



TEXAS
Health and Human
Services

Texas Department of State
Health Services

5010 Outpatient Professional THCIC 837 Technical Specifications

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Healthcare Facility Procedures and Technical Specifications Manual

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1. Introduction

Texas Health Care Information Collection's (THCIC) primary charge is to collect data and report on the quality performance and differences in charges of hospitals 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.

1.1 Governing Legislation

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

The Hospital Procedures and Technical Specifications guides are available for download from the THCIC website at DSHS THCIC Hospital Reporting Requirements

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

TITLE - 25 Health Services

PART - 1 Department of State Health Services

CHAPTER - 421 Health Care Information

SUBCHAPTER – D - Collection and Release of Outpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers

SUBCHAPTER – E - Collection and Release of Hospital Outpatient Emergency Room Data

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

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2. General Information

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 Overview

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

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

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

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

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



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For claims submitted in a test file, the result of the auditing process will be made available to the submitter.

For more detail on the file submission process as well as the use of the System13/THCIC system please see: [DSHS THCIC Outpatient Data Reporting Requirements](#).

2.2 Reference Information

The 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: Professional, 837, ASC X12N 837 (005010X222), May 2006 version, and the addenda published by the Washington Publishing Company in October 2007 (ANSI 837 Professional Guide, 005010X222A1) which can be purchased and downloaded from the following website: [X12 Product Licensing Program](#).

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

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

2.3 THCIC Business Associate - System13, Inc.

System13, Inc. provides a testing process to ensure that a hospital or vendor submits a HIPAA compatible ANSI 837 Institutional and Professional Guide formatted file with the additional required fields listed in this manual then that data file should pass the audits at System13, Inc. System13, Inc. (System13) located in Charlottesville, Virginia, is



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contracted to provide data collection, auditing, and warehousing of the data submitted by hospitals. System13, Inc. Contact Information:

E-mail: thcichelp@system13.com

Helpdesk: (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/>

2.4 THCIC Web Site

The [THCIC web site](#) 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 THCIC staff contact information.

2.4.1 Important Links

- [Data Reporting Schedule](#)
- [Outpatient Data Reporting Requirements](#)
- [Latest Version of these Specifications](#)
- [5010 Inpatient and Outpatient Appendices](#)



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3. Definitions and Acronyms

Term	Definition
Accurate and Consistent Data	Data that has been edited by DSHS and subjected to provider validation and certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(1)
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 Washington Publishing Company and Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(5)]
Attending Physician	The individual licensed under the Medical Practice Act (Occupations Code, Chapter 151) or the licensed health professional primarily responsible for the care of the patient during the hospital episode as reported on the claim. For Skilled Nursing Facility (SNF) services, the attending physician is the individual who certifies the SNF plan of care. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(3)
Audit	For the purposes of this manual, a methodological examination and review of data. Audits are performed during data collection to identify errors or potential errors (warnings).
Certification Process	The process by which a provider confirms the accuracy and completeness of the encounter data set required to produce the public use data file as specified in §421.7 of this title (relating to Certification of Discharge Reports). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(4)
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. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(5)
CHS	Texas Department of State Health Services, Center for Health Statistics.
CPT	Current Procedural Terminology – HCPCS Level 1 procedure codes



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Term	Definition
Comments	The notes or explanations submitted by the hospitals, physicians or other health professionals concerning the provider quality reports or the encounter data for public use as described in the Texas Health and Safety Code, §108.010(c) and (e) and §108.011(g) respectively. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(6)
Discharge	The formal release of a patient by a hospital; that is, the termination of a period of hospitalization by death or by disposition to a residence or another health care provider. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(9)
Discharge Claim	A computer record as specified in §421.9 of this title (relating to Discharge Reports--Records, Data Fields and Codes) relating to a specific patient. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(10)
Discharge Report	A computer file as defined in §421.9 of this title periodically submitted on or on behalf of a Hospital in compliance with the provisions of this chapter. "Discharge report" corresponds to the ANSI 837 Institutional Guide terms, "Communication Envelope" or "Interchange Envelope." Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(11)
DRG	Diagnosis Related Group. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(12)
EDI	Electronic Data Interchange. A method of sending data electronically from one computer to another. EDI helps providers and payers maintain a flow of vital information by enabling the transmission of claims and managed care transactions. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(13)
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>For the purposes of this manual:</p> <ol style="list-style-type: none"> 1. To make changes to a data file. 2. The process of adding, deleting, or changing data. The THCIC edits the public use data file to protect the confidentiality of patients and physicians. Title 25 Texas



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Term	Definition
	Administrative Code, Chapter 421, Rule 421.1(14)
Electronic Filing	The submission of computer records in machine readable form by modem transfer from one computer to another (EDI) or by recording the records on a nine-track magnetic tape, computer diskette or other magnetic media acceptable to the executive director. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(15)
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. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(16)
Ethnicity	The status of patients relative to Hispanic background. Facilities shall report this data element according to the following ethnic types: Hispanic or Non- Hispanic. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(17)
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. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(18)
Geographic Identifiers	A set of codes indicating the public health region and county in which the patient resides. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(19)



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Term	Definition
HCDCS	Health Care Data Collection System
HCPCS	Healthcare Common Procedure Coding System
Healthcare Facility	A hospital, an ambulatory surgery center licensed under Chapter 243 of the Health and Safety Code, a chemical dependency treatment facility licensed under Chapter 464 of the Health and Safety Code, a renal dialysis center, a birthing center, a rural health clinic or a federally qualified health center as defined by 42 United States Code, §1396(1)(2)(B). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(21)
HIPPS	Health Insurance Prospective Payment System. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(22)
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. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(23)
ICD	International Classification of Disease. The International Classification of Diseases, Clinical Modification (ICD-CM) is a system used to code and classify mortality data from death certificates. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(24)
Inpatient	A patient, including a newborn infant, who is formally admitted to the inpatient service of a hospital, and who is subsequently discharged, regardless of status or disposition. Inpatients include patients admitted to medical/surgical, intensive care, nursery, sub-acute, skilled nursing, long-term, psychiatric, substance abuse, physical rehabilitation, and all other types of hospital units. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(25)
Institutional Review Board	The department's appointees or agent who have experience and expertise in ethics, patient confidentiality, and health care data who review and approve or disapprove requests for data or information other than the public use data as described in §421.10 of this title (relating to Institutional



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Term	Definition
	Review Board). The Institutional Review Board acts as the Scientific Review Panel described in the Health and Safety Code, §108.0135. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(26)
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 principal procedure or performed the surgical procedure most closely related to the principal diagnosis. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(27)
Other Exempted Provider	A hospital exempt by rule Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(28) or by waiver (2014 Sunset Review Commission Waiver Recommendation) to be established in rule.
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. 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 hospital to admit or treat patients. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(29)
Patient Account Number	A number assigned to each patient by the hospital, which appears on each computer record in a patient discharge claim. This number is not consistent for a given patient from one hospital to the next, or from one admission to the next in the same hospital. The department deletes or encrypts this number to protect patient confidentiality prior to release of data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(30)



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Term	Definition
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. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(31)
Present on Admission (POA)	Diagnosis present on admission. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(32)
Provider	A hospital, physician, or other health professional that provides health care services to patients. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(33)
Provider Quality Data	A report or reports authored by the department on provider quality or outcomes of care, as defined in Health and Safety Code, Chapter 108, created from data collected by the department or obtained from other sources. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(34)
Public Use Data File	A data file composed of discharge claims with risk and severity adjustment scores 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 hospital discharge data imposed by statute. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(35)
Race	A division of patients according to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Hospitals shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(36)
Required Minimum Data Set	The list of data elements which hospitals are required to submit in a discharge claim for each inpatient stay in the hospital. The required minimum data set is specified in §421.9(d) of this title. This list does not include the data elements that are required by the ANSI 837 Institutional Guide to submit an acceptable discharge report. For example: Interchange Control Headers and Trailers,



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Term	Definition
	Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify which qualify as subsequent data elements). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(37)
Research Data File	A customized data file, which includes the data elements in the public use file and may include data elements other than the required minimum data set submitted to the department, except those data elements that could reasonably identify a patient or physician. The data elements may be released to a requestor when the requirements specified in §421.8 of this title (relating to Hospital Discharge Data Release) are completed. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(38)
Risk Adjustment	A statistical method to account for a patient's severity of illness at the time of admission and the likelihood of development of a disease or outcome, prior to any medical intervention. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(39)
Service Unit Indicator	An indicator derived from submitted data (based on bill type or revenue codes), which represent the type of service unit or units (e.g., Coronary Care Unit, Detoxification Unit, Intensive Care Unit, Hospice Unit, Nursery, Obstetric Unit, Oncology Unit, Pediatric Unit, Psychiatric Unit, Rehabilitation Unit, Sub acute Care Unit, or Skilled Nursing Unit) where the patient received treatment. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(40)
Severity Adjustment	A method to stratify patient groups by degrees of illness and mortality. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(41)
Submission	The transfer of a set of computer records as specified in §421.9 of this title that constitutes the discharge report for one or more hospitals. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(42)
Submitter	The person or organization, which physically prepares discharge reports for one or more hospitals and submits them to THCIC. A submitter may be a hospital or an agent designated by a hospital or its owner. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(43)



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Term	Definition
Submitting Agent	An organization authorized by a health care provider to submit billing claims on behalf of the provider.
System13, Inc.	System13, Inc. The contractor that collects, audits, and warehouses the inpatient and outpatient health care claim data on behalf of THCIC.
THCIC	Texas Health Care Information Collection sub-unit in the Department of State Health Services, Center for Health Statistics Unit.
THCIC Identification Number	A string of six characters assigned by THCIC to identify health care facilities for reporting and tracking purposes. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(44)
Uniform Facility Identifier	A unique number assigned by the department to each health care facility licensed in the state. For hospitals, this will include the hospital's state license number. For hospitals operating multiple facilities under one license number and duplicating services, the department will assign a distinguishable uniform facility identifier for each separate facility. The relationship between facility identifier and the name and license number of the facility is public information. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(45)
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 inpatient admissions. The relationship of the identifier to the patient-specific data elements used to assign it is confidential. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(46)
Uniform Physician Identifier	A unique identifier assigned by the THCIC to a physician or other health professional who is reported as attending or treating a hospital inpatient and which remains constant across hospitals. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(47)



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Term	Definition
User	For the purposes of this manual, Hospital or Submitter.
Validation	The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(48)



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4. Technical Requirements Summary

4.1 Patient Inclusion Requirements

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

4.1.1 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.

Code	Description
320	Radiology - Diagnostic General Classification
321	Radiology - Diagnostic Angiocardiology
322	Radiology - Diagnostic Arthrography
323	Radiology - Diagnostic Arteriography
329	Radiology - Diagnostic Other Radiology – Diagnostic
330	Radiology - Therapeutic General Classification
333	Radiology - Therapeutic Radiation Therapy
339	Radiology - Therapeutic Other Radiology – Therapeutic
340	Nuclear Medicine General Classification
341	Nuclear Medicine Diagnostic
342	Nuclear Medicine Therapeutic
343	Nuclear Medicine Diagnostic Pharmaceuticals
344	Nuclear Medicine Therapeutic Pharmaceuticals
349	Nuclear Medicine Other Nuclear Medicine



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Code	Description
350	Computed Tomography (CT) Scan General Classification
351	Computed Tomography (CT) - Head Scan
352	Computed Tomography (CT) - Body Scan
359	Computed Tomography (CT) - Other
360	Operating Room Services General Classification
361	Operating Room Services Minor Surgery
369	Operating Room Services Other Operating Room Services
400	Other Imaging Services General Classification
401	Other Imaging Services Diagnostic Mammography
403	Other Imaging Services Screening Mammography
404	Other Imaging Services Positron Emission Tomography (PET)
409	Other Imaging Services Other Imaging Services
450	ER -- General Classification
451	ER -- Emergency Medical Screening – EMTALA
452	ER -- Beyond EMTALA
456	ER -- Urgent Care
459	ER -- Other
481	Cardiology Cardiac Catheterization Lab
483	Cardiology Echocardiology
489	Cardiology Other Cardiology Services
490	Ambulatory Surgical Care General Classification
499	Ambulatory Surgical Care Other Ambulatory Surgical
500	Outpatient Services General Classification
509	Outpatient Services Other Outpatient
610	Magnetic Resonance Technology General Classification
611	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Brain/Brainstem
612	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Spinal Cord/Spine



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Code	Description
614	Magnetic Resonance Technology Magnetic Resonance Imaging (MRI) - Other
615	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Head and Neck
616	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Lower Extremities
618	Magnetic Resonance Technology Magnetic Resonance Angiography (MRA) - Other
619	Magnetic Resonance Technology Other Magnetic Resonance Technology
760	Specialty Room – Treatment/Observation Room General Classification
761	Specialty Room – Treatment Room
762	Specialty Room – Observation Room
769	Specialty Room – Other Specialty Room

4.1.2 Service and Procedure Categories

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

- [Services and Procedures Categories and related HCPCS Codes 2024](#)
- [Services and Procedures Categories and related HCPCS Codes 2025](#)

These are the lists of outpatient procedure codes that, if performed by a hospital or ASC, indicates the patient claim requires submission for 2024-2025 under 25 TAC §§ 421.61-421.68.

4.2 Communications Requirements

4.2.1 Data Submissions

Texas Administrative Code (TAC) rules require that all hospitals, in operation for any or all of the reporting periods described in Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(a) and (b) relating to the Collection and release of Hospital Discharge Data, shall submit data on all discharged inpatients to the Texas Health Care Information Collection program and are advised to reference Chapter 108, Health & Safety Code and



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the Texas Health Care Information Collection rules Title 25 Texas Administrative Code, Chapter 421, Rule 421.1 – 421.9 relating to data reporting.

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

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

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

For more information, see [THCIC Submitter and Provider Enrollment Guide](#).

4.2.2 Data Corrections

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

1. Replacement of Errant Claim Data

Submit "Replacement claims" (XX7) to System13, Inc. "Replacement claims" are required to have the following data elements match exactly to replace the claim data from System13, Inc.:

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



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2. Void or Cancel Errant Claim Data and Resubmit

Submit “Void/Cancel claims” (XX8) to System13, Inc., then resubmit original bill type codes (XX0, XX1, XX2, XX3, XX4, XX5, or XX6) with the corrected data included. “Void/Cancel claims” are required to have the following data elements match exactly to delete the claim data from System13, Inc.:

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

3. Delete Errant Claim Data and Resubmit

- a. The designated Facility “Data Administrator” may log into the secure website and delete errant or duplicate batches or claims using the “Batches” tab or “Data Mgmt” tab.
- b. Contact System13, Inc. and request that they delete the claims/batches with errors (a charge is associated with this process), and then resubmit original bill type codes (XX0, XX1, XX2, XX3, XX4, XX5 or XX6) with the corrected data.

4.2.3 System13, Inc. Help Desk

System13, Inc. Help Desk Contact Information:

E-mail: thcichelp@system13.com

Helpdesk: (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/>

4.3 Billing Claims Validation and Acceptance

All submitted claims are audited and validated for adherence to the THCIC 837 Specifications prior to being accepted for processing by System13, Inc. Audits required



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for validation include, at a minimum, those audits specified in the 5010 Inpatient and Outpatient Appendices found at [Outpatient Data Reporting Requirements](#). 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.

