THCIC Data Collection

**Healthcare Facility Procedures
and
Technical Specifications
5010 Inpatient and Outpatient Appendices**

Version 3.2   December 7, 2015

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APPENDIX - A1
VALID COUNTRY CODES

Code	Short Name	Code	Short Name
AD	Andorra	CL	Chile
AE	United Arab Emirates	CN	China
AF	Afghanistan	CX	Christmas Island
AX	Aland Islands !Åland Islands	CC	Cocos (Keeling) Islands
AL	Albania	CO	Colombia
DZ	Algeria	KM	Comoros
AS	American Samoa	CG	Congo
AD	Andorra	CD	Congo, the Democratic Republic of the
AO	Angola	CK	Cook Islands
AI	Anguilla	CR	Costa Rica
AQ	Antarctica	CI	Cote d'Ivoire !Côte d'Ivoire
AG	Antigua and Barbuda	HR	Croatia
AR	Argentina	CU	Cuba
AM	Armenia	CW	Curacao !Curaçao
AW	Aruba	CY	Cyprus
AU	Australia	CZ	Czech Republic
AT	Austria	DK	Denmark
AZ	Azerbaijan	DJ	Djibouti
BS	Bahamas	DM	Dominica
BH	Bahrain	DO	Dominican Republic
BD	Bangladesh	EC	Ecuador
BB	Barbados	EG	Egypt
BY	Belarus	SV	El Salvador
BE	Belgium	GQ	Equatorial Guinea
BZ	Belize	ER	Eritrea
BJ	Benin	EE	Estonia
BM	Bermuda	ET	Ethiopia
BT	Bhutan	FK	Falkland Islands (Malvinas)
BO	Bolivia, Plurinational State of	FO	Faroe Islands
BQ	Bonaire, Sint Eustatius and Saba	FJ	Fiji
BA	Bosnia and Herzegovina	FI	Finland
BW	Botswana	FR	France
BV	Bouvet Island	GF	French Guiana
BR	Brazil	PF	French Polynesia
IO	British Indian Ocean Territory	TF	French Southern Territories
BN	Brunei Darussalam	GA	Gabon
BG	Bulgaria	GM	Gambia
BF	Burkina Faso	GE	Georgia
BI	Burundi	DE	Germany
CV	Cabo Verde	GH	Ghana
KH	Cambodia	GI	Gibraltar
CM	Cameroon	GR	Greece
CA	Canada	GL	Greenland
KY	Cayman Islands	GD	Grenada
CF	Central African Republic	GP	Guadeloupe
TD	Chad	GU	Guam

Code	Short Name	Code	Short Name
GT	Guatemala	FM	Micronesia, Federated States of
GG	Guernsey	MD	Moldova, Republic of
GN	Guinea	MC	Monaco
GW	Guinea-Bissau	MN	Mongolia
GY	Guyana	ME	Montenegro
HT	Haiti	MS	Montserrat
HM	Heard Island and McDonald Islands	MA	Morocco
VA	Holy See (Vatican City State)	MZ	Mozambique
HN	Honduras	MM	Myanmar
HK	Hong Kong	NA	Namibia
HU	Hungary	NR	Nauru
IS	Iceland	NP	Nepal
IN	India	NL	Netherlands
ID	Indonesia	NC	New Caledonia
IR	Iran, Islamic Republic of	NZ	New Zealand
IQ	Iraq	NI	Nicaragua
IE	Ireland	NE	Niger
IM	Isle of Man	NG	Nigeria
IL	Israel	NU	Niue
IT	Italy	NF	Norfolk Island
JM	Jamaica	MP	Northern Mariana Islands
JP	Japan	NO	Norway
JE	Jersey	OM	Oman
JO	Jordan	PK	Pakistan
KZ	Kazakhstan	PW	Palau
KE	Kenya	PS	Palestine, State of
KI	Kiribati	PA	Panama
KP	Korea, Democratic People's Republic of	PG	Papua New Guinea
KR	Korea, Republic of	PY	Paraguay
KW	Kuwait	PE	Peru
KG	Kyrgyzstan	PH	Philippines
LA	Lao People's Democratic Republic	PN	Pitcairn
LV	Latvia	PL	Poland
LB	Lebanon	PT	Portugal
LS	Lesotho	PR	Puerto Rico
LR	Liberia	QA	Qatar
LY	Libya	RE	Reunion !Réunion
LI	Liechtenstein	RO	Romania
LT	Lithuania	RU	Russian Federation
LU	Luxembourg	RW	Rwanda
MO	Macao	BL	Saint Barthelemy !Saint Barthélemy
MK	Macedonia, the former Yugoslav Republic of	SH	Saint Helena, Ascension and Tristan da Cunha
MG	Madagascar	KN	Saint Kitts and Nevis
MW	Malawi	LC	Saint Lucia
MY	Malaysia	MF	Saint Martin (French part)
MV	Maldives	PM	Saint Pierre and Miquelon
ML	Mali	VC	Saint Vincent and the Grenadines
MT	Malta	WS	Samoa
MH	Marshall Islands	SM	San Marino
MQ	Martinique	ST	Sao Tome and Principe
MR	Mauritania	SA	Saudi Arabia
MU	Mauritius	SN	Senegal
YT	Mayotte	RS	Serbia
MX	Mexico	SC	Seychelles

Code	Short Name
SL	Sierra Leone
SG	Singapore
SX	Sint Maarten (Dutch part)
SK	Slovakia
SI	Slovenia
SB	Solomon Islands
SO	Somalia
ZA	South Africa
GS	South Georgia and the South Sandwich Islands
SS	South Sudan
ES	Spain
LK	Sri Lanka
SD	Sudan
SR	Suriname
SJ	Svalbard and Jan Mayen
SZ	Swaziland
SE	Sweden
CH	Switzerland
SY	Syrian Arab Republic
TW	Taiwan, Province of China
TJ	Tajikistan
TZ	Tanzania, United Republic of
TH	Thailand
TL	Timor-Leste
TG	Togo
TK	Tokelau

Code	Short Name
TO	Tonga
TT	Trinidad and Tobago
TN	Tunisia
TR	Turkey
TM	Turkmenistan
TC	Turks and Caicos Islands
TV	Tuvalu
UG	Uganda
UA	Ukraine
AE	United Arab Emirates
GB	United Kingdom
US	United States
UM	United States Minor Outlying Islands
UY	Uruguay
UZ	Uzbekistan
VU	Vanuatu
VE	Venezuela, Bolivarian Republic of
VN	Viet Nam
VG	Virgin Islands, British
VI	Virgin Islands, U.S.
WF	Wallis and Futuna
EH	Western Sahara
YE	Yemen
ZM	Zambia
ZW	Zimbabwe

OFFICIAL USPS, MILITARY "STATE" ABBREVIATIONS CODES

https://www.usps.com/send/official-abbreviations.htm

AND FOR PROVINCES AND TERRITORIES IN CANADA

http://canadaonline.about.com/od/postalservices/a/abbreviations-provinces-canada.htm

Abbreviation	Description	Abbreviation	Description
AA	Armed Forces Americas	MS	MISSISSIPPI
AE	Armed Forces Africa	MT	MONTANA
AE	Armed Forces Middle East	NB	NEW BRUNSWICK
AB	ALBERTA	NC	NORTH CAROLINA
AE	ARMED FORCES EUROPE	ND	NORTH DAKOTA
AK	ALASKA	NE	NEBRASKA
AL	ALABAMA	NF	NEWFOUNDLAND
AP	ARMED FORCES PACIFIC	NH	NEW HAMPSHIRE
AR	ARKANSAS	NJ	NEW JERSEY
AS	AMERICAN SAMOA	NL	NEWFOUNDLAND AND LABRADOR
AZ	ARIZONA	NM	NEW MEXICO
BC	BRITISH COLUMBIA	NS	NOVA SCOTIA
CA	CALIFORNIA	NT	NORTHWEST TERRITORY
CO	COLORADO	NU	NUNAVUT
CT	CONNECTICUT	NV	NEVADA
CZ	CANAL ZONE	NY	NEW YORK
DC	DIST. OF COLUMBIA	OH	OHIO
DE	DELAWARE	OK	OKLAHOMA
FC	When Address not in USA	ON	ONTARIO
FL	FLORIDA	OR	OREGON
FM	FEDERATED STATES OF MICRONESIA	PA	PENNSYLVANIA
GA	GEORGIA	PE	PRINCE EDWARD ISLAND
GU	GUAM	PR	PUERTO RICO
HI	HAWAII	QC	QUEBEC
IA	IOWA	RI	RHODE ISLAND
ID	IDAHO	SC	SOUTH CAROLINA
IL	ILLINOIS	SD	SOUTH DAKOTA
IN	INDIANA	SK	SASKATCHEWAN
KS	KANSAS	TN	TENNESSEE
KY	KENTUCKY	TT	TRUST TERRITORIES
LA	LOUISIANA	TX	TEXAS
LB	LABRADOR	UT	UTAH
MA	MASSACHUSETTS	VA	VIRGINIA
MB	MANITOBA	VI	VIRGIN ISLANDS
MD	MARYLAND	VT	VERMONT
ME	MAINE	WA	WASHINGTON
MH	MARSHALL ISLANDS	WI	WISCONSIN
MI	MICHIGAN	WV	WEST VIRGINIA
MN	MINNESOTA	WY	WYOMING
MO	MISSOURI	XX	When Address not in USA
MP	NORTHERN MARIANA ISLANDS	YT	YUKON

