



TEXAS
Health and Human
Services

Texas Department of State
Health Services

5010 Outpatient Institutional 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: Institutional, 837, ASC X12N 837 (005010X223), May 2006 version, and the addenda published by the Washington Publishing Company in June 2010 (ANSI 837 Professional Guide, 005010X223A2) 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. This document is published under the following copyright statement:

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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	An electronic standardized process developed and implemented by the THCIC to identify potential errors and mistakes in data elements by reviewing data fields for the presence or absence of data, and the accuracy and appropriateness of data. (§108.002(8) Health and Safety Code) For the purposes of this manual: 1. To make changes to a data file. 2. The process of adding, deleting, or changing data. The THCIC edits the public use data file to protect the confidentiality of patients and physicians. 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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RJ002	ISA06 (Interchange Sender ID) contains invalid Submitter_ID='SUB999'	Our system has stopped processing this file. 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.
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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 Institutional Claim, X223A2) 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. Patient's Reason for Visit
- 17. External Cause of Injury (E-Code) - up to 10 occurrences (if applicable)
- 18. Other Diagnosis Codes - up to 24 occurrences (if applicable)
- 19. Occurrence Span Code - up to 4 occurrences (if applicable)
- 20. Occurrence Span Code Associated Dates (From/Thru) – up to 4 occurrences (If applicable)
- 21. Occurrence Code - up to 12 occurrences (if applicable)
- 22. Occurrence Code Associated Date - up to 12 occurrences (if applicable)
- 23. Value Code - up to 12 occurrences (if applicable)
- 24. Value Code Associated Amount - up to 12 occurrences (if applicable)
- 25. Condition Code - up to 8 occurrences (if applicable)



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- 26. Other Provider or Other Health Professional Name (if applicable)
 - a. Other Provider or Other Health Professional Last Name
 - b. Other Provider or Other Health Professional First Name
 - c. Other Provider or Other Health Professional Middle Initial
- 27. Other Provider or Other Health Professional Primary Identifier (National Provider Identifier, when HIPAA rule is implemented)
- 28. Other Provider or Other Health Professional Secondary Identifier (Texas state license number)
- 29. Operating Physician or Other Health Professional Name (if applicable)
 - a. Operating Physician or Other Health Professional Last Name
 - b. Operating Physician or Other Health Professional First Name
 - c. Operating Physician or Other Health Professional Middle Initial
- 30. Operating Physician or Other Health Professional Primary Identifier (National Provider Identifier, when HIPAA rule is implemented)
- 31. Operating Physician or Other Health Professional Secondary Identifier (Texas state license number)
- 32. Total Claim Charges
- 33. Revenue Service Line Details (up to 999 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. Service Line Dates
 - h. Charge Amount
 - i. Unit Code
 - j. Unit Quantity
 - k. Unit Rate
 - l. Non-covered Charge Amount
- 34. Service Provider Name
- 35. Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier (when HIPAA rule is implemented)
- 36. Service Provider Address
 - a. Service Provider Address Line 1
 - b. Service Provider Address Line 2 (if applicable)



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- c. Service Provider City
 - d. Service Provider State
 - e. Service Provider Zip
37. Service Provider Secondary Identifier - THCIC 6-digit Hospital ID assigned to each facility

4.7.1 Emergency Department Visits

It is expected Freestanding Emergency Medical Centers, or Hospitals submitting claims with a Revenue Code indicating “Emergency Room” (045x) are required to provide the following additional data:

- 38. Attending Physician or Attending Practitioner Name
 - a. Attending Physician or Attending Practitioner Last Name
 - b. Attending Physician or Attending Practitioner First Name
 - c. Attending Physician or Attending Practitioner Middle Initial
- 39. Attending Physician or Attending Practitioner Primary Identifier (National Provider Identifier, when HIPAA rule is implemented)
- 40. Attending Physician or Attending Practitioner Secondary Identifier (Texas state license number)
- 41. Point of Origin (Source of Admission)
- 42. Patient (Discharge) Status

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 2010CA	NM103
Patient First Name	2010BA or 2010CA	NM104
Patient Middle Initial	2010BA or 2010CA	NM105
Patient Street Address	2010BA or	N301



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DATA ELEMENT	Loop ID	Ref. Des.
	2010CA	
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
Type of Bill	2300	CLM05
Statement Covers Period From	2300	DTP03
Statement Covers Period Through	2300	DTP03
Principal Diagnosis Code	2300	HI01



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DATA ELEMENT	Loop ID	Ref. Des.
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
Provider Address	2010AA or 2310E	N301
Provider City	2010AA or 2310E	N401
Provider ZIP Code	2010AA or 2310E	N403



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DATA ELEMENT	Loop ID	Ref. Des.
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 Inpatient 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: Institutional, 837, ASC X12N 837 (005010X223), May 2006 version, and the addenda published by the Washington Publishing Company in June 2010 (ANSI 837 Institutional Guide, 005010X223A2) 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	The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets. It also provides control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.
Control Segment, Transaction Set Segments	The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer defines the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.
Control Segment, Hierarchical Level Segments	Hierarchical Level segments denote the start of a group of information. The information may be about a provider of date, about the insured person, or about a patient claim. It ends when another Hierarchical Loop occurs, or when a transaction trailer (SE) is received.
Control Segment, Relations among Control Segments	The control segments of this standard must have a nested relationship, as shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments. ISA Interchange Control Header



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Term	Definition
	GS Functional Group Header starts a group of related Transaction sets. ST Transaction Set Header starts a transaction set. HL Hierarchical Level starts a bounded loop of data segments. SE Transaction Set Trailer ends a transaction set. GE Functional Group Trailer ends a group of related transaction sets. IEA Interchange Control Trailer
Data Element	The data element is the smallest unit of information in the X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinal positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.
Data Element, Numeric	A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data. The data element dictionary defines the number of implied decimal positions. The representation for this data element type is Nn where N indicates that it is numeric, and n



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Term	Definition
	indicates the number of decimal positions to the right of the implied decimal point. If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of numeric type data elements does not include the optional sign. FOR EXAMPLE: Value is "-123.4". Numeric type is "N2" where the "2" indicates an implied decimal placement two positions from the right. The data stream value is "-12340". The length is 5 (note padded zero).
Data Element, Decimal Number	A decimal data element contains an explicit decimal point and is used for numeric values that have a varying number of decimal positions. The representation for this data element type is "R." The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted. Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly



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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. The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment



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Term	Definition
	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. For example: The first simple element of the SVC segment would be identified as SVC01 because the position count



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Term	Definition
	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 a condition code (see table below) and the reference



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Term	Definition												
	designators of the affected data elements. A data element may be subject to more than one relational condition. <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><tr><td>L- List Conditional</td><td>If the first element specified in the condition is present, then at</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.	L- List Conditional	If the first element specified in the condition is present, then at
Condition Code	Definition												
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L- List Conditional	If the first element specified in the condition is present, then at												



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Term	Definition		
	<table><tr><td></td><td>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>		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.
	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	Simple data elements or composite data structures may have a designation that indicates the existence of a semantic note. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements. Semantic notes are considered part of the relevant transaction set standard. Semantic Note (Z) A semantic note is referenced in the segment directory for this data element with respect to its use in this data segment.		
Data Segment, Absence of Data	Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the		



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Term	Definition
	segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order, to maintain the element's or structure's position as defined in the data segment.
Delimiter	A delimiter is a character used to separate two data elements (or sub elements) or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header segment, ISA and are not to be used in a data element value elsewhere in the interchange. These delimiters can be visualized on the printed page. They also display each segment on a separate line, adding human readability to the transaction set. Due to potential conflicts with either the data elements or with the special needs of transmission and device control, the historically used delimiters have caused problems.
Dependent	In the hierarchical loop coding, the dependent code 23 indicates the use of the patient hierarchical loop (Loop ID-2000C).
Destination Payer	The destination payer is the payer who is specified in the Subscriber/Payer loop (Loop ID-2010BB)



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Term	Definition
Functional Group	A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group.
Patient	The term "patient" is intended to convey the case where the Patient loop (Loop ID- 2000C) is used. In that case, the patient is not the same person as the subscriber, and the patient is a person (e.g., spouse, children, others) who is covered by the subscriber's insurance plan. However, it also happens that the patient is sometimes the same person as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 2.3.2.1, HL Segment, (ANSI 837 Institutional and Professional Guides) for further details. Every effort has been made to ensure that the meaning of the word "patient" is clear in its specific context.
Provider	In a generic sense, the provider is the entity that originally submitted the claim/encounter. A provider may also have provided or participated in some aspect of the health care service described in the transaction. Specific types of providers are identified in this implementation section (e.g., billing provider, other provider, operating physician, rendering provider).



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Term	Definition
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	The transaction set header and trailer segments are constructed as follows: • Transaction Set Header (ST) • Data Segment Group • Transaction Set Trailer (SE) The transaction set identifier uniquely identifies the transaction set. This identifier is the first data element of the transaction set header segment. The value for the transaction set control number, in the header and trailer control segments must be identical for any given transaction. The value for the number of included



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Term	Definition
	segments is the total number of segments in the transaction set including the ST and SE segments.
Transaction Set, Data Segment Groups	The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.
Transaction Set, Repeated Occurrences of Single Data Segments	When a single data segment is allowed, to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is ">1".
Transaction Set, Loops of Data Segments	Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded
Transaction Set, Unbounded Loops.	In order, to establish the iteration of a loop, the first data segment in the loop shall appear Unbounded once and only once in each iteration. Loops may have a specified maximum number of Loops repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions ">1". There is a specified sequence of segments in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.



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Term	Definition
	The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If unbounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop shall not start with the same segment as its immediate outer loop. For any segment that occurs in a loop and in the parent structure of that loop, that segment must occur prior to that loop in the parent structure or subsequent, to an intervening mandatory segment in the parent structure (parent structure is composed of all segments at the same level of nesting as the beginning segment of the loop).
Transaction Set, Bounded Loops	The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start segment to appear before the first occurrence and a loop end segment to appear after the last occurrence of the loop. If the loop does not occur, the segments shall be suppressed. The requirement designator on the segments must match the requirement designator of the beginning segment of the loop. A bounded loop may contain only one loop structure at the level bracketed by the segments. Subordinate loops are permissible. If bounded loops are nested within loops, the inner loop shall not start at



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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	A data segment, or loop, has one of the following requirement designators for health care Data Segment and insurance transaction sets, indicating its appearance in the data stream of a Requirement transmission. These requirement designators are represented by a single character code. <table><tr><th>Designator</th><th>Requirement</th></tr><tr><td>(M) Mandatory</td><td>This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)</td></tr><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

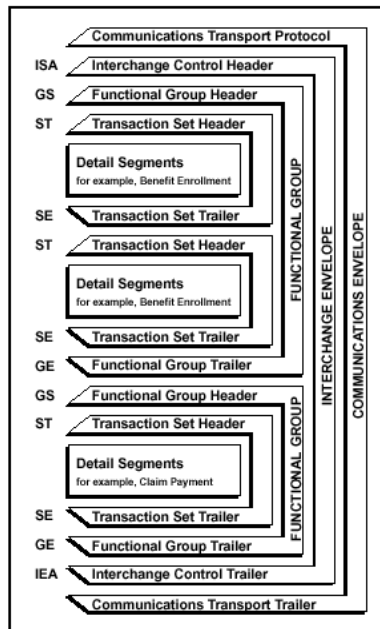


Figure 1. Basic 837 Structure

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	
1350	DTP	Statement Dates	R	1	
1400	CL1	Institutional Claim Code	S	1	
1800	REF	Medical Record Number	R	1	
1850	K3	File Information	R	10	



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POS	ID	NAME	USG	RPT	LOOP RPT
2310	HI	Principal Diagnosis	R	1	
2310	HI	Patient’s Reason for Visit	R	1	
2310	HI	External Cause of Injury	S	1	
2310	HI	Other Diagnosis Information	S	2	
2310	HI	Occurrence Span Information	S	1	
2310	HI	Occurrence Information	S	1	
2310	HI	Value Information	S	1	
2310	HI	Condition Information	S	1	
LOOP ID - 2310A ATTENDING PROVIDER NAME					1
2500	NM1	Attending Provider Name	S	1	
2710	REF	Attending Provider Secondary Identification	S	1	
LOOP ID - 2310B OPERATING PHYSICIAN NAME					1
2500	NM1	Operating Physician Name	S	1	
2710	REF	Operating Physician Secondary Identification	S	1	
LOOP ID - 2310C OTHER OPERATING Physician NAME					1
2500	NM1	Other Operating Physician Name	S	1	
2710	REF	Other Operating Physician Secondary Identification	S	1	
LOOP ID - 2310E SERVICE FACILITY LOCATION NAME					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					999
3650	LX	Service Line Number	R	1	
3750	SV2	Institutional Service Line	R	1	
4550	DTP	Date – Service Date	R	1	
5550	SE	Transaction Set Trailer	R	1	



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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/005010X223 Health Care Claim: Institutional (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*005010X223A2~**

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											



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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:

CODE	DEFINITION
005010X223A2	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 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



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Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set

CODE DEFINITION

0019 Information Source, Subscriber, Dependent

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.