4.4 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 mailboxes for notification are available seven (7) days a week, twenty-four (24) hours a day to the Submitter for retrieval of information.

4.5 Auditing of Data by System13, Inc.

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 audit codes and descriptions of the codes can be found in the [Appendices](#) document. In general, the audits support the following rules:

- Each billing claims submission must contain at least one valid file, including valid file header /trailer records.
- A file/Transaction Set must contain one valid claim for the file/Transaction Set to be accepted.
- Claim file numbers may not be reused within six months of acceptance of the first use of the batch number.
- Claim detail charges and claim counts must balance with batch and file totals.
- Claims submission may contain only valid record types/Data segments as defined in the ANSI 837 specifications.
- All fields defined as number must contain numerical data.
- 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.

Table 1. Sample Pre-Processing Audits (Format Check)

Audit ID	Message	Description
RJ001	Missing/Invalid ISA Interchange Control Header Segment.	The first three characters in all 837 files are 'ISA'. This file does not start with 'ISA'.



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

Table 2. Sample Claim-Level Audits

Audit ID	Status	Message	Description	Severity
600	I	Missing Principal Procedure Date	If the Principal Procedure exists, the Principal Procedure Date must exist and contain a valid date of the format	Error
601	I	Principal Procedure not reported when Other Procedure(s) reported	The Principal Procedure is not reported, is blank or contains zeroes and Other Procedure(s) are reported.	Error

4.6 Required Data File Format

Claims data must be submitted in the THCIC 837 (modified ANSI X12N 837, version 5010 Professional Claim, X222A1) Specification format. See Section 5 - THCIC 837 File Specifications of this document.

4.7 State Required Data Elements

The following data elements must be submitted for each inpatient stay.

1. Patient Name
 - a. Patient Last Name



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- 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
- 3. Patient Birth Date
- 4. Patient Sex (at birth)
- 5. Patient Race
- 6. Patient Ethnicity
- 7. Patient Social Security Number
- 8. Patient Account Number
- 9. Patient Medical Record Number
- 10. Claim Filing Indicator Code (Payer Source – primary and secondary (if applicable 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. Statement Dates (i.e. Statement Period From and Statement Period Thru dates)
- 15. Principal Diagnosis
- 16. Other Diagnosis Codes - up to 24 occurrences (if applicable)
- 17. Related Cause Codes - up to 3 occurrences (if applicable)
- 18. Revenue Service Line Details (up to 50 service lines)
 - a. Revenue Code
 - b. Procedure Code
 - c. HCPCS/HIPSS Procedure Modifier 1 (if applicable)
 - d. HCPCS/HIPSS Procedure Modifier 2 (if applicable)
 - e. HCPCS/HIPSS Procedure Modifier 3 (if applicable)
 - f. HCPCS/HIPSS Procedure Modifier 4 (if applicable)
 - g. Procedure From Date
 - h. Procedure Thru Date



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- i. Charge Amount
- j. Unit Code
- k. Unit Quantity
- l. Unit Rate
- m. Non-covered Charge Amount
- 19. Rendering Provider or Rendering Other Health Professional Name - up to 2 occurrences (if applicable)
 - a. Rendering Provider or Rendering Other Health Professional Last Name
 - b. Rendering Provider or Rendering Other Health Professional First Name
 - c. Rendering Provider or Rendering Other Health Professional Middle Initial
- 20. Rendering Provider or Rendering Other Health Professional Primary Identifier (National Provider Identifier, when HIPAA rule is implemented) - up to 2 occurrences (if applicable)
- 21. Rendering Provider or Rendering Other Health Professional Secondary Identifier (Texas state license number) - up to 2 occurrences (if applicable)
- 22. Total Claim Charges
- 23. Service Provider Name
- 24. Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier (when HIPAA rule is implemented)
- 25. Service Provider Address
 - a. Service Provider Address Line 1
 - b. Service Provider Address Line 2 (if applicable)
 - c. Service Provider City
 - d. Service Provider State
 - e. Service Provider Zip
- 26. Service Provider Secondary Identifier - THCIC 6-digit Hospital ID assigned to each facility

4.8 Data Element Locations

Data elements and their respective locations in the approved formats.

Table 3. Data Element Locations

DATA ELEMENT	Loop ID	Ref. Des.
Patient Last Name	2010BA or	NM103



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DATA ELEMENT	Loop ID	Ref. Des.
	2010CA	
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 (at birth)	2010BA or 2010CA	DMG03
Patient Race	2300	K301
Patient Ethnicity	2300	K301
Subscriber/Patient Social Security Number	2010BA	REF02
Patient Social Security Number	2300	K301
Patient Control Number/Patient Account Number	2300	CLM01
Medical Record Number	2300	REF02
Source of Payment Code (Standard)/ Claim Filing Indicator Code	2000B or 2320	SBR09
Payer Name	2010BB (and 2330B, if secondary payer)	NM103
National Plan Identifier (when implemented by Federal Government)	2010BB (and 2330B, if secondary payer)	NM109



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DATA ELEMENT	Loop ID	Ref. Des.
Type of Bill	2300	CLM05
Statement Covers Period From	2300	DTP03
Statement Covers Period Through	2300	DTP03
Principal Diagnosis Code	2300	HI01
Other Diagnosis Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01-HI12
Diagnosis Present on Admission	2300	HIIn-9 (nn = 01- 12)
Attending Physician Name	2310A	NM103, NM104, and NM105
Attending Physician Number	2310A	NM109 (NPI) or REF02 (State License)
Operating or Other Physician Name	2310B	NM103, NM104, and NM105
Operating or Other Physician Number	2310B	NM109 (NPI) or REF02 (State License)
Total Claim Charges	2300	CLM02
Accommodations Revenue Codes or Revenue Codes	2400	SV201
HCPCS/HIPPS Procedure Codes	2400	SV202-2
HCPCS/HIPPS Procedure Code Modifiers	2400	SV202-3 to SV202- 6
Accommodation Total Charges or Charge Amount	2400	SV203
Ancillary Charges Total or Charge Amount	2400	SV203
Unit Code	2400	SV204
Accommodations Days or Unit Quantity	2400	SV205
Units of Service or Unit Quantity	2400	SV205
Accommodations Rate or Unit Rate	2400	SV206
Provider Name	2010AA or 2310E	NM103



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DATA ELEMENT	Loop ID	Ref. Des.
Provider Address	2010AA or 2310E	N301
Provider City	2010AA or 2310E	N401
Provider ZIP Code	2010AA or 2310E	N403
Provider National Provider Identification Number (NPI)	2010AA or 2310E	NM109
Provider Tax Identification (EIN)	2010AA or 2310E	REF02
Provider THCIC ID Identification (6 Digit) number assigned by THCIC	2010AA or 2010BB or 2310E	REF02



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5. THCIC 837 File Specifications

5.1 Reference Information

The THCIC 837 Outpatient Professional Claim Specification draws from the specifications for the ANSI 837 health care claim format published in 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 June 2010 (ANSI 837 Professional Guide, 005010X222A1) which can be purchased from the following website:

[X12 Product Licensing Program](#)

5.1.1 Nomenclature

Key terms and phrases to better understand this portion of the specifications document, after which you will have a basic understanding of X12 syntax, usage, and related information.

Term	Definition
Control Segment	A control segment has the same structure as a data segment but is used for transferring control information rather than application information.
Control Segment, Interchange Control Segments	The Interchange Control Header (ISA) is used to denote the start and end of Functional Groups (GS). Each element on the line is in a fixed position. It defines what characters are used for segment, element, and other control characters. The ISA has an associate Interchange Control Trailer (IEA) to



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Term	Definition
Control Segment, Functional Group Segments	<p>The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets. It also provides control number and application identification information.</p> <p>The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.</p>
Control Segment, Transaction Set Segments	<p>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.</p>
Control Segment, Hierarchical Level Segments	<p>Hierarchical Level segments denote the start of a group of information. The information may be about a provider of date, about the insured person, or about a patient claim. It ends when another Hierarchical Loop occurs, or when a transaction trailer (SE) is received.</p>
Control Segment, Relations among Control Segments	<p>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.</p> <p>ISA Interchange Control Header</p>



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Term	Definition
	<p>GS Functional Group Header starts a group of related Transaction sets.</p> <p>ST Transaction Set Header starts a transaction set.</p> <p>HL Hierarchical Level starts a bounded loop of data segments.</p> <p>SE Transaction Set Trailer ends a transaction set.</p> <p>GE Functional Group Trailer ends a group of related transaction sets.</p> <p>IEA Interchange Control Trailer</p>
Data Element	<p>The data element is the smallest unit of information in the X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinal positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.</p>
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</p>



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Term	Definition
	<p>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 does 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</p>



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Term	Definition
Data Element, Identifier	An identifier data element always contains a value from a predefined list of values. Trailing spaces should be suppressed unless necessary to satisfy minimum length. The representation for this data element type is "ID."
Data Element, String	A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified and shall be space filled. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy minimum length. The representation for this data element type is "AN."
Data Element, Date	A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the century or first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is "DT." Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.
Data Element, Time	A time data element is used to express the ISO standard time HHMMSSdd format in which HH is the hour for a 24-hour clock (00 to 23), MM is the minute (00 to 59), SS is



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Term	Definition
	the second (00 to 59) and dd is decimal seconds. The representation for this data element type is "TM."
Data Element, Length	Length: Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements
Data Element, Reference Number	Data elements are assigned a unique reference number to locate them in the data dictionary. For each data element, the dictionary specifies the name, description, type, minimum length, and maximum length. For ID data elements, the dictionary lists all code values and their descriptions or references where the valid code list can be obtained.
Data Element Type	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.



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Term	Definition
	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 Data Element	Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two- digit number that defines the position of the simple data element or composite data structure in that segment. For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is a two- digit number, prefixed with a hyphen that defines the position of the component data element in the composite data structure.



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



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Term	Definition										
	<p>a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition.</p> <table><tr><th>Condition Code</th><th>Definition</th></tr><tr><td>P- Paired or Multiple</td><td>If any element specified in the relational condition is present, then all the elements specified must be present.</td></tr><tr><td>R- Required</td><td>At least one of the elements specified in the condition must be present.</td></tr><tr><td>E- Exclusion</td><td>Not more than one of the elements specified in the condition may be present.</td></tr><tr><td>C- Conditional</td><td>If the first element specified in the condition is present, then all other elements must be present. However, any or all 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.</td></tr></table>	Condition Code	Definition	P- Paired or Multiple	If any element specified in the relational condition is present, then all 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 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.
Condition Code	Definition										
P- Paired or Multiple	If any element specified in the relational condition is present, then all 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 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.										



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Term	Definition		
	<table border="1"><tr><td data-bbox="548 363 881 972">L- List Conditional</td><td data-bbox="881 363 1393 972">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 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.</td></tr></table>	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 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 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	<p>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.</p> <p>Semantic notes are considered part of the relevant transaction set standard. Semantic Note (Z)</p> <p>A semantic note is referenced in the segment directory for this data element with respect to its use in this data segment.</p>		



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Term	Definition
Data Segment, Absence of Data	<p>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.</p>
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	<p>In the hierarchical loop coding, the dependent code 23 indicates the use of the patient hierarchical loop (Loop ID-2000C).</p>



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Term	Definition
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



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Term	Definition
	(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, In Section 1.4.3.2.2.1 Hierarchical Level, HL Segment, (ANSI 837 Institutional) and for (ANSI 837 Professional) see Section B.1.1.4.3 in Appendix B contains a general description of HL structures Guides) for further details.
Transaction Set	The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment.
Transaction Set, Header, and Trailer	<p>The transaction set header and trailer segments are constructed as follows:</p> <ul style="list-style-type: none">• Transaction Set Header (ST)• Data Segment Group• Transaction Set Trailer (SE) <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</p>



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Term	Definition
	control segments must be identical for any given transaction. The value for the number of included segments is the total number of segments in the transaction set including the ST and SE segments.
Transaction Set, Data Segment Groups	The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.
Transaction Set, Repeated Occurrences of Single Data Segments	When a single data segment is allowed, to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is ">1".
Transaction Set, Loops of Data Segments	Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded
Transaction Set, Unbounded Loops.	<p>In order, to establish the iteration of a loop, the first data segment in the loop shall appear Unbounded once and only once in each iteration. Loops may have a specified maximum number of Loops repetitions.</p> <p>Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions ">1".</p> <p>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</p>



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Term	Definition
	<p>required. Each appearance of the beginning segment defines an occurrence of the loop.</p> <p>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.</p> <p>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).</p>
Transaction Set, Bounded Loops	<p>The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start segment to appear before the first occurrence and a loop end segment to appear after the last occurrence of the loop. If the loop does not occur, the segments shall be suppressed.</p> <p>The requirement designator on the segments must match the requirement designator of the beginning segment of the loop.</p> <p>A bounded loop may contain only one loop structure at the level bracketed by the segments. Subordinate loops are permissible. If bounded loops are nested within loops, the inner loop shall not start at</p>



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Term	Definition						
	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 Segment in a Transaction Set	When data segments are combined to form a transaction set, three characteristics are applied to each data segment: A requirement designator, a position in the transaction set, and a maximum occurrence.						
Transaction Set, Data Segment Requirement Designators	<p>A data segment, or loop, has one of the following requirement designators for health care Data Segment and insurance transaction sets, indicating its appearance in the data stream of a Requirement transmission. These requirement designators are represented by a single character code.</p> <table><tr><th>Designator</th><th>Requirement</th></tr><tr><td>(M) Mandatory</td><td>This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)</td></tr><tr><td>(O) Optional</td><td>The presence of this data segment is the option of the sending party.</td></tr></table>	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.
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 requirement						



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Term	Definition
	designators of the segments, this positioning must be maintained.
Transaction Set, Data Segment Occurrence	A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number.
Transmission Intermediary	A transmission intermediary is any entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term "intermediary" is not used to convey a specific Medicare contractor type.

5.1.2 Basic Structure

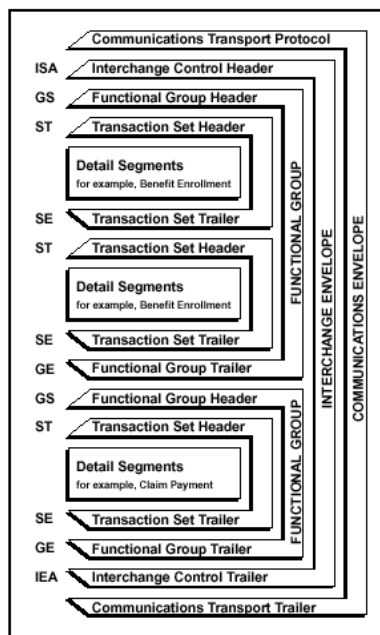


Figure 1. Basic 837 Structure

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 except for 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



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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.

