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-9-CM) PATIENT’S REASON FOR VISIT. BEGINNING OCTOBER 1, 2014,				

ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC.

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 ID 1/1

SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION	O
			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

PR INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-9-CM) PATIENT'S REASON FOR VISIT. BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC.

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 1
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O 1

IMPLEMENTATION

HEALTH CARE DIAGNOSIS CODE (*PROF.*)

Loop: 2300 — CLAIM INFORMATION
 Usage: REQUIRED
 Repeat: 1
 Notes: 1. THCIC REQUIRES a “Principal Diagnosis Code”, “External Cause of Injury Codes” and “Other Diagnosis Codes” are required if applicable, therefore are “Situational”
 2. Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.
 Example: HI*BK:8901*BF:87200*BF:5559~

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	M ID 1/3
			CODE DEFINITION	
			BK PRINCIPAL DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
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) Procedure. Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC.	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 IMPLEMENTATION NAME: Present on Admission Indicator	X ID 1/1
			CODE DEFINITION	
			N NO	
			U UNKNOWN	
			W NOT APPLICABLE	
			Y YES	
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION 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.	O
REQUIRED	HI02 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list ZZ used to indicate the “Patient Reason For Visit.”	M ID 1/3
			CODE DEFINITION	

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

BF DIAGNOSIS
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE
REQUIRED ON DATA SUBMITTED TO THCIC.

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

Code indicating a code from a specific industry code list

CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM).
 Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to
 THCIC.

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE DEFINITION

N NO

U UNKNOWN

W NOT APPLICABLE

Y YES

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

BF DIAGNOSIS
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE
REQUIRED ON DATA SUBMITTED TO THCIC.

BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON
DATA SUBMITTED TO THCIC.

REQUIRED HI03 - 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

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM).
 Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data
 submitted to THCIC.

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE DEFINITION

N NO

U UNKNOWN

W NOT APPLICABLE
 Y YES

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
 BF DIAGNOSIS
 BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE
 REQUIRED ON DATA SUBMITTED TO THCIC.
 BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)
 BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON
 DATA SUBMITTED TO THCIC.

REQUIRED HI04 - 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
 CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
 Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data
 submitted to THCIC.

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
 IMPLEMENTATION NAME: Present on Admission Indicator

CODE DEFINITION
 N NO
 U UNKNOWN
 W NOT APPLICABLE
 Y YES

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
 BF DIAGNOSIS
 BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE
 REQUIRED ON DATA SUBMITTED TO THCIC.
 BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)
 BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON
 DATA SUBMITTED TO THCIC.

REQUIRED HI05 - 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
 CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
 Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data
 submitted to THCIC.

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

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
BF	DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.
BN	DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

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			
			CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM). Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.			

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

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
BF	DIAGNOSIS

BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

**BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.**

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]
CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM).
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE DEFINITION

N NO

U UNKNOWN

W NOT APPLICABLE

Y YES

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

**BF DIAGNOSIS
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.**

**BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.**

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]
CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM).
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE DEFINITION

N NO

U	UNKNOWN
W	NOT APPLICABLE
Y	YES

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
BF **DIAGNOSIS**
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.
BN **DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)**
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

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]
 CODE SOURCE **131**: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
 Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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**

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

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
BF **DIAGNOSIS**
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.
BN **DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)**
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

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]

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

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
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Code identifying a specific industry code list

CODE	DEFINITION
BF	DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.
BN	DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

REQUIRED	HI11 - 2	1271	Industry Code	M	AN	1/30
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Code indicating a code from a specific industry code list

INDUSTRY: Other Diagnosis

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

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .

Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

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
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Code identifying a specific industry code list

CODE	DEFINITION
BF	DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.
BN	DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

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]
CODE SOURCE **131**: International Classification of Diseases Clinical Mod. (ICD-9-CM).
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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 NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES



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:33414~

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 1				
REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M ID 1/3				
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>BP</td> <td>HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM PRINCIPAL PROCEDURE CODE SOURCE 130: Healthcare Common Procedural Coding System</td> </tr> </tbody> </table>					CODE	DEFINITION	BP	HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM PRINCIPAL PROCEDURE CODE SOURCE 130: Healthcare Common Procedural Coding System
CODE	DEFINITION							
BP	HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM PRINCIPAL PROCEDURE CODE SOURCE 130: Healthcare Common Procedural Coding System							
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 1				
REQUIRED	HI02 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M ID 1/3				
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>BO</td> <td>HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM CODE SOURCE 130: HEALTHCARE COMMON PROCEDURAL CODING SYSTEM</td> </tr> </tbody> </table>					CODE	DEFINITION	BO	HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM CODE SOURCE 130: HEALTHCARE COMMON PROCEDURAL CODING SYSTEM
CODE	DEFINITION							
BO	HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURAL CODING SYSTEM CODE SOURCE 130: HEALTHCARE COMMON PROCEDURAL CODING SYSTEM							
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	1	
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O	1	

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*BF:V9782~

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	M ID 1/3
			CODE DEFINITION	
			BF DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
			BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
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] CODE SOURCE 131 : International Classification of Diseases Clinical Mod. (ICD-9-CM). Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.	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
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	M ID 1/3
			CODE DEFINITION	
			BF DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
			BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

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
BF	DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.
BN	DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) Procedure

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]

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

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
BF	DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.
BN	DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

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]

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

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
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BF	DIAGNOSIS
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	

BN	DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	

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]

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

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
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BF	DIAGNOSIS
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	

BN	DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	

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]

CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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

SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION	O
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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	M ID 1/3
			CODE DEFINITION	
			BF DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
			BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
REQUIRED	HI09 - 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] CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) . Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.	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
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	M ID 1/3
			CODE DEFINITION	
			BF DIAGNOSIS BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
			BN DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC) BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.	
REQUIRED	HI10 - 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] CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM) . Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.	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
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	M ID 1/3
			CODE DEFINITION	

BF **DIAGNOSIS**
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

BN **DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)**
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

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]

CODE SOURCE **131**: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
 Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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**

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**

BF **DIAGNOSIS**
BEGINNING OCTOBER 1, 2014, ICD-10-CM DIAGNOSIS CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

BN **DHHS, OFFICE OF VITAL STATISTICS E-CODE (ALLOWED BY THCIC)**
BEGINNING OCTOBER 1, 2014, ICD-10-CM E-CODES WILL BE REQUIRED ON DATA SUBMITTED TO THCIC.

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]

CODE SOURCE **131**: International Classification of Diseases Clinical Mod. (ICD-9-CM) .
 Beginning October 1, 2014, ICD-10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC.

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**



IMPLEMENTATION

OCCURRENCE SPAN INFORMATION (INST.)

Loop: 2300 — CLAIM INFORMATION
 Usage: SITUATIONAL
 Repeat: 1
 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	M ID 1/3				
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>BI</td> <td>OCCURRENCE SPAN</td> </tr> </tbody> </table>					CODE	DEFINITION	BI	OCCURRENCE SPAN
CODE	DEFINITION							
BI	OCCURRENCE SPAN							
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	X ID 2/3				
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>RD8</td> <td>RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD</td> </tr> </tbody> </table>					CODE	DEFINITION	RD8	RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD
CODE	DEFINITION							
RD8	RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD							
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				
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	M ID 1/3				
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>BI</td> <td>OCCURRENCE SPAN</td> </tr> </tbody> </table>					CODE	DEFINITION	BI	OCCURRENCE SPAN
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**

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**

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**

BI **OCCURRENCE SPAN**

REQUIRED **HI04 - 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	HI04 - 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	HI04 - 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	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	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

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:D8:19981208~

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	M ID 1/3				
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CODE	DEFINITION							
BH	OCCURRENCE							
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M AN 1/30				
INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes								
REQUIRED	HI01 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X ID 2/3				
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CODE	DEFINITION							
D8	DATE EXPRESSED IN FORMAT CCYYMMDD							
REQUIRED	HI01 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35				
INDUSTRY: Occurrence Code Associated Date								
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				
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O				
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	M ID 1/3				
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CODE	DEFINITION							
BH	OCCURRENCE							
REQUIRED	HI02 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M AN 1/30				

INDUSTRY: Occurrence 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

D8 **DATE EXPRESSED IN FORMAT 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 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**