CODE DEFINITION

00 Original

18 Reissue

REQUIRED BHT03 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: 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



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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

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	



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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	
			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	
			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	



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

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~**

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)							



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			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

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 or the Pay-to-Provider then do not use Loop 2310E.
 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~**



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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
			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~**

**Healthcare Facility Procedures and Technical Specifications Manual***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
			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: 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



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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
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	M 1 AN 1/55
			Address information	
			INDUSTRY NAME: Billing Provider Address Line	
SITUATIONAL	N302	166	Address Information	O 1 AN 1/55
			Address information	
			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



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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 Code (Standard State/Province) as defined by appropriate government agency	X 1 ID 2/2
			INDUSTRY NAME: Billing Provider State or Province Code	
REQUIRED	N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	O 1 ID 3/15
			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.



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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													
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>EI</td><td>Employer's Identification Number</td></tr><tr><td colspan="2">The Employer's Identification Number must be a string of exactly nine numbers with no separators.</td></tr></table>								CODE	DEFINITION	EI	Employer's Identification Number	The Employer's Identification Number must be a string of exactly nine numbers with no separators.	
CODE	DEFINITION												
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													
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>nnnnnnnnnn</td><td>Employer Identification Number (EIN)</td></tr></table>								CODE	DEFINITION	nnnnnnnnnn	Employer Identification Number (EIN)		
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



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(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			
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 - 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).



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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 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



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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

Usage: REQUIRED

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

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	
			CODE DEFINITION	
			P Primary	
SITUATIONAL	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.	
			Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.	
			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



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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	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 - SUBSCRIBER NAME

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

Loop: 2010BA — SUBSCRIBER NAME Loop Repeat: 1

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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 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	

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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

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



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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.

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	M 1 AN 1/55
			Address information	
			INDUSTRY NAME: Subscriber Address Line	
SITUATIONAL	N302	166	Address Information	O 1 AN 1/55
			Address information	
			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.



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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	O	1	AN	2/30								
Free-form text for city name															
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															
<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								
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.															
<table><tr><th>CODE</th><th>DEFINITION</th></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								



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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~**

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										



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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

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							
		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

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

INDUSTRY NAME: Subscriber Supplemental Identifier**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		

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								
<table border="0"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>PR</td> <td>Payer</td> </tr> </tbody> </table>					CODE	DEFINITION	PR	Payer
CODE	DEFINITION							
PR	Payer							

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REQUIRED	NM102	1065	Entity Type Qualifier	M	1	ID	1/1								
Code qualifying the type of entity															
SEMANTIC: NM102 qualifies NM103.															
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>								CODE	DEFINITION	2	Non-Person Entity				
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															
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>SELF-PAY</td><td>For Self-Pay Claims (Claim Filing Indicator Code is "ZZ")</td></tr><tr><td>CHARITY</td><td>For Charity Claims (Claim Filing Indicator Code is "ZZ")</td></tr><tr><td>UNKNOWN</td><td>With Unknown Pay Source (Claim Filing Indicator Code is "ZZ")</td></tr></table>								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")
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)															
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>PI</td><td>Payor Identification unless Self-Pay, Charity, or Unknown Payer claim</td></tr><tr><td>XV</td><td>Centers for Medicare and Medicaid Services PlanID</td></tr><tr><td>ZY</td><td>Temporary Identification Number for use with Self-Pay, Charity, or Unknown Payer claim</td></tr></table>								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
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															
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XXXXXXXXXX</td><td>National Plan Identifier (NPI) Number</td></tr><tr><td></td><td>CMS currently has delayed the implementation date for all plans and providers until further notice.</td></tr></table>								CODE	DEFINITION	XXXXXXXXXX	National Plan Identifier (NPI) Number		CMS currently has delayed the implementation date for all plans and providers until further notice.		
CODE	DEFINITION														
XXXXXXXXXX	National Plan Identifier (NPI) Number														
	CMS currently has delayed the implementation date for all plans and providers until further notice.														

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			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.

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

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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.

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.



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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
			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
			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	O 1 ID 2/2

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Code indicating the relationship between two individuals or entities

Specifies the patient's relationship to the person insured.

CODE	DEFINITION
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

NOT USED	PAT02	1384	Patient Location Code	O	1	ID	1/1
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.



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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	
			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



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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~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES			
REQUIRED	N301	166	Address Information	M	1	AN	1/55
			Address information				
			INDUSTRY NAME: Patient Address Line				
SITUATIONAL	N302	166	Address Information	O	1	AN	1/55
			Address information				
			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~**



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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								
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.															
<table><tr><th>CODE</th><th>DEFINITION</th></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								

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.



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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				
			SEMANTIC: DMG02 is the date of birth.				
			INDUSTRY NAME: Patient Birth Date				
REQUIRED	DMG03	1068	Gender Code	O	1	ID	1/1
			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	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

CLM - CLAIM INFORMATION

To specify basic data about the claim.



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- 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 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*12345656*500***12:A:1*Y*A*Y*I~**

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				

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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
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Monetary amount

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 Institutional Service Line (SV2) segments for this claim.

NOT USED	CLM03	1032	Claim Filing Indicator Code	O	1	ID	1/2
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NOT USED	CLM04	134	Non-Institutional Claim Type Code	O	1	ID	1/2
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REQUIRED	CLM05	C023	HEALTH CARE SERVICE LOCATION INFORMATION	O	1		
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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
-----------------	--------------	------------	-------------	----------------------------	----------	-----------	------------

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: Facility Type Code

CODE	DEFINITION
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12	Hospital Inpatient (Medicare Part B only)
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13	Hospital Outpatient
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				14	Hospital Laboratory Services to Non-patients				
				22	Skilled Nursing – Inpatient (Medicare Part B only)				
				23	Skilled Nursing – Outpatient				
				43	Religious Non-Medical Health Care Institutions – Outpatient Services				
				78	Licensed Freestanding Emergency Medical Facility				
				82	Hospice (hospital based)				
				83	Ambulatory Surgery Center				
				85	Critical Access Hospital				
				89	Special Facility - Other				
REQUIRED	CLM05	- 2	1332	Facility Code Qualifier		O	ID	1/2	
				Code identifying the type of facility referenced					
				CODE	DEFINITION				
				A	Uniform Billing Claim Form Bill Type				
REQUIRED	CLM05	- 3	1325	Claim Frequency Type		O	ID	1/1	
				Code					
				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				
				2	Interim – First Claim				
				3	Interim – Continuing Claim				
				4	Interim – Last Claim				
				5	Late Charge(s) Only				
				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
NOT USED	CLM07		1359	Provider Accept Assignment Code		O	1	ID	1/1
NOT USED	CLM08		1073	Yes/No Condition or Response Code		O	1	ID	1/1
NOT USED	CLM09		1363	Release of Information Code		O	1	ID	1/1
NOT USED	CLM10		1351	Patient Signature Source Code		O	1	ID	1/1

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NOT USED	CLM11	C024	RELATED CAUSES INFORMATION	O	1		
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
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

DTP - STATEMENT DATES

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

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: REQUIRED

Example: **DTP*434*RD8*20041209-20041214~**

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			
			434	Statement			
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				



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SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE DEFINITION

RD8 **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**
Use RD8 to indicate the from and through date of the statement.
When the statement is for a single date of service, the from and through date are the same.

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: Statement From and To Date

CL1 - INSTITUTIONAL CLAIM CODE

To supply information specific to hospital claims.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required for Emergency Department claims. See 4.7.1 Emergency Department Visits for additional information.

2. When specifying admission type code '4', Newborn, you are required to specify the newborn's weight as value code '54'. See segment HI Value Information in Loop ID-2300.

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

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	CL101	1315	Admission Type Code	O 1 ID 1/1
			Code indicating the priority of this admission	
REQUIRED	CL102	1314	Admission Source Code	O 1 ID 1/1
			Code indicating the source of this admission	
REQUIRED	CL103	1352	Patient Status Code	O 1 ID 2/2
			Code indicating patient status as of the "statement covers through date"	



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NOT USED CL104 1345 Nursing Home Residential O 1 ID 1/1
Status Code

REF - MEDICAL RECORD NUMBER

To specify identifying information.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: REQUIRED

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

K3 - FILE INFORMATION

To transmit a fixed-format record or matrix contents.

Loop: 2300 — CLAIM INFORMATION

Repeat: 10

Usage: REQUIRED



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- 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																
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>American Indian/Eskimo/Aleut</td></tr><tr><td>2</td><td>Asian, Native Hawaiian or Pacific Islander</td></tr><tr><td>3</td><td>Black or African American</td></tr><tr><td>4</td><td>White</td></tr><tr><td>5</td><td>Other Race</td></tr></table>					CODE	DEFINITION	1	American Indian/Eskimo/Aleut	2	Asian, Native Hawaiian or Pacific Islander	3	Black or African American	4	White	5	Other Race
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																



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

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

HI - PRINCIPAL DIAGNOSIS

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: REQUIRED

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

Example: **HI*ABK:S98141A~**

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



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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
SITUATIONAL	HI01	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
NOT USED	HI02		C022	HEALTH CARE CODE INFORMATION	M	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	
NOT USED	HI09		C022	HEALTH CARE CODE INFORMATION	M	1	



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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

HI - PATIENT'S REASON FOR VISIT

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: REQUIRED

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

Example: **HI* APR:R110 ~**

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
			APR	International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit
REQUIRED	HI01 - 2	1271	Industry Code	M AN 1/30
			Code indicating a code from a specific industry code list	
			INDUSTRY NAME: Patient Reason For Visit	
NOT USED	HI01 - 3	1250	Date Time Period Format Qualifier	X ID 2/3
NOT USED	HI01 - 4	1251	Date Time Period	X AN 1/35

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

Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. If not required by this implementation guide, do not send.

REQUIRED	HI02	- 1	1270	Code List Qualifier Code	M	ID	1/3
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Code identifying a specific industry code list

CODE	DEFINITION
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ABR	International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit
-----	---

REQUIRED	HI02	- 2	1271	Industry Code	M	AN	1/30
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Code indicating a code from a specific industry code list

INDUSTRY NAME: Patient Reason For Visit

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

SITUATIONAL	HI03		C022	HEALTH CARE CODE INFORMATION	M	1	
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To send health care codes and their associated dates, amounts and quantities



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Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. If not required by this implementation guide, do not send.

REQUIRED	HI03	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABR	International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit		
REQUIRED	HI03	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Patient Reason For Visit			
NOT USED	HI03	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI03	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI03	- 6	380	Quantity	O	R	1/15
NOT USED	HI03	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI03	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI03	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI04		C022	HEALTH CARE CODE INFORMATION	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	
NOT USED	HI09		C022	HEALTH CARE CODE INFORMATION	M	1	
NOT USED	HI10		C022	HEALTH CARE CODE INFORMATION	M	1	



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

HI - EXTERNAL CAUSE OF INJURY

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

- Notes:
1. Required when an External Cause of Injury is needed to describe an injury, poisoning, or adverse effect. If not required by this implementation guide, do not send.
 2. Do not transmit the decimal point for ICD codes. The decimal point is implied.
 3. To fully describe an injury using ICD-10-CM, it will be necessary to report a series of 3 external cause of injury codes.
 4. The ICD-10-CM External Cause of Morbidity codes are in the V00-Y99 code group.
 5. Up to 10 External Causes of Injury can be defined.