APPENDIX - A2
DEFAULT OR MISSING DATA VALUES

Unknown Patient Address:

If the address of the patient is unknown, use the following:

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

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

ANSI Loop.Data Segment	
2010BA or 201CA.N404 (Patient State)	XX or FC
2010BA or 201CA.N402 (Patient ZIP)	Spaces

Unknown Social Security Number:
If an SSN could not be obtained:

2010BA REF02 or 201CA.K301 (Patient Social Security Number)	Spaces, or 999999999 (if system requires an entry)

Unknown Date of Birth:

 If a patient's date of birth is not known:

ANSI Loop.Data Segment	
201CA.DMG02(Patient Birth Date)	19010101 = 01/01/1901

Unknown ZIP Code:

ANSI Loop.Data Segment	
2010BA or 201CA.N403(Patient ZIP)	XXXXX OR 00000

Temporary Licenses
If a practitioner does not have a state license, use the following:

ANSI Loop.Data Segment	Default Code or Information
INPATIENT CLAIMS DATA	
2310A or 2310B. NM109 (NPI) or REF02 (State License) Physicians, respectively) (Attending or Operating	TXTEMP OTHnnn RESnnn or TEMPnn Where "n" = a number (0-9) assigned by the healthcare facility
OUTPATIENT CLAIMS DATA	
INST. – 2310B or 2310C. NM109 (NPI) or REF02 (State License) Operating Physicians or Other Operating Physicians	TXTEMP OTHnnn RESnnn or TEMPnn Where "n" = a number (0-9) assigned by the healthcare facility
PROF. - 2310B or 2420A NM109 (NPI) or REF02 (State License) (Rendering Physicians 1 or 2 respectively	TXTEMP OTHnnn RESnnn or TEMPnn Where "n" = a number (0-9) assigned by the healthcare facility

Alcohol, Drug Use or HIV Conditions

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

Data Element	Loop	Data Element	Action and Default Value
Patient Control Number	2300	CLM01	Retain. Unique to institution and episode of care. Will be used by healthcare facility to review and certify data. This data element is not included in the public use data file.
Patient Last Name	2010BA or 2010CA	NM103	Remove. Replace with "Doe"
Patient First Name	2010BA or 2010CA	NM104	Remove. Replace with "Jane" if female, or "John" if male, can include a sequential number, e.g., John1, John2, John3.
Patient Middle Initial	2010BA or 2010CA	NM105	Remove. Leave blank.
Patient Date of Birth	2010BA or 2010CA	DMG02	Retain. DOB will not be provided in the public use data file and it will be transformed to age (in years).
Patient Address	2010BA or 2010CA	N301	Remove. Replace with healthcare facility street address.

Patient City	2010BA or 2010CA	N401	Retain.
Patient State	2010BA or 2010CA	N402	Retain.
Patient Zip Code	2010BA or 2010CA	N403	Retain.
Patient Country Code	2010CA	N404	Retain.
Medical Record Number	2300	REF02	Remove. Replace with 99999.
Patient SSN	2010BA or 2300	REF02, K301	Remove. Replace with default value of 999999999.

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

APPENDIX - A3
RACE AND ETHNICITY QUESTIONNAIRE DOCUMENTS

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

An instruction sheet follows this page that the healthcare facility may provide it to its personnel to use as a guide for administering collection of this information, which followed by English and Spanish versions of the questions to be presented to the patient is on pages 14 and 15. Use of these documents is optional, though the collection and submission of the data is required; the healthcare facility can modify the documents formatting, but not the content. Also, you may translate the document into other languages, as appropriate.

If you have questions regarding this document and the requirements, please contact:

Bruce Burns, Mgr. at (512) -776-7261

INSTRUCTIONS FOR STATE ETHNICITY AND RACE QUESTIONNAIRE

(For Hospitals and Ambulatory Surgery Centers Use Only)
For collecting and reporting patient Ethnicity and Race

RECOMMENDED PROCEDURE

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

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

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

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

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

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

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

STATE REQUIRED ETHNICITY AND RACE QUESTIONS

BACKGROUND INFORMATION

Texas law requires the Department of State Health Services to collect information on the race/ethnic backgrounds **of Hospital and Ambulatory Surgery center (ONLY)** patients. The rules state "In order to obtain this 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 (Hospital or Ambulatory Surgery Center) staff is to use its best judgment to make the correct classification based on available data."

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

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

QUESTIONS

Question #1:   Ethnic Background
(mark the box that the patient believes most accurately identifies his/her <u>ethnic background</u>)

Is the patient . . .?

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

Question #2:   Race
(mark the box that the patient believes most accurately identifies his/her <u>race</u>)

Is the patient . . .?

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

PREGUNTAS SOBRE EL ORIGEN ÉTNICO Y LA RAZA EXIGIDAS POR EL ESTADO

EL CONTEXTO

La ley de Texas exige al Departamento Estatal de Servicios de Salud de Texas que reúna información sobre la raza y el origen étnico de los pacientes en los centros de salud. El reglamento establece que "Para obtener dichos datos, el personal del centro recupera la respuesta del paciente de un formulario escrito o le pregunta al paciente o le pide a la persona que habla por el paciente que clasifique al paciente. Si el paciente o la persona que habla por el paciente se rehúsa a contestar, el personal del centro (u hospital) ha de, a su mejor juicio, hacer la clasificación correcta basada en los datos disponibles".

Los datos obtenidos mediante este proceso se usarán para ayudar a que los investigadores determinen si todos los ciudadanos de Texas reciben acceso a una asistencia sanitaria adecuada.

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

PREGUNTAS

Pregunta #1: origen étnico
(Marque la casilla que el paciente cree que más fielmente identifica su origen étnico)

¿Qué es el paciente?

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

Pregunta #2: raza
(Marque la casilla que el paciente cree que más fielmente identifica su raza)

¿Qué es el paciente?

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

APPENDIX - A4
REVENUE CODE GROUPINGS FOR PUDF

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

	Category	Type	Revenue Codes
1	Accommodation	Private Room Days & Charges	011x, 014x
2	Accommodation	Semi-private Room Days & Charges	010x, 012x, 013x, 016x, 017x, 018x, 019x
3	Accommodation	Ward Days & Charges	015x
4	Accommodation	Intensive Care Days & Charges	020x
5	Accommodation	Coronary Care Days & Charges	021x
1	Ancillary	Other Charges	0002-0099, 022x, 023x, 024x, 052x, 053x, 055x, 056x, 057x, 058x, 059x, 060x, 064x, 065x, 066x, 067x, 068x, 069x, 070x, 076x, 077x, 078x, 090x, 091x, 092x, 093x, 094x, 095x, 099x, 210x, 310x
2	Ancillary	Pharmacy Charges	025x, 026x, 063x
3	Ancillary	Medical/Surgical Supply Charges	027x, 062x
4	Ancillary	Durable Medical Equipment Charges	0290, 0291, 0292, 0294-0299
5	Ancillary	Used Durable Medical Equipment Charges	0293
6	Ancillary	Physical Therapy Charges	042x
7	Ancillary	Occupational Therapy Charges	043x
8	Ancillary	Speech Pathology Charges	044x, 047x
9	Ancillary	Inhalation Therapy Charges	041x, 046x
10	Ancillary	Blood Charges	038x
11	Ancillary	Blood Administration Charges	039x
12	Ancillary	Operating Room Charges	036x, 071x, 072x
13	Ancillary	Lithotripsy Charges	079x
14	Ancillary	Cardiology Charges	048x, 073x
15	Ancillary	Anesthesia Charges	037x