5.1.3 Control Segments

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

5.1.4 Delimiters

A delimiter (from Section B.1.1.2.5 of ANSI 837 Institutional Guides) is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered in implementations compliant with this guide (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, and recommends, the delimiters shown in Table 4 - Delimiters, in all examples.

Table 4. Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
^	Caret	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator



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5.1.5 THCIC Implementation Usage

Only the sections and segments that are required or situational required by THCIC that are different from the ANSI 837 Institutional Guide sections are written in this manual. Following is a table of the data elements that have been modified from the ANSI 837 Institutional 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 formatted file with the additional required fields listed below, that data file should pass the audits at System13, Inc.

Some data elements are listed as “Situational” or “Not Used” in the ANSI 837 Institutional Guide but are REQUIRED by THCIC, as detailed in the following table.

Table 5. Data Element Comparisons

Data Element	Loop ID	Ref. Des.	Difference
National Provider Identification (NPI) number (facility)	2010AA or 2310C ¹	NM109	The Name segments in Loop 2310E are dependent upon who renders the service.
Employer Identification Number	2010AA or 2310C ¹	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.
Facility ID Number (THCIC ID #)	2010AA or 2010BB ² or 2310C	REF02	REF Segment is situational for all loops. Loop is dependent upon who renders the service to patient. Loop 2010BB usage is changed to “SITUATIONAL” from “REQUIRED” since this THCIC ID could be submitted in Loop 2010AA REF02
Claim Filing Indicator Code	2000B or 2320	SBR09	SBR09
Subscriber/Patient Social Security Number	2010BA	REF02	REF segment
Patient Social Security Number	2300	K301	K3 segment (Required, if patient is not listed as the subscriber and SSN reported in 2010BA REF02. SSN moves to 3rd -11th characters with



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Data Element	Loop ID	Ref. Des.	Difference
			change to new contract in response to HB 2641 84th Texas Legislature)
Patient Race	2300	K301	K3 segment second character
Principal Diagnosis	2300	HI01	HI segment
Patient Ethnicity	2300	K301	K3 segment first character
Medical Record Number	2300	REF02	REF segment
Subscriber Name	2010BA	NM103-Last NM104-First NM105-MI	Segment is situational for THCIC submissions, only required if Subscriber is Patient

1. Dependent on which facility is indicated as rendering the services to the patient.
2. Loop 2010BB (REF Segment) would not be used if THCIC ID reported in Loop 2010AA.

5.2 Transaction Set Listing

This section lists the levels, loops, and segments contained in the THCIC 837 Institutional Specifications, and describes the expected Transaction Set for each Inpatient claim submission.

Table 6. Header

POS	ID	NAME	USG	RPT	LOOP RPT
0050	ST	Transaction Set Header	R	1	
0100	BHT	Beginning of Hierarchical Transaction	R	1	
LOOP ID - 1000A SUBMITTER NAME					1
0200	NM1	Submitter Name	R	1	
LOOP ID - 1000B RECEIVER NAME					1
0200	NM1	Receiver Name	R	1	

Table 7. Billing Provider Detail

POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2000A BILLING PROVIDER HIERARCHICAL LEVEL					>1
0010	HL	Billing Provider Hierarchical Level	R	1	



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POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2010AA BILLING PROVIDER NAME					1
0150	NM1	Billing Provider Name	R	1	
0250	N3	Billing Provider Address	R	1	
0300	N4	Billing Provider City, State, ZIP Code	R	1	
0350	REF	Billing Provider Tax Identification	R	1	
0350	REF	Billing Provider THCIC Identification	S	1	

Table 8. Subscriber Detail

POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL					>1
0010	HL	Subscriber Hierarchical Level	R	1	
0050	SBR	Subscriber Information	R	1	
LOOP ID - 2010BA SUBSCRIBER NAME					1
0150	NM1	Subscriber Name	S	1	
0250	N3	Subscriber Address	R	1	
0300	N4	Subscriber City, State, ZIP Code	R	1	
0320	DMG	Subscriber Demographic Information	R	1	
0350	REF	Subscriber Secondary Identification	R	1	
LOOP ID - 2010BB PAYER NAME					1
0150	NM1	Payer Name	R	1	
0350	REF	Billing Provider Secondary Identification	S	1	

Table 9. Patient Detail

POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL					>1
0010	HL	Patient Hierarchical Level	S	1	
0070	PAT	Patient Information	R	1	
LOOP ID - 2010CA PATIENT NAME					1
0150	NM1	Patient Name	S	1	
0250	N3	Patient Address	R	1	
0300	N4	Patient City, State, ZIP Code	R	1	
0320	DMG	Patient Demographic Information	R	1	
LOOP ID - 2300 CLAIM INFORMATION					100
1300	CLM	Claim Information	R	1	
1800	REF	Medical Record Number	S	1	
1850	K3	File Information	S	10	
2310	HI	Health Care Diagnosis Code	R	1	
2310	HI	Anesthesia Related Procedure	S	1	



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POS	ID	NAME	USG	RPT	LOOP RPT
LOOP ID - 2310B RENDERING PROVIDER NAME					1
2500	NM1	Attending Provider Name	R	1	
2710	REF	Attending Provider Secondary Identification	R	1	
LOOP ID - 2310C SERVICE FACILITY LOCATION NAM					1
2500	NM1	Service Facility Location Name	S	1	
2650	N3	Service Facility Location Address	R	1	
2700	N4	Service Facility Location City, State, ZIP Code	R	1	
2710	REF	Service Facility Location Secondary Identification	S	1	
LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION					1
2900	SBR	Other Subscriber Information	S	1	
LOOP ID - 2330B OTHER PAYER NAME					1
3250	NM1	Other Payer Name	S	1	
LOOP ID - 2400 SERVICE LINE NUMBER					50
3650	LX	Service Line Number	R	1	
3750	SV1	Professional Service	R	1	
4550	DTP	Date - Service Date	R	1	
LOOP ID - 2420A RENDERING PROVIDER NAME					1
2500	NM1	Attending Provider Name	R	1	
2710	REF	Attending Provider Secondary Identification	R	1	
5550	SE	Transaction Set Trailer	R	1	

5.3 837 Segment Detail

This section specifies the segments, data elements, and codes for this implementation. Additional segment details can be found in Section 2.4 837 Segment Detail of the ASC X12N/005010X222 Health Care Claim: Professional (837) Specifications.

ST - TRANSACTION SET HEADER

To indicate the start of a transaction set and to assign a control number.

Repeat: 1

Usage: REQUIRED

Example: **ST*837*987654*005010X222A1~**



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Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES				
REQUIRED	ST01	143	Transaction Set Identifier Code	M 1 ID 3/3				
Code uniquely identifying a Transaction Set								
SEMANTIC: The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).								
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>837</td><td>Health Care Claim</td></tr></table>					CODE	DEFINITION	837	Health Care Claim
CODE	DEFINITION							
837	Health Care Claim							
REQUIRED	ST02	329	Transaction Set Control Number	M 1 AN 4/9				
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. The number must be unique within a specific interchange (ISA-IEA) but can repeat in other interchanges.								
REQUIRED	ST03	1705	Implementation Convention Reference	O 1 AN 1/35				
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.								
INDUSTRY NAME: Implementation Guide Version Name								
This element must be populated with the following value:								
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>005010X222A1</td><td>Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003</td></tr></table>					CODE	DEFINITION	005010X222A1	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
CODE	DEFINITION							
005010X222A1	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003							
This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (ST-SE) processing. Providing the information from the GS08 at this level								



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will ensure that the appropriate application mapping is used at translation time.

BHT - BEGINNING OF HIERARCHICAL TRANSACTION

To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time.

Repeat: 1

Usage: REQUIRED

Notes: 1. THCIC treats each submission as Original, irrespective of the value in BHT02.
2. The value for BHT03 MUST NOT be duplicated or reused within a 12-month timeframe.

At the time of this writing, Subrogation Demand is not a HIPAA mandated use of the 837 transaction.

Example: **BHT*0019*00*0123*20040618*0932*CH~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	BHT01	1005	Hierarchical Structure Code	M 1 ID 4/4						
Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0019</td><td>Information Source, Subscriber, Dependent</td></tr></table>					CODE	DEFINITION	0019	Information Source, Subscriber, Dependent		
CODE	DEFINITION									
0019	Information Source, Subscriber, Dependent									
REQUIRED	BHT02	353	Transaction Set Purpose Code	M 1 ID 2/2						
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.										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>00</td><td>Original</td></tr><tr><td>18</td><td>Reissue</td></tr></table>					CODE	DEFINITION	00	Original	18	Reissue
CODE	DEFINITION									
00	Original									
18	Reissue									
REQUIRED	BHT03	127	Reference Identification	O 1 AN 1/50						



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Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.

INDUSTRY NAME: Originator Application Transaction Identifier

The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control number.

REQUIRED BHT04 373 Date O 1 DT 8/8

Date expressed as CCYYMMDD

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

INDUSTRY NAME: Transaction Set Creation Date

This is the date that the original submitter created the claim file from their business application system.

REQUIRED BHT05 337 Time O 1 TM 4/8

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

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

INDUSTRY NAME: Transaction Set Creation Time

This is the time that the original submitter created the claim file from their business application system.

REQUIRED BHT06 640 Transaction Type Code O 1 ID 2/2

Code specifying the type of transaction

IMPLEMENTATION NAME: Claim Identifier

CODE	DEFINITION
31	Subrogation Demand
CH	Chargeable
RP	Reporting



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NM1 - SUBMITTER NAME

To supply the full name of an individual or organizational entity.

Loop: 1000A — SUBMITTER NAME Loop Repeat: 1

Repeat: 1

Usage: REQUIRED

Notes: 1. The submitter is the entity responsible for the creation and formatting of this transaction.

2. The value of NM109 MUST match ISA06 and GS02.

Example: **NM1*41*2*ABC SUBMITTER*****46*999999999~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			CODE	DEFINITION
			41	Submitter
REQUIRED	NM102	1065	Entity Type Qualifier	M 1 ID 1/1
			Code qualifying the type of entity	
			SEMANTIC: NM102 qualifies NM103.	
			CODE	DEFINITION
			1	Person
			2	Non-Person Entity
REQUIRED	NM103	1035	Name Last or Organization Name	X 1 AN 1/60
			Individual last name or organizational name	
			INDUSTRY NAME: Submitter Last or Organization Name	
SITUATIONAL	NM104	1036	Name First	O 1 AN 1/35
			Individual first name	
			Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.	
			INDUSTRY NAME: Submitter First Name	
SITUATIONAL	NM105	1037	Name Middle	O 1 AN 1/25

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Individual middle name or initial

Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.**INDUSTRY NAME: Submitter Middle Name or Initial**

NOT USED	NM106	1038	Name Prefix	O	1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O	1	AN	1/10
REQUIRED	NM108	66	Identification Code Qualifier	X	1	ID	1/2

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

CODE DEFINITION

46	Electronic Transmitter Identification Number (ETIN)
	Established by trading partner agreement

REQUIRED	NM109	67	Identification Code	X	1	AN	2/80
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Code identifying a party or other code

INDUSTRY NAME: Submitter Identifier**CODE DEFINITION**

SUBnnn	System13, Inc. Submitter ID Number
---------------	---

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

NM1 - RECEIVER NAME

To supply the full name of an individual or organizational entity.

Loop: 1000B — RECEIVER NAME Loop Repeat: 1

Repeat: 1

Usage: REQUIRED

Example: **NM1*40*2*XYZRECEIVER*****46*111222333~**



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Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	NM101	98	Entity Identifier Code	M	1	ID	2/3
			Code identifying an organizational entity, a physical location, property or an individual				
			CODE	DEFINITION			
			40	Receiver			
REQUIRED	NM102	1065	Entity Type Qualifier	M	1	ID	1/1
			Code qualifying the type of entity				
			SEMANTIC: NM102 qualifies NM103.				
			CODE	DEFINITION			
			2	Non-Person Entity			
REQUIRED	NM103	1035	Name Last or Organization Name	X	1	AN	1/60
			Individual last name or organizational name				
			INDUSTRY NAME: Receiver Name				
			CODE	DEFINITION			
			THCIC	Identifies THCIC as the Receiver			
NOT USED	NM104	1036	Name First	O	1	AN	1/35
NOT USED	NM105	1037	Name Middle	O	1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O	1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O	1	AN	1/10
REQUIRED	NM108	66	Identification Code Qualifier	X	1	ID	1/2
			Code designating the system/method of code structure used for Identification Code (67)				
			CODE	DEFINITION			
			46	Electronic Transmitter Identification Number (ETIN)			
REQUIRED	NM109	67	Identification Code	X	1	AN	2/80
			Code identifying a party or other code				
			INDUSTRY NAME: Receiver Primary Identifier				
			CODE	DEFINITION			
			YTH837	THCIC Receiver Code			
NOT USED	NM110	706	Entity Relationship Code	X	1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O	1	AN	1/60

**Healthcare Facility Procedures and Technical Specifications Manual****HL - BILLING PROVIDER HIERARCHICAL LEVEL**

To identify dependencies among and the content of hierarchically related groups of data segments.

- Loop: 2000A — BILLING PROVIDER HIERARCHICAL LEVEL Loop Repeat: >1
- Repeat: 1
- Usage: REQUIRED
- Notes:
1. Use the Billing Provider HL to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.
 2. The Billing Provider Hierarchical Level may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID- 2010AA.
 3. If the Service Facility Provider is the same entity as the Billing Provider then do not use Loop 2310C.
 4. 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~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12
			A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	
			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.	
NOT USED	HL02	734	Hierarchical Parent ID Number	O 1 AN 1/12
REQUIRED	HL03	735	Hierarchical Level Code	M 1 ID 1/2

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Code defining the characteristic of a level in a hierarchical structure

CODE DEFINITION**20 Information Source**

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

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

CODE DEFINITION**1 Additional Subordinate HL Data Segment in This Hierarchical Structure.****NM1 - BILLING PROVIDER NAME**

To supply the full name of an individual or organizational entity.

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

Repeat: 1

Usage: REQUIRED

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
2. Use Loop ID 2310E if the Billing Provider did not render

Example: **NM1*85*2*ABC HOSPITAL*****XX*1234567890~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3

Code identifying an organizational entity, a physical location, property or an individual

CODE DEFINITION**85 Billing Provider**

REQUIRED	NM102	1065	Entity Type Qualifier	M 1 ID 1/1
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Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

CODE DEFINITION



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		2	Non-Person Entity			
REQUIRED	NM103	1035	Name Last or Organization Name	X	1	AN 1/60
			Individual last name or organizational name			
			INDUSTRY NAME: Billing Provider Organizational Name			
			This is the name of the facility as reported to Bureau of Facility Licensing, Texas Department of Health.			
NOT USED	NM104	1036	Name First	O	1	AN 1/35
NOT USED	NM105	1037	Name Middle	O	1	AN 1/25
NOT USED	NM106	1038	Name Prefix	O	1	AN 1/10
NOT USED	NM107	1039	Name Suffix	O	1	AN 1/10
SITUATIONAL	NM108	66	Identification Code Qualifier	X	1	ID 1/2
			Code designating the system/method of code structure used for Identification Code (67)			
			CODE	DEFINITION		
			XX	Centers for Medicare and Medicaid Services National Provider Identifier		
SITUATIONAL	NM109	67	Identification Code	X	1	AN 2/80
			Code identifying a party or other code			
			INDUSTRY NAME: Billing Provider Identifier			
			CODE	DEFINITION		
			XXXXXXXXXX	National Provider Identifier (NPI) Number		
			nnnnnnnnnn	Employer Identification Number (EIN)		
NOT USED	NM110	706	Entity Relationship Code	X	1	ID 2/2
NOT USED	NM111	98	Entity Identifier Code	O	1	ID 2/3
NOT USED	NM112	1035	Name Last or Organization Name	O	1	AN 1/60

N3 - BILLING PROVIDER ADDRESS

To specify the location of the named party.