Example: **HI*ABN:V0409XA~**

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

**Healthcare Facility Procedures and Technical Specifications Manual**

REQUIRED	HI01	- 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			
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
SITUATIONAL	HI01	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI02		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI02	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

**Healthcare Facility Procedures and Technical Specifications Manual**

REQUIRED	HI02	- 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			
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
SITUATIONAL	HI02	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI03		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI03	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

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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			
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
SITUATIONAL	HI03	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI04		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI04	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

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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			
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
SITUATIONAL	HI04	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI05		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI05	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

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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			
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
SITUATIONAL	HI05	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI06		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI06	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

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REQUIRED	HI06	- 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			
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
SITUATIONAL	HI06	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI07		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI07	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

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REQUIRED	HI07	- 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			
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
SITUATIONAL	HI07	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI08		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI08	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

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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			
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
SITUATIONAL	HI08	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI09		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI09	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		

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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			
NOT USED	HI09	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI09	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI09	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI09	- 6	380	Quantity	O	R	1/15
NOT USED	HI09	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI09	- 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI09	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
				Code indicating a Yes or No condition or response			
				INDUSTRY NAME: Present on Admission Indicator			
				Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.			
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
SITUATIONAL	HI10		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				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	HI10	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code		



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REQUIRED	HI10	- 2	1271	Industry Code	M	AN	1/30
Code indicating a code from a specific industry code list							
INDUSTRY NAME: External Cause of Injury Code							
NOT USED	HI10	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI10	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI10	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI10	- 6	380	Quantity	O	R	1/15
NOT USED	HI10	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI10	- 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI10	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
Code indicating a Yes or No condition or response							
INDUSTRY NAME: Present on Admission Indicator							
Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.							
				CODE	DEFINITION		
				N	No		
				U	Unknown		
				W	Not Applicable		
				Y	Yes		
NOT USED	HI11		C022	HEALTH CARE CODE INFORMATION	M	1	
NOT USED	HI12		C022	HEALTH CARE CODE INFORMATION	M	1	

HI - OTHER DIAGNOSIS INFORMATION

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 2

Usage: SITUATIONAL



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- Notes:
1. Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment. If not required by this implementation guide, do not send.
 2. Do not transmit the decimal point for ICD codes. The decimal point is implied.
 3. Up to 24 Other Diagnoses can be defined.

Example: **HI*ABF:K5900~**

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
				ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
REQUIRED	HI01	- 2	1271	Industry Code	M AN 1/30
				Code indicating a code from a specific industry code list	
				INDUSTRY NAME: Other Diagnosis	
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
SITUATIONAL	HI01	- 9	1073	Yes/No Condition or Response Code	X ID 1/1
				Code indicating a Yes or No condition or response	
				INDUSTRY NAME: Present on Admission Indicator	



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI02

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

Code identifying a specific industry code list

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

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

Code indicating a code from a specific industry code list

INDUSTRY NAME: Other Diagnosis

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

SITUATIONAL HI02 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI03

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

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

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

Code indicating a code from a specific industry code list

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

SITUATIONAL HI03 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI04

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

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

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

Code indicating a code from a specific industry code list

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

SITUATIONAL HI04 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI05

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

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

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

Code indicating a code from a specific industry code list

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

SITUATIONAL HI05 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI06

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

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

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

Code indicating a code from a specific industry code list

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

SITUATIONAL HI06 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI07

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

Code identifying a specific industry code list

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

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

Code indicating a code from a specific industry code list

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

SITUATIONAL HI07 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI08

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

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

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

Code indicating a code from a specific industry code list

INDUSTRY NAME: Other Diagnosis

NOT USED HI08 - 3 1250 Date Time Period Format Qualifier X ID 2/3

NOT USED HI08 - 4 1251 Date Time Period X AN 1/35

NOT USED HI08 - 5 782 Monetary Amount O R 1/18

NOT USED HI08 - 6 380 Quantity O R 1/15

NOT USED HI08 - 7 799 Version Identifier O AN 1/30

NOT USED HI08 - 8 1271 Industry Code X AN 1/30

SITUATIONAL HI08 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI09

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

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

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

Code indicating a code from a specific industry code list

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

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

SITUATIONAL HI09 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI10

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

Code identifying a specific industry code list

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

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

Code indicating a code from a specific industry code list

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

NOT USED HI10 - 8 1271 Industry Code X AN 1/30

SITUATIONAL HI10 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI11

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

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

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

Code indicating a code from a specific industry code list

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

SITUATIONAL HI11 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL HI12

C022 HEALTH CARE CODE M 1 INFORMATION

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

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

Code identifying a specific industry code list

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

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

Code indicating a code from a specific industry code list

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

SITUATIONAL HI12 - 9 1073 Yes/No Condition or Response Code X ID 1/1

Code indicating a Yes or No condition or response

INDUSTRY NAME: Present on Admission Indicator



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Required as directed by 4.7.1 Diagnosis Present on Admission of this implementation guide.

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

HI - OCCURRENCE SPAN INFORMATION

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required when there is an Occurrence Span Code that applies to this claim. If not required by this implementation guide, do not send.
2. Up to 4 Occurrence Span Codes can be defined.
Example: **HI*BI:70:RD8:20051202-20051212~**

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	
			BI Occurrence Span	
REQUIRED	HI01 - 2	1271	Industry Code	M AN 1/30
			Code indicating a code from a specific industry code list	
			INDUSTRY NAME: Occurrence Span Code	
REQUIRED	HI01 - 3	1250	Date Time Period Format Qualifier	X ID 2/3



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				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		
REQUIRED	HI01	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Span Code Date			
NOT USED	HI01	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI01	- 6	380	Quantity	O	R	1/15
NOT USED	HI01	- 7	799	Version Identifier	O	AN	1/30
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. 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		
				BI	Occurrence Span		
REQUIRED	HI02	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Span Code			
REQUIRED	HI02	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		



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REQUIRED	HI02	- 4	1251	Date Time Period	X	AN	1/35	Expression of a date, a time, or range of dates, times or dates and times				
INDUSTRY NAME: Occurrence Span Code Date												
NOT USED	HI02	- 5	782	Monetary Amount	O	R	1/18					
NOT USED	HI02	- 6	380	Quantity	O	R	1/15					
NOT USED	HI02	- 7	799	Version Identifier	O	AN	1/30					
NOT USED	HI02	- 8	1271	Industry Code	X	AN	1/30					
NOT USED	HI02	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1					
SITUATIONAL	HI03		C022	HEALTH CARE CODE INFORMATION	M	1		To send health care codes and their associated dates, amounts and quantities				
Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. 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				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BI</td><td>Occurrence Span</td></tr></table>									CODE	DEFINITION	BI	Occurrence Span
CODE	DEFINITION											
BI	Occurrence Span											
REQUIRED	HI03	- 2	1271	Industry Code	M	AN	1/30	Code indicating a code from a specific industry code list				
INDUSTRY NAME: Occurrence Span Code												
REQUIRED	HI03	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3	Code indicating the date format, time format, or date and time format				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>RD8</td><td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</td></tr></table>									CODE	DEFINITION	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
CODE	DEFINITION											
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD											
REQUIRED	HI03	- 4	1251	Date Time Period	X	AN	1/35	Expression of a date, a time, or range of dates, times or dates and times				



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				INDUSTRY NAME: Occurrence Span Code Date			
NOT USED	HI03	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI03	- 6	380	Quantity	O	R	1/15
NOT USED	HI03	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI03	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI03	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI04		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. 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			
				CODE	DEFINITION		
				BI	Occurrence Span		
REQUIRED	HI04	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Span Code			
REQUIRED	HI04	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		
REQUIRED	HI04	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Span Code Date			
NOT USED	HI04	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI04	- 6	380	Quantity	O	R	1/15



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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
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	
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	

HI - OCCURRENCE INFORMATION

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when there is an Occurrence Code that applies to this claim. If not required by this implementation guide, do not send.
2. Up to 12 Occurrence Codes can be defined.

Example: **HI*BH:42:D8:20051208*BH:A3:D8:20051203~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1

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REQUIRED	HI01	- 1	1270	To send health care codes and their associated dates, amounts and quantities		
				Code List Qualifier Code	M	ID 1/3
				Code identifying a specific industry code list		
				CODE	DEFINITION	
				BH	Occurrence	
REQUIRED	HI01	- 2	1271	Industry Code	M	AN 1/30
				Code indicating a code from a specific industry code list		
				INDUSTRY NAME: Occurrence Code		
REQUIRED	HI01	- 3	1250	Date Time Period Format Qualifier	X	ID 2/3
				Code indicating the date format, time format, or date and time format		
				CODE	DEFINITION	
				D8	Date Expressed in Format CCYYMMDD	
REQUIRED	HI01	- 4	1251	Date Time Period	X	AN 1/35
				Expression of a date, a time, or range of dates, times or dates and times		
				INDUSTRY NAME: Occurrence Date		
NOT USED	HI01	- 5	782	Monetary Amount	O	R 1/18
NOT USED	HI01	- 6	380	Quantity	O	R 1/15
NOT USED	HI01	- 7	799	Version Identifier	O	AN 1/30
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
				To send health care codes and their associated dates, amounts and quantities		
				Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. 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	



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REQUIRED	HI02	- 2	1271	BH	Occurrence			
				Industry Code	M	AN	1/30	
				Code indicating a code from a specific industry code list				
REQUIRED	HI02	- 3	1250	INDUSTRY NAME: Occurrence Code				
				Date Time Period Format	X	ID	2/3	Qualifier
				Code indicating the date format, time format, or date and time format				
REQUIRED	HI02	- 4	1251	CODE	DEFINITION			
				D8	Date Expressed in Format CCYYMMDD			
				Date Time Period	X	AN	1/35	
				Expression of a date, a time, or range of dates, times or dates and times				
NOT USED	HI02	- 5	782	INDUSTRY NAME: Occurrence Date				
				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		
				To send health care codes and their associated dates, amounts and quantities				
				Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. 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				
REQUIRED	HI03	- 2	1271	CODE	DEFINITION			
				BH	Occurrence			
				Industry Code	M	AN	1/30	
				Code indicating a code from a specific industry code list				
				INDUSTRY NAME: Occurrence Code				

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REQUIRED	HI03	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
Code indicating the date format, time format, or date and time format							
				CODE	DEFINITION		
				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI03	- 4	1251	Date Time Period	X	AN	1/35
Expression of a date, a time, or range of dates, times or dates and times							
INDUSTRY NAME: Occurrence Date							
NOT USED	HI03	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI03	- 6	380	Quantity	O	R	1/15
NOT USED	HI03	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI03	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI03	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI04		C022	HEALTH CARE CODE INFORMATION	M	1	
To send health care codes and their associated dates, amounts and quantities							
Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. 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							
				CODE	DEFINITION		
				BH	Occurrence		
REQUIRED	HI04	- 2	1271	Industry Code	M	AN	1/30
Code indicating a code from a specific industry code list							
INDUSTRY NAME: Occurrence Code							
REQUIRED	HI04	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
Code indicating the date format, time format, or date and time format							
				CODE	DEFINITION		



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				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI04	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Date			
NOT USED	HI04	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI04	- 6	380	Quantity	O	R	1/15
NOT USED	HI04	- 7	799	Version Identifier	O	AN	1/30
NOT USED	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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. 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			
				CODE	DEFINITION		
				BH	Occurrence		
REQUIRED	HI05	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Code			
REQUIRED	HI05	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI05	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			

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				INDUSTRY NAME: Occurrence Date			
NOT USED	HI05	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI05	- 6	380	Quantity	O	R	1/15
NOT USED	HI05	- 7	799	Version Identifier	O	AN	1/30
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. 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			
				CODE	DEFINITION		
				BH	Occurrence		
REQUIRED	HI06	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Code			
REQUIRED	HI06	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI06	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Date			
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



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NOT USED	HI06	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI07		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 occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.			
REQUIRED	HI07	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				BH	Occurrence		
REQUIRED	HI07	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Code			
REQUIRED	HI07	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI07	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Date			
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	



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

Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. 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			
				CODE	DEFINITION		
				BH	Occurrence		
REQUIRED	HI08	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Code			
REQUIRED	HI08	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI08	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Date			
NOT USED	HI08	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI08	- 6	380	Quantity	O	R	1/15
NOT USED	HI08	- 7	799	Version Identifier	O	AN	1/30
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	

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

Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not

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				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		
				CODE	DEFINITION	
				BH	Occurrence	
REQUIRED	HI09	- 2	1271	Industry Code	M	AN 1/30
				Code indicating a code from a specific industry code list		
				INDUSTRY NAME: Occurrence Code		
REQUIRED	HI09	- 3	1250	Date Time Period Format Qualifier	X	ID 2/3
				Code indicating the date format, time format, or date and time format		
				CODE	DEFINITION	
				D8	Date Expressed in Format CCYYMMDD	
REQUIRED	HI09	- 4	1251	Date Time Period	X	AN 1/35
				Expression of a date, a time, or range of dates, times or dates and times		
				INDUSTRY NAME: Occurrence Date		
NOT USED	HI09	- 5	782	Monetary Amount	O	R 1/18
NOT USED	HI09	- 6	380	Quantity	O	R 1/15
NOT USED	HI09	- 7	799	Version Identifier	O	AN 1/30
NOT USED	HI09	- 8	1271	Industry Code	X	AN 1/30
NOT USED	HI09	- 9	1073	Yes/No Condition or Response Code	X	ID 1/1
SITUATIONAL	HI10		C022	HEALTH CARE CODE INFORMATION	M	1
				To send health care codes and their associated dates, amounts and quantities		
				Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.		
REQUIRED	HI10	- 1	1270	Code List Qualifier Code	M	ID 1/3
				Code identifying a specific industry code list		
				CODE	DEFINITION	