	Category	Type	Revenue Codes
16	Ancillary	Laboratory Charges	030x, 031x, 074x, 075x,
17	Ancillary	Radiology Charges	028x, 032x, 033x, 034x, 035x, 040x
18	Ancillary	MRI Charges	061x
19	Ancillary	Outpatient Services Charges	049x, 050x
20	Ancillary	Emergency Room Charges	045x
21	Ancillary	Ambulance Charges	054x
22	Ancillary	Professional Fees Charges	096x, 097x, 098x
23	Ancillary	Organ Acquisition Charges	081x, 089x
24	Ancillary	ESRD Revenue Setting Charges	080x, 082x, 083x, 084x, 085x, 086x, 087x, 088x
25	Ancillary	Clinic Visit Charges	051x

APPENDIX - A5
INPATIENT & OUTPATIENT AUDIT ID'S

Table A	Pre-Processing Audits (Format Check)
Audit MSG. ID` **Message**	**Audit Description**
RJ001 - Missing/Invalid ISA Interchange Control Header Segment.	RJ001 - The first three characters in all 837 files are 'ISA'. This file does not start with 'ISA'. Our system has stopped processing this file.
RJ002 - ISA06 (Interchange Sender ID) contains invalid Submitter _ID='SUB999'.	RJ002 - Submitter Id's are six characters long, begin with 'SUB', and are followed by three numbers (e.g. SUB999). Do not put 'TH' in front of your Submitter Id. THSUB999 is a login, SUB999 is a Submitter Id.
RJ003 - ISA08 (Interchange Receiver ID) must = YTH837 or YTHCIC.	RJ003 - The 8th element of the ISA segment (ISA08) holds the receiver id. This must be either 'YTH837' or 'YTHCIC'. It identifies the intended recipient of this transmission.
RJ004 - ISA13 (Interchange Control Number) must be > zero.	RJ004 - The 13th element of the ISA segment (ISA13) must contain a non-zero control number. This 'Interchange Control Number' is assigned by the sender and it must match the same number in the IEA02 data element at the end of the data interchange.
RJ005 - ISA15 (Usage Indicator) must be a 'P' or 'T'. Your file has '?'.	RJ005 - The test/Production (T/P) indicator must be in the 103rd position in the ISA segment (first line in the file). The ISA segment must be 106 characters long. This error can occur when the ISA segment is edited directly.
RJ006 - Data Element Separator is blank or not distinct value. Your file has '?'.	RJ006 - The 'data element separator' is read from the 4th position of the ISA segment (first line in the file). It separates all pieces of data in every segment for the rest of the file. It must be distinct and non-blank.
RJ007 - Component Element Separator blank or not distinct value. Your file has '?'.	RJ007 - The 'component element separator' is read from the 105th position of the ISA segment (first line in the file). It is used to parse out fields containing related data. It must be distinct and non-blank.
RJ008 – Segment` Terminator is blank, missing, or not a distinct value.	RJ008 - The 'segment terminator' is read from the 106th position of the ISA segment (first line in the file). It indicates the end of a data segment. It must be distinct and non-blank. This error can occur when the ISA segment is edited directly. The ISA segment MUST BE 106 characters long.
RJ009 - Data Element Separator, Component Element Separator, and Segment Terminator are not distinct values.	RJ009 - The 'data element separator', the 'component element separator', and the 'segment terminator' tell our software how to locate and break apart all the remaining information in the rest of the file. They must be distinct values.

Table A Pre-Processing Audits (Format Check)	
Audit MSG. ID` Message	**Audit Description**
RJ010 - Missing Functional Group Header (GS Segment).	RJ010 - The GS (group start) segment is missing. This segment follows an ISA segment in a valid 837 submission file. It signifies the start of a group of claims.
RJ011 - GS06 (Group Control Number) must be > zero.	RJ011 - GS06 (group control number) is a number at the start and end of every group of claim data. This number must not be zero.
RJ012 - GS08 (Ver/Rel/Ind Code=?????) not valid	RJ012 - The 8th element of the GS segment (GS08) is supposed to be an 837 format version number. Your file has an invalid value in this data field
RJ013 - Missing Transaction Set Header (ST Segment).	RJ013 - The ST (start of transaction) segment is missing. This segment follows the GS segment and signifies the beginning of a transaction set.
RJ014 - ST01 (Transaction Set Identifier Code) is not '837'.	RJ014 - The 1st element of the ST segment (ST01) must be '837'.
RJ015 - ST02 (Transaction Set Control Number) is blank.	RJ015 - The 2nd element in the ST segment (ST02) must contain a control number. It cannot be blank, and it must match the control number later in the file in segment SE02.
RJ016 - Missing BHT segment (Beginning of Hierarchical Transaction).	RJ016 - The BHT segment is the 4th segment in an 837 file. It signifies the beginning of an hierarchical transaction set.
RJ017 - BHT03 (Reference Identification) is blank.	RJ017 - The 3rd element of the BHT segment (BHT03) is designed to contain Reference Identification information assigned by your system. This gives you a way to record transaction sets. This element cannot be blank.
RJ018 - BHT04 Transaction Set Creation Date not valid. Your file has '??/??/????'. Format should be YYYYMMDD.	RJ018 - The 4th element of the BHT segment (BHT04) must contain a valid date. This data element is defined as the transaction set creation date.
RJ019 - Missing/invalid Billing/Pay-To Hierarchical Level Segment (HL03 = '20').	RJ019 - The hierarchical structure (HL segments) of every 837 file is validated. Our system looks for correct relationships between 'parent' and 'child' HL segments. Your file has a subscriber HL segment that does not point to a billing parent HL segment.

Table A	Pre-Processing Audits (Format Check)	
Audit MSG. ID`	**Message**	**Audit Description**
RJ020 - Billing/Pay-To Hierarchical ID Number (HL01) not greater than Previous Hierarchical ID Number.		RJ020 - The hierarchical structure (HL segments) of every 837 file is validated. The id number of every HL billing segment must be greater than the preceding HL segment id number.
RJ021 - Billing/Pay-To Hierarchical Child Code (HL04) not = 1.		RJ021 - The hierarchical structure (HL segments) of every 837 file is validated. For HL billing segments the 4th element (HL04) must = 1.
RJ022 - Missing Subscriber Hierarchical Level Segment.		RJ022 - The hierarchical structure (HL segments) of every 837 file is validated. Our system looks for correct relationships between 'parent' and 'child' HL segments. In this case, a child HL record does not point to its parent HL record.
RJ023 - Subscriber Hierarchical ID Number (HL01) not greater than Previous Hierarchical ID Number.		RJ023 - The hierarchical structure (HL segments) of every 837 file is validated. The id number of every HL subscriber segment must be greater than the preceding HL segment id number.
RJ024 - Subscriber Hierarchical Parent ID Number (HL02) not less than Subscriber Hierarchical ID Number (HL01).		RJ024 - The hierarchical structure (HL segments) of every 837 file is validated. The parent id points to a previous HL segment. This parent id therefore must always be less than the current HL segment id.
RJ025 - Missing Patient Hierarchical Level Segment.		RJ025 - The subscriber HL segment will indicate if a patient HL segment comes next. This error is triggered when no following patient HL segment is found.
RJ026 - Patient Hierarchical ID Number(HL01) not greater than Previous Hierarchical ID		RJ026 - The hierarchical structure (HL segments) of every 837 file is validated. The id number of every HL patient segment must be greater than the preceding HL segment id number.
RJ027 - Patient Hierarchical Parent ID Number (HL02) not less than Patient Hierarchical ID Number (HL01).		RJ027 - The hierarchical structure (HL segments) of every 837 file is validated. The parent id points to a previous HL segment. This parent id therefore must always be less than the current HL segment id.
RJ028 - Missing Transaction Set Trailer (SE Segment).		RJ028 - The SE (end of transaction) segment is missing. All transaction sets must begin with an ST segment and end with an SE segment.