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

BH **OCCURRENCE**

REQUIRED **HI03 - 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

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

D8 **DATE EXPRESSED IN FORMAT 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 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**

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

BH **OCCURRENCE**

REQUIRED **HI04 - 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

REQUIRED	HI04 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X	ID	2/3
			CODE DEFINITION			
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD			
REQUIRED	HI04 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X	AN	1/35
			INDUSTRY: Occurrence Code Associated Date			
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
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	HI05 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
			CODE DEFINITION			
			BH OCCURRENCE			
REQUIRED	HI05 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
			INDUSTRY: Occurrence Code			
			CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	HI05 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X	ID	2/3
			CODE DEFINITION			
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD			
REQUIRED	HI05 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X	AN	1/35
			INDUSTRY: Occurrence Code Associated Date			
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
SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	HI06 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
			CODE DEFINITION			
			BH OCCURRENCE			

REQUIRED	HI08 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
			CODE DEFINITION			
			BH OCCURRENCE			
REQUIRED	HI08 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
			INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
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
			CODE DEFINITION			
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD			
REQUIRED	HI08 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X	AN	1/35
			INDUSTRY: Occurrence Code Associated Date			
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
SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		
			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	M	ID	1/3
			CODE DEFINITION			
			BH OCCURRENCE			
REQUIRED	HI09 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
			INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	HI09 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X	ID	2/3
			CODE DEFINITION			
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD			
REQUIRED	HI09 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X	AN	1/35
			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
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 Code identifying a specific industry code list	M ID 1/3
			CODE DEFINITION	
			BH OCCURRENCE	
REQUIRED	HI10 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M AN 1/30
			INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
REQUIRED	HI10 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X ID 2/3
			CODE DEFINITION	
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD	
REQUIRED	HI10 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
			INDUSTRY: Occurrence Code Associated Date	
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

SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O
			Used when necessary to report multiple additional co-existing conditions.	
REQUIRED	HI11 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M ID 1/3
			CODE DEFINITION	
			BH OCCURRENCE	
REQUIRED	HI11 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M AN 1/30
			INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
REQUIRED	HI11 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X ID 2/3
			CODE DEFINITION	
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD	
REQUIRED	HI11 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
			INDUSTRY: Occurrence Code Associated Date	
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				
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O				
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	M ID 1/3				
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CODE	DEFINITION							
BH	OCCURRENCE							
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	X ID 2/3				
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CODE	DEFINITION							
D8	DATE EXPRESSED IN FORMAT CCYYMMDD							
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				

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	M ID 1/3
			CODE DEFINITION BE Value	
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
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O
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	M ID 1/3
			CODE DEFINITION BE Value	
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
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O

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	M	ID 1/3
			CODE DEFINITION		
			BE Value		
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
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O	
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	M	ID 1/3
			CODE DEFINITION		
			BE Value		
REQUIRED	HI04 - 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	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
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O	
Used when necessary to report multiple additional co-existing conditions.					
REQUIRED	HI05 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID 1/3
			CODE DEFINITION		
			BE Value		
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	O	R 1/18

INDUSTRY: Value Code Associated Amount

NOT USED	HI05 - 6	380	Quantity	O	R	1/15
NOT USED	HI05 - 7	799	Version Identifier	O	AN	1/30
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
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Code identifying a specific industry code list

CODE	DEFINITION
------	------------

BE	Value
----	-------

REQUIRED	HI06 - 2	1271	Industry Code	M	AN	1/30
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Code indicating a code from a specific industry code list

INDUSTRY: Value Code

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

NOT USED	HI06 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
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NOT USED	HI06 - 4	1251	Date Time Period	X	AN	1/35
----------	----------	------	-------------------------	---	----	------

REQUIRED	HI06 - 5	782	Monetary Amount	O	R	1/18
----------	----------	-----	------------------------	---	---	------

Monetary amount

INDUSTRY: Value Code Associated Amount

NOT USED	HI06 - 6	380	Quantity	O	R	1/15
----------	----------	-----	----------	---	---	------

NOT USED	HI06 - 7	799	Version Identifier	O	AN	1/30
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SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION	O		
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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
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Code identifying a specific industry code list