Loop: 2010AA — BILLING PROVIDER NAME

Repeat: 1

Usage: REQUIRED



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- Notes:
1. The first 15 characters of N301 are used to validate the billing provider.
 2. Post Office Box addresses are not allowed.

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
			INDUSTRY NAME: Billing Provider Address Line	
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
			Required when there is a second address line. If not required by this implementation guide, do not send.	
			INDUSTRY NAME: Billing Provider Address Line	

N4 - BILLING PROVIDER CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2010AA — BILLING PROVIDER NAME
Repeat: 1
Usage: REQUIRED
Notes: 1. THCIC does not require a nine-digit zip code for Billing Provider.
Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name	O 1 AN 2/30
			INDUSTRY NAME: Billing Provider City Name	
REQUIRED	N402	156	State or Province Code	X 1 ID 2/2



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Code (Standard State/Province) as defined by appropriate government agency

INDUSTRY NAME: Billing Provider State or Province Code

REQUIRED	N403	116	Postal Code	O	1	ID	3/15
-----------------	-------------	------------	--------------------	----------	----------	-----------	-------------

Code defining international postal zone code excluding punctuation and blanks (zip code for United States)

INDUSTRY NAME: Billing Provider Postal Zone or ZIP Code

When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.

NOT USED	N404	26	Country Code	X	1	ID	2/3
NOT USED	N405	309	Location Qualifier	X	1	ID	1/2
NOT USED	N406	310	Location Identifier	O	1	AN	1/30
NOT USED	N407	1715	Country Subdivision Code	X	1	ID	1/3

REF - BILLING PROVIDER TAX IDENTIFICATION

To specify identifying information.

Loop: 2010AA — BILLING PROVIDER NAME

Repeat: 1

Usage: REQUIRED

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~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	REF01	128	Reference Identification Qualifier	M	1	ID	2/3
Code qualifying the Reference Identification							
		CODE	DEFINITION				



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			EI	Employer's Identification Number			
			The Employer's Identification Number must be a string of exactly nine numbers with no separators.				
REQUIRED	REF02	127	Reference Identification	X	1	AN	1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			INDUSTRY NAME: Billing Provider Tax Identification Number				
			CODE	DEFINITION			
			nnnnnnnnnn	Employer Identification Number (EIN)			
NOT USED	REF03	352	Description	X	1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O	1		

REF - BILLING PROVIDER THCIC IDENTIFICATION

To specify THCIC identifying information.

Loop: 2010AA — BILLING PROVIDER NAME

Repeat: 1

Usage: SITUATIONAL

Notes:

1. THCIC allows a second REF segment in Loop 2010AA. THCIC requires the 6-digit number (THCIC ID) assigned to the Provider identified in Loop 2010AA. The THCIC ID, along with either the NPI (NM109), EIN (REF02), and the Address (N301) is used to verify a Provider's identity.
2. If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310E.
3. The Billing Provider Secondary Identification moved to Loop 2010BB (Payer Name) in the Subscriber Hierarchical Level. THCIC allows for either location to be used.

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
-------	-----------	-----------------	------	------------



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REQUIRED	REF01	128	Reference Identification Qualifier	M	1	ID	2/3				
Code qualifying the Reference Identification											
<table><tr><td>CODE</td><td>DEFINITION</td></tr><tr><td>1J</td><td>Facility ID Number</td></tr></table>								CODE	DEFINITION	1J	Facility ID Number
CODE	DEFINITION										
1J	Facility ID Number										
REQUIRED	REF02	127	Reference Identification	X	1	AN	1/50				
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier											
<table><tr><td>CODE</td><td>DEFINITION</td></tr><tr><td>nnnnnn</td><td>ID Number assigned by THCIC</td></tr></table>								CODE	DEFINITION	nnnnnn	ID Number assigned by THCIC
CODE	DEFINITION										
nnnnnn	ID Number assigned by THCIC										
NOT USED	REF03	352	Description	X	1	AN	1/80				
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O	1						

HL - SUBSCRIBER HIERARCHICAL LEVEL

To identify dependencies among and the content of hierarchically related groups of data segments.

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL Loop Repeat: >1
Repeat: 1
Usage: REQUIRED
Notes: 1. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA).
2. 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.

Example: **HL*2*1*22*1~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12
A unique number assigned by the sender to identify a particular data segment in a hierarchical structure				
The first HL01 within each ST-SE envelope must begin with "1" and be incremented by one each				



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			time an HL is used in the transaction. Only numeric values are allowed in HL01.			
REQUIRED	HL02	734	Hierarchical Parent ID Number	O	1	AN 1/12
			Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to			
REQUIRED	HL03	735	Hierarchical Level Code	M	1	ID 1/2
			Code defining the characteristic of a level in a hierarchical structure			
			CODE	DEFINITION		
			22	Subscriber		
REQUIRED	HL04	736	Hierarchical Child Code	O	1	ID 1/1
			Code indicating if there are hierarchical child data segments subordinate to the level being described			
			The claim (Loop ID-2300) can be used 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 for one or more dependents of the subscriber are being sent under the same billing provider HL (for example, a spouse and son are both treated by the same provider).			
			CODE	DEFINITION		
			0	No Subordinate HL Segment in This Hierarchical Structure.		
			1	Additional Subordinate HL Data Segment in This Hierarchical Structure.		

SBR - SUBSCRIBER INFORMATION

To record information specific to the primary insured and the insurance carrier for that insured.

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL

Repeat: 1



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Usage: REQUIRED

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

Element Detail

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	1	ID	1/1
				CODE	DEFINITION		
				P	Primary		
SITUATIONAL	SBR02	1069	Individual Relationship Code Code indicating the relationship between two individuals or entities SEMANTIC: SBR02 specifies the relationship to the person insured. Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.	O	1	ID	2/2
				CODE	DEFINITION		
				18	Self		
NOT USED	SBR03	127	Reference Identification	O	1	AN	1/50
NOT USED	SBR04	93	Name	O	1	AN	1/60
NOT USED	SBR05	1336	Insurance Type Code	O	1	ID	1/3
NOT USED	SBR06	1143	Coordination of Benefits Code	O	1	ID	1/1
NOT USED	SBR07	1073	Yes/No Condition or Response Code	O	1	ID	1/1
NOT USED	SBR08	584	Employment Status Code	O	1	ID	2/2
REQUIRED	SBR09	1032	Claim Filing Indicator Code Code identifying type of claim	O	1	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		



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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	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	Use Code ZZ when Type of Insurance is not known.

NM1 - SUBSCRIBER NAME

To supply the full name of an individual or organizational entity.

Loop: 2010BA — SUBSCRIBER NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

- Notes:
1. Loop ID 2010BA is Required when Subscriber is the Patient.
 2. Loop ID 2010BA is Not Used when Subscriber is not the Patient.
 3. Loop ID 2010CA is Required when Subscriber is not the Patient.
 4. In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (for example, the employer).
 5. NM109, when it contains SSN, MUST match the value for REF – Subscriber Secondary Information.

For patients that are covered by 42 USC 290DD-2 or 42 CFR Part 2 and facilities that are participating with SAMSHA, use



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the following naming conventions: JOHN or JANE DOE. Sequential Numbering is allowed, for example: JOHN1, JANE2, etc.

Example: **NM1*IL*1*DOE*JOHN*T**JR*MI*123456~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			CODE	DEFINITION
			IL	Insured or Subscriber
REQUIRED	NM102	1065	Entity Type Qualifier	M 1 ID 1/1
			Code qualifying the type of entity	
			SEMANTIC: NM102 qualifies NM103.	
			CODE	DEFINITION
			1	Person
			2	Non-Person Entity
REQUIRED	NM103	1035	Name Last or Organization Name	X 1 AN 1/60
			Individual last name or organizational name	
			INDUSTRY NAME: Subscriber Last Name	
SITUATIONAL	NM104	1036	Name First	O 1 AN 1/35
			Individual first name	
			Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.	
			INDUSTRY NAME: Subscriber First Name	
SITUATIONAL	NM105	1037	Name Middle	O 1 AN 1/25
			Individual middle name or initial	
			Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.	
			INDUSTRY NAME: Subscriber Middle Name or Initial	
NOT USED	NM106	1038	Name Prefix	O 1 AN 1/10
NOT USED	NM107	1039	Name Suffix	O 1 AN 1/10

*Healthcare Facility Procedures and Technical Specifications Manual***SITUATIONAL NM108 66 Identification Code Qualifier X 1 ID 1/2**

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

Required when NM102 = 1 (person). If not required by this implementation guide, do not send.**CODE DEFINITION****II** Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value `MI' instead.**MI** Member Identification Number The code MI is intended to be the subscriber's identification number as assigned by the payer. (For example, Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.)

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 (SSN) is also available on an IHS/CHS claim, put the SSN in REF02.

SITUATIONAL NM109 67 Identification Code X 1 AN 2/80

Code identifying a party or other code

Required when NM102 = 1 (person). If not required by this implementation guide, do not send.**INDUSTRY NAME: Subscriber Primary Identifier****NOT USED NM110 706 Entity Relationship Code X 1 ID 2/2****NOT USED NM111 98 Entity Identifier Code O 1 ID 2/3****NOT USED NM112 1035 Name Last or Organization Name O 1 AN 1/60****N3 - SUBSCRIBER ADDRESS**

To specify the location of the named party.



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Loop: 2010BA — SUBSCRIBER NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
			INDUSTRY NAME: Subscriber Address Line	
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
			Required when there is a second address line. If not required by this implementation guide, do not send.	
			INDUSTRY NAME: Subscriber Address Line	

N4 - SUBSCRIBER CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2010BA — SUBSCRIBER NAME

Repeat: 1

Usage: REQUIRED

Notes: 1. Refer to Appendix A1 – Valid Country Codes and State Codes for a list of valid State and Province Codes allowed in N402.

Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name	O 1 AN 2/30



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			INDUSTRY NAME: Subscriber City Name			
REQUIRED	N402	156	State or Province Code	X	1	ID 2/2
			Code (Standard State/Province) as defined by appropriate government agency			
			INDUSTRY NAME: Subscriber State Code			
			CODE	DEFINITION		
			aa	Valid State or Province Code		
			FC	Foreign Country		
			XX	Foreign Country		
REQUIRED	N403	116	Postal Code	O	1	ID 3/15
			Code defining international postal zone code excluding punctuation and blanks (zip code for United States)			
			INDUSTRY NAME: Subscriber Postal Zone or ZIP Code			
			When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.			
			CODE	DEFINITION		
			00000	Foreign Country; Recommended value for foreign addresses		
			XXXXX	Foreign Country		
NOT USED	N404	26	Country Code	X	1	ID 2/3
NOT USED	N405	309	Location Qualifier	X	1	ID 1/2
NOT USED	N406	310	Location Identifier	O	1	AN 1/30
NOT USED	N407	1715	Country Subdivision Code	X	1	ID 1/3

DMG - SUBSCRIBER DEMOGRAPHIC INFORMATION

To supply demographic information.

Loop: 2010BA — SUBSCRIBER NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.
2. DMG03 is gender, or sex at birth.

Example: **DMG*D8*19690815*M~**



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Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES											
REQUIRED	DMG01	1250	Date Time Period Format Qualifier	X	1	ID	2/3								
Code indicating the date format, time format, or date and time format															
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>D8</td><td>Date Expressed in Format CCYYMMDD</td></tr></table>								CODE	DEFINITION	D8	Date Expressed in Format CCYYMMDD				
CODE	DEFINITION														
D8	Date Expressed in Format CCYYMMDD														
REQUIRED	DMG02	1251	Date Time Period	X	1	AN	1/35								
Expression of a date, a time, or range of dates, times or dates and times															
SEMANTIC: DMG02 is the date of birth.															
INDUSTRY NAME: Subscriber Birth Date															
REQUIRED	DMG03	1068	Gender Code	O	1	ID	1/1								
Code indicating the sex of the individual															
INDUSTRY NAME: Subscriber Gender Code															
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>F</td><td>Female</td></tr><tr><td>M</td><td>Male</td></tr><tr><td>U</td><td>Unknown</td></tr></table>								CODE	DEFINITION	F	Female	M	Male	U	Unknown
CODE	DEFINITION														
F	Female														
M	Male														
U	Unknown														
NOT USED	DMG04	1067	Marital Status	O	1	ID	I/1								
NOT USED	DMG05	C056	COMPOSITE RACE OR ETHNICITY INFORMATION	X	10										
NOT USED	DMG06	1066	Citizenship Status Code	O	1	ID	1/2								
NOT USED	DMG07	26	Country Code	O	1	ID	2/3								
NOT USED	DMG08	659	Basis of Verification Code	O	1	ID	1/2								
NOT USED	DMG09	380	Quantity	O	1	R	1/15								
NOT USED	DMG10	1270	Code List Qualifier Code	X	1	ID	1/3								
NOT USED	DMG11	1271	Industry Code	X	1	AN	1/30								

REF - SUBSCRIBER SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2010BA — SUBSCRIBER NAME

Repeat: 1



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Usage: SITUATIONAL

- Notes:
1. Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.
 2. Required when an additional identification number to that provided in NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.
 3. The value in REF02 MUST match NM109 when the Subscriber is the patient and NM109 contains the SSN.

Example: **REF*SY*123456789~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	REF01	128	Reference Identification Qualifier	M 1 ID 2/3						
Code qualifying the Reference Identification										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>SY</td><td>Social Security Number The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.</td></tr></table>					CODE	DEFINITION	SY	Social Security Number The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.		
CODE	DEFINITION									
SY	Social Security Number The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.									
REQUIRED	REF02	127	Reference Identification	X 1 AN 1/50						
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier										
INDUSTRY NAME: Subscriber Supplemental Identifier										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>nnnnnnnnnn</td><td>Social Security Number</td></tr><tr><td>999999999</td><td>Unknown SSN This value is required for: 1. Newborns without an SSN 2. Foreigners without an SSN 3. Patients refusing or cannot provide an SSN</td></tr></table>					CODE	DEFINITION	nnnnnnnnnn	Social Security Number	999999999	Unknown SSN This value is required for: 1. Newborns without an SSN 2. Foreigners without an SSN 3. Patients refusing or cannot provide an SSN
CODE	DEFINITION									
nnnnnnnnnn	Social Security Number									
999999999	Unknown SSN This value is required for: 1. Newborns without an SSN 2. Foreigners without an SSN 3. Patients refusing or cannot provide an SSN									
NOT USED	REF03	352	Description	X 1 AN 1/80						
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1						



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NM1 - PAYER NAME

To supply the full name of an individual or organizational entity.