Table A Pre-Processing Audits (Format Check)	
Audit MSG. ID` Message	**Audit Description**
RJ029 - Value (SE01=???) not equal num of segments counted in Transaction Set (actual cnt ST thru SE=???).	RJ029 - 837 submission files keep a count of how many segments (data lines) are within each transaction set. Transaction sets start with an ST segment and end with an SE segment. The SE segment contains the count of all segments in the group. This count does not match the actual count in your file. This error commonly occurs after manually editing an 837 file because the segment count is no longer accurate after lines have been added or deleted.
RJ030 - SE02 (Transaction Set Control Number) not equal to segment ST02 (Transaction Set Control Number).	RJ030 - The 2nd element of the SE segment (SE02, transaction set end) contains a control number that must match the same number in the 2nd element of the preceding ST segment (ST02, transaction set start).
RJ031 - Missing Functional Group Trailer (GE Segment).	RJ031 - The GE (group end) segment is missing. GS and GE segments are used to signify the start and end of functional groups in 837 files.
RJ032 - Value (GE01=???) not equal number of transaction sets included in Functional Group (actual count=???).	RJ032 - 837 submission files keep a count of how many transaction sets (ST segments) are within each functional group. This count is reported in the 1st element of the GE segment (GE01). This count does not match the actual count of ST segments in your file.
RJ033 - GS06 (Group Control Number=?) value not equal segment GE02 (Group Control Number=?) Value.	RJ033 - Claims are grouped inside 'starting' and 'ending' segments. A group control number is assigned to each group of claims. This control number is inserted in the GS (group start) and GE (group end) segments. In your submission file these control numbers do not match each other.
RJ034 - Missing Interchange Control Trailer (IEA Segment).	RJ034 - The IEA segment is the last data segment found in an interchange of 837 claim data. It is missing in your file. Check to ensure your transmission was not truncated or terminated incorrectly.
RJ035 - Value (IEA01=?) not equal number of Functional Groups included in Interchange (actual count=?).	RJ035 - The IEA segment (interchange control trailer) signifies the end of an interchange of data. The 1st element (IEA01) contains a count of the number of functional groups (GS segments) within the interchange. This count is incorrect in your file.
RJ036 - IEA02 (Interchange Ctrl Number=?) value not equal ISA13 (Interchange Control Number=?) value.	RJ036 - 837 files contain a control number for validation of interchange transmissions. This control number appears at the start (ISA segment) and end (IEA segment) of each interchange transmission. In your submission file these control numbers do not match each other.
RJ037 - Primary Subscriber is self-pay, but no claim present.	RJ037 - We did not find a CLM (claim) segment after an SBR (subscriber) segment that indicated the claim was self-pay.

Table A Pre-Processing Audits (Format Check)	
Audit MSG. ID` **Message**	**Audit Description**
RJ038 - Subscriber Claim is present, but Subscriber is NOT the Primary Subscriber	RJ038 - Your file contains a claim where the first insurance payer is not flagged as the primary subscriber to insurance. This audit is designed to ensure that THCIC receives primary (not secondary or tertiary) claims. The PCN (patient control number) is located in the CLM segment that can be found in the current HL block referenced above.
RJ039 - Invalid Relationship code in Subscriber Segment.	RJ039 - The 2nd element of the SBR (subscriber) segment is invalid. This element holds the 'Patient Relationship to Insured' value. If the patient is the subscriber, then SBR02 must = '18'. Otherwise it must be blank.
RJ040 - Subscriber is not the Patient, but the Subscriber Hierarchical Child Code (HL04) NOT = 1.	RJ040 - The 'Patient Relationship to Insured' value from segment SBR02 is blank, meaning that the subscriber is not the patient. In this case, a separate patient HL (hierarchical level) section is anticipated. This patient HL section has not been found. If the patient is the insured, then the SBR02 must = '18'. If the patient is not the insured, then you must insert the missing patient claim HL section.
RJ041 - Element REF*1J (THCIC_ID=999999) lookup validation on this Provider Id failed.	RJ041 - The THCIC provider id is located in segment REF*1J. This error is triggered when a REF*1J has an invalid provider id, or has no provider id, or when there are no REF*1J segments found in an ST-SE block. The provider id is a six digit number assigned by THCIC.
RJ042 - Element NM109, provider NPI num validation failed. Your #: ?????????? Our #: ??????????	RJ042 - The 9th element of the NM1 segment (NM109) contains the NPI number. The NPI number in your submission file does not match our internal records.
RJ043 - Element N3 (street addr) validation on provider failed. Your addr: ??? Our addr: ??? (1st 15 characters only)	RJ043 - The street address is found in the N3 segment. The first fifteen characters of the provider street address in your file do not match the first 15 characters (see above) in our internal records.
RJ044 - More than one Payer Name Segment for Primary Subscriber.	RJ044 - There is more than one NM1 (payer name) segment associated with a primary subscriber (SBR) segment.
RJ045 - More than one Payer Name Segment for Secondary Subscriber.	RJ045 - There is more than one NM1 (payer name) segment associated with a secondary subscriber (SBR) segment.
RJ046 - Submitter ID mismatch in ISA06and NM109 Segments.	RJ046 - The submitter id is repeated in three places in your file: **1.** ISA06 (6th element of the ISA segment) **2.** GS02 (2nd element of the GS segment) **3.** NM109 (9th element of the NM1*41 segment) The submitter id is either missing from the NM1, or it is not the 9th field.

Table A Pre-Processing Audits (Format Check)	
Audit MSG. ID`　　　　　**Message**	**Audit Description**
RJ047 - Number of LX Service Line Segments exceeds maximum 999.	RJ047 - There cannot be more than 999 service lines (charges) in a claim. The PCN (patient control number) is located in the CLM segment. To find the PCN, locate the segment causing the error and search backward to find the CLM segment.
RJ048 - THIS MESSAGE IS DISABLED IN THE CODE.	**RJ048 - THIS MESSAGE IS DISABLED IN THE CODE**
RJ049 - First character in segment must be alphanumeric.	RJ049 - All data segments start with a 2-3 letter acronym indicating what type of data follows, and end with the 'segment terminator' located and read from position 106 of the ISA line (first line). All data segments must start with an alpha character.
RJ050 - The first five characters of all GS08 elements must match the first five characters in the ISA12 element.	RJ050 - The 8th element of the GS segment (GS08) and 12th element of the ISA segment (ISA12) hold the interchange version number. The first five characters of these two locations must match
RJ051 - The 837 file format Version 4010 is not allowed after June 30, 2012. This file is rejected	RJ051 - 4010 is an older version of the 837 electronic formats. It is no longer allowed. You must contact your software vendor to discuss how to get your system to create 837 files in the 5010 format version.
RJ052 - Element REF*EI, provider EIN num validation failed. Your #: ????????? Our #: ?????????	RJ052 - The 2nd element of the REF*EI segment contains the EIN number. The provider EIN number in your submission file does not match our internal records.
RJ053 - Too many claims for test submission. You must limit test submissions to 1000 claims or less.	RJ053 - The THCIC Data Warehouse requires test submissions to be no greater than 1000 claims. This limit does not apply to production data.
RJ054 - Provider 999999 is listed as 'Inactive' by THCIC.	RJ054 - THCIC's records for this facility show it is listed as inactive. Contact THCIC directly to discuss this issue: **(512) - 776 - 3374.**
RJ055 - Logged in Submitter Id=SUB999 does not match the ISA06 Submitter Id=SUB???	RJ055 - The 6th element of the ISA segment (ISA06) is the submitter id. The submitter id for your login account does not match the submitter id indicated by your upload file in location ISA06.
RJ056 - Bad character found in segment, position number nnn.	RJ056 - Non-ASCII characters are not allowed in 837 transmission files. This may be a binary file, or a bad character may be in your claim data. You can find the PCN (patient control number) by looking in your submission file for the 'CLM' segment preceding the bad character.

Table A Pre-Processing Audits (Format Check)	
Audit MSG. ID` Message	**Audit Description**
RJ057 – Un-Zip failed. Zip file corrupted or password protected.	RJ057 - The THCIC Data Warehouse only accepts compressed files in '.zip' or '.gz' format, without a password.
RJ058 - Line item error. A line item number (charge) was skipped.	RJ058 - The service lines (charges) must begin with line number 1 and must be sequential throughout the claim. Charge line numbers are stored in the 1st field of the LX segment (LX01).
RJ059 - [SV2/SV1] service line incompatible with version number for [inst/prof] claims (your claims (your ver#=??????????).	RJ059 - Institutional version claims transmit service lines using 'SV2' segments. Professional version claims transmit services lines using 'SV1' segments. The service lines in your file are not formatted in accordance with the 'Inst/Prof' version number indicated in the GS segment. The version number is in the 8th field of the GS segment (GS08).
RJ060 - Facility not ASC, Institutional 5010 version format required	The facility is not an ASC. The institutional format (005010X223A2) is required. If Provider table: Facility Type <> "ASC" and <> "Dental ASC" then GS08 must = 005010X223A2
RJ061 - SBR (subscriber) segment missing in HL (hierarchical level).	RJ061 - The Subscriber SBR segment is required in order to properly identify the patient. The SBR segment (along with it's associated fields) normally appears immediately after an HL (hierarchical level) segment.