CODE	DEFINITION
------	------------

BE	Value
----	-------

REQUIRED	HI07 - 2	1271	Industry Code	M	AN	1/30
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Code indicating a code from a specific industry code list

INDUSTRY: Value 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
----------	----------	------	-------------------------	---	----	------

REQUIRED	HI07 - 5	782	Monetary Amount	O	R	1/18
----------	----------	-----	------------------------	---	---	------

Monetary amount

INDUSTRY: Value Code Associated Amount

NOT USED	HI07 - 6	380	Quantity	O	R	1/15
----------	----------	-----	----------	---	---	------

NOT USED	HI07 - 7	799	Version Identifier	O	AN	1/30
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SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION	O		
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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
------	------------

BE	Value
----	-------

REQUIRED	HI08 - 2	1271	Industry Code	M	AN	1/30
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Code indicating a code from a specific industry code list

INDUSTRY: Value 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
REQUIRED	HI08 - 5	782	Monetary Amount	O	R	1/18
			Monetary amount			
			INDUSTRY: Value Code Associated Amount			

NOT USED	HI08 - 6	380	Quantity	O	R	1/15
NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30
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
------	------------

BE	Value
----	-------

REQUIRED	HI09 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			INDUSTRY: Value Code			

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

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	O	R	1/18
			Monetary amount			
			INDUSTRY: Value Code Associated Amount			

NOT USED	HI09 - 6	380	Quantity	O	R	1/15
NOT USED	HI09 - 7	799	Version Identifier	O	AN	1/30
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
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BE	Value
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REQUIRED	HI10 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			INDUSTRY: Value Code			

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

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	O	R	1/18
			Monetary amount			
			INDUSTRY: Value Code Associated Amount			

NOT USED	HI10 - 6	380	Quantity	O	R	1/15
NOT USED	HI10 - 7	799	Version Identifier	O	AN	1/30
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			
			BE	Value			
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
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	M	ID	1/3
			CODE	DEFINITION			
			BE	Value			
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

IMPLEMENTATION

CONDITION INFORMATION (INST. and PROF.)

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: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	M ID 1/3
			CODE DEFINITION	
			BG CONDITION	
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
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O
			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	M ID 1/3
			CODE DEFINITION	
			BG CONDITION	
REQUIRED	HI02 - 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	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
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O

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	M	ID	1/3
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	HI03 - 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	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
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		

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	M	ID	1/3
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	HI04 - 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	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
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		

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

REQUIRED	HI05 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	HI05 - 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	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
SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		

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

REQUIRED	HI06 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	HI06 - 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	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
SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		
			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	M	ID	1/3
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	HI07 - 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	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
SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts, and quantities	O		
			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	M	ID	1/3
			CODE DEFINITION			
			BG CONDITION			
REQUIRED	HI08 - 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	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	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

OPERATING PHYSICIAN NAME (INST.)

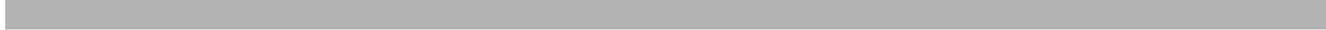
Loop: 2310B — OPERATING PHYSICIAN NAME Repeat: 1
 Usage: SITUATIONAL
 Repeat: 1
 Notes: 1. **Required by THCIC when any surgical procedure code is listed on this claim.**
 2. For THCIC reporting, the operating physician name is that of the individual that performed the principal procedure.
 Example: NM1*72*1*MEYERS*JANE*****XX*12345678~

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.	M ID 2/3
			CODE DEFINITION 72 OPERATING PHYSICIAN	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION 1 PERSON	
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name INDUSTRY: Operating Physician Last Name	O 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) 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 Required if no State License Number or UPIN is submitted when applicable in Loop 2310B 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

OPERATING PHYSICIAN SECONDARY IDENTIFICATION (INST.)