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				BH	Occurrence		
REQUIRED	HI10	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Code			
REQUIRED	HI10	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
				Code indicating the date format, time format, or date and time format			
				CODE	DEFINITION		
				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI10	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Date			
NOT USED	HI10	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI10	- 6	380	Quantity	O	R	1/15
NOT USED	HI10	- 7	799	Version Identifier	O	AN	1/30
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. 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			
				CODE	DEFINITION		
				BH	Occurrence		
REQUIRED	HI11	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Occurrence Code			

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REQUIRED	HI11	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
Code indicating the date format, time format, or date and time format							
				CODE	DEFINITION		
				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI11	- 4	1251	Date Time Period	X	AN	1/35
Expression of a date, a time, or range of dates, times or dates and times							
INDUSTRY NAME: Occurrence Date							
NOT USED	HI11	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI11	- 6	380	Quantity	O	R	1/15
NOT USED	HI11	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI11	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI12		C022	HEALTH CARE CODE INFORMATION	M	1	
To send health care codes and their associated dates, amounts and quantities							
Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.							
REQUIRED	HI12	- 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list							
				CODE	DEFINITION		
				BH	Occurrence		
REQUIRED	HI12	- 2	1271	Industry Code	M	AN	1/30
Code indicating a code from a specific industry code list							
INDUSTRY NAME: Occurrence Code							
REQUIRED	HI12	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
Code indicating the date format, time format, or date and time format							
				CODE	DEFINITION		



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				D8	Date Expressed in Format CCYYMMDD		
REQUIRED	HI12	- 4	1251	Date Time Period	X	AN	1/35
				Expression of a date, a time, or range of dates, times or dates and times			
				INDUSTRY NAME: Occurrence Date			
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

HI - VALUE INFORMATION

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes:

1. Required when there is a Value Code that applies to this claim. If not required by this implementation guide, do not send.
2. When the accompanying claim has a Newborn type of admission (i.e. 4), Value Code '54' is required. The amount is expected to be a positive numeric value.
3. Up to 12 Value Codes can be defined.

Example: **HI*BE:08::1740*BE:A7::940~**

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			

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				CODE BE	DEFINITION Value			
REQUIRED	HI01	- 2	1271	Industry Code	M	AN	1/30	
				Code indicating a code from a specific industry code list				
				INDUSTRY NAME: Value 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	
REQUIRED	HI01	- 5	782	Monetary Amount	O	R	1/18	
				Monetary Amount				
				INDUSTRY NAME: Value Code Amount				
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		
				To send health care codes and their associated dates, amounts and quantities				
				Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. 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 BE	DEFINITION Value			
REQUIRED	HI02	- 2	1271	Industry Code	M	AN	1/30	
				Code indicating a code from a specific industry code list				
				INDUSTRY NAME: Value 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	
REQUIRED	HI02	- 5	782	Monetary Amount	O	R	1/18	
				Monetary Amount				

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				INDUSTRY NAME: Value Code Amount			
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.			
REQUIRED	HI03	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				BE	Value		
REQUIRED	HI03	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Value Code			
NOT USED	HI03	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI03	- 5	782	Monetary Amount	O	R	1/18
				Monetary Amount			
				INDUSTRY NAME: Value Code Amount			
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional value code and the preceding HI			

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				data elements have been used to report other value codes. 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			
				CODE	DEFINITION		
				BE	Value		
REQUIRED	HI04	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Value Code			
NOT USED	HI04	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI04	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI04	- 5	782	Monetary Amount	O	R	1/18
				Monetary Amount			
				INDUSTRY NAME: Value Code Amount			
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. 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			
				CODE	DEFINITION		
				BE	Value		
REQUIRED	HI05	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Value Code			

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NOT USED	HI05	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI05	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI05	- 5	782	Monetary Amount	O	R	1/18
				Monetary Amount			
				INDUSTRY NAME: Value Code Amount			
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. 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			
				CODE	DEFINITION		
				BE	Value		
REQUIRED	HI06	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Value Code			
NOT USED	HI06	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI06	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI06	- 5	782	Monetary Amount	O	R	1/18
				Monetary Amount			
				INDUSTRY NAME: Value Code Amount			
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



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SITUATIONAL	HI07		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 value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.			
REQUIRED	HI07	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE BE	DEFINITION Value		
REQUIRED	HI07	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Value Code			
NOT USED	HI07	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI07	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI07	- 5	782	Monetary Amount	O	R	1/18
				Monetary Amount			
				INDUSTRY NAME: Value Code Amount			
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	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. 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			
				CODE	DEFINITION		



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				BE	Value			
REQUIRED	HI08	- 2	1271	Industry Code	M	AN	1/30	
				Code indicating a code from a specific industry code list				
				INDUSTRY NAME: Value Code				
NOT USED	HI08	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3	
NOT USED	HI08	- 4	1251	Date Time Period	X	AN	1/35	
REQUIRED	HI08	- 5	782	Monetary Amount	O	R	1/18	
				Monetary Amount				
				INDUSTRY NAME: Value Code Amount				
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		
				To send health care codes and their associated dates, amounts and quantities				
				Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. 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				
				CODE	DEFINITION			
				BE	Value			
REQUIRED	HI09	- 2	1271	Industry Code	M	AN	1/30	
				Code indicating a code from a specific industry code list				
				INDUSTRY NAME: Value Code				
NOT USED	HI09	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3	
NOT USED	HI09	- 4	1251	Date Time Period	X	AN	1/35	
REQUIRED	HI09	- 5	782	Monetary Amount	O	R	1/18	
				Monetary Amount				
				INDUSTRY NAME: Value Code Amount				

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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	

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

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

CODE	DEFINITION
BE	Value

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

Code indicating a code from a specific industry code list

INDUSTRY NAME: Value Code

NOT USED	HI10	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI10	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI10	- 5	782	Monetary Amount	O	R	1/18

Monetary Amount

INDUSTRY NAME: Value Code Amount

NOT USED	HI10	- 6	380	Quantity	O	R	1/15
NOT USED	HI10	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI10	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI10	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI11		C022	HEALTH CARE CODE INFORMATION	M	1	

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

Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report



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				other value codes. 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			
				CODE	DEFINITION		
				BE	Value		
REQUIRED	HI11	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Value Code			
NOT USED	HI11	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI11	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI11	- 5	782	Monetary Amount	O	R	1/18
				Monetary Amount			
				INDUSTRY NAME: Value Code Amount			
NOT USED	HI11	- 6	380	Quantity	O	R	1/15
NOT USED	HI11	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI11	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI12		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.			
REQUIRED	HI12	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				BE	Value		
REQUIRED	HI12	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Value Code			
NOT USED	HI12	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3

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NOT USED	HI12	- 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI12	- 5	782	Monetary Amount	O	R	1/18
				Monetary Amount			
INDUSTRY NAME: Value Code Amount							
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

HI - CONDITION INFORMATION

To supply information related to the delivery of health care.

Loop: 2300 — CLAIM INFORMATION

Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when there is a Condition Code that applies to this claim.
If not required by this implementation guide, do not send.
2. Up to 8 Condition Codes can be defined.

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

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	
		BG	Condition	
REQUIRED	HI01	- 2 1271	Industry Code	M AN 1/30
Code indicating a code from a specific industry code list				
INDUSTRY NAME: Condition Code				

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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	
To send health care codes and their associated dates, amounts and quantities							
Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. 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		
				BG	Condition		
REQUIRED	HI02	- 2	1271	Industry Code	M	AN	1/30
Code indicating a code from a specific industry code list							
INDUSTRY NAME: Condition 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	
To send health care codes and their associated dates, amounts and quantities							



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				Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.			
REQUIRED	HI03	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				BG	Condition		
REQUIRED	HI02	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Condition Code			
NOT USED	HI03	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI03	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI03	- 6	380	Quantity	O	R	1/15
NOT USED	HI03	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI03	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI03	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI04		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. 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			
				CODE	DEFINITION		
				BG	Condition		
REQUIRED	HI04	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Condition Code			

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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	
To send health care codes and their associated dates, amounts and quantities							
Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. 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							
				CODE	DEFINITION		
				BG	Condition		
REQUIRED	HI05	- 2	1271	Industry Code	M	AN	1/30
Code indicating a code from a specific industry code list							
INDUSTRY NAME: Condition Code							
NOT USED	HI05	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI05	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI05	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI05	- 6	380	Quantity	O	R	1/15
NOT USED	HI05	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI05	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI05	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI06		C022	HEALTH CARE CODE INFORMATION	M	1	
To send health care codes and their associated dates, amounts and quantities							

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				Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. 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			
				CODE	DEFINITION		
				BG	Condition		
REQUIRED	HI06	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Condition Code			
NOT USED	HI06	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI06	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI06	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI06	- 6	380	Quantity	O	R	1/15
NOT USED	HI06	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI06	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI06	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI07		C022	HEALTH CARE CODE INFORMATION	M	1	
				To send health care codes and their associated dates, amounts and quantities			
				Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.			
REQUIRED	HI07	- 1	1270	Code List Qualifier Code	M	ID	1/3
				Code identifying a specific industry code list			
				CODE	DEFINITION		
				BG	Condition		
REQUIRED	HI07	- 2	1271	Industry Code	M	AN	1/30
				Code indicating a code from a specific industry code list			
				INDUSTRY NAME: Condition Code			

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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	
To send health care codes and their associated dates, amounts and quantities							
Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. 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							
				CODE	DEFINITION		
				BG	Condition		
REQUIRED	HI08	- 2	1271	Industry Code	M	AN	1/30
Code indicating a code from a specific industry code list							
INDUSTRY NAME: Condition Code							
NOT USED	HI08	- 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI08	- 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI08	- 5	782	Monetary Amount	O	R	1/18
NOT USED	HI08	- 6	380	Quantity	O	R	1/15
NOT USED	HI08	- 7	799	Version Identifier	O	AN	1/30
NOT USED	HI08	- 8	1271	Industry Code	X	AN	1/30
NOT USED	HI08	- 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI09		C022	HEALTH CARE CODE INFORMATION	M	1	
NOT USED	HI10		C022	HEALTH CARE CODE INFORMATION	M	1	



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

NM1 - ATTENDING PROVIDER NAME

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

Loop: 2310A — ATTENDING PROVIDER NAME Loop Repeat: 1
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required for Emergency Department claims. See 4.7.1 Emergency Department Visits for additional information.
2. Must use physician or practitioner individual NPI, not group practice or organizational NPI.
3. THCIC requires either the Attending Provider's NPI, NM109, or Texas State License Number, REF02.

Example: **NM1*71*1*JONES*JOHN****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	
			CODE DEFINITION	
			71 Attending Physician	
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	
REQUIRED	NM103	1035	Name Last or Organization Name	X 1 AN 1/60
			Individual last name or organizational name	
			INDUSTRY NAME: Attending Provider Last Name	

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REQUIRED	NM104	1036	Name First	O	1	AN	1/35
			Individual first name				
			INDUSTRY NAME: Attending 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: Attending 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: Attending Provider Primary 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



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

REF - ATTENDING PROVIDER SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2310A — ATTENDING 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
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
			INDUSTRY NAME: Attending Provider Secondary Identifier	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

NM1 - OPERATING PHYSICIAN NAME

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

Loop: 2310B — OPERATING PHYSICIAN NAME Loop Repeat: 1



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Repeat: 1

Usage: SITUATIONAL

Notes: 1. Required when a surgical procedure code is listed on this claim. If not required by this implementation guide, do not send.
2. The Operating Physician is the individual with primary responsibility for performing the surgical procedure(s).
3. Must use physician or practitioner individual NPI, not group practice or organizational NPI.
4. THCIC requires either the Operating Physician's NPI, NM109, or Texas State License Number, REF02.