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
600	I	Missing Principal Procedure Date	If the Principal Procedure exists, the Principal Procedure Date must exist and contain a valid date of the format cyymmdd.	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
602	I	Invalid Principal Procedure	The Principal Procedure field does not contain a valid ICD, CPT or HCPCS code. The Principal Procedure code must be valid for the time period covering the discharge date.	Error
603	I, Out/I, Out/P	Duplicate Diagnosis Codes	The same ICD diagnosis code is reported more than once on the same claim.	Error
604	I ,Out/I, Out/P	Patient Gender not consistent with Other Diagnosis	The Gender of the patient does not agree with a gender specific Other Diagnosis.	Error
605	I ,Out/I, Out/P	Invalid Other Diagnosis	If reported, the Other Diagnosis Code field must contain a valid ICD code.	Error
606	I ,Out/I, Out/P	Invalid E-Code	If an E-Code field is reported, it must contain a valid value.	Error
607	I ,Out/I, Out/P	Invalid Principal Diagnosis	Principal Diagnosis is a required field and must contain a valid ICD code.	Error
608	I ,Out /I, Out/P	Missing Principal Diagnosis	Principal Diagnosis is a required field.	Error
609	I	Invalid Principal Procedure Date	If the Principal Procedure exists, the Principal Procedure Date must contain a valid date of the format ccyymmdd.	Error
610	I ,Out/I, Out/P	Duplicate E-Codes	The same ICD E-code value is reported more than once in the same record.	Error
612	I	Principal Procedure Date Before 1971	The Principal Procedure Date Field Must Contain A Date After 1970.	Error
613	I, Out/I	Invalid Value Code	The Value Code field does not contain a valid NUBC code value.	Error
614	I, Out/I	Invalid Occurrence Span Code	If Reported, The Occurrence Span Code Field Must Contain A Valid NUBC Code Value.	Error
615	I	Invalid Admitting Diagnosis	Admitting Diagnosis is a required field and must contain a valid ICD code.	Error

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Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
616	I	Age > 1 day and Principal Diagnosis = newborn before admission	The age, at admission, of an infant not born in the hospital, is greater than 1 day.	Warning
617	I	Other Procedure Date earlier than three days before Admission Date or after Statement Thru Date	The Other Procedure Date must be on or after the third day before Admission Date and on or before the Statement Thru Date.	Error
618	I	Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date.	The Principal Procedure` Date must be on or after the third day before the Admission Date and on or before the Statement Thru Date.	Error
619	I	Other Procedure Date Before 1971	The Other Procedure Date field must contain a date after 1970.	Error
620	I	Invalid Other Procedure Date	The Other Procedure Date field must contain a valid date of the format ccyymmdd.	Error
621	I	Procedure Date missing for Other Procedure	An Other Procedure Date is required when a corresponding Other Procedure is present.	Error
622	I	Patient Gender not consistent with Other Procedure	Patient Gender is not consistent with a gender related Other Procedure.	Error
623	I	Invalid Other Procedure	If reported, an Other Procedure field must contain valid ICD, CPT or HCPCS code. The Other Procedure code also must be valid for the discharge date of the claim.	Error
624	I, Out/I	Invalid Condition Code	The Condition Code field must contain a valid NUBC code value.	Error
625	I, Out/I, Out/P	Patient Gender not consistent with the Principal Diagnosis	The patient Gender does not agree with a gender specific Principal Diagnosis.	Error
626	I, Out/I, Out/P	Missing Patient State	The Patient State field is required.	Error
627	I, Out/I, Out/P	Missing Patient ZIP	The ZIP code of the patient address is a required field.	Error
628	I, Out/I, Out/P	Invalid Patient Country	The Patient Country field of the patient address contains an invalid value.	Error

			Table B Claim Level Audit's		
Audit ID	**Status**	**Audit Message**	**Audit Description**		**Audit Severity**
629	**I, Out/I, Out/P**	Missing Patient Country	The Patient State indicates a foreign country but the Country field of the patient address is invalid or missing. The Country is required when a patient's address is not in the US or a US territory.		Error
630	**I, Out/I, Out/P**	Missing Patient Birth Date	Patient Birth Date is a required field and must contain a valid date of format ccyymmdd.		Error
631	**I, Out/I, Out/P**	Patient age > 115 years or < zero years	The value in the Patient Birth Date field indicates that the patient is older than 115 years or has not yet been born.		Error
632	**I**	Patient Birth Date > Admission Date and Admission Type not newborn	The patient's Birth Date is after the Admission Date but the Admission Type is not for a newborn (4). The patient Birth Date cannot be later than the Admission Date, unless the Admission Type is newborn.		Error
633	**I, Out/I, Out/P**	Missing Patient Gender	Patient Gender is a required field and must contain M, F or U.		Error
634	**I, Out/I, Out/P**	Missing Patient Race	Patient Race is a required field.		Error
635	**I, Out/I, Out/P**	Missing Patient ethnicity	Patient Ethnicity is a required field and must contain 1 or 2.		Error
636	**I, Out/I, Out/P**	Patient SSN not 9 numeric characters	Patient Social Security Number is a required field and must contain 9 numeric characters.		Error
637	**I, Out/I, Out/P**	Invalid Patient SSN	The Patient Social Security Number field contains a number is that is not the confidentiality default (999999999) and is not a valid number recognized by the Social Security Administration.		Error
638	**I, Out/I, Out/P**	Missing Patient Medical Record Number	The Medical Record Number field is required and cannot contain spaces or all zeroes.		Warning
639	**I, Out/I, Out/P**	Missing Facility Type Code	Facility Type Code field is required field. The Facility Type Code is the first two characters of the claim's bill type.		Error
640	**I, Out/I, Out/P**	Missing Claim Frequency Type Code	Claim Frequency Type Code is a required field. The Claim Frequency Type Code is the third character of the claim's bill type.		Error

Table B Claim Level Audit's				
Audit ID	Status	Audit Message	Audit Description	Audit Severity
641	I	Statement From Date after Statement Thru Date	The Statement From Date must be on or before the Statement Thru Date.	Error
641	Out/I	Statement From Date after Statement Thru Date	If Statement Date Range submitted the Statement From Date must be on or before the Statement Thru Date.	Error
642	I	Statement From Date before Patient Birth Date	The Statement From Date must be on or after the Patient Birth Date.	Error
642	Out/I	Statement From Date before Patient Birth Date	If Statement Date Range submitted the Statement From Date must be on or after the Patient Birth Date.	Error
643	I	Admission Date before 1971	The patient Admission Date must be after 1970.	Error
644	I	Admission Date after Statement Thru Date	The patient Admission Date must be on or before the Statement Thru Date.	Error
645	I	Missing Admission Type	Admission Type field is required.	Error
646	I	Missing Point of Origin (Admission Source)	Point of Origin (Admission Source) is a required field.	Error
646	Out/ED	Missing Point of Origin (Admission Source)	Point of Origin (Admission Source) is a required field for ED claims.	Error
647	I	Missing Patient Discharge Status	Patient Discharge Status is a required field.	Error
647	Out/ED	Missing Patient Discharge Status	Patient Discharge Status is a required field for ED claims.	Error
648	I	Missing Admitting Diagnosis	Admitting Diagnosis is a required field.	Error
649	I, Out/I	Invalid Occurrence Code	If an Occurrence Code field exists, the field must contain a valid NUBC value.	Error
650	I	Date of Birth not = Admission Date and Admission Type = Newborn	The Patient Birth Date is not equal to the Admission Date yet the Admission Type is newborn.	Warning
651	I	Newborn with birth date not within 3 days (+/-) of the Admission Date and newborn diagnosis present	If the Admission Type indicates a newborn, then the Date of Birth must be within 3 days of the admission Date and a newborn Diagnosis must be present.	Error

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
652	I	Admission Type = Newborn and Principal Diagnosis Not = Newborn	The Admission Type code indicates newborn, but the Principal Diagnosis is not for a newborn.	Error
653	I	Patient Birth Date Not = Admission Date and (Principal Diagnosis = Newborn or Admission Type = Newborn)	The Principal Diagnosis or the Admission Type indicates newborn in this hospital, but the Patient Birth Date and Admission Date are not the same.	Warning
654	I	Missing 019x Revenue Code for Bill Type 17x. Will expire 10/1/05.	If Bill Type 17x is reported, then one Revenue Code field must contain 019x.	Error
655	I, Out/I	Invalid Point of Origin (Admission Source)	The Point of Origin (Admission Source) Code is required and must contain one of the following values: 1, 2, 4, 5, 6, 8, 9, D, E, F.	Error
656	I, Out/I	Invalid Admission Type	The Admission Type field must contain one of the following values: 1, 2, 3, 4, 5, 9.	Error
657	I	Invalid Facility Type Code	The Facility Type Code field contains an invalid value. The Facility Type Code is the first two characters of the claim's bill type.	Error
657	Out/I	Invalid Facility Type Code	The Facility Type Code field contains an invalid Outpatient-I unique allowable value. The Facility Type Code is the first two characters of the claim's bill type.	Error
657	Out/P	Invalid Facility Type Code	The Facility Type Code field contains an invalid Outpatient-P unique allowable value. The Facility Type Code is the first two characters of the claim's bill type.	Error
658	I	Invalid Claim Frequency Type Code	The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type.	Error
658	Out/I	Invalid Claim Frequency Type Code	The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type.	Error