Loop: 2310B — OPERATING PHYSICIAN NAME

Usage: SITUATIONAL

Repeat: 5

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	M ID 2/3				
Required by THCIC to report if the National Provider Identification Number is NOT submitted in Loop 2310B NM109								
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>0B</td> <td>STATE LICENSE NUMBER</td> </tr> </tbody> </table>					CODE	DEFINITION	0B	STATE LICENSE NUMBER
CODE	DEFINITION							
0B	STATE LICENSE NUMBER							
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	X AN 1/50				
Required by THCIC to report if the National Provider Identification Number is NOT submitted in Loop 2310B NM109								
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:
- 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.
 - 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).
 - 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.**
 - 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 tenans) was used, that person should be entered here.
- Example: NM1*82*1*BEATTY*GARY*C**SR*XX*12345678~

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.	M ID 2/3
			CODE DEFINITION	
			82 RENDERING PROVIDER	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			1 PERSON	
			2 NON-PERSON ENTITY	
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	O AN 1/10
			Suffix to individual name INDUSTRY: Rendering Provider Name Suffix ALIAS: Rendering Provider Generation	
REQUIRED	NM108	66	Identification Code Qualifier	X ID 1/2
			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.	
REQUIRED	NM109	67	Identification Code	X AN 2/80
			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.	
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: 5

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	M ID 2/3
			CODE DEFINITION	
			0B STATE LICENSE NUMBER REQUIRED IF NPI NOT SUBMITTED IN 2310B NM109	
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
			NSF Reference: FA0-58.0	
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 tenans) 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.	M ID 2/3
			CODE DEFINITION 73 OTHER PROVIDER	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION 1 PERSON 2 NON-PERSON ENTITY	
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	O	AN	1/10
Required if known.						
SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67)	X	ID	1/2
			CODE	DEFINITION		
			XX	CMS NATIONAL PROVIDER IDENTIFIER (<i>THCIC RECOMMENDED</i>) REQUIRED IF NO STATE LICENSE NUMBER SUBMITTED IN 2310C REF02 .		
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code INDUSTRY: Other Provider Primary Identifier	X	AN	2/80
			CMS National Provider Identifier Required if NO State License Number Submitted in 2310C REF02.			
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: 5
 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	M ID 2/3
			CODE DEFINITION	
			0B STATE LICENSE NUMBER	
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 IDENTIFIER	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) or 2010AB (Pay-to Provider) loops.
 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) or Pay-to Provider (2010AB) 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 M ID 2/3 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.
REQUIRED	NM102	1065	Entity Type Qualifier M ID 1/1 Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.
		CODE	DEFINITION
		2	NON-PERSON ENTITY
SITUATIONAL	NM103	1035	Name Last or Organization Name O AN 1/60 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.

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)
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.

SITUATIONAL	NM109	67	Identification Code	X AN 2/80
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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.

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 or Pay-to 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	M AN 1/55
			INDUSTRY: Laboratory or Facility Address Line ALIAS: Laboratory/Facility Address 1	
			NSF Reference: EA1-06.0	
SITUATIONAL	N302	166	Address Information Address information	O AN 1/55
			INDUSTRY: Laboratory or Facility Address Line ALIAS: Laboratory/Facility Address 2	
			NSF Reference: EA1-07.0	
			Required if a second address line exists.	

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 or Pay-to 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	O 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.	O 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: 5
 Notes: 1. Required by THCIC if the Service Facility Provider is different than the Billing Provider or the Pay-To Provider.
 2 **THCIC REQUIRES if Billing Provider or Pay-to 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	M ID 2/3
			CODE DEFINITION	
			1J FACILITY ID NUMBER (THCIC ID)	
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	X AN 1/50
			CODE DEFINITION	
			NNNNNN THCIC ID NUMBER (ASSIGNED BY THCIC)	
NOT USED	REF03	352	Description	X AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

SERVICE FACILITY NAME (INST.)