Example: **NM1*72*1*MEYERS*JANE****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	
			CODE	DEFINITION
			72	Operating Physician
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
REQUIRED	NM103	1035	Name Last or Organization Name	X 1 AN 1/60
			Individual last name or organizational name	
			INDUSTRY NAME: Operating Physician Last Name	
REQUIRED	NM104	1036	Name First	O 1 AN 1/35
			Individual first name	
			INDUSTRY NAME: Operating Physician 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: Operating Physician 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
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SITUATIONAL	NM109	67	Identification Code	X	1	AN	2/80
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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: Operating Physician Primary 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 - OPERATING PHYSICIAN SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2310B — OPERATING PHYSICIAN 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*OB*A12345~**

Element Detail

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

NM1 - OTHER OPERATING PHYSICIAN NAME

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

Loop: 2310C — OTHER OPERATING PHYSICIAN NAME Loop Repeat: 1
Repeat: 1
Usage: SITUATIONAL
Notes: 1. Required when another Operating Physician is involved. If not required by the implementation guide, do not send.
2. The Other Operating Physician is the individual performing a secondary surgical procedure or assisting the Operating Physician. This Other Operating Physician segment can only be used when

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Operating Physician information (Loop ID-2310B) is also sent on this claim.

3. Must use physician or practitioner individual NPI, not group practice or organizational NPI.

4. THCIC requires either the Operating Physician's NPI, NM109, or Texas State License Number, REF02.

Example: **NM1*73*1*MEYERS*JANE****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	
			CODE	DEFINITION
			73	Other Physician
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
REQUIRED	NM103	1035	Name Last or Organization Name	X 1 AN 1/60
			Individual last name or organizational name	
			INDUSTRY NAME: Operating Physician Last Name	
REQUIRED	NM104	1036	Name First	O 1 AN 1/35
			Individual first name	
			INDUSTRY NAME: Operating Physician 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: Operating Physician Middle Name or Initial	
NOT USED	NM106	1038	Name Prefix	O 1 AN 1/10



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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.											
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier</td></tr></table>								CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier
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: Operating Physician Primary Identifier											
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XXXXXXXXXX</td><td>National Provider Identifier (NPI) Number</td></tr></table>								CODE	DEFINITION	XXXXXXXXXX	National Provider Identifier (NPI) Number
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 – OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION

To specify identifying information.

Loop: 2310C — OTHER OPERATING PHYSICIAN 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



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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
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
			INDUSTRY NAME: Operating Physician 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: 2310E — 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. Required by THCIC when the Service Facility Provider is different than the Billing Provider or the Pay-To Provider.
3. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.

Example: **NM1*FA*2*REHAB FACILITY*****XX*1234567890~**



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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			
			FA	Facility			
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



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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.

Loop: 2310E — SERVICE FACILITY LOCATION NAME

Repeat: 1

Usage: REQUIRED

Notes: 1. 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: 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: 2310E — SERVICE FACILITY LOCATION NAME

Repeat: 1

Usage: REQUIRED

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



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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: 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				
			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.				
			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: 2310E — SERVICE FACILITY LOCATION NAME



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Repeat: 1

Usage: SITUATIONAL

Notes: 1. THCIC requires the 6-digit number (THCIC ID) assigned to the Service Facility identified in Loop 2310E. The THCIC ID, along with either the NPI (NM109), EIN (REF02), 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 or the Pay-To 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

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- 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.
 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	
			CODE	DEFINITION
			S	Secondary
SITUATIONAL	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.	
			Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.	
			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	O 1 ID 1/2
			Code identifying type of claim	
			CODE	DEFINITION



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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.
2. This is the secondary payer.
3. For the purposes of this implementation the term payer is synonymous with several other terms, such as, reprinter and third-party administrator.

**Healthcare Facility Procedures and Technical Specifications Manual**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
			PI	Payor Identification unless Self-Pay, Charity, or Unknown Payer claim
			XV	Centers for Medicare and Medicaid Services PlanID



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			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: 999

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~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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REQUIRED LX01 554 Assigned Number M 1 NO 1/6
Number assigned for differentiation within a transaction set

SV2 - INSTITUTIONAL SERVICE LINE

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

Loop: 2400 — SERVICE LINE NUMBER
Repeat: 1
Usage: REQUIRED
Example: **SV2*0300*HC:81099*73.42*UN*1~**
SV2*01201500*DA*5~**

Element Detail

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SV201	2334	Product/Service ID	X 1 AN 1/48
			Identifying number for a product or service SEMANTIC: SV201 is the revenue code. INDUSTRY NAME: Service Line Revenue Code	
REQUIRED	SV202	C003	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	X 1
			To identify a medical procedure by its standardized codes and applicable modifiers Required for inpatient claims when an appropriate HCPCS (drugs and/or biologics only) or HIPPS code exists for this service line item.	
REQUIRED	SV202 - 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



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				HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.			
				HP Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code			
REQUIRED	SV202	- 2	234	Product/Service ID	M	AN	1/48
				Identifying number for a product or service			
				INDUSTRY NAME: Procedure Code			
SITUATIONAL	SV202	- 3	1339	Procedure Modifier	O	AN	2/2
				This identifies special circumstances related to the performance of the service, as defined by trading partners			
				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	SV202	- 4	1339	Procedure Modifier	O	AN	2/2
				This identifies special circumstances related to the performance of the service, as defined by trading partners			
				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	SV202	- 5	1339	Procedure Modifier	O	AN	2/2
				This identifies special circumstances related to the performance of the service, as defined by trading partners			
				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	SV202	- 6	1339	Procedure Modifier	O	AN	2/2

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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.

NOT USED SV202 - 7 352
NOT USED SV202 - 8 234
REQUIRED SV203 782

Description O AN 1/80
Product/Service ID M AN 1/48
Monetary Amount O 1 R 1/18

Monetary Amount

SEMANTIC: SV203 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 amounts reported within this line's AMT segments.

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

REQUIRED SV204 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

DA Days

F2 International Unit

UN Unit

REQUIRED SV205 380

Quantity X 1 R 1/15

Numeric value of quantity

INDUSTRY NAME: Service Unit Count

NOT USED SV206 1371

Unit Rate O 1 R 1/10

SITUATIONAL SV207 782

Monetary Amount O 1 R 1/18

Monetary Amount

SEMANTIC: SV207 is a non-covered service amount.



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Required if needed to report line specific non-covered charge amount. If not required this implementation guide, do not send.

INDUSTRY NAME: Line Item Denied Charge or Non-Covered Charge Amount

NOT USED	SV208	1073	Yes/No Condition or Response Code	O	1	ID	1/1
NOT USED	SV209	1345	Nursing Home Residential Status Code	O	1	ID	1/1
NOT USED	SV210	1337	Level of Care 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

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



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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

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
			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 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													
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>00</td><td>No Authorization Information Present</td></tr><tr><td>03</td><td>Additional Data Identification</td></tr></table>								CODE	DEFINITION	00	No Authorization Information Present	03	Additional Data Identification
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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REQUIRED	ISA07	I05	The Submitter ID Number must be obtained from System13, Inc.			
			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

REQUIRED GS08 480

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

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

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
*250422*1633*^*00501*000000001*0*P*:~
GS*HC*SUB999*YTH837*20250422*1633*000000002*X*005010X223A2~
ST*837*0003*005010X223A2~
BHT*0019*00*20250422*1633*20250422*1633*RP~
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*****MA~
NM1*IL*1*DOE*JANE*~
N3*100 MAIN ST*~
N4*AUSTIN*TX*78756*US~
DMG*D8*19640626*F**~
REF*SY*999999999~
NM1*PR*2*MEDICARE OF TEXAS*****PI*~
CLM*20000*855.00***85:A:1~
DTP*434*RD8*20250106-20250106~
CL1*3*1*01~
REF*EA*50000~
K3*15~
HI*ABK:R059::::::::~
HI*APR:R059~
HI*ABF:K219::::::::~
HI*BH:11:D8:20250106~
HI*BE:80:::1.00~
NM1*72*1*STEPHENS*MICHAEL*P***XX*1234567890~
LX*1~
SV2*0300*HC:83013::::*572.00*UN*1**~
DTP*472*D8*20250106~
LX*2~
SV2*0300*HC:83014::::*89.00*UN*1**~
DTP*472*D8*20250106~
LX*3~
SV2*0320*HC:71046::::*195.00*UN*1**~
DTP*472*D8*20250106~
SE*37*0003~
GE*1*000000002~
IEA*1*000000001~



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6. Revision Changes

Revision Changes

Version 12.0

1. Extracted Outpatient Professional Specifications to separate document
2. Updated CL1 Segment for newborn claims
3. Update HI Value Information Segment for newborn claims
4. Add 837 Example

Version 11.4

1. Remove references to Last Name for 2010BB Payer Name
2. Add note about No PII being present for 2010BB Payer Name
3. Remove references to Last Name for 2330B Other Payer Name
4. Add note about No PII being present for 2330B Other Payer Name

Version 11.3

1. Section 1 was assigned to Introduction. All other sections and section references were renumbered.
2. Section 2.2 Reference Information - updated X12 Product link.
3. Section 4.2.1 - updated link to THCIC Submitter and Provider Enrollment Guide.
4. Section 4.2.2 - updated matching formulas for Replacement of Erroneous Claim Data, Void or Cancel Erroneous Claim Data and Resubmit, and Delete Erroneous Claim Data and Resubmit.
5. Section 4.3.2 - removed semi-colons from data elements lists.
6. Section 4 - updated 5010 IP and OP Appendices link in multiple locations.



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Revision Changes

7. Section 5.1 - replaced Washington Publishing Company link with X12 Product link.
8. Section 5.2 - table titles, headers, and footnotes added, modified, or moved for clarity and better formatting.
9. Section 5.6 - first sentence of 5.7 moved here.
10. Section 5.7 - reference to Appendix C removed because it is not applicable to the current document.
11. Section 5.14 - In two tables, position 1850 K3 File Information usage changed from N/R to R. This makes it consistent with audit rules in the Appendix that have been enforced since K3 was implemented.
12. Section 5.15 - removed unnecessary details from NOT USED data elements including but not limited to references, codes, definitions, INDUSTRY name, SEMANTIC information, etc.
13. 2010BA - SUBSCRIBER NAME - removed Note 2 (details about how to complete Race are unnecessary due to Race collection in the K3 segment), Note 3 (rephrasing of Note 1), and Note 4 (describes the future of adoption of the K3 segment that has already happened).
14. 2010CA - PATIENT NAME - removed Note 2 (details about how to complete Race are unnecessary due to Race collection in the K3 segment) and Note 3 (describes the future of adoption of the K3 segment that has already happened).

Version 11.2

1. Fixed incorrect and inconsistent spelling, grammar, capitalization, formatting and punctuation throughout document (did not affect implementation).
2. Removed "THCIC Hospital Discharge Data Collection" from document title.
3. Changed "WebCorrect" to "Claim Correction" for all occurrences.



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Revision Changes

4. Reworded website links to match destination page titles.
5. Updated section numbers so Introduction is section 1, General Information and Overview is section 2, and the rest of the sections renumbered appropriately.
6. Section 1 Introduction
7. Updated the lists of provider types from whom we collect data.
8. Section 2 General Information and Overview
9. Renamed section Loop Labeling, Sequence and Use to General Overview.
10. Section 2.1 General Overview
11. Inserted 2nd paragraph describing the HCDCS.
12. Changed "receiver process also" to "system pre-process" in 4th paragraph.
13. Updated wording for clarity in the 5th paragraph.
14. Added subsection title "2.2 Reference Information".
15. Removed paragraph about System13 testing submitted files because it is described elsewhere.
16. Added "System13, Inc." to section title 2.3 The THCIC Business Associate, added System13 description, and changed the contact information formatting.
17. In 2.4 THCIC Web Site, changed the wording of the description for clarity.
18. Section 3 Definitions and Acronyms
19. Removed "We are providing this section to aid our audiences with accurate and consistent definitions and acronyms:"
20. Changed the definition of ASC.
21. Section 4 Technical Requirements



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Revision Changes

- 22.Changed section title 4.1.1 Required Patients to Patient Inclusion Requirements and added emergency department requirements.
- 23.In 4.2.1 Data Submission, added 1st paragraph concerning name and contact information requirement.
- 24.4.2.2 Data Corrections
- 25.In 2.a., added "XX5" to the list of resubmitted original bill type codes.
- 26.Added System13 contact information.
- 27.
- 28.4.3.1 Data File Specifications
- 29.Institutional Data Elements
- 30.Added "if applicable" to item (10).
- 31.Added Occurrence Span Code as new item (19) and Occurrence Span Associated Dates as new item (20).
- 32.Removed old item (24) Related Cause Code.
- 33.Changed field numbering to account for one additional field item.
- 34.Changed new items (21), (22), (23), (24), and (25) from 12 (or 8) occurrences to 24 occurrences.
- 35.Professional Data Elements
- 36.Added "if applicable" to item (10).
- 37.Changed item (16) from 7 to 24 occurrences.
- 38.Revenue Codes
- 39.Removed "New Revenue Codes for Emergency Room (Effective for services beginning January 1, 2015)".
- 40.Service and Procedure Categories
- 41.Changed this section to match current processes.