Loop: 2010BB — PAYER NAME Loop Repeat: 1
Repeat: 1
Usage: REQUIRED
Notes: 1. No Patient Personally Identifiable Information (PII) data should be present.
2. This is the destination payer; primary or only payer.
3. For the purposes of this implementation the term payer is synonymous with several other terms, such as, reprinter and third-party administrator.

Example: **NM1*PR*2*ABC INSURANCE CO*****PI*11122333~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			CODE	DEFINITION
			PR	Payer
REQUIRED	NM102	1065	Entity Type Qualifier	M 1 ID 1/1
			Code qualifying the type of entity	
			SEMANTIC: NM102 qualifies NM103.	
			CODE	DEFINITION
			2	Non-Person Entity
REQUIRED	NM103	1035	Name Last or Organization Name	X 1 AN 1/60
			Individual last name or organizational name	
			INDUSTRY NAME: Payer Name	
			CODE	DEFINITION
			SELF-PAY	For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")
			CHARITY	For Charity Claims (Claim Filing Indicator Code is "ZZ")



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			UNKNOWN With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")			
NOT USED	NM104	1036	Name First	O	1	AN 1/35
NOT USED	NM105	1037	Name Middle	O	1	AN 1/25
NOT USED	NM106	1038	Name Prefix	O	1	AN 1/10
NOT USED	NM107	1039	Name Suffix	O	1	AN 1/10
REQUIRED	NM108	66	Identification Code Qualifier	X	1	ID 1/2
Code designating the system/method of code structure used for Identification Code (67)						
			CODE	DEFINITION		
			PI	Payor Identification unless Self-Pay, Charity, or Unknown Payer claim		
			XV	Centers for Medicare and Medicaid Services PlanID		
			ZY	Temporary Identification Number for use with Self-Pay, Charity, or Unknown Payer claim		
REQUIRED	NM109	67	Identification Code	X	1	AN 2/80
Code identifying a party or other code						
INDUSTRY NAME: Payer Identifier						
			CODE	DEFINITION		
			XXXXXXXXXX	National Plan Identifier (NPI) Number		
				CMS currently has delayed the implementation date for all plans and providers until further notice.		
			SELF-PAY	For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")		
			CHARITY	For Charity Claims (Claim Filing Indicator Code is "ZZ")		
			UNKNOWN	With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")		
NOT USED	NM110	706	Entity Relationship Code	X	1	ID 2/2
NOT USED	NM111	98	Entity Identifier Code	O	1	ID 2/3
NOT USED	NM112	1035	Name Last or Organization Name	O	1	AN 1/60

REF - BILLING PROVIDER SECONDARY IDENTIFICATION

To specify THCIC identifying information.



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Loop: 2010BB — PAYER NAME
Repeat: 1
Usage: SITUATIONAL
Notes: 1. If the THCIC ID is not submitted in Loop ID 2010AA REF segment REF01 (with qualifier "1J" in the REF02), then it is REQUIRED to be submitted here.
2. THCIC requires the 6-digit number (THCIC ID) assigned to the Provider identified in Loop 2010AA. The THCIC ID, along with either the NPI (NM109), EIN (REF02), and the Address (N301) is used to verify a Provider's identity.
3. If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310E.

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier	M 1 ID 2/3
			Code qualifying the Reference Identification	
			CODE	DEFINITION
			1J	Facility ID Number
REQUIRED	REF02	127	Reference Identification	X 1 AN 1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
			CODE	DEFINITION
			nnnnnn	ID Number assigned by THCIC
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

HL - PATIENT HIERARCHICAL LEVEL

To identify dependencies among and the content of hierarchically related groups of data segments.



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Loop: 2000C — PATIENT HIERARCHICAL LEVEL Loop Repeat: >1
Repeat: 1
Usage: SITUATIONAL
Notes: 1. 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.
2. There are no HLs subordinate to the Patient HL.
3. 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.

Example: **HL*3*2*23*0~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12						
A unique number assigned by the sender to identify a particular data segment in a hierarchical structure										
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.										
REQUIRED	HL02	734	Hierarchical Parent ID Number	O 1 AN 1/12						
Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to										
REQUIRED	HL03	735	Hierarchical Level Code	M 1 ID 1/2						
Code defining the characteristic of a level in a hierarchical structure										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>23</td><td>Dependent</td></tr><tr><td colspan="2">The code DEPENDENT conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.</td></tr></table>					CODE	DEFINITION	23	Dependent	The code DEPENDENT conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.	
CODE	DEFINITION									
23	Dependent									
The code DEPENDENT conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.										
REQUIRED	HL04	736	Hierarchical Child Code	O 1 ID 1/1						



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

CODE	DEFINITION
0	No Subordinate HL Segment in This Hierarchical Structure.

PAT - PATIENT INFORMATION

To supply patient information.

Loop: 2000C — PATIENT HIERARCHICAL LEVEL

Repeat: 1

Usage: SITUATIONAL

Notes: 1. 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: **PAT*01~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																							
REQUIRED	PAT01	1069	Individual Relationship Code	0	1	ID	2/2																				
Code indicating the relationship between two individuals or entities																											
Specifies the patient's relationship to the person insured.																											
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>01</td><td>Spouse</td></tr><tr><td>18</td><td>Self</td></tr><tr><td>19</td><td>Child</td></tr><tr><td>20</td><td>Employee</td></tr><tr><td>21</td><td>Unknown</td></tr><tr><td>39</td><td>Organ Donor</td></tr><tr><td>40</td><td>Cadaver Donor</td></tr><tr><td>53</td><td>Life Partner</td></tr><tr><td>G8</td><td>Other Relationship</td></tr></table>								CODE	DEFINITION	01	Spouse	18	Self	19	Child	20	Employee	21	Unknown	39	Organ Donor	40	Cadaver Donor	53	Life Partner	G8	Other Relationship
CODE	DEFINITION																										
01	Spouse																										
18	Self																										
19	Child																										
20	Employee																										
21	Unknown																										
39	Organ Donor																										
40	Cadaver Donor																										
53	Life Partner																										
G8	Other Relationship																										
NOT USED	PAT02	1384	Patient Location Code	0	1	ID	1/1																				



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

NM1 - PATIENT NAME

To supply the full name of an individual or organizational entity.

Loop: 2010CA — PATIENT NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Loop ID 2010CA is Required when Subscriber is not the Patient.
2. Patient SSN MUST be captured in the K3 segment.

For patients that are covered by 42 USC 290DD-2 or 42 CFR Part 2 and facilities that are participating with SAMSHA, use the following naming conventions: JOHN or JANE DOE. Sequential Numbering is allowed, for example: JOHN1, JANE2, etc.

Example: **NM1*QC*1*DOE*SALLY*J~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			CODE DEFINITION	
			QC Patient	
REQUIRED	NM102	1065	Entity Type Qualifier	M 1 ID 1/1
			Code qualifying the type of entity	



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SEMANTIC: NM102 qualifies NM103.

			CODE	DEFINITION				
			1	Person				
REQUIRED	NM103	1035	Name Last or Organization Name		X	1	AN	1/60
			Individual last name or organizational name					
			INDUSTRY NAME: Patient Last Name					
SITUATIONAL	NM104	1036	Name First		O	1	AN	1/35
			Individual first name					
			Required when the person has a first name. If not required by this implementation guide, do not send.					
			INDUSTRY NAME: Patient First Name					
SITUATIONAL	NM105	1037	Name Middle		O	1	AN	1/25
			Individual middle name or initial					
			Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.					
			INDUSTRY NAME: Patient Middle Name or Initial					
NOT USED	NM106	1038	Name Prefix		O	1	AN	1/10
NOT USED	NM107	1039	Name Suffix		O	1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier		X	1	ID	1/2
NOT USED	NM109	67	Identification Code		X	1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code		X	1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code		O	1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name		O	1	AN	1/60

N3 - PATIENT ADDRESS

To specify the location of the named party.

Loop: 2010CA — PATIENT NAME

Repeat: 1

Usage: REQUIRED

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



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Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
INDUSTRY NAME: Patient Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
Required when there is a second address line. If not required by this implementation guide, do not send.				
INDUSTRY NAME: Patient Address Line				

N4 - PATIENT CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2010CA — PATIENT NAME
Repeat: 1
Usage: REQUIRED
Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES											
REQUIRED	N401	19	City Name	O	1	AN	2/30								
Free-form text for city name															
INDUSTRY NAME: Patient City Name															
REQUIRED	N402	156	State or Province Code	X	1	ID	2/2								
Code (Standard State/Province) as defined by appropriate government agency															
INDUSTRY NAME: Patient State Code															
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>aa</td><td>Valid State or Province Code</td></tr><tr><td>FC</td><td>Foreign Country</td></tr><tr><td>XX</td><td>Foreign Country</td></tr></table>								CODE	DEFINITION	aa	Valid State or Province Code	FC	Foreign Country	XX	Foreign Country
CODE	DEFINITION														
aa	Valid State or Province Code														
FC	Foreign Country														
XX	Foreign Country														
REQUIRED	N403	116	Postal Code	O	1	ID	3/15								



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Code defining international postal zone code excluding punctuation and blanks (zip code for United States)

INDUSTRY NAME: Patient Postal Zone or ZIP Code

When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.

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

00000	Foreign Country; Recommended value for foreign addresses
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XXXXX	Foreign Country
--------------	------------------------

NOT USED	N404	26	Country Code	X	1	ID	2/3
NOT USED	N405	309	Location Qualifier	X	1	ID	1/2
NOT USED	N406	310	Location Identifier	O	1	AN	1/30
NOT USED	N407	1715	Country Subdivision Code	X	1	ID	1/3

DMG - PATIENT DEMOGRAPHIC INFORMATION

To supply demographic information.

Loop: 2010CA — PATIENT NAME

Repeat: 1

Usage: REQUIRED

Notes: 1. DMG03 is gender, or sex at birth.

Example: **DMG*D8*19690815*M~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	DMG01	1250	Date Time Period Format Qualifier	X	1	ID	2/3
Code indicating the date format, time format, or date and time format							
		CODE	DEFINITION				
		D8	Date Expressed in Format CCYYMMDD				
REQUIRED	DMG02	1251	Date Time Period	X	1	AN	1/35
Expression of a date, a time, or range of dates, times or dates and times							

**Healthcare Facility Procedures and Technical Specifications Manual****SEMANTIC:** DMG02 is the date of birth.**INDUSTRY NAME: Patient Birth Date**

REQUIRED	DMG03	1068	Gender Code	O	1	ID	1/1
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Code indicating the sex of the individual

INDUSTRY NAME: Patient Gender Code**CODE** **DEFINITION****F** **Female****M** **Male****U** **Unknown**

NOT USED	DMG04	1067	Marital Status	O	1	ID	1/1
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NOT USED	DMG05	C056	COMPOSITE RACE OR ETHNICITY INFORMATION	X	10		
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NOT USED	DMG06	1066	Citizenship Status Code	O	1	ID	1/2
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NOT USED	DMG07	26	Country Code	O	1	ID	2/3
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NOT USED	DMG08	659	Basis of Verification Code	O	1	ID	1/2
-----------------	--------------	------------	-----------------------------------	----------	----------	-----------	------------

NOT USED	DMG09	380	Quantity	O	1	R	1/15
-----------------	--------------	------------	-----------------	----------	----------	----------	-------------

NOT USED	DMG10	1270	Code List Qualifier Code	X	1	ID	1/3
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NOT USED	DMG11	1271	Industry Code	X	1	AN	1/30
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CLM - CLAIM INFORMATION

To specify basic data about the claim.

Loop: 2300 — CLAIM INFORMATION Loop Repeat: 100

Repeat: 1

Usage: REQUIRED

Notes: 1. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.

2. 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



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dependent. In other words, the claim information, Loop ID-2300, is placed following Loop ID-2010BB in the Subscriber Hierarchical Level (HL) when patient information is sent in Loop ID-2010BA of the Subscriber HL. Claim information is placed in the Patient HL when the patient information is sent in Loop ID-2010CA of the Patient HL. When the patient is the subscriber, Loop ID-2000C and Loop ID-2010CA are not sent.

Example: **CLM*A37YH556*500***11:B:1*Y*A*Y*I*P~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	CLM01	1028	Claim Submitter's Identifier	M 1 AN 1/38
			Identifier used to track a claim from creation by the health care provider through payment	
			INDUSTRY NAME: Patient Control Number	
			The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use unique numbers for this field for each individual claim.	
			The maximum number of characters to be supported for this field is `20'. Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.	
REQUIRED	CLM02	782	Monetary Amount	O 1 R 1/18
			Monetary amount	



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SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim.

INDUSTRY NAME: Total Claim Charge Amount

The Total Claim Charge Amount must be greater than or equal to zero.

The total claim charge amount must balance to the sum of all service line charge amounts reported in the Professional Service (SV1) segments for this claim.

NOT USED	CLM03	1032	Claim Filing Indicator	O	1	ID	1/2
			Code				

NOT USED	CLM04	134	Non-Institutional	O	1	ID	1/2
			Claim Type Code				

REQUIRED	CLM05	C023	HEALTH CARE SERVICE	O	1		
			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

REQUIRED	CLM05	- 1	1331	Facility Code Value	M	AN	1/2
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Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.

INDUSTRY NAME: Place of Service Code

CODE	DEFINITION
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
34	Hospice
50	Federally Qualified Health Center
52	Psychiatric Facility Partial Hospitalization
62	Comprehensive Outpatient Rehabilitation Facility
99	Other Unlisted Facility

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REQUIRED	CLM05	- 2	1332	Facility Code Qualifier	O	ID	1/2
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Code identifying the type of facility referenced

CODE DEFINITION

B	Place of Service Codes for Professional or Dental Services
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REQUIRED	CLM05	- 3	1325	Claim Frequency Type Code	O	ID	1/1
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Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

INDUSTRY NAME: Claim Frequency Code**CODE DEFINITION**

0	Non-Payment/Zero
1	Admit through Discharge Claim
6	Corrected (Adjustment to Prior Claim)
7	Replacement of Prior Claim
8	Void/Cancel of Prior Claim

NOT USED	CLM06		1073	Yes/No Condition or Response Code	O	1	ID	1/1
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NOT USED	CLM07		1359	Provider Accept Assignment Code	O	1	ID	1/1
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NOT USED	CLM08		1073	Yes/No Condition or Response Code	O	1	ID	1/1
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NOT USED	CLM09		1363	Release of Information Code	O	1	ID	1/1
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NOT USED	CLM10		1351	Patient Signature Source Code	O	1	ID	1/1
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SITUATIONAL	CLM11		C024	RELATED CAUSES INFORMATION	O	1		
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To identify one or more related causes and associated state or country information

Required when the services provided are employment related or the result of an accident. If not required by this implementation guide, do not send.