Loop: 2310E — SERVICE FACILITY NAME Repeat: 1
 Usage: SITUATIONAL
 Repeat: 1
 Notes: 1. **Required by THCIC when the Service Facility Provider is different than the Billing Provider (2010AA).**
 2. 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*12345678~

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	M ID 2/3
			CODE DEFINITION	
			FA FACILITY	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			2 NON-PERSON ENTITY	
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)	X ID 1/2
			CODE DEFINITION	
			24 EMPLOYER'S IDENTIFICATION NUMBER	
			XX HEALTH CARE FINANCING ADMINISTRATION NATIONAL PROVIDER IDENTIFIER	
REQUIRED	NM109	67	Identification Code Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier	X AN 2/80
			CODE DEFINITION	
			NNNNNNNNN EMPLOYER IDENTIFICATION NUMBER	
			XXXXXXXXXX NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) <i>RECOMMENDED BY THCIC</i>	

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 (Loop 2310E | 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	M AN 1/40
DO NOT USE PO BOX				
SITUATIONAL	N302	166	Address Information Address information INDUSTRY: Laboratory or Facility Address Line	O AN 1/25
DO NOT USE PO BOX				
REQUIRED IF A SECOND ADDRESS LINE EXISTS.				

IMPLEMENTATION

**SERVICE FACILITY CITY/STATE/ZIP CODE
(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.**
 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 INDUSTRY: Laboratory or Facility 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.	O 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 3/9
NOT USED	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.	O ID 2/3
NOT USED	N405	309	Location Qualifier	X ID 1/2
NOT USED	N406	310	Location Identifier	O AN 1/30

IMPLEMENTATION

SERVICE FACILITY SECONDARY IDENTIFICATION (INST.)

Loop: 2310E — SERVICE FACILITY NAME
 Usage: SITUATIONAL
 Repeat: 5
 Notes: 1. **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	M ID 2/3
			CODE DEFINITION	
			1J FACILITY ID NUMBER	
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	X AN 1/50
			CODE DEFINITION	
			NNNNNN THCIC ID NUMBER <i>(ASSIGNED BY THCIC)</i>	
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	1138	Payer Responsibility Sequence Number Code Code identifying the insurance carrier's level of responsibility for a payment of a claim	M ID 1/1						
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>S</td> <td>SECONDARY</td> </tr> <tr> <td>U</td> <td>UNKNOWN</td> </tr> </tbody> </table> <p>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.</p>	CODE	DEFINITION	S	SECONDARY	U	UNKNOWN	
CODE	DEFINITION									
S	SECONDARY									
U	UNKNOWN									
NOT USED	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						
NOT USED	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						
NOT USED	SBR04	93	Name Free-form name INDUSTRY: Other Insured Group Name SEMANTIC: SBR04 is plan 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 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.
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	M ID 2/3
			CODE DEFINITION	
			PR PAYER	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			2 NON-PERSON ENTITY	
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name INDUSTRY: Other Payer Last or Organization Name ALIAS: Payer Name	O AN 1/60
			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).	
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) Activated when the National Plan Identification Number is implemented by CMS.	X ID 1/2
			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	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**



IMPLEMENTATION

SERVICE LINE NUMBER (INST.)

Loop: 2400 — SERVICE LINE NUMBER Repeat: **999**
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	M N0 1/6

The service line number incremented by 1 for each service line.

IMPLEMENTATION

PROFESSIONAL SERVICE (PROF.)

Loop: 2400 — SERVICE LINE
 Usage: REQUIRED
 Repeat: 1
 1702 Example: SV1*HC:99211:25*12.25*UN*1*11**1:2:3**N~

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				
<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>HC</td> <td>HEALTHCARE COMMON PROCEDURAL CODING SYSTEM (HCPCS) CODES BECAUSE THE AMA'S CPT CODES ARE ALSO LEVEL 1 HCPCS CODES, THEY ARE REPORTED UNDER " HC".</td> </tr> </tbody> </table> <p>CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System</p>					CODE	DEFINITION	HC	HEALTHCARE COMMON PROCEDURAL CODING SYSTEM (HCPCS) CODES BECAUSE THE AMA'S CPT CODES ARE ALSO LEVEL 1 HCPCS CODES, THEY ARE REPORTED UNDER " HC".
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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				
<p>Use this modifier for the first procedure code modifier.</p> <p>Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>								
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 2
NSF Reference: FA0-11.0

Use this modifier for the second 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 3

NSF Reference: FA0-12.0

Use this modifier for the third 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 4

NSF Reference: FA0-12.0

Use this modifier for the third 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

NSF Reference: FA0-18.0, FA0-19.0, FB0-16.0

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**
To identify one or more diagnosis code pointers

ALIAS: Diagnosis Code Pointer

Required if HI segment in Loop ID-2300 is used.