		Table B Claim Level Audit's		
Audit ID	**Status**	**Audit Message**	**Audit Description**	**Audit Severity**
658	**Out/P**	Invalid Claim Frequency Type Code	The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type.	Error
659	**I, Out/I, Out/P**	Invalid Patient Birth Date	Patient Birth Date is a required field and must contain a valid date of format ccyymmdd.	Error
660	**I, Out/I, Out/P**	Invalid Patient Ethnicity	The Patient Ethnicity field contains an invalid value. Patient Ethnicity is a required field and must contain 1 or 2.	Error
661	**I, Out/I, Out/P**	Invalid Patient Gender	Patient Gender is a required field and must contain M, F or U.	Error
662	**I, Out/I, Out/P**	Invalid Patient State	The value in the Patient State field of the patient address is not valid.	Error
663	**I, Out/I, Out/P**	Invalid Patient ZIP	The ZIP Code of the patient address must be at least 5 numeric characters in length and must contain XXXXX's or 00000's or a valid ZIP Code (USPS ZIP Code table).	Error
664	**I, Out/I, Out/P**	Invalid Patient Race	Patient Race is a required field and must contain a valid code value.	Error
665	**I, Out/I, Out/P**	Missing Patient Social Security Number	Patient Social Security Number is a required field and must contain 9 numeric characters.	Error
666	**I, Out/I**	Invalid Patient Discharge Status	The Patient Discharge Status must contain a valid NUBC code value.	Error
667	**I, Out/I, Out/P**	Missing Total Claim Charges	Total Claim Charges field is a required field and must contain a numeric value.	Error
668	**I, Out/I, Out/P**	Total Claim Charges not = sum of Service Lines Charges	The Total Claim Charges must equal the sum of all Service Line Charges.	Error
669	**I, Out/I**	Non-numeric Value Code Associated Amount	If the Value Code exists, the Value Code Associated Amount must exist and contain a numeric value.	Error
670	**I, Out/I**	Revenue Code in first service line detail is missing	At least one revenue code is required.	Error
671	**I, Out/I**	Invalid Revenue Code	The Revenue Code field must contain a valid revenue code (per Texas UB04 Manual).	Error

Table B Claim Level Audit's				
Audit ID	**Status**	**Audit Message**	**Audit Description**	**Audit Severity**
672	**I**	Invalid Revenue Procedure Code	If it exists, the Revenue Procedure Code field must contain a valid HCPCS or HIPPS code.	Error
672	**Out/I**	Invalid Revenue Procedure Code	If it exists, the Product/Service Procedure Code field must contain a valid CPT, HCPCS or HOPPS-I code.	Error
672	**Out/P**	Invalid Product/Service Procedure Code	If it exists, the Product/Service Procedure Code field must contain a valid CPT, HCPCS or HOPPS-P code	Error
673	**I, Out/I**	Charges not present for Revenue Code	The Charge Amount field is required when a corresponding service line Revenue Code is present.	Error
673	**Out/P**	Charges not present for Product/Service Procedure Code	The Charge Amount field is required when a corresponding service line Product/Service Procedure Code is present.	Error
674	**I, Out/I**	Service Line Charge not numeric	The Service Line Charge Amount must be numeric if a corresponding Revenue Code is present.	Error
674	**Out/P**	Service Line Charge not numeric	The Service Line Charge Amount must be numeric if a corresponding Product/Service Procedure Code is present.	Error
675	**I, Out/I**	Invalid Unit Code	Unit Code field must contain "DA" or "UN" or "F2".	Error
675	**Out/P**	Invalid Unit Code	Unit Code field must contain "DA" or "UN" or "MJ".	Error
676	**I, Out / I, Out/P**	Missing or Invalid Unit Quantity	A Unit Quantity field is required when a corresponding revenue code is present and the field must contain a numeric value.	Error
677	**I, Out / I, Out/P**	Invalid Unit Rate	The Unit Rate field must contain a numeric value.	Error
678	**I, Out/I**	Non-numeric Non-Covered Charge Amount	When present, a service line Non-Covered Charge Amount field must contain a numeric value.	Error
679	**I, Out/I**	Charges present but no corresponding Revenue Code	Service Line Charges exists but there is no corresponding Revenue Code.	Error
679	**Out/P**	Charges present but no corresponding Product/Service Procedure Code	Service Line Charges exists but there is no corresponding Product/Service Procedure Code.	Error

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
680	I	Questionable Revenue Procedure Modifier 1	The HCPCS/HIPPS Revenue Procedure Modifier Code 1 field contains a value not recognized by Medicare.	Warning
680	Out/I, Out/P	Questionable Revenue Procedure Modifier 1	The HCPCS/HOPPS Product/Service Procedure Modifier Code 1 field contains a value not recognized by Medicare.	Warning
681	I	Questionable Revenue Procedure Modifier 2	The HCPCS/HIPPS Revenue Procedure Modifier Code 2 field contains a value not recognized by Medicare.	Warning
681	Out/I, Out/P	Questionable Revenue Procedure Modifier 2	The HCPCS/HOPPS Revenue Procedure Modifier Code 2 field contains a value not recognized by Medicare.	Warning
682	I	Questionable Revenue Procedure Modifier 3	The HCPCS/HIPPS Revenue Procedure Modifier Code 3 field contains a value not recognized by Medicare.	Warning
682	Out/I, Out/P	Questionable Revenue Procedure Modifier 3	The HCPCS/HOPPS Product/Service Procedure Modifier Code 3 field contains a value not recognized by Medicare.	Warning
683	I	Questionable Revenue Procedure Modifier 4	The HCPCS/HIPPS Revenue Procedure Modifier Code 4 field contains a value not recognized by Medicare.	Warning
683	Out/I, Out/P	Questionable Revenue Procedure Modifier 4	The HCPCS/HOPPS Product/Service Procedure Modifier Code 4 field contains a value not recognized by Medicare.	Warning
684	I, Out/I ,Out/P	Invalid Total Claim Charges	Total Claim Charges field is a required field and must contain a numeric value not less than zero.	Error
685	I, Out/I, Out/P	Missing Unit Measurement Code.	A Revenue Code field exists but there is not a corresponding Unit Measurement Code field.	Error
686	I, Out/I, Out/P	Invalid Product Service ID qualifier	The qualifier for the Product Service ID must contain a valid code. The Product Service ID Qualifier qualifies the Revenue Procedure Code that follows.	Error
687	I, Out/I	Missing Value Code Associated Amount	If the Value Code is reported, the Value Code Associated Amount must exist and be numeric.	Error
688	I	Invalid Attending Practitioner Qualifier	The Attending Practitioner Qualifier field identifies the type of license contained in the Attending Practitioner Identifier field and the field must contain "XX" or "0B".	Error

| **Table B Claim Level Audit's** |
Audit ID	**Status**	**Audit Message**	**Audit Description**	**Audit Severity**
688	**Out/ED**	Invalid Physician 2 (ED Attending) Qualifier for ED claim	The Physician 2 (ED Attending) Qualifier field for ED claims identifies the type of license contained in the Physician 2 Identifier field on ED claims and the field must contain "XX" or "0B".	Error
689	**I**	Missing Attending Practitioner Identifier	The Attending Practitioner Identifier field is required. The Attending Practitioner Identifier field must contain the practitioner's NPI, state license number, or a recognized temporary license number.	Error
689	**Out/ED**	Missing Physician 2 (ED Attending) Identifier for ED claim	The Physician **2** (ED Attending) Identifier field for ED claims is required. The Physician **2** Identifier field for ED claims must contain the practitioner's NPI, state license number, or a recognized temporary license number.	
690	**I**	Invalid Attending Practitioner Identifier	The Attending Practitioner Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn").	Error
690	**Out/ED**	Missing Physician 2 (ED Attending) Identifier for ED claim	The Physician 2 (ED Attending) Identifier field for an ED claim does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn").	Error
691	**I**	Missing Attending Practitioner Last Name	The Attending Practitioner Last Name is a required field.	Error
691	**Out/ED**	Missing Physician 2 (ED Attending) Last Name on ED claim	The Physician 2 (ED Attending) Last Name on ED claims is a required field.	Error
692	**I**	Invalid Operating Practitioner Qualifier	The Operating Practitioner Qualifier field identifies the type of license contained in the Operating Practitioner Identifier field and the field must contain "XX" or "0B".	Error