REQUIRED	CLM11	- 1	1362	Related-Causes Code	M	ID	2/3
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Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY NAME: Related Causes Code**CODE DEFINITION**

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				AA	Auto Accident				
				AB	Abuse				
				AP	Another Party Responsible				
				EM	Employment				
				OA	Other Accident				
SITUATIONAL	CLM11	- 2	1362	Related-Causes Code	O	ID	2/3		
				Code identifying an accompanying cause of an illness, injury or an accident					
				INDUSTRY NAME: Related Causes Code					
				Required when more than one related cause code applies. If not required by this implementation guide, do not send.					
				CODE	DEFINITION				
				AA	Auto Accident				
				AB	Abuse				
				AP	Another Party Responsible				
				EM	Employment				
				OA	Other Accident				
SITUATIONAL	CLM11	- 3	1362	Related-Causes Code	O	ID	2/3		
				Code identifying an accompanying cause of an illness, injury or an accident					
				INDUSTRY NAME: Related Causes Code					
				Required when more than one related cause code applies. If not required by this implementation guide, do not send.					
				CODE	DEFINITION				
				AA	Auto Accident				
				AB	Abuse				
				AP	Another Party Responsible				
				EM	Employment				
				OA	Other Accident				
NOT USED	CLM11	- 4	156	State or Province Code	O	ID	2/2		
NOT USED	CLM11	- 5	26	Country Code	O	ID	2/2		
NOT USED	CLM12		1366	Special Program Code	O	1 ID	2/3		
NOT USED	CLM13		1073	Yes/No Condition or Response Code	O	1 ID	1/1		
NOT USED	CLM14		1338	Level of Service Code	O	1 ID	1/3		
NOT USED	CLM15		1073	Yes/No Condition or Response Code	O	1 ID	1/1		
NOT USED	CLM16		1360	Provider Agreement Code	O	1 ID	1/1		



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NOT USED	CLM17	1029	Claim Status Code	O	1	ID	1/2
NOT USED	CLM18	1073	Yes/No Condition or Response Code	O	1	ID	1/1
NOT USED	CLM19	1383	Claim Submission Reason Code	O	1	ID	2/2
NOT USED	CLM20	1514	Delay Reason Code	O	1	ID	1/2

REF - MEDICAL RECORD NUMBER

To specify identifying information.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when the provider needs to identify for future inquiries, the actual medical record of the patient identified in either Loop ID-2010BA or Loop ID-2010CA for this episode of care. If not required by this implementation guide, do not send.

Example: **REF*EA*44444TH56~**

Element Detail

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



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K3 - FILE INFORMATION

To transmit a fixed-format record or matrix contents.

Loop: 2300 — CLAIM INFORMATION

Repeat: 10

Usage: REQUIRED

Notes: 1. Per Texas Government Code, Title 4, Section 531.0162, to meet national standard reporting requirements, the "Patient Ethnicity" and "Patient Race" is collected in the K3 segment. The adopted location for "Patient Ethnicity" is the 1st character of the K301 data element, and the "Patient Race" is the 2nd character. To obtain "Patient Race" and "Patient Ethnicity" data, the facility staff retrieves the patient's response from a written form or asks the patient, or the person speaking for the patient, to classify the patient. If the patient, or person speaking for the patient, declines to answer, the facility staff is to use its best judgment to make the correct classification based on available data.

2. When the patient is not the subscriber their Social Security Number is required to be reported in the 3rd through 11th characters of the K301 data element. THCIC requires that the Patient's Social Security Number be submitted to be used in conjunction with other submitted data elements to generate the uniform patient identification for longitudinal studies and epidemiological studies.

Example: **K3*25~**

K3*1199999999~

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	K301	449	Fixed Format Information	M 1 AN 1/80						
Data in fixed format agreed upon by sender and receiver										
SEMANTIC: Position 1 denotes Ethnicity										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Hispanic or Latino</td></tr><tr><td>2</td><td>Not Hispanic or Latino</td></tr></table>					CODE	DEFINITION	1	Hispanic or Latino	2	Not Hispanic or Latino
CODE	DEFINITION									
1	Hispanic or Latino									
2	Not Hispanic or Latino									
SEMANTIC: Position 2 denotes Race										



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CODE	DEFINITION
1	American Indian/Eskimo/Aleut
2	Asian, Native Hawaiian or Pacific Islander
3	Black or African American
4	White
5	Other Race

SEMANTIC: Positions 3 to 11 denotes Social Security Number

Required when the patient is not the subscriber. If not required by this implementation guide, do not send.

CODE	DEFINITION
nnnnnnnnn	Social Security Number
999999999	Unknown SSN
	This value is required for:
	1. Newborns without an SSN
	2. Foreigners without an SSN
	3. Patients refusing or cannot provide an SSN

NOT USED	K302	1333	Record Format Code	O	1	ID	1/2
NOT USED	K303	C001	COMPOSITE UNIT OF MEASURE	O	1		

HI - HEALTH CARE DIAGNOSIS CODE

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: REQUIRED

Notes: 1. THCIC REQUIRES a "Principal Diagnosis Code/Health Care Diagnosis Code". "External Cause of Injury/Morbidity Codes (Ecodes)" and "Other Diagnosis Codes", if required to provide additional information, can be specified in this segment.

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

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



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Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
			To send health care codes and their associated dates, amounts and quantities	
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3
			Code identifying a specific industry code list	
			INDUSTRY NAME: Diagnosis Type Code	
			CODE	DEFINITION
			ABK	International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis
REQUIRED	HI01 - 2	1271	Industry Code	M AN 1/30
			Code indicating a code from a specific industry code list	
			INDUSTRY NAME: Principal Diagnosis Code	
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	M 1
			Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.	
			Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.	
REQUIRED	HI02 - 1	1270	Code List Qualifier Code	M ID 1/3



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Code identifying a specific industry code list

INDUSTRY NAME: Diagnosis Type Code

CODE DEFINITION

ABF International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis

ABN International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code

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

Code indicating a code from a specific industry code list

INDUSTRY NAME: Other Diagnosis

INDUSTRY NAME: External Cause of Injury Code

NOT USED HI02 - 3 1250 Date Time Period Format Qualifier X ID 2/3

NOT USED HI02 - 4 1251 Date Time Period X AN 1/35

NOT USED HI02 - 5 782 Monetary Amount O R 1/18

NOT USED HI02 - 6 380 Quantity O R 1/15

NOT USED HI02 - 7 799 Version Identifier O AN 1/30

NOT USED HI02 - 8 1271 Industry Code X AN 1/30

NOT USED HI02 - 9 1073 Yes/No Condition or Response Code X ID 1/1

SITUATIONAL HI03 C022 HEALTH CARE CODE INFORMATION M 1

Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.

Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. 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

INDUSTRY NAME: Diagnosis Type Code

CODE DEFINITION



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				ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		
REQUIRED	HI03	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: External Cause of Injury Code			
				INDUSTRY NAME: Other Diagnosis			
NOT USED	HI03	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI03	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI03	- 6	380	Quantity	O	R	1/15
NOT USED	HI03	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI03	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI03	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI04		C022	HEALTH CARE CODE INFORMATION	M	1	
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.			
				Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.			
REQUIRED	HI04	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				INDUSTRY NAME: Diagnosis Type Code			
				CODE	DEFINITION		
				ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis		



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				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
REQUIRED	HI04	- 2	1271	Industry Code	M	AN	1/30	
				Code indicating a code from a specific industry code list				
				INDUSTRY NAME: External Cause of Injury Code				
				INDUSTRY NAME: Other Diagnosis				
NOT USED	HI04	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3	
NOT USED	HI04	- 4	1251	Date Time Period	X	AN	1/35	
NOT USED	HI04	- 5	782	Monetary Amount	O	R	1/18	
NOT USED	HI04	- 6	380	Quantity	O	R	1/15	
NOT USED	HI04	- 7	799	Version Identifier	O	AN	1/30	
NOT USED	HI04	- 8	1271	Industry Code	X	AN	1/30	
NOT USED	HI04	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1	
SITUATIONAL	HI05		C022	HEALTH CARE CODE INFORMATION	M	1		
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.				
				Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.				
REQUIRED	HI05	- 1	1270	Code List Qualifier Code	M	ID	1/3	
				Code identifying a specific industry code list				
				INDUSTRY NAME: Diagnosis Type Code				
				CODE	DEFINITION			
				ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis			
				ABN	International Classification of Diseases Clinical Modification			



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				(ICD-10-CM) External Cause of Injury Code			
REQUIRED	HI05	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: External Cause of Injury Code			
				INDUSTRY NAME: Other Diagnosis			
NOT USED	HI05	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI05	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI05	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI05	- 6	380	Quantity	O	R	1/15
NOT USED	HI05	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI05	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI05	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI06		C022	HEALTH CARE CODE INFORMATION	M	1	
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.			
				Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.			
REQUIRED	HI06	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				INDUSTRY NAME: Diagnosis Type Code			
				CODE	DEFINITION		
				ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		
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 NAME: External Cause of Injury Code**INDUSTRY NAME: Other Diagnosis**

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

Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.

Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.

REQUIRED	HI07	- 1	1270	Code List Qualifier Code	M	ID	1/3
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Code identifying a specific industry code list

INDUSTRY NAME: Diagnosis Type Code**CODE DEFINITION**

ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code

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



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				INDUSTRY NAME: External Cause of Injury Code			
				INDUSTRY NAME: Other Diagnosis			
NOT USED	HI07	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI07	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI07	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI07	- 6	380	Quantity	O	R	1/15
NOT USED	HI07	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI07	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI07	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI08		C022	HEALTH CARE CODE INFORMATION	M	1	
				Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.			
				Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.			
REQUIRED	HI08	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				INDUSTRY NAME: Diagnosis Type Code			
				CODE	DEFINITION		
				ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		
REQUIRED	HI08	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: External Cause of Injury Code			
				INDUSTRY NAME: Other Diagnosis			

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NOT USED	HI08	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3						
NOT USED	HI08	- 4	1251	Date Time Period	X	AN	1/35						
NOT USED	HI08	- 5	782	Monetary Amount	O	R	1/18						
NOT USED	HI08	- 6	380	Quantity	O	R	1/15						
NOT USED	HI08	- 7	799	Version Identifier	O	AN	1/30						
NOT USED	HI08	- 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI08	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI09		C022	HEALTH CARE CODE INFORMATION	M	1							
Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.													
Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.													
REQUIRED	HI09	- 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list													
INDUSTRY NAME: Diagnosis Type Code													
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABF</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis</td></tr><tr><td>ABN</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code</td></tr></table>								CODE	DEFINITION	ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis	ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code
CODE	DEFINITION												
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis												
ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code												
REQUIRED	HI09	- 2	1271	Industry Code	M	AN	1/30						
Code indicating a code from a specific industry code list													
INDUSTRY NAME: External Cause of Injury Code													
INDUSTRY NAME: Other Diagnosis													
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						

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

Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.

Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.

REQUIRED	HI10	- 1	1270	Code List Qualifier Code	M	ID	1/3
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Code identifying a specific industry code list

INDUSTRY NAME: Diagnosis Type Code**CODE DEFINITION**

ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code

REQUIRED	HI10	- 2	1271	Industry Code	M	AN	1/30
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Code indicating a code from a specific industry code list

INDUSTRY NAME: External Cause of Injury Code**INDUSTRY NAME: Other Diagnosis**

NOT USED	HI10	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI10	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI10	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI10	- 6	380	Quantity	O	R	1/15
NOT USED	HI10	- 7	799	Version Identifier	O	AN	1/30

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NOT USED	HI10	- 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI10	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI11		C022	HEALTH CARE CODE INFORMATION	M	1							
Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.													
Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.													
REQUIRED	HI11	- 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list													
INDUSTRY NAME: Diagnosis Type Code													
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABF</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis</td></tr><tr><td>ABN</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code</td></tr></table>								CODE	DEFINITION	ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis	ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code
CODE	DEFINITION												
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis												
ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code												
REQUIRED	HI11	- 2	1271	Industry Code	M	AN	1/30						
Code indicating a code from a specific industry code list													
INDUSTRY NAME: External Cause of Injury Code													
INDUSTRY NAME: Other Diagnosis													
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						

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SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION	M	1	
			<p>Required when an additional External Cause of Injury must be sent, and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.</p> <p>Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.</p>			
REQUIRED	HI12	- 1	1270	Code List Qualifier Code	M	ID 1/3
				Code identifying a specific industry code list		
				INDUSTRY NAME: Diagnosis Type Code		
				CODE	DEFINITION	
				ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis	
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code	
REQUIRED	HI12	- 2	1271	Industry Code	M	AN 1/30
				Code indicating a code from a specific industry code list		
				INDUSTRY NAME: External Cause of Injury Code		
				INDUSTRY NAME: Other Diagnosis		
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



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HI - ANESTHESIA RELATED PROCEDURE

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes: 1. 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~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
			To send health care codes and their associated dates, amounts and quantities	
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3
			Code identifying a specific industry code list	
			CODE	DEFINITION
			BP	Health Care Financing Administration Common Procedural Coding System Principal Procedure
REQUIRED	HI01 - 2	1271	Industry Code	M AN 1/30
			Code indicating a code from a specific industry code list	
			INDUSTRY NAME: Anesthesia Related Surgical Procedure	
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



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NOT USED	HI01	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI02		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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.			
REQUIRED	HI02	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				BO	Health Care Financing Administration Common Procedural Coding System		
REQUIRED	HI02	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
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	M	1	
NOT USED	HI04		C022	HEALTH CARE CODE INFORMATION	M	1	
NOT USED	HI05		C022	HEALTH CARE CODE INFORMATION	M	1	
NOT USED	HI06		C022	HEALTH CARE CODE INFORMATION	M	1	
NOT USED	HI07		C022	HEALTH CARE CODE INFORMATION	M	1	
NOT USED	HI08		C022	HEALTH CARE CODE INFORMATION	M	1	



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NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	M	1
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	M	1
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	M	1
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	M	1

NM1 - RENDERING PROVIDER NAME

To supply the full name of an individual or organizational entity.

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

Repeat: 1

Usage: SITUATIONAL

Notes:

1. Required when the Rendering Provider information is different than that carried in Loop ID-2010AA - Billing Provider. If not required by this implementation guide, do not send.
2. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here.
3. 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.

Example: **NM1*82*1*DOE*JANE*C***XX*1234567804~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	NM101	98	Entity Identifier Code	M	1	ID	2/3
			Code identifying an organizational entity, a physical location, property or an individual				
			CODE	DEFINITION			
			82	Rendering Provider			
REQUIRED	NM102	1065	Entity Type Qualifier	M	1	ID	1/1



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Code qualifying the type of entity

SEMANTIC: NM102 qualifies NM103.

CODE DEFINITION

1 Person

2 Non-Person Entity

REQUIRED NM103 1035 Name Last or Organization X 1 AN 1/60 Name

Individual last name or organizational name

INDUSTRY NAME: Rendering Provider Last or Organization Name

SITUATIONAL NM104 1036 Name First O 1 AN 1/35

Individual first name

Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.

INDUSTRY NAME: Rendering Provider First Name

SITUATIONAL NM105 1037 Name Middle O 1 AN 1/25

Individual middle name or initial

Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.

INDUSTRY NAME: Rendering Provider Middle Name or Initial

NOT USED NM106 1038 Name Prefix O 1 AN 1/10

NOT USED NM107 1039 Name Suffix O 1 AN 1/10

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

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

Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send.