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** **M N0 1/2**
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.

SITUATIONAL **SV107 - 2** **1328** **Diagnosis Code Pointer** **O N0 1/2**
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.

SITUATIONAL **SV107 - 3** **1328** **Diagnosis Code Pointer** **O N0 1/2**
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.

SITUATIONAL **SV107 - 4** **1328** **Diagnosis Code Pointer** **O N0** **1/2**

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.

NOT USED **SV108** **782** **Monetary Amount** **O R** **1/18**

NOT USED **SV109** **1073** **Yes/No Condition or Response Code** **O ID** **1/1**

Code indicating a Yes or No condition or response

INDUSTRY: Emergency Indicator

SEMANTIC: SV109 is the emergency-related indicator; a "Y" value indicates service provided was emergency related; an "N" value indicates service provided was not emergency related.

NSF Reference: FA0-20.0

CODE	DEFINITION
N	NO

Y	YES
---	-----

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**

Code indicating a Yes or No condition or response

INDUSTRY: EPSDT Indicator

SEMANTIC: SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement.

NSF Reference: FB0-22.0

Required if Medicaid services are the result of a screening referral.

CODE	DEFINITION
Y	YES

NOT USED **SV112** **1073** **Yes/No Condition or Response Code** **O ID** **1/1**

Code indicating a Yes or No condition or response

INDUSTRY: Family Planning Indicator

SEMANTIC: SV112 is the family planning involvement indicator. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement.

NSF Reference: FB0-23.0

Required if applicable for Medicaid claims.

CODE	DEFINITION
Y	YES

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**

Code indicating whether or not co-payment requirements were met on a line by

line basis

INDUSTRY: Co-Pay Status Code

ALIAS: Co-Pay Waiver

NSF Reference: FB0-21.0

Required if patient was exempt from co-pay.

CODE DEFINITION

0 COPAY EXEMPT

NOT USED	SV116	1334	Health Care Professional Shortage Area Code	O	ID	1/1
NOT USED	SV117	127	Reference Identification	O	AN	1/30
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 inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication.
 Example: SV2*300*HC:80019*73.42*UN*1~
 Example: SV2*120**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 IV HOME INFUSION EDI COALITION (HIEC) PRODUCT/SERVICE CODE CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List ZZ MUTUALLY DEFINED CODE SOURCE 130: Division of Institutional Care, Health Care Financing Administration, S1-03-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.	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 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 http://www.cms.hhs.gov/medicare/hcpcs/ for HCPCS modifiers.	O AN 2/2

SITUATIONAL	SV202 - 4	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: HCPCS Modifier 2 See SV202-3	O AN 2/2
SITUATIONAL	SV202 - 5	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: HCPCS Modifier 3 See SV202-3	O AN 2/2
SITUATIONAL	SV202 - 6	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: HCPCS Modifier 4 See SV202-3	O AN 2/2
NOT USED	SV202 - 7	352	Description	O AN 1/80
REQUIRED	SV203	782	Monetary Amount Monetary amount 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.	O R 1/18
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 will turn-off the audit for this data field and will amend the rules accordingly. 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~

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	M ID 3/3
			CODE DEFINITION	
			472 SERVICE	
			USE RD8 IN DTP02 TO INDICATE BEGIN/END OR FROM/TO DATES.	
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.	M ID 2/3
			CODE DEFINITION	
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD	
			RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDDCCYYMMDD	
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~

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	M ID 3/3
			CODE DEFINITION	
			472 SERVICE	
			Use RD8 in DTP02 to indicate begin/end or from/to dates.	
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.	M ID 2/3
			CODE DEFINITION	
			D8 DATE EXPRESSED IN FORMAT CCYYMMDD	
			RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDDCCYYMMDD 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.	
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
			NSF Reference: FA0-05.0, FA0-06.0	

IMPLEMENTATION

LINE NOTE (*PROF.*)

Loop: 2400 — CLAIM INFORMATION

Usage: [SITUATIONAL for Prof. may be submitted in Loop 2300 - Claim Note or 2400 Loop Third Party Organization Notes](#)

Repeat: 1

Notes: **1. Required to report PATIENT ETHNICITY.**
 2. THCIC requires that the code that corresponds to the race, and the code that corresponds to the ethnicity be reported. Example: Multi racial without Hispanic origin would be reported as a race code of 5 and an ethnicity code of 2. A black Hispanic would be reported as a race code of 3 and an ethnicity code of 1.