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Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
692	Out/ED	Invalid Physician 1 (Operating) Qualifier	The Operating Practitioner Qualifier field identifies the type of license contained in the Operating Practitioner Identifier field and the field must contain "XX" or "0B".	Error
693	I	Invalid Operating Practitioner Identifier	The Operating Practitioner Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number"TXTnnn","OTHnnn", "RESnnn","TEMnnn").	Error
693	Out/I, Out /ED	Invalid Physician 1 (Operating) Identifier	The Physician 1 (Operating) Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn").	Error
694	I	Missing Attending Practitioner First Name	Attending Practitioner First Name is a required field.	Error
694	Out/ED	Missing Physician 2 (ED Attending) First Name	Physician 2 (ED Attending) First Name is a required field.	Error
695	I	Invalid Attending Practitioner Name Match	The 1st three characters of the Attending Practitioner's Last Name field and the first character of the Attending Practitioner's First Name field do not match an entry in the THCIC Practitioner Reference File.	Warning
695	Out/ED	Invalid Physician 2 (ED Attending) Name Match	The 1st three characters of the Physician 2 (ED Attending) Last Name field and the first character of the Physician 2 First Name field do not match an entry in the THCIC Practitioner Reference File.	Warning
696	I	Invalid Operating Practitioner Name Match	The 1st three characters of the Operating Practitioner's Last Name field and the first character of the Operating Practitioner's First Name field does not match an entry in the THCIC Practitioner Reference File.	Warning
696	Out/I,Out/EDI	Invalid Physician 1 (Operating) Name Match	The 1st three characters of the Physician 1 (Operating) Last Name field and the first character of the Physician 1 First Name field do not match an entry in the THCIC Practitioner Reference File.	Warning

Table B Claim Level Audit's				
Audit ID	**Status**	**Audit Message**	**Audit Description**	**Audit Severity**
697	**I, Out/I, Out/P**	Missing Claim Filing Indicator Code for Subscriber	Claim Filing Indicator Code for the subscriber is a required field and must contain the primary source of payment.	Error
698	**I, Out/I, Out/P**	Invalid Claim Filing Indicator Code for Other Subscriber	The Claim Filing Indicator Code field for the Other Subscriber does not contain a valid value. The Claim Filing Indicator Code field in the Other Subscriber segment contains the Secondary Payer Source code.	Error
699	**I, Out/I, Out/P**	Missing Primary Payer Plan ID	NOTE: This audit is suspended until the NPI rule is implemented for payers. The Primary Payer Plan ID is required.	Warning
700	**I, Out/I, Out/P**	Invalid Claim Filing Indicator Code for Subscriber	The Claim Filing Indicator Code field for the Subscriber does not contain a valid value. The Claim Filing Indicator Code field in the Subscriber segment contains the Primary Payer Source code.	Error
701	**I, Out/I, Out/P**	Primary Payer Name is required	The Primary Payer Name is required.	Error
702	**I, Out/I, Out/P**	Missing Secondary Payer Name	The Secondary Payer Name is required when a Claim Filing Indicator Code containing the secondary payer source code exists for the Other Subscriber (secondary subscriber).	Error
703	**I, Out/I, Out/P**	Missing Secondary Payer Plan ID	"NOTE: This audit is suspended until the NPI rule is implemented. The Secondary Payer Plan ID field is required when a secondary source of payment is reported."	Warning
704	**Out/I**	Missing Physician 2 (Other) Identifier	The Physician 2 (Other) Identifier field is required if the Physician 2 Qualifier is not = spaces. The Physician 2 Identifier field must contain the practitioner's NPI, state license number, or a recognized temporary license number.	Error
705	**Out/P**	Invalid Related_ Cause_Two Code	If Related_Cause_Two code value is reported, it must contain a valid value.	Error
706	**Out/P**	Invalid Related_Cause_Three Code	If Related _Cause _Three code value is reported, it must contain a valid value.	Error
707	**I**	Missing Operating Practitioner Identifier	If the operating practitioner qualifier is reported, the Identifier for the Operating Practitioner is required.	Error

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
707	Out/I,Out/ED	Missing Physician 1 (Operating) Identifier	If the Physician 1 (Operating) qualifier is reported, the Identifier for the Physician 1 is required.	Error
708	I	Missing Operating Practitioner First Name	The Operating Practitioner First Name is required if an operating practitioner is reported.	Error
708	Out/I,Out/ED	Missing Physician 1 (Operating) First Name	The Physician 1 (Operating) First Name is required if an operating practitioner is reported.	Error
709	I, Out/I	Invalid Length for Occurrence Span Associated Date	If the Occurrence Span Code Associated exists, then the Occurrence Span Associated Date field must contain 17 characters.	Error
710	Out/I	Invalid Physician 2 (Other) Identifier	The Physician 2 (Other) Qualifier field identifies the type of license contained in the Physician 2 Identifier field and the field must contain "XX" or "0B".	Error
711	Out/I	Invalid Physician 2 (Other) Identifier	The Physician 2 (Other) Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn").	Error
712	Out/I	Missing Physician 2 (Other) First Name	Physician 2 (Other) First Name is a required field if the associated provider number is present.	Error
713	I, Out/I	Missing Occurrence Code Associated Date	If an Occurrence Code exists, then the Occurrence Date field must exist.	Error
714	I	Patient Gender not consistent with the Principal Procedure	The patient gender does not agree with a gender specific principal procedure.	Error
715	I ,Out/I	Invalid Occurrence Span From Date	If an Occurrence Span Code exists, then the Occurrence Span From Date must contain a valid date of format ccyymmdd. The Occurrence Span From Date is the first 8 characters of the Occurrence Span Associated Date field.	Error

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
716	I, Out/I	Invalid Occurrence Code Associated Date	If the Occurrence Code exists, the Occurrence Code Associated Date field must exist and contain a valid date of format ccyymmdd.	Error
717	I ,Out/I	Invalid Occurrence Span Thru Date	If an Occurrence Span Code exists, then the Occurrence Span Thru Date must be a valid date of format ccyymmdd. The Occurrence Span Thru Date is the last 8 characters of the Occurrence Span Associated Date field.	Error
718	I ,Out/I	Missing Occurrence Span Code Associated Date	If an Occurrence Span Code exists, then the Occurrence Span Code Associated Date field must exist. The Occurrence Span Code Associated Date field contains the Occurrence Span From Date and the Occurrence Span Thru Date and is of the format ccyymmdd-ccyymmdd	Error
719	I, Out/I, Out/P	Invalid Statement From Date	Statement From Date is a required field and must be a valid date. The Statement From Date is the first 8 characters of the Statement Dates field and is of format ccyymmdd.	Error
720	I, Out/I, Out/P	Invalid Statement Thru Date	Statement Thru Date is a required field and must be a valid date. The Statement Thru Date is the last 8 characters of the Statement Dates field and of format ccyymmdd.	Error
721	I	Invalid Admission Date	Admission Date is a required field. The admission date is taken from the Admission Date and Hour field. The first eight characters of the Admission Date and Hour field must be a valid date of the format ccyymmdd.	Error
722	I	Invalid Admission Hour	Admission Hour is a required field. The admission hour is taken from the 9th and 10th characters of the Admission Date and Hour field. The Admission Hour field must contain one of (00-23).	Error
723	I	Birth Date after Statement Thru Date or Procedure Date	The patient Birth Date is after one of the following dates: Statement Thru Date, Principal Procedure Date, Other Procedure Date.	Error