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Revision Changes

- 42.Data Elements by THCIC 837 Institutional Location
- 43.Change table to include complete list of fields.
- 44.4.7 Auditing of Data by System13, Inc
- 45.Changed appendices description.
- 46.Section 5 THCIC 837 Technical Specifications
- 47.In PATIENT DEMOGRAPHIC INFORMATION (INST. and PROF.), 2010CA - PATIENT
- 48.NAME, removed Note item "Required if the "Subscriber" is not the "Patient." since it is a duplicate of another Note item.
- 49.In CLAIM INFORMATION (INST.), 2300 - CLAIM INFORMATION, CLM05-1, data element 1331, added "78 LICENSED FREESTANDING EMERGENCY MEDICAL
- 50.FACILITY", a value already collected by the THCIC System but not correctly documented.
- 51.In CLAIM INFORMATION (PROF.), 2300 - CLAIM INFORMATION, CLM11 - 1, data
- 52.element 1362, added values "AB ABUSE" and "AP ANOTHER PARTY RESPONSIBLE", values already collected by the THCIC System but not correctly documented.
- 53.In CLAIM INFORMATION (PROF.), 2300 - CLAIM INFORMATION, changed CLM11 -
- 54.2 and 3 to match CLM11 - 1, values already collected by the THCIC System but not correctly documented.
- 55.In THE PRINCIPAL DIAGNOSIS (INST.), 2300 - CLAIM INFORMATION, removed "IS
- 56.REQUIRED ON ALL OUTPATIENT CLAIMS" from element name because it's in the Notes, and changed Note 1 from "inpatient" to "outpatient".



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- 57.In HEALTH CARE DIAGNOSIS CODE (PROF.), 2300 - CLAIM INFORMATION,
- 58.removed "IS REQUIRED ON ALL PROFESSIONAL CLAIMS" from element name because it's in the Notes, and changed Note 1 from "Principal Diagnosis Code" to "Principal Diagnosis Code/Health Care Diagnosis Code".
- 59.In OTHER DIAGNOSIS INFORMATION (INST.), 2300 - CLAIM INFORMATION,
- 60.changed Example, removing "HI*BF:94425~" and adding "HI*ABN:X0820XA~".
- 61.In CONDITION INFORMATION (INST. and PROF.), 2300 - CLAIM INFORMATION,
- 62.removed "and PROF." from element name.
- 63.In ATTENDING PHYSICIAN NAME, 2310A - ATTENDING PHYSICIAN NAME, NM102,
- 64.data element 1065, removed "2 NON PERSON ENTITY" from list of values.
- 65.
- 66.In SERVICE FACILITY NAME (INST.), 2310E - SERVICE FACILITY LOCATION NAME,
- 67.added "LOCATION" to Element and Loop names.
- 68.In SERVICE LINE NUMBER (INST.), 2400 - SERVICE LINE NUMBER, changed
- 69.Repeat from 50 to 200.
- 70.In INSTITUTIONAL SERVICE LINE (INST.), 2400 - SERVICE LINE NUMBER, changed
- 71.Notes from " This segment is required for inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication" to " This segment is required for outpatient claims that



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require procedure or drug information to be reported for claim adjudication."

Version 11.1.1

1. Loop 2400 SERVICE LINE NUMBER (INST.) the "Repeat" number is changed to "200" it was "50"
2. Removed Claim note and NTE segment completely.

Version 11.1

1. DMG05 is changed to NOT USED from REQUIRED in loop 2010BA and 2010CA.
2. Removed Claim note and NTE segment completely.

Version 11.0

1. Section 5.2 DATA ELEMENTS WITH REQUIREMENTS DIFFERENT THAN THE ANSI 837 GUIDE Table of Required Data Elements - Patient SSN, Patient Race and Patient Ethnicity language was added regarding change of location due to HB 2641 for next contract.
2. Section 5.12 SEGMENT ID BREAKOUT
 - a. Loop 2010BA - DMG Subscriber Demographic Information (INST and PROF):
 - i. Note 4 - Added language regarding change of Patient Race collection with new contract due to implementation of HB 2641.
 - ii. DMG05 - note added regarding change of Patient Race collection with new contract due to implementation of HB 2641.



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- b. Loop 2010BB Payer Name - NM109 - Note added to National Plan Identifier code regarding CMS delay of implementation.
- c. Loop 2010CA DMG Patient Demographic Information (INST. and PROF.):
 - i. Note 4 - Added language regarding change of Patient Race collection with new contract due to implementation of HB 2641.
 - ii. DMG05 - note added regarding change of Patient Race collection with new contract due to implementation of HB 2641.
- d. Loop 2300 K3 State Required Data Elements:
 - i. Note 3 - Added language regarding change of Patient SSN, Patient Race, and Patient Ethnicity collection with new contract due to implementation of HB 2641.
 - ii. K301 - Note 4 - Added language regarding change of Patient SSN, Patient Race, and Patient Ethnicity collection with new contract due to implementation of HB 2641.
 - iii. Added CODE and DEFINATION to Loop200 K3 segment regarding Ethnicity, Race, and Social Security Number in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data Collection efforts.
- e. Loop 2300 NTE Claim Note (INST.)
 - i. Note 3 - Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.
 - ii. K301 - Note 4 - Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.
- f. Loop 2300 NTE Claim Note (PROF.)



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- i. Note 3 - Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.
 - ii. K301 - Note 4 - Added language regarding change of Patient Ethnicity collection with new contract due to implementation of HB 2641.
 - g. Loop 2300 HI PRINCIPAL DIAGNOSIS CODE - Segment Title was incorrect and was corrected to HEALTHCARE DIAGNOSIS Code (PROF.)
 - h. Loop 2400 SV2 INSTITUTIONAL SERVICE LINE - SV206 the gray note is amended regarding THCIC turning off the audit for the Unit Rate.
- 3. Changed the examples for Principal Diagnosis code for ICD-9 and ICD-10.
 - 4. Changed the examples for Principal Diagnosis code for ICD-9 and ICD-10.
 - 5. Changed the examples for Reason for Visit Diagnosis code for ICD-9 and ICD-10.
 - 6. Changed the examples for External Causes of Injury/Morbidity, for ICD-9 and ICD-10 codes. Modified the definition to describe ICD-10 code ranges of V00-Y99.
 - 7. Changed the examples for Other Diagnosis code for ICD-9 and ICD-10.
 - 8. Changed the example for Anesthesia Related Procedure code.
 - 9. Changed the Condition Code example to use the asterisk.
 - 10.Changed the Attending Physician example to have a 10-digit NPI number.
 - 11.Changed the Operating Physician example to have a 10-digit NPI number.
 - 12.Changed the Service Facility example to have a 10-digit NPI number
 - 13.Changed the Service Facility Location and Service Facility Address examples to use the asterisk.



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- 14.Changed the example in SV1 to use the asterisk.
- 15.Removed "IV", "ZZ", "HP", and "WK" as valid HCPCS qualifiers for segment SV1. The only valid value for the HCPCS qualifier is "HC".
- 16.Changed the example in segment SV2 to have 0300, not 300, and 0120, not 120, as the revenue codes. Modified the HCPCS example.
- 17.Removed "IV" and "ZZ" as valid HCPCS qualifiers for segment SV2. The only valid value for the HCPCS qualifier is "HC".
- 18.Inspected accessibility results and removed the errors.

Version 10.2.1

1. CMS switched to the NPI and does not support UPIN any longer. There for THCIC has removed the references to UPIN. (page 171)
2. On Page 113 of this manual, we have changed the title to reflect the following: "THE PRINCIPAL DIAGNOSIS IS REQUIRED ON ALL OUTPATIENT CLAIMS"
3. On Page 118 of this manual, we have changed the title to reflect the following: "PRINCIPAL DIAGNOSIS CODE IS REQUIRED ON PROFESSIONAL CLAIMS"

Version 10.2

1. The format of Tables, headings, section numbers, when uploaded to Adobe Acrobat format from a Word Document written in MS Word 2007 or 2010 of Version 10.1, we encounter compatibility issues. All have been verified and fixed. (Paragraph, style, breaks, fonts, tables, pages, alignment)
2. Modifications made to all the Texas administration rules 25 TAC –B421.xx from the old link:
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1)



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To the new link:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_d
ir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_d
ir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1)

Version 10.1

1. H101-1 Code List Qualifier Code - Principal Diagnosis
 - a. Code List Qualifier Code - Qualifying Code "ABK" is added for ICD-10-CM Principal Diagnosis and a note about the implementation dates is added.
 - b. Code List Qualifier Code - Qualifying Code "ABN" is added for ICD-10-CM External Cause of Injury and a note is added about the implementation dates is added.
 - c. Qualifying Code "ABF" is added for ICD-10-CM Other Diagnosis Information and a note is added about the implementation dates is added.
 - d. Phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
2. Section 6 - PAST VERSION CHANGES THAT HAVE BEEN MADE TO THIS DOCUMENT - The listing of all past changes to the different Inpatient manual versions is added to the end of the document, under Section 6.
3. Rider 93 specifically states that DSHS shall collect emergency room data as set forth in Chapter 108, Health and Safety Code. Chapter 108 does authorize the collection of data from hospitals but does not list or authorize the collection from free-standing emergency centers.
4. Collection and Release of Hospital Outpatient Emergency Room Data
 - a. New §§421.71 - 421.78 The hospital outpatient emergency room data rules were drafted in conjunction with amendments regarding the repeal of rural provider exemptions in SB 7, (82nd First Called Session, section 7.07(b)) from the amendments to 421.1, 421.2, 421.5 and 421.8, 421.62, 421.67 and 421.68,



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concerning the collection and release of outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers. The new rules and the amendments were combined and proposed and published in the May 2, 2014, issue of the Texas Register (39 TexReg 3553) and were adopted and published in the September 19, 2014, issues of the Texas Register (39 TexReg 7582). Three organizations submitted comments on the proposed rules. One commenter requested physician assistants be added to the list of the definition of "Other Health Professional". The other two commenters recommended staggering the implementation dates and for the department to be lenient on penalizing rural facilities that will be submitting for the first time.

5. Section 5.10 THCIC Transaction Set - Table 2 Table 2 Detail - Patient Hierarchical Level (INST.) - the CL1 Data segment is added
6. Section 5.4 Segment ID Breakout - Loop 2300 - Claim Information HI - Health Care Diagnosis Code (PROF.) -
 - a. CL1 - Institutional Claim Code (INST.) segment is added include the following situationally required data elements for Emergency Department visits
 - i. CL102 - Admission Source Code (Point of Origin) includes note on requirement for Emergency Department Visits
 - ii. CL103 - Patient Status Code - includes note on requirement for Emergency Department Visits
 - b. HI - Principal Diagnosis - HI01-2 The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
 - c. HI - HI - Patient's Reason for Visit (INST.) -
 - i. HInn-1 (nn = 01 through 03) the description under Code "PR" is amended by adding the phrase "Procedure Beginning



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October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."

- ii. HIInn-2 (nn = 01 through 03) The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9- CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."

- 7. HI01-1 the description under Code "BK" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."

Version 10.0

- 1. Section 1 Introduction, 2nd Paragraph, the language has been added stating the reason for the guide and how to get the action Rule text. This guide is written to be complementary to the Hospital Discharge Data Collection and Release rules 25 TAC –§421.61- –§421.68, which can be found at The Office of Secretary of State's Web site:

<http://www.sos.state.tx.us/texreg/index.shtml>

Or:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=3&ti=25&pt=1](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=25&pt=1)

Select from the list CHAPTER 421 HEALTH CARE INFORMATION

- 2. Section 3 - Definition and Acronyms -

- a. The following terms, acronyms and descriptions were added:
"Accurate and Consistent Data", "Certification Process",
"Comments", "Discharge", "Discharge claim", "Discharge report"
"DRG", "Electronic Filling", "Ethnicity", "Geographic identifiers",
"HCPCS--HCFA's", "Health care facility", "HIPPS", "Institutional
Review Board", "Operating or Other Physician", "Other exempted
provider", "Patient account number", "Present on admission (POA)",
"Provider quality data", "Public use data file", "Race", "Research data"



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file", "Risk adjustment", "Rural provider", "Submission", "Uniform facility identifier", and "Validation".

b. The following terms were modified: "Required minimum data set

c. Terms and definitions that are in the rules 25 TAC 421.61-421.68 are modified to be equivalent and note the words and terms, to the exact rule(s) section used in this document to follow the meaning of the context in which the legislation was written.