Situational Rule: For Professional Claims. Required when Race code is not submitted in the Loop 2300 Claim Note or the Loop 2400 Third Party Organization Notes segments

Example: NTE*UPI*1~

NTE Note/Special Instruction

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NTE01	363	Note Reference Code Code identifying the functional area or purpose for which the note applies	O ID 3/3
			UPI	UPDATED INFORMATION
REQUIRED	NTE02	352	Description A free-form description to clarify the related data elements and their content	M AN 1/80
			THCIC requires that the code that corresponds to the “Ethnicity” of the patient be reported in NTE02 and the code that corresponds to the “Race” be reported in Loop 2010BA or 2010CA segment, element DMG05.	
			1	HISPANIC OR LATINO
			2	NOT HISPANIC OR LATINO

IMPLEMENTATION

THIRD PARTY ORGANIZATION NOTES (*PROF.*)

Loop: 2400 — CLAIM INFORMATION
 Usage: [SITUATIONAL for Prof. maybe submitted in Loop 2300 - Claim Note or 2400 Loop - Line Note](#)
 Repeat: 1
 Notes: **1. Required to report PATIENT ETHNICITY.**
 2. THCIC requires that the code that corresponds to the race, and the code that corresponds to the ethnicity be reported. Example: Multi racial without Hispanic origin would be reported as a race code of 5 and an ethnicity code of 2. A black Hispanic would be reported as a race code of 3 and an ethnicity code of 1.
 Situational Rule: For Professional Claims. Required when Race code is not submitted in the Loop 2300 Claim Note or the Loop 2400 Line Note segments
 Example: NTE*UPI*1~

NTE Note/Special Instruction

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NTE01	363	Note Reference Code Code identifying the functional area or purpose for which the note applies	O ID 3/3
			CODE DEFINITION	
			UPI UPDATED INFORMATION	
REQUIRED	NTE02	352	Description A free-form description to clarify the related data elements and their content	M AN 1/80
			THCIC requires that the code that corresponds to the “Ethnicity” of the patient be reported in NTE02 and the code that corresponds to the “Race” be reported in Loop 2010BA or 2010CA segment, element DMG05.	
			CODE DEFINITION	
			1 HISPANIC OR LATINO	
			2 NOT HISPANIC OR LATINO	

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 tenans) 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*87654321~

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.	M ID 2/3
			CODE DEFINITION	
		82	RENDERING PROVIDER	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
		1	PERSON	
		2	NON-PERSON ENTITY	
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	O AN 1/60
			NSF Reference: FB1-14.0	
SITUATIONAL	NM104	1036	Name First Individual first name INDUSTRY: Rendering Provider First Name	O AN 1/35

NSF Reference:
 FBI-15.0

Required if NM102=1 (person).

SITUATIONAL **NM105** **1037** **Name Middle** **O AN 1/25**
 Individual middle name or initial
 INDUSTRY: **Rendering Provider Middle Name**

NSF Reference:
 FBI-16.0

Required if NM102=1 and the middle name/initial of the person is known.

NOT USED **NM106** **1038** **Name Prefix** **O AN 1/10**
SITUATIONAL **NM107** **1039** **Name Suffix** **O AN 1/10**

Suffix to individual name
 INDUSTRY: **Rendering Provider Name Suffix**
 ALIAS: **Rendering Provider Generation**

Required if known.

REQUIRED **NM108** **66** **Identification Code Qualifier** **X ID 1/2**
 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.
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REQUIRED **NM109** **67** **Identification Code** **X AN 2/80**
 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

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: 5

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*1D*A12345~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01 1	28	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3
			CODE DEFINITION	
			0B STATE LICENSE NUMBER <i>THCIC REQUIRES IF NPI NOT SUBMITTED IN 2420A / NM109</i>	
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.	M AN 4/9

MUST MATCH NUMBER IN ST02