CODE DEFINITION

XX Centers for Medicare and Medicaid Services National Provider Identifier

SITUATIONAL NM109 67 Identification Code X 1 AN 2/80

Code identifying a party or other code



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Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send.

INDUSTRY NAME: Rendering Provider Identifier

CODE	DEFINITION
XXXXXXXXXX	National Provider Identifier (NPI) Number

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

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2310B — RENDERING PROVIDER NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.

Example: **REF*OB*A12345~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	REF01	128	Reference Identification Qualifier	M	1	ID	2/3
Code qualifying the Reference Identification							
			CODE	DEFINITION			
			OB	State License Number			
REQUIRED	REF02	127	Reference Identification	X	1	AN	1/50



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Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**INDUSTRY NAME: Rendering Provider
Secondary Identifier**

NOT USED	REF03	352	Description	X	1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O	1		

NM1 - SERVICE FACILITY LOCATION NAME

To supply the full name of an individual or organizational entity.

Loop: 2310C — SERVICE FACILITY LOCATION NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes:

1. 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.
2. When an organization health care provider's NPI is provided to identify the Service Location, the organization health care provider must be external to the entity identified as the Billing Provider (for example, reference lab). It is not permissible to report an organization health care provider NPI as the Service Location if the entity being identified is a component (for example, subpart) of the Billing Provider. In that case, the subpart must be the Billing Provider.
3. The purpose of this loop is to identify specifically where the service was rendered.
4. 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.

Example: **NM1*77*2*ABC CLINIC*****XX*1234567891~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	



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			CODE	DEFINITION				
			77	Service Location				
REQUIRED	NM102	1065	Entity Type Qualifier		M	1	ID	1/1
			Code qualifying the type of entity					
			SEMANTIC: NM102 qualifies NM103.					
			CODE	DEFINITION				
			2	Non-Person Entity				
REQUIRED	NM103	1035	Name Last or Organization Name		X	1	AN	1/60
			Individual last name or organizational name					
			INDUSTRY NAME: Laboratory or Facility Name					
NOT USED	NM104	1036	Name First		O	1	AN	1/35
NOT USED	NM105	1037	Name Middle		O	1	AN	1/25
NOT USED	NM106	1038	Name Prefix		O	1	AN	1/10
NOT USED	NM107	1039	Name Suffix		O	1	AN	1/10
REQUIRED	NM108	66	Identification Code Qualifier		X	1	ID	1/2
			Code designating the system/method of code structure used for Identification Code (67)					
			CODE	DEFINITION				
			XX	Centers for Medicare and Medicaid Services National Provider Identifier				
			24	Employer's Identification Number				
REQUIRED	NM109	67	Identification Code		X	1	AN	2/80
			Code identifying a party or other code					
			INDUSTRY NAME: Laboratory or Facility Primary Identifier					
			CODE	DEFINITION				
			XXXXXXXXXX	National Provider Identifier (NPI) Number				
			nnnnnnnnnn	Employer Identification Number (EIN)				
NOT USED	NM110	706	Entity Relationship Code		X	1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code		O	1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name		O	1	AN	1/60

N3 - SERVICE FACILITY LOCATION ADDRESS

To specify the location of the named party.



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Loop: 2310C — SERVICE FACILITY LOCATION NAME
Repeat: 1
Usage: REQUIRED
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 (for example, "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".)

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
			INDUSTRY NAME: Laboratory or Facility Address Line	
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
			Required when there is a second address line. If not required by this implementation guide, do not send.	
			INDUSTRY NAME: Laboratory or Facility Address Line	

N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE

To specify the geographic place of the named party.

Loop: 2310C — SERVICE FACILITY LOCATION NAME
Repeat: 1
Usage: REQUIRED
Example: **N4*KANSAS CITY*MO*64108~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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REQUIRED	N401	19	City Name	O	1	AN	2/30								
Free-form text for city name															
INDUSTRY NAME: Laboratory or Facility City Name															
REQUIRED	N402	156	State or Province Code	X	1	ID	2/2								
Code (Standard State/Province) as defined by appropriate government agency															
INDUSTRY NAME: Laboratory or Facility State or Province Code															
<table><tr><td>CODE</td><td>DEFINITION</td></tr><tr><td>aa</td><td>Valid State or Province Code</td></tr><tr><td>FC</td><td>Foreign Country</td></tr><tr><td>XX</td><td>Foreign Country</td></tr></table>								CODE	DEFINITION	aa	Valid State or Province Code	FC	Foreign Country	XX	Foreign Country
CODE	DEFINITION														
aa	Valid State or Province Code														
FC	Foreign Country														
XX	Foreign Country														
REQUIRED	N403	116	Postal Code	O	1	ID	3/15								
Code defining international postal zone code excluding punctuation and blanks (zip code for United States)															
INDUSTRY NAME: Laboratory or Facility Postal Zone or ZIP Code															
When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.															
<table><tr><td>CODE</td><td>DEFINITION</td></tr><tr><td>00000</td><td>Foreign Country; Recommended value for foreign addresses</td></tr><tr><td>XXXXX</td><td>Foreign Country</td></tr></table>								CODE	DEFINITION	00000	Foreign Country; Recommended value for foreign addresses	XXXXX	Foreign Country		
CODE	DEFINITION														
00000	Foreign Country; Recommended value for foreign addresses														
XXXXX	Foreign Country														
NOT USED	N404	26	Country Code	X	1	ID	2/3								
NOT USED	N405	309	Location Qualifier	X	1	ID	1/2								
NOT USED	N406	310	Location Identifier	O	1	AN	1/30								
NOT USED	N407	1715	Country Subdivision Code	X	1	ID	1/3								

REF - SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

To specify THCIC identifying information.

Loop: 2310C — SERVICE FACILITY LOCATION NAME

Repeat: 1

Usage: SITUATIONAL

Notes: 1. THCIC requires the 6-digit number (THCIC ID) assigned to the Service Facility identified in Loop 2310C. The THCIC ID, along with



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either the NPI (NM109), EIN (NM109), and the Address (N301) is used to verify a Provider's identity.

2. Required by THCIC when the Service Facility Provider is different than the Billing Provider.

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier	M 1 ID 2/3
			Code qualifying the Reference Identification	
			CODE	DEFINITION
			1J	Facility ID Number
REQUIRED	REF02	127	Reference Identification	X 1 AN 1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
			CODE	DEFINITION
			nnnnnn	ID Number assigned by THCIC
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SBR - OTHER SUBSCRIBER INFORMATION

To record information specific to the primary insured and the insurance carrier for that insured.

Loop: 2320 — OTHER SUBSCRIBER INFORMATION Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when other payers are known to potentially be involved in paying on this claim. If not required by this implementation guide, do not send.

2. All information contained in Loop ID-2320 applies only to the payer identified in Loop ID-2330B of this iteration of Loop ID-2320. It is specific only to that payer.

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3. THCIC only collects Secondary Payer data.

Example: **SBR*S*01*GR00786*****13~***Element Detail*

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																							
REQUIRED	SBR01	1138	Payer Responsibility Sequence Number Code	M	1	ID	1/1																				
Code identifying the insurance carrier's level of responsibility for a payment of a claim																											
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>S</td><td>Secondary</td></tr></table>								CODE	DEFINITION	S	Secondary																
CODE	DEFINITION																										
S	Secondary																										
REQUIRED	SBR02	1069	Individual Relationship Code	O	1	ID	2/2																				
Code indicating the relationship between two individuals or entities																											
SEMANTIC: SBR02 specifies the relationship to the person insured.																											
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>01</td><td>Spouse</td></tr><tr><td>18</td><td>Self</td></tr><tr><td>19</td><td>Child</td></tr><tr><td>20</td><td>Employee</td></tr><tr><td>21</td><td>Unknown</td></tr><tr><td>39</td><td>Organ Donor</td></tr><tr><td>40</td><td>Cadaver Donor</td></tr><tr><td>53</td><td>Life Partner</td></tr><tr><td>G8</td><td>Other Relationship</td></tr></table>								CODE	DEFINITION	01	Spouse	18	Self	19	Child	20	Employee	21	Unknown	39	Organ Donor	40	Cadaver Donor	53	Life Partner	G8	Other Relationship
CODE	DEFINITION																										
01	Spouse																										
18	Self																										
19	Child																										
20	Employee																										
21	Unknown																										
39	Organ Donor																										
40	Cadaver Donor																										
53	Life Partner																										
G8	Other Relationship																										
SITUATIONAL	SBR03	127	Reference Identification	O	1	AN	1/50																				
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier																											
SEMANTIC: SBR03 is policy or group number.																											
Required when the subscriber's identification card for the non-destination payer identified in Loop ID-2330B of this iteration of Loop ID-2320 shows a group number. If not required by this implementation guide, do not send.																											
INDUSTRY NAME: Insured Group or Policy Number																											
This is not the number uniquely identifying the subscriber. The unique subscriber number is																											



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			submitted in Loop 2330A-NM109 for this iteration of Loop ID-2320.			
SITUATIONAL	SBR04	93	Name	O	1	AN 1/60
			Free-form name			
			SEMANTIC: SBR04 is plan name.			
			Required when SBR03 is not used, and the group name is available. If not required by this implementation guide, do not send.			
			INDUSTRY NAME: Other Insured Group Name			
SITUATIONAL	SBR05	1336	Insurance Type Code	O	1	ID 1/3
			Code identifying the type of insurance policy within a specific insurance program			
			Required when the payer identified in Loop ID-2330B for this iteration of Loop ID-2320 is Medicare and Medicare is not the primary payer (Loop ID-2320 SBR01 is not P). If not required by this implementation guide, do not send.			
			CODE	DEFINITION		
			12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan		
			13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan		
			14	Medicare Secondary, No-fault Insurance including Auto is Primary		
			15	Medicare Secondary Worker's Compensation		
			16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency		
			41	Medicare Secondary Black Lung		
			42	Medicare Secondary Veteran's Administration		
			43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)		
			47	Medicare Secondary, Other Liability Insurance is Primary		
NOT USED	SBR06	1143	Coordination of Benefits Code	O	1	ID 1/1
NOT USED	SBR07	1073	Yes/No Condition or Response Code	O	1	ID 1/1



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NOT USED	SBR08	584	Employment Status Code	O	1	ID	2/2
REQUIRED	SBR09	1032	Claim Filing Indicator Code	O	1	ID	1/2

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	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	Use Code ZZ when Type of Insurance is not known.

NM1 - OTHER PAYER NAME

To supply the full name of an individual or organizational entity.

Loop: 2330B — OTHER PAYER NAME Loop Repeat: 1

Repeat: 1

Usage: SITUATIONAL

Notes: 1. No Patient Personally Identifiable Information (PII) data should be present.



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2. This is the secondary 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*ABC INSURANCE CO*****PI*11122333~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	NM101	98	Entity Identifier Code	M	1	ID	2/3
			Code identifying an organizational entity, a physical location, property or an individual				
			CODE	DEFINITION			
			PR	Payer			
REQUIRED	NM102	1065	Entity Type Qualifier	M	1	ID	1/1
			Code qualifying the type of entity				
			SEMANTIC: NM102 qualifies NM103.				
			CODE	DEFINITION			
			2	Non-Person Entity			
REQUIRED	NM103	1035	Name Last or Organization Name	X	1	AN	1/60
			Individual last name or organizational name				
			INDUSTRY NAME: Other Payer Organization Name				
			CODE	DEFINITION			
			SELF-PAY	For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")			
			CHARITY	For Charity Claims (Claim Filing Indicator Code is "ZZ")			
			UNKNOWN	With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")			
NOT USED	NM104	1036	Name First	O	1	AN	1/35
NOT USED	NM105	1037	Name Middle	O	1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O	1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O	1	AN	1/10
REQUIRED	NM108	66	Identification Code Qualifier	X	1	ID	1/2
			Code designating the system/method of code structure used for Identification Code (67)				
			CODE	DEFINITION			



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			PI	Payor Identification unless Self-Pay, Charity, or Unknown Payer claim			
			XV	Centers for Medicare and Medicaid Services PlanID			
			ZY	Temporary Identification Number for use with Self-Pay, Charity, or Unknown Payer claim			
REQUIRED	NM109	67	Identification Code	X	1	AN	2/80
Code identifying a party or other code							
INDUSTRY NAME: Other Payer Identifier							
			CODE	DEFINITION			
			XXXXXXXXXX	National Plan Identifier (NPI) Number			
				CMS currently has delayed the implementation date for all plans and providers until further notice.			
			SELF-PAY	For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")			
			CHARITY	For Charity Claims (Claim Filing Indicator Code is "ZZ")			
			UNKNOWN	With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")			
NOT USED	NM110	706	Entity Relationship Code	X	1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O	1	AN	1/60

LX - SERVICE LINE NUMBER

To reference a line number in a transaction set.

Loop: 2400 — SERVICE LINE NUMBER Loop Repeat: 50

Repeat: 1

Usage: REQUIRED

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

Example: **LX*1~**



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Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	LX01	554	Assigned Number	M 1 N0 1/6
			Number assigned for differentiation within a transaction set	

SV1 - PROFESSIONAL SERVICE LINE

To specify the service line-item detail for a health care institution.

Loop: 2400 — SERVICE LINE NUMBER

Repeat: 1

Usage: REQUIRED

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SV101	C003	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	X 1
			To identify a medical procedure by its standardized codes and applicable modifiers	
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 NAME: Product or Service ID Qualifier

CODE	DEFINITION
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes



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Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.

REQUIRED	SV101	- 2	234	Product/Service ID	M	AN	1/48	Identifying number for a product or service
INDUSTRY NAME: Procedure Code								
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
Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.								
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
Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.								
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
Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.								
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
Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.								

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

Monetary Amount

SEMANTIC: SV102 is the submitted service line-item amount.

INDUSTRY NAME: Line Item Charge Amount

This is the total charge amount for this service line. The amount is inclusive of the provider's base charge and any applicable tax and/or postage claimed amounts reported within this line's AMT segments.

Zero "0" is an acceptable value for this element.

REQUIRED	SV103		355	Unit or Basis for Measurement Code	X	1 ID	2/2
----------	-------	--	-----	------------------------------------	---	------	-----

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

CODE DEFINITION

MJ	Minutes
UN	Unit

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

Numeric value of quantity

INDUSTRY NAME: Service Unit Count

Note: When a decimal is needed to report units, include it in this element, for example, "15.6".

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

Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.

SEMANTIC: SV105 is the place of service.

Required when value is different than value carried in CLM05-1 in Loop ID-2300. If not required by this implementation guide, do not send.

INDUSTRY NAME: Place of Service Code



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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** **1** **ID** **1/2**

REQUIRED **SV107** **C004** **COMPOSITE DIAGNOSIS** **O** **1**
CODE POINTER

To identify one or more diagnosis code pointers

REQUIRED **SV107** **- 1** **1328** **Diagnosis Code Pointer** **M** **N0** **1/2**

A pointer to the diagnosis code in the order of importance to this service

This first pointer designates the primary diagnosis for this service line. Remaining diagnosis pointers indicate declining level of importance to service line. Acceptable values are 1 through 12 and correspond to Composite Data Elements 01 through 12 in the Health Care Diagnosis Code HI segment in the Claim Loop ID-2300.