3. Section 4.2.1 - Data Submission

a. Clarifying language (which is enclosed in parentheses) is added.

b. Website URL is updated. Old paragraph three and four delete and replaced by statement to see the THCIC Submitter and Provider Enrollment Guides document along with a hyperlink to the document

c. Old paragraph three and four delete and replaced by statement to see the THCIC Submitter and Provider Enrollment Guides document along with a hyperlink to the document

d. We have replaced the old documentation link with a new and the URL has been update

4. Section 4.2.2 - Data Correction Number 3 Delete Errant Claim Data and Resubmit two sub-sections were create, the first addressing that how the facilities "Data Administrator" (THCIC Liaison) can login to the System13, Inc. (THCIC) secure website and go the "User Management" tab to delete batches or individual claims from the system. Contact information to Helpdesk is provided for any assistance that may be needed. The previous option to contact System13, Inc. a contract with them to delete or modify a facilities data is moved to the second option.

5. Section 4.2.2 - Data Corrections- We made we few modifications:

a. Replacement of Errant Claim Data

i. Removed Date of Birth Removed Statement Date(s)



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- ii. And replace them with the following
 - 1. Admission Date
 - 2. Admission Hour
 - 3. Statement Covers Period From Date
 - 4. Statement Covers Period Through Date
- b. Void or Cancel Errant Claim Data and Resubmit we did the same:
 - i. Admission Date
 - ii. Admission Hour
 - iii. Statement Covers Period From Date
 - iv. Statement Covers Period Through Date
- 6. Section 4.3.2 State Required Data Elements - language is added to the bottom of the list regarding the submission of diagnosis present on admission (POA) and which facilities are exempt from having to report the POA indicator.
- 7. Section 4.3.2.1 THCIC ANSI 837 INSTITUTIONAL GUIDE DATA ELEMENTS - the table is updated
 - a. Service Line Date (was added and which had previously not been added)
 - b. Point of Origin (Source of Admission) (Hospital Emergency Department Visits only) is added and will be effective for service beginning January 1, 2015.
 - c. Patient Status (Hospital Emergency Department Visits only) is added and will be effective for service beginning January 1, 2015.
- 8. Section 4.3.2.3 Revenue Codes - We have added the following new Revenue Codes to the table for Emergency Room: 0450 ER - (General Classification), 0451 ER (Emergency Medical Screening - EMTALA), 0452



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ER-(Beyond EMTALA), 0456 ER- (Urgent Care), 0459 ER - (Other), these become effective with services beginning January 1, 2015.

9. Section 4.3.2.5 DATA ELEMENTS BY THCIC 837 INSTITUTIONAL LOCATION
-

- a. Numbering of the header was added back in, loss in a previous version.
- b. Table was updated
 - i. Source of Admission (Point of Origin for Admission or Visit) (Hospital Emergency Department Visits only) is added
 - ii. Patient Status (Hospital Emergency Department Visits only)

10. Section 4.3.2.6 DATA ELEMENTS BY THCIC 837 INSTITUTIONAL LOCATION
- header numbering is updated

11. Section 4.6.1 Provider Enrollment / Signature Requirements - the document title and hyperlink are updated. "THCIC Submitter and Provider Enrollment Guide"

12. Section 4.7 - Auditing of Data by System13, Inc. The link to the website is updated and replaced. "5010_Inpatient_and_Outpatient_Appendices ver._3"

Version 9.0

- 1. Section 3 - Definitions - Other Health Professional - the phrase "or outpatients" is added to the end of the first sentence.
- 2. Section 4.2.2 - Data Corrections Item 2 (b) ANSI 837 Professional - the description is changed to "Submit Void/Cancel Claims which have the following:" to "Submit Corrected Claims which have the following:"
- 3. Section 4.3.2 - State Required Data Elements - The sentence below the title is change to "The following data elements must be submitted for each



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outpatient events" from "The following data elements must be submitted for each inpatient stay"

4. Section 5.11 Segment ID Breakout - Loop 2300 - Claim Information -
 - a. CL1 - Institutional Claim Code (Inst) segment is added.
 - b. HI - Principal Diagnosis - HI01-2 The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9- CM)" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10.
 - c. HI - Patient's Reason For Visit (INST.) -
 - i. HInn-1 (nn = 01 through 03) the description under Code "PR" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
 - ii. HInn-2 (nn = 01 through 03) The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9- CM)" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
 - d. HI - Health Care Diagnosis Code (PROF.) -
 - i. HI01-1 the description under Code "BK" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
 - ii. HI02-1 the description under Code "BF" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
 - iii. HInn-1 (nn = 03 through 12) the description under Code "BF" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."



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- iv. HInn-1 (nn = 03 through 12) the description under Code "BN" is amended by adding the phrase "Procedure Beginning October 1, 2014, ICD-10-CM E-Codes will be required on data submitted to THCIC."
- v. HInn-2 (nn = 01 through 12) the description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9- CM)" is amended by adding the phrase "Beginning October 1, 2014, ICD- 10-CM Diagnosis Codes or E- Codes will be required on data submitted to THCIC."
- e. HI - Other Diagnosis Information (INST.) -
 - i. HInn-1 (nn = 03 through 12) the description under Code "BF" is amended by adding the phrase "Beginning October 1, 2014, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
 - ii. HInn-1 (nn = 03 through 12) the description under Code "BN" is amended by adding the phrase "Beginning October 1, 2014, ICD-10-CM E-Codes will be required on data submitted to THCIC."
 - iii. HInn-2 (nn = 01 through 12) the description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9- CM)" is amended by adding the phrase "Beginning October 1, 2014, ICD- 10-CM Diagnosis Codes or E-Codes will be required on data submitted to THCIC."
- f. HI - Value Information (INST.) - Extraneous HI10-1 through HI10-7 that was between HI11 and HI12 were deleted.
- 5. Section 5.11 Segment ID Breakout - Loop 2310B Rendering Provider Name - Rendering Provider Secondary Identification (PROF.) the Gis changed to "REF*0B*A12345~" from "REF*1D*A12345~"



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6. Section 5.11 Segment ID Breakout - Loop 2320 OTHER SUBSCRIBER INFORMATION - Other Subscriber Information (INST. and PROF.) - SBR01 Coed P- Primary is deleted from the list.
7. Section 5.11 Segment ID Breakout - Loop 2400 Service Line - Professional Service (PROF.) - SV101 - 6 Procedure Modifier - the "Alias" information was changed to "Procedure Modifier 4" from "Procedure Modifier 3".

Version 7.0

1. Section 2.2 Reference Information version updated to 005010X223A2 from 005010X223A1.
2. Section 4.3.2 State Required Data Elements - The list of the data elements and their respective locations in the approved formats
 - a. Type of Admission text added to identify new UB-04 name "Priority (Type) of Admission".
 - b. Source of Admission text added to identify new UB-04 name "Point of Origin for Admission or Visit".
3. Section 5.1 Reference Information
 - a. First paragraph last sentence the version updated to 005010X223A2 from 005010X223A1.
 - b. List of THCIC Data Elements Where Usage Differs From ANSI 837 Institutional Guide
 - i. Type of Admission text added to identify new UB-04 name "Priority (Type) of Admission".
 - ii. Source of Admission text added to identify new UB-04 name "Point of Origin for Admission or Visit".
4. Section 5.2.1 Control Segment Elements Breakout - Interchange Control Header
 - a. Note 1 - the phrase "fixed record length segment" is underlined.



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- b. Boxes noting the fixed length record beginning and ending positions are added for each data element.
 - c. ISA14 - note referencing Section A.1.5.1 is removed.
- 5. Section 5.2.1 Control Segment Elements Breakout - Functional Group Header
 - a. Example is updated to 005010X223A2 from 005010X223A1.
 - b. GS08 Version/Release/Industry Identifier Code is updated to 005010X223A2 from 005010X223A1 and description updated to A2 from A1.
- 6. Section 5.3 THCIC Transaction Set - Table 2 Detail - Subscriber Hierarchical Level - Loop ID 2010BA Subscriber Name - The "Usage" is changed to "R/N" for Subscriber Name, Subscriber Address, Subscriber City/State/ZIP Code, Subscriber Demographic Information and Subscriber Secondary Identification and boxed note added stating "Required" if "Subscriber" is the "Patient" otherwise "Not Used".
- 7. Section 5.3 THCIC Transaction Set - Table 2 Detail - Patient Hierarchical Level
 - a. Loop ID 2010CA Patient Name - The "Usage" is changed to "N/R" for Patient Name, Patient Address, Patient City/State/ZIP Code and Patient Demographic Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".
 - b. Loop ID 2300 K3 State Required Data Elements (Patient SSN) File Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".
- 8. Section 5.4 Segment ID Breakout - ST Transaction Set Header - Example changed to ST*837*987654*005010X223A2~ from ST*837*987654*005010X223~
- 9. Section 5.4 Segment ID Breakout - Loop 2010BA Subscriber Name - Note changed to "The Subscriber Name is REQUIRED when the subscriber is the



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patient. Subscriber Name data segment is "NOT USED" if Subscriber is NOT the Patient."

10. Section 5.4 Segment ID Breakout - Loop 2010BB Payer Name - NM103- SELF PAY code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).

11. Section 5.4 Segment ID Breakout - Loop 2010BB Billing Provider Secondary Identification - REF02 Reference Identification - Length changed to 50 from 30.

12. Section 5.4 Segment ID Breakout - Loop 2300 Institutional Claim Code

a. Note is shortened to "This segment is REQUIRED when reporting hospital-based admissions.

b. CL102 - Code Source name changed to "Point of Origin for Admission or Visit, National Uniform Billing Committee UB -04 Manual." from "Source of Referral for Admission or Visit, , National Uniform Billing Committee UB -04 Manual."

13. Section 5.4 Segment ID Breakout - Loop 2310A Attending Physician Secondary Identification - REF02 - Reference Identification - Length change to 50 from 30.

14. Section 5.4 Segment ID Breakout - Loop 2310B Operating Physician Secondary Identification - REF02 - Reference Identification - Length change to 50 from 30.

15. Section 5.4 Segment ID Breakout - Loop 2310E Service Facility Secondary Identification - REF02 - Reference Identification - Length change to 50 from 30.

16. Section 5.4 Segment ID Breakout - Loop 2330B Other Payer Name

a. NM103- SELF PAY code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).

b. NM109- SELF code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).



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Version 6.0

1. Section 2.1 General Overview - Second paragraph language is clarified regarding the submission process.
2. Section 2.2 Reference Information - Third paragraph is modified to state that the testing process checks for a HIPAA compatible file submission.
3. Section 2.3.1 - System13, Inc.
 - a. Title is changed by removing reference to "Commonwealth Clinical Systems, Inc."
 - b. Help Desk e-mail is updated to thcichelp@system13.com
 - c. Help Desk hours change to 8:00 am to 5:00 pm Central Time
 - d. Data Portal Web Site - description is changed to clarify that the link can be used to address any web system issues.
4. Section 3 Definitions and Acronyms
 - a. CCS is deleted
 - b. System13, Inc. - the reference to Commonwealth Clinical System, Inc. is removed, and the definition is clarified that System13, Inc. collects inpatient and outpatient data on behalf of THCIC.
5. Section 4.2.2 Data Correction - The reference to the THCIC Hospital Data Corrections Manual and Data Corrections is removed and replaced with information about WebCorrect and the hyperlink for help about the WebCorrect components
6. Section 4.3.2 State Required Data Elements - Table listing Data Elements and Locations
 - a. References to Loop 2010AB for Pay-To-Provider are removed from the following rows:
 - i. Provider Name



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- ii. Provider Address
 - iii. Provider City
 - iv. Provider ZIP Code
- b. "Diagnosis Present on Admission" is added.
- c. "Provider National Provider Identification" was changed from "Provider Federal
- d. Tax ID/EIN/NPI"
- e. Provider Tax Identification was added with associated loops and reference descriptors.
- f. THCIC ID - Loop 2010BB replaces 2010AB.
- 7. Section 4.7 AUDITING OF DATA BY System13, INC. - Language is updated and hyperlink is updated to the audits on the website.
- 8. Section 5.1. Reference Information - THCIC DATA ELEMENTS WHERE USAGE DIFFERS FROM ANSI 837 INSTITUTIONAL GUIDE
 - a. National Provider Identification Number (NPI)
 - i. Employer Identification Number reference was deleted
 - ii. Loop 2010AB references were deleted
 - b. Employer Identification Number - Loop 2010AA- REF02 (or NM109) and the difference added
 - c. Facility ID Number (THCIC ID#) - Loop 2010BB replaces 2010AB. Language added about usage change to "SITUATIONAL". Footnote added also for Loop 2010BB.
- 9. Section 5.2 - Control Segments - Information added about Delimiters.
- 10. Section 5.2.1 - CONTROL SEGMENT ELEMENTS BREAKOUT- Interchange Control Header
 - a. Example is updated in ISA11.



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- b. ISA11 Repetition Separator replaces Interchange Control Standards Identifier

11. Section 5.3 - THCIC Transaction Set table

- a. Table 2 Detail - Billing Provider Hierarchical Level
 - i. Table Title was updated, removed "/Pay-to"
 - ii. Loop Title Loop ID - 2000A Billing Provider title updated, removed "/Pay-to"
 - iii. HL - Billing Provider Hierarchical segment name updated removed "/Pay-to"
 - iv. PRV Billing Provider Specialty Information segment deleted
 - v. REF - Billing Provider Tax Identification is added
 - vi. REF - Billing Provider THCIC Identification has name changed from Billing Provider Secondary Identification and the repeat level is changed to "1" from "8"
 - vii. REF - Pay-To Provider Secondary Information segment is deleted
- b. Table 2 Detail - Subscriber Hierarchical Level - Loop 2010BB Payer Name – REF - Billing Provider Secondary Identification is added.
- c. Table 2 Detail - Patient Hierarchical Level
 - i. Loop ID - 2300 Claim Information - K3 - State Required Data Elements (Patient SSN) File Information, "File Information" was added to refer to name in ANSI X12N 837 Institutional Guide.
 - ii. Loop ID 2310E Service Facility Name - REF - Service Facility Secondary Identification segment repeat was updated and reduced to "3".

12. Section 5.4 Segment ID Breakout -



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- a. Loop 2010AA BILLING PROVIDER NAME - NM109
 - i. Notes are added regarding the requirement that this information must be on file with THCIC to have data submission properly identified.
 - ii. The EIN code was moved to the bottom and a note stating THCIC would allow EIN to be reported here.
- b. Loop 2010AA BILLING PROVIDER THCIC IDENTIFICATION is added
- c. Loop 2000B - SUBSCRIBER INFORMATION - SBR01 - All codes except "P" - Primary are removed.
- d. Loop 2010BB - BILLING PROVIDER SECONDARY IDENTIFICATION
 - i. Usage was changed from REQUIRED to SITUATIONAL
 - ii. Note 1 the language was modified to explain that THCIC ID is required and if not submitted in the Loop 2010AA REF segment with the "1J" qualifier and the NPI or other identifier (that is on file with THCIC) in Loop 2010AA NM109 then the data cannot be identified properly. Removed reference to 2010AB Pay- to-Provider Loop.
- e. LOOP 2310E - SERVICE FACILITY SECONDARY IDENTIFICATION
 - i. Repeat is reduced to "3" from "5"
 - ii. Note - reference to "Pay-to Provider is removed
- f. LOOP 2320 - OTHER SUBSCRIBER INFORMATION - SBR09 - Code "LI" Liability was not previously removed.
- g. Loop 2400 - INSTITUTIONAL SERVICE LINE - SV206 - Note of requirement removed. Note added stating the field will be calculated for the Certification Data and the Public Use Data File and Research Files by following formula (Monetary Amount (SV203) divided by Quantity (SV205)).



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Version 5.0

1. Section 2.2 Reference Information versions updated for ANSI 837 Institutional Claim format to 005010X223A2 from 005010X223A1 and 837 Professional Claim format to 005010X222A1 from 005010X222.
2. Section 4.3.2.4 Table listing Data Elements by THCIC 837 Institutional Location
 - a. Operating or Other Physician Number - NPI is reported in Loop 2310B, NM109 or State License is reported in Loop 2310B, REF02.
 - b. Other Provider Number - NPI is reported in Loop 2310C, NM109 or State License is reported in Loop 2310C, REF02.
3. Section 5.1 Reference Information -First paragraph, last sentence the version is updated for ANSI 837 Institutional Claim format to 005010X223A2 from 005010X223A1 and 837 Professional Claim format to 005010X222A1 from 005010X222.
4. Section 5.5.1 Control Segment Elements Breakout - INTERCHANGE CONTROL HEADER (INST. and PROF.) Segment
 - a. Note 1 - the phrase "fixed record length segment" is underlined.
 - b. Boxes noting the fixed length record beginning and ending positions are added for each data element.
5. Section 5.2.1 Control Segment Elements Breakout - Functional Group Header (INST. and PROF.)
 - a. INST Example is updated to 005010X223A2 from 005010X223A1.
 - b. PROF Example is updated to 005010X222A1 from 005010X222.
 - c. GS08 Version/Release/Industry Identifier Code is updated to 005010X223A2 from 005010X223A1 and description updated to A2 from A1.



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- d. GS08 Version/Release/Industry Identifier Code is updated to 005010X222A1 from 005010X222 and description updated to Addendum A1 for Release 00501 (Prof.)
- 6. Section 5.10 THCIC Transaction Set - INSTITUTIONAL Table 2 Detail - Subscriber Hierarchical Level
 - a. Loop ID 2010BA Subscriber Name - The "Usage" is changed to "R/N" for Subscriber Name, Subscriber Address, Subscriber City/State/ZIP Code, Subscriber Demographic Information and Subscriber Secondary Identification and boxed note added stating "Required" if "Subscriber" is the "Patient" otherwise "Not Used".
 - b. Loop 2010BB Payer Name - REF Billing Provider Secondary Identification was added.
- 7. Section 5.10 THCIC Transaction Set - INSTITUTIONAL Table 2 Detail - Patient Hierarchical Level
 - a. Loop ID 2010CA Patient Name - The "Usage" is changed to "N/R" for Patient Name, Patient Address, Patient City/State/ZIP Code and Patient Demographic Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".
 - b. Loop ID 2300 Claim Information - K3 Segment
 - i. Usage changed to N/R
 - ii. Note added "Not Used" if "Subscriber" is the "Patient", otherwise "Required".
- 8. Section 5.10 THCIC Transaction Set - PROFESSIONAL Table 2 Detail - Subscriber Hierarchical Level
 - a. Loop ID 2010BA Subscriber Name - The "Usage" is changed to "R/N" for Subscriber Name, Subscriber Address, Subscriber City/State/ZIP Code, Subscriber Demographic Information and Subscriber Secondary Identification and boxed note added stating "Required" if "Subscriber" is the "Patient" otherwise "Not Used".



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- b. Loop 2010BB Payer Name - REF Billing Provider Secondary Identification was added.
- 9. Section 5.10 THCIC Transaction Set - PROFESSIONAL Table 2 Detail - Patient Hierarchical Level
 - a. Loop ID 2010CA Patient Name - The "Usage" is changed to "N/R" for Patient Name, Patient Address, Patient City/State/ZIP Code and Patient Demographic Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".
 - b. Loop ID 2300 Claim Information - K3 Segment
 - i. Usage changed to N/R
 - ii. Note added "Not Used" if "Subscriber" is the "Patient", otherwise "Required".
- 10. Section 5.10 Segment ID Breakout - ST Transaction Set Header - Examples changed
 - a. Added ST*837*987654*005010X223A2~ (INST)
 - b. Updated ST*837*987654*005010X222A1~ (PROF) from ST*837*987654~
- 11. Section 5.10 Segment ID Breakout - Loop 2010AA Billing Provider THCIC Identification (INST. and PROF.) - REF02 Reference Identification - Length changed to 50 from 30.
- 12. Section 5.10 Segment ID Breakout - Loop 2010BA Subscriber Name (INST. And PROF.) - Note changed to "The Subscriber Name is REQUIRED when the subscriber is the patient. Subscriber Name data segment is "NOT USED" if Subscriber is NOT the Patient."
- 13. Section 5.10 Segment ID Breakout - Loop 2010BA Subscriber Address (INST. And PROF.) - Note 2 the sentence "Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.
- 14. Section 5.10 Segment ID Breakout - Loop 2010BA Subscriber City/State/ZIP Code (INST. And PROF.) - Note 2 the sentence "Subscriber



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Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.

15. Section 5.10 Segment ID Breakout - Loop 2010BA Subscriber Demographic Information (INST. And PROF.) - Note 3 the sentence "Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.

16. Section 5.10 Segment ID Breakout - Loop 2010BA Subscriber Secondary Identification (INST. And PROF.)

a. Note 2 the sentence "Subscriber Name data segment is "Not Used" if Subscriber is NOT the Patient." was added.

b. REF02 Reference Identification - Length changed to 50 from 30.

17. Section 5.10 Segment ID Breakout - Loop 2010BB Billing Provider Secondary Identification (INST. And PROF.) - REF02 Reference Identification - Length changed to 50 from 30.

18. Section 5.10 Segment ID Breakout - Loop 2010CA Patient Name (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

19. Section 5.10 Segment ID Breakout - Loop 2010CA Patient Address (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

20. Section 5.10 Segment ID Breakout - Loop 2010CA Patient City/State/ZIP Code (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

21. Section 5.10 Segment ID Breakout - Loop 2010CA Patient Demographic Information (INST. And PROF.) - Note 1 changed to add the sentence "NOT USED" if Subscriber is NOT the Patient."

22. Section 5.10 Segment ID Breakout - Loop 2300 Medical Record Number (INST. And PROF.) - REF02 Reference Identification - Length changed to 50 from 30.



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- 23. Section 5.10 Segment ID Breakout - Loop 2300 State Required Data Elements - K3 Segment - Note 1 sentence added "Not Used" if "Subscriber" is the "Patient", otherwise "Required".
- 24. Section 5.10 Segment ID Breakout - Loop 2310B Operating Physician Secondary Identification (INST.) - REF02 Reference Identification - Length changed to 50 from 30.
- 25. Section 5.10 Segment ID Breakout - Loop 2310B Rendering Provider Secondary Identification (PROF.) - REF02 Reference Identification - Length changed to 50 from 30.
- 26. Section 5.10 Segment ID Breakout - Loop 2310C Other Provider Secondary Identification (INST.) - REF02 Reference Identification - Length changed to 50 from 30.
- 27. Section 5.10 Segment ID Breakout - Loop 2310C Service Facility Location Secondary Identification (PROF.) - REF02 Reference Identification - Length changed to 50 from 30.
- 28. Section 5.10 Segment ID Breakout - Loop 2310E Service Facility Location Secondary Identification (INST.) - REF02 Reference Identification - Length changed to 50 from 30.
- 29. Section 5.10 Segment ID Breakout - Loop 2310B Rendering Provider Secondary Identification (PROF.) - REF02 Reference Identification - Length changed to 50 from 30.
- 30. Section 5.10 Segment ID Breakout - Loop 2420A Rendering Provider Secondary Identification (PROF.) - REF02 Reference Identification - Length changed to 50 from 30

Version 4.0

- 1. Section 5.5.1 Control Segment Elements Breakout - Interchange Control Header (Inst. and Prof.)
 - a. Example - Version Code is updated to 00501 from 00401



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Revision Changes

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

Version 3.0

- 1. Section 2.2 - Reference Information - Versions and dates are updated
- 2. Section 4.3.1 Data File Specifications - Version is updated
- 3. Section 4.3.2 State Required Data Elements (Table)
 - a. Payer Name Loop is updated from 2010BC to 2010BB.
 - b. National Plan Identifier is updated from 2010BC to 2010BB.
- 4. Section 5.1 Reference Information - Versions and dates are updated.
- 5. Section 5.7 Loop Labeling and Use - Loop 2010BC is deleted.
- 6. Section 5.11 THCIC Transaction Set - Table 2 Detail - Subscriber Hierarchical Level - Loop 2010BC changed to 2010BB.
- 7. Section 5.12 Segment ID Breakout



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Revision Changes

- a. 2000A Billing Provider Hierarchical Level - Note the Loop ID 2010BC is updated to 2010BB.
- b. 2300 External Cause of Injury - HInn-9 (nn = 01-12) Yes/No Condition or Response Code - Situational Rule is added.
- c. 2300 Other Diagnosis Information -
 - i. Hinn-8 (nn - 01-12) - Industry Code is added
 - ii. HInn-9 (nn - 01-12) - Yes/No Condition or Response Code is added
- d. 2320 Other Subscriber Information - SBR09 codes update to match codes in Loop 2000B.

Version 2.0

- 1. Table of Contents added, inadvertently deleted
- 2. Section 5.5.1 Interchange Control Header, ISA12 code is updated from 00401 to 00501.
- 3. Section 5.12 Loop 2300, Other Diagnosis Information added, inadvertently deleted.