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

A pointer to the diagnosis code in the order of importance to this service

Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.

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

A pointer to the diagnosis code in the order of importance to this service

Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as



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				SV107-1. If not required by this implementation guide, do not send.			
SITUATIONAL	SV107	- 4	1328	Diagnosis Code Pointer	O	N0	1/2
				A pointer to the diagnosis code in the order of importance to this service			
				Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.			
NOT USED	SV108		782	Monetary Amount	O	1 R	1/18
NOT USED	SV109		1073	Yes/No Condition or Response Code	O	1 ID	1/1
NOT USED	SV110		1340	Multiple Procedure Code	O	1 ID	1/2
NOT USED	SV111		1073	Yes/No Condition or Response Code	O	1 ID	1/1
NOT USED	SV112		1073	Yes/No Condition or Response Code	O	1 ID	1/1
NOT USED	SV113		1364	Review Code	O	1 ID	1/2
NOT USED	SV114		1341	National or Local Assigned Review Value	O	1 ID	1/2
NOT USED	SV115		1327	Copay Status Code	O	1 ID	1/1
NOT USED	SV116		1327	Health Care Professional Shortage Area Code	O	1 ID	1/1
NOT USED	SV117		127	Reference Identification	O	1 AN	1/50
NOT USED	SV118		116	Postal Code	O	1 ID	3/15
NOT USED	SV119		782	Monetary Amount	O	1 R	1/18
NOT USED	SV120		1337	Level of Care Code	O	1 ID	1/1
NOT USED	SV121		1360	Provider Agreement Code	O	1 ID	1/1

DTP - DATE - SERVICE DATE

To specify any or all a date, a time, or time period.

Loop: 2400 — SERVICE LINE NUMBER
Repeat: 1
Usage: REQUIRED



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Example: **DTP*472*RD8*20050314-20050325~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	Date/Time Qualifier	M 1 ID 3/3
			Code specifying type of date or time, or both date and time	
			INDUSTRY NAME: Date Time Qualifier	
			CODE	DEFINITION
			472	Service
REQUIRED	DTP02	1250	Date Time Period Format Qualifier	M 1 ID 2/3
			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.	
			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.	
			CODE	DEFINITION
			D8	Date Expressed in Format CCYYMMDD
			RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
REQUIRED	DTP03	1251	Date Time Period	M 1 AN 1/35
			Expression of a date, a time, or range of dates, times or dates and times	
			INDUSTRY NAME: Service Date	

NM1 - RENDERING PROVIDER NAME

To supply the full name of an individual or organizational entity.

Loop: 2420A — RENDERING PROVIDER NAME Loop Repeat: 1
Repeat: 1
Usage: SITUATIONAL



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- Notes:
1. Required when the Rendering Provider NM1 information is different than that carried in the Loop ID-2310B Rendering Provider.
 2. 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*DOE*JANE*C***XX*1234567804~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			CODE	DEFINITION
			82	Rendering Provider
REQUIRED	NM102	1065	Entity Type Qualifier	M 1 ID 1/1
			Code qualifying the type of entity	
			SEMANTIC: NM102 qualifies NM103.	
			CODE	DEFINITION
			1	Person
			2	Non-Person Entity
REQUIRED	NM103	1035	Name Last or Organization Name	X 1 AN 1/60
			Individual last name or organizational name	
			INDUSTRY NAME: Rendering Provider Last or Organization Name	
SITUATIONAL	NM104	1036	Name First	O 1 AN 1/35
			Individual first name	
			Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.	
			INDUSTRY NAME: Rendering Provider First Name	
SITUATIONAL	NM105	1037	Name Middle	O 1 AN 1/25
			Individual middle name or initial	
			Required when the middle name or initial of the person is needed to identify the individual. If	



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			not required by this implementation guide, do not send.			
			INDUSTRY NAME: Rendering Provider Middle Name or Initial			
NOT USED	NM106	1038	Name Prefix	O	1	AN 1/10
NOT USED	NM107	1039	Name Suffix	O	1	AN 1/10
SITUATIONAL	NM108	66	Identification Code Qualifier	X	1	ID 1/2
			Code designating the system/method of code structure used for Identification Code (67)			
			Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send.			
			CODE	DEFINITION		
			XX	Centers for Medicare and Medicaid Services National Provider Identifier		
SITUATIONAL	NM109	67	Identification Code	X	1	AN 2/80
			Code identifying a party or other code			
			Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. If not required by this implementation guide, do not send.			
			INDUSTRY NAME: Rendering Provider Identifier			
			CODE	DEFINITION		
			XXXXXXXXXX	National Provider Identifier (NPI) Number		
NOT USED	NM110	706	Entity Relationship Code	X	1	ID 2/2
NOT USED	NM111	98	Entity Identifier Code	O	1	ID 2/3
NOT USED	NM112	1035	Name Last or Organization Name	O	1	AN 1/60

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2420A — RENDERING PROVIDER NAME



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Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES							
REQUIRED	REF01	128	Reference Identification Qualifier	M	1	ID	2/3				
Code qualifying the Reference Identification											
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0B</td><td>State License Number</td></tr></table>								CODE	DEFINITION	0B	State License Number
CODE	DEFINITION										
0B	State License Number										
REQUIRED	REF02	127	Reference Identification	X	1	AN	1/50				
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier											
INDUSTRY NAME: Rendering Provider Secondary Identifier											
NOT USED	REF03	352	Description	X	1	AN	1/80				
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O	1						

SE - TRANSACTION SET TRAILER

To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Repeat: 1

Usage: REQUIRED

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SE01	96	Number of Included Segments	M 1 N0 1/10



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Total number of segments included in a transaction set including ST and SE segments

IMPLEMENTATION NAME: Transaction Segment Count

REQUIRED SE02 329 Transaction Set Control Number M 1 AN 4/9

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. The number must be unique within a specific interchange (ISA-IEA) but can repeat in other interchanges.



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5.4 Control Segments

ISA - INTERCHANGE CONTROL HEADER

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

Repeat: 1

Usage: REQUIRED

- Notes:
1. All positions within each of the data elements must be filled.
 2. For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive unsigned number. Therefore, the ISA segment can be considered a fixed record length segment.
 3. The first element separator defines the element separator to be used through the entire interchange.
 4. The ISA segment terminator defines the segment terminator used throughout the entire interchange.
 5. Spaces in the example interchanges are represented by "." for clarity.
 6. Submitters will receive an Acknowledgement and a Claim Acceptance Response Report, regardless of ISA14 value.
 7. Submitters must submit test data to System13, Inc. and receive approval prior to submitting production data. Submitters must be on the approved Submitter List at System13, Inc. prior to submitting Production Data.

Example: **ISA*00*.....*01*SECRET....*ZZ*SUB999.....*ZZ*YTH837..
.....*030101*1253*^*00501*000000905*1*T*:~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	ISA01	I01	Authorization Information Qualifier	M 1 ID 2/2
			Code identifying the type of information in the Authorization Information	
			CODE	DEFINITION
			00	No Authorization Information Present
			03	Additional Data Identification
REQUIRED	ISA02	I02	Authorization Information	M 1 AN 10/10



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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)

This element is fixed in length with identical minimum and maximum lengths. Spaces are inserted to meet the minimum length in an AN data element. With the associated code 00 in ISA01 or ISA03, an all space value indicates no information.

REQUIRED ISA03 I03 Security Information M 1 ID 2/2
Qualifier

Code identifying the type of information in the Security Information

CODE	DEFINITION
00	No Security Information Present
01	Password

REQUIRED ISA04 I04 Security Information M 1 AN 10/10

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

This element is fixed in length with identical minimum and maximum lengths. Spaces are inserted to meet the minimum length in an AN data element. With the associated code 00 in ISA01 or ISA03, an all space value indicates no information.

REQUIRED ISA05 I05 Interchange ID Qualifier M 1 ID 2/2

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

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
ZZ	Mutually Defined

REQUIRED ISA06 I06 Interchange Sender ID M 1 AN 15/15

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

CODE	DEFINITION
SUBnnn	System13, Inc. Submitter ID Number

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The Submitter ID Number must be obtained from System13, Inc.

REQUIRED	ISA07	I05	Interchange ID Qualifier	M	1	ID	2/2
Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified							
This ID qualifies the Receiver in ISA08.							
CODE DEFINITION							
ZZ Mutually Defined							
REQUIRED	ISA08	I07	Interchange Receiver ID	M	1	AN	15/15
Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them							
CODE DEFINITION							
YTH837 Required by THCIC							
REQUIRED	ISA09	I08	Interchange Date	M	1	DT	6/6
Date of the interchange							
The date format is YYMMDD.							
REQUIRED	ISA10	I09	Interchange Time	M	1	TM	4/4
Time of the interchange							
The time format is HHMM.							
REQUIRED	ISA11	I65	Repetition Separator	M	1		1/1
Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator							
CODE DEFINITION							
^ THCIC-Recommended Repetition Separator							
REQUIRED	ISA12	I11	Interchange Control Version Number	M	1	ID	5/5
Code specifying the version number of the interchange control segments							
CODE DEFINITION							
00501 Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003							
REQUIRED	ISA13	I12	Interchange Control Number	M	1	N0	9/9



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A control number assigned by the interchange sender

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

Must be a positive unsigned number and must be identical to the value in IEA02.

REQUIRED ISA14 I13 Acknowledgment Requested M 1 ID 1/1

Code indicating sender's request for an interchange acknowledgment

CODE DEFINITION

0 No Interchange Acknowledgment Requested

1 Interchange Acknowledgment Requested (TA1)

REQUIRED ISA15 I14 Interchange Usage Indicator M 1 ID 1/1

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

CODE DEFINITION

P Production Data

T Test Data

REQUIRED ISA16 I15 Component Element Separator M 1 1/1

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

CODE DEFINITION

: THCIC-Recommended Component Element Separator

GS - FUNCTIONAL GROUP HEADER

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

Repeat: 1

Usage: REQUIRED

Notes: 1. A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.



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Example: **GS*XX*SUB999*YTH837*20150101*0700*1*X*005010X223
A2~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	GS01	479	Functional Identifier Code	M 1 ID 2/2
			Code identifying a group of application related transaction sets.	
			CODE DEFINITION	
			HC Health Care Claim (837)	
REQUIRED	GS02	142	Application Sender's Code	M 1 AN 2/15
			Code identifying party sending transmission; codes agreed to by trading partners.	
			CODE DEFINITION	
			SUBnnn System13, Inc. Submitter ID Number	
			The Submitter ID Number must be obtained from System13, Inc.	
			Must be identical to the value in ISA06.	
REQUIRED	GS03	124	Application Receiver's Code	M 1 AN 2/15
			Code identifying party receiving transmission; codes agreed to by trading partners.	
			CODE DEFINITION	
			YTH837 Required by THCIC	
REQUIRED	GS04	373	Date	M 1 DT 8/8
			Date expressed as CCYYMMDD	
			SEMANTIC: GS04 is the group date.	
			Use this date for the functional group creation date.	
REQUIRED	GS05	337	Time	M 1 TM 4/8
			Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	
			SEMANTIC: GS05 is the group time.	
			Use this time for the creation time. The recommended format is HHMM.	
REQUIRED	GS06	28	Group Control Number	M 1 NO 1/9
			Assigned number originated and maintained by the sender.	



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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.

For implementations compliant with this guide, GS06 must be unique within a single transmission (that is, within a single ISA to IEA enveloping structure). The authors recommend that GS06 be unique within all transmissions over a period to be determined by the sender.

REQUIRED GS07 455

Responsible Agency Code M 1 ID 1/2

Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480

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

X	Accredited Standards Committee X12
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REQUIRED GS08 480

Version / Release / Industry Identifier Code M 1 AN 1/12

Code indicating the version, release, subrelease, 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 subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

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

005010X223A2	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
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GE - FUNCTIONAL GROUP TRAILER

To indicate the end of a functional group and to provide control information.

Repeat: 1

Usage: REQUIRED

Notes: 1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Example: **GE*1*1~**



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Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	GE01	97	Number of Transaction Sets Included	M 1 NO 1/6
			Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.	
REQUIRED	GE02	28	Group Control Number	M 1 NO 1/9
			Assigned number originated and maintained by the sender	
			SEMANTIC: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	
			Must be a positive unsigned number and must be identical to the value in GS06.	

IEA - INTERCHANGE CONTROL TRAILER

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

Repeat: 1
Usage: REQUIRED
Example: **IEA*1*000000905~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	IEA01	I16	Number of Included Functional Groups	M 1 NO 1/5
			A count of the number of functional groups included in an interchange.	
REQUIRED	IEA02	I12	Interchange Control Number	M 1 NO 9/9
			A control number assigned by the interchange sender.	
			Must be a positive unsigned number and must be identical to the value in ISA13.	



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5.5 Examples

1. Subscriber is the Patient

```
ISA*00*                *00*                *ZZ*SUB999                *ZZ*YTH837
*250401*1512*^^*00501*000000001*0*P*:~
GS*HC*SUB999*YTH837*20250401*1512*000000002*X*005010X222A1~
ST*837*0003*005010X222A1~
BHT*0019*00*202504011512*20250401*1512*RP~
NM1*41*2*ABC SUBMITTER*****46*SUB999~
PER*IC*ABC SUBMITTER*TE*8883084953~
NM1*40*2*THCIC*****46*YTH837~
HL*1**20*1~
NM1*85*2*SYSTEM13 QA 1*****XX*0100000008~
N3*1648 STATE FARM~
N4*CHARLOTTESVILLE*TX*22911~
REF*EI*987654321~
REF*1J*000001~
HL*2*1*22*0~
SBR*P*18*****MB~
NM1*IL*1*DOE*JOHN****MI*1A2B3C4D~
N3*100 MAIN ST~
N4*AUSTIN*TX*78756*US~
DMG*D8*19590918*M~
REF*SY*999999999~
NM1*PR*2*MEDICARE OF TEXAS*****PI*99999~
CLM*10000*2089.10***24:A:1**A*Y*Y~
CL1*3*1*01~
REF*EA*50000~
HI*ABK:H25812~
HI*APR:H25812~
HI*BBR:66984:D8:20250102~
HI*BBQ:J1097:D8:20250102*BBQ:J1096:D8:20250102~
K3*24~
NM1*82*1*STEPHENS*MICHAEL*P***XX*1234567890~
SBR*S*****MC~
NM1*PR*2*MEDICAID*****PI*88888~
LX*1~
SV1*HC:66984:LT*1083.18*UN*1.00***1~
DTP*472*D8*20250102~
LX*2~
SV1*HC:J1097:JZ*500.00*UN*4.00***1~
DTP*472*D8*20250102~
LX*3~
SV1*HC:J1096:JZ*505.92*UN*4.00***1~
DTP*472*D8*20250102~
SE*40*0003~
GE*1*000000002~
IEA*1*000000001~
```



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6. Revision Changes

Revision Changes

Version 1.0

1. Extracted from Outpatient Technical Specifications v11.4
2. Add 837 Example