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
723	Out/I, Out/P	Birth Date after Statement Date, Statement Thru Date or Service Date	The patient Birth Date is after one of the following dates: Statement Date, Statement Thru Date, or a Service Date.	Error
724	I	Missing Patient Discharge Hour	Patient Discharge Hour is a required field of format hhmm.	Error
725	I, Out/I, Out/P	Missing Patient Address Line 1	The first line of the patient's address of residence is required.	Error
726	I, Out/I, Out/P	Missing Patient Account Number	The Patient Account Number is required.	Error
727	I	Missing Admission Date and Hour	Admission Date and Hour is a required field.	Error
728	I	Invalid Discharge Hour	Discharge Hour is a required field and must contain a valid hour of 00 - 23.	Error
729	I, Out /I, Out/P	Missing Patient City	The city of the patient's address is required.	Error
730	I	Missing Operating Practitioner Last Name	If the operating practitioner is reported, the Operating Practitioner Last Name field is required.	Error
730	Out/I,Out/ED	Missing Physician 1 (Operating) Last Name	If the Physician 1 (Operating) is reported, the Physician 1 Last Name field is required.	Error
731	Out/I	Missing Physician 2 (Other) Last Name	The Physician 2 (Other) Last Name is a required field if the associated provider number is present.	Error
732	Out/I	Invalid Physician 2 (Other) Name Match	'The 1st three characters of the Physician 2 (Other) Last Name field and the first character of the Physician 2 First Name field do not match an entry in the THCIC Practitioner Reference File..	Warning
733	Out/I	Invalid Reason for Visit Code	Reason for Visit Code is a required field, if visit is unscheduled, and must contain a valid ICD code.	Error
~~733~~	~~Out/P~~	~~Invalid Reason for Visit Code~~	~~Reason for Visit Code contains an invalid ICD code. It is not a required field for Outpatient Professional claims.~~	~~Error~~
734	Out/P	Invalid Related Cause Code	If Related Cause code value is reported, it must contain a valid value.	Error

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
735	**Out/I, Out/P**	Invalid Procedure Date	Procedure Date is a required field when a procedure code is present and it must be a valid date. The Procedure Date is the first 8 characters of the Service Date field and is of format ccyymmdd.	Error
736	**Out/I, Out/P**	Procedure Date is more than 30 days before the Statement Date or after the Statement Thru Date.	The Procedure Date must be within the range of 30 days before the Statement From Date and before the Statement Thru Date inclusive.	Error
742	**Out/P**	Invalid Rendering Provider Qualifier	The Rendering Provider Qualifier field identifies the type of license contained in the Rendering Provider Identifier field and the field must contain "XX" or "0B".	Error
743	**Out/P**	Missing Rendering Provider Identifier	If the Rendering Provider Qualifier is reported, the Rendering Provider Identifier field is required. The Rendering Provider Identifier field must contain the practitioner's NPI or state license number.	Error
744	**Out/P**	Invalid Rendering Provider Identifier	The Rendering Provider Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number "TXTnnn","OTHnnn", "RESnnn","TEMnnn").	Error
745	**Out/P**	Missing Rendering Provider First Name	Rendering Provider First Name is a required field if the associated provider number is present.	Error
746	**Out/P**	Missing Rendering Provider Last Name	Rendering Provider Last Name is a required field if the associated provider number is present.	Error
747	**Out/P**	Invalid Rendering Provider Name Match	The 1st three characters of the Rendering Provider's Last Name field and the first character of the Rendering Provider's First Name field do not match an entry in the THCIC Practitioner Reference File.	Warning

Table B Claim Level Audit's				
Audit ID	**Status**	**Audit Message**	**Audit Description**	**Audit Severity**
751	**Out/P**	Invalid Rendering2 Provider Qualifier	The Rendering2 Provider Qualifier field identifies the type of license contained in the Rendering2 Provider Identifier field and the field must contain "XX" or "0B".	Error
752	**Out/P**	Missing Rendering2 Provider Identifier	If the Rendering2 Provider Qualifier is reported, the Rendering2 Provider Identifier field is required. The Rendering2 Provider Identifier field must contain the practitioner's NPI or state license number.	Error
753	**Out/P**	Invalid Rendering2 Provider Identifier	The Rendering2 Provider Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn").	Error
754	**Out/P**	Missing Rendering2 Provider First Name	Rendering2 Provider First Name is a required field if the associated provider number is present.	Error
755	**Out/P**	Missing Rendering2 Provider Last Name	Rendering2 Provider Last Name is a required field if the associated provider number is present.	Error
756	**Out/P**	Invalid Rendering2 Provider Name Match	The 1st three characters of the Rendering2 Provider's Last Name field and the first character of the Rendering2 Provider's First Name field do not match an entry in the THCIC Practitioner Reference File.	Warning
757	**I,Out/I, Out/P**	Missing Patient First Name	Patient First Name is a required field.	Error
758	**I, Out/I, Out/P**	Missing Patient Last Name	Patient Last Name is a required field.	Error
759	**Out/I, Out/P**	Invalid Procedure Through Date	Procedure Through Date must be a valid date. The Procedure Through Date is located in characters 10-17of the Service Date field and is of format ccyymmdd.	Error
760	**Out/I, Out/P**	Procedure Through Date is more than 30 days before the Statement From Date or after Statement Thru Date.	The Procedure Through Date must be within the range of 30 days before the Statement From Date and before Statement Thru Date inclusive.	Error

Table B Claim Level Audit's				
Audit ID	**Status**	**Audit Message**	**Audit Description**	**Audit Severity**
761	**Out/P**	Invalid Service Line Facility Type Code	The Service Line Facility Type Code field contains an invalid value for ANSI 837 Professional Claim.	Error
762	**Out/I, Out/P**	The Claim must have either a THCIC required HCPCS code, or the Claim must have a THCIC required revenue code and contain at least one procedure code.	The claim does not contain at least one required HCPCS code, or it does not contain at least one required revenue code and contain at least one procedure code.	Error
763	**I**	Invalid POA value	If the associated diagnosis code is present, then the Present On Admission (POA) indicator must be either N, U, W, Y or 1. A space is allowed only if the reporting provider is exempt from reporting POA.	Error
764	**I**	Invalid POA value	If the associated e-code is present, then the Present On Admission (POA) indicator must be either N, U, W, Y or 1. A space is allowed only if the reporting provider is exempt from reporting POA.	Error
765	**I,Out/I,Out/P**	Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Principal Diagnosis.	Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Principal Diagnosis.	Error
766	**I,Out/I,Out/P**	Only Ecodes may be reported with the Ecode qualifier or in the Ecode section.	Only Ecodes (External Causes of Morbidity) may be reported with the Ecode qualifier or in the Ecode section.	Error
767	**I,Out/I,Out/P**	Manifest diagnosis codes may not be used as the Principal Diagnosis Code	Manifest diagnosis codes may not be used as the Principal Diagnosis Code	Error
768	**I**	Manifest diagnosis codes may not be used as the Admitting Diagnosis Code	Manifest diagnosis codes may not be used as the Admitting Diagnosis Code	Error
769	**Out/I,Out/P**	Manifest diagnosis codes may not be used as the Reason for Visit Code	Manifest diagnosis codes may not be used as the Reason for Visit Code	Error

Table B Claim Level Audit's

Audit ID	Status	Audit Message	Audit Description	Audit Severity
770	I,Out/I,Out/P	Principal Diagnosis code is the wrong ICD version for the claim's statement through date	Principal Diagnosis code is the wrong ICD version for the claim's statement through date	Error
771	I	Admitting Diagnosis code is the wrong ICD version for the claim's statement through date	Admitting Diagnosis code is the wrong ICD version for the claim's statement through date	Error
772	Out/I,Out/P	Reason for Visit Diagnosis code is the wrong ICD version for the claim's statement through date	Reason for Visit Diagnosis code is the wrong ICD version for the claim's statement through date	Error
773	I,Out/I,Out/P	Other Diagnosis code is the wrong ICD version for the claim's statement through date	Other Diagnosis code is the wrong ICD version for the claim's statement through date	Error
774	I,Out/I,Out/P	Ecode is the wrong ICD version for the claim's statement through date	Ecode is the wrong ICD version for the claim's statement through date	Error
775	I	Principal Procedure code is the wrong ICD version for the claim's statement through date	Principal Procedure code is the wrong ICD version for the claim's statement through date	Error
776	I	Other Procedure code is the wrong ICD version for the claim's statement through date	Other Procedure code is the wrong ICD version for the claim's statement through date	Error
777	I	Patient Gender not consistent with Admitting Diagnosis	The Gender of the patient does not agree with a gender specific Admitting Diagnosis.	Error
778	Out/I,Out/P	Patient Gender not consistent with Reason for Visit Diagnosis	The Gender of the patient does not agree with a gender specific Reason for Visit Diagnosis.	Error
779	I,Out/I,Out/P	Patient Gender not consistent with Ecode	The Gender of the patient does not agree with a gender specific Ecode.	Error

	Table B Claim Level Audit's			
Audit ID	**Status**	**Audit Message**	**Audit Description**	**Audit Severity**
780	**I**	Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Admitting Diagnosis.	Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Admitting Diagnosis.	Error
781	**Out/I,Out/P**	Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Reason for Visit Diagnosis.	Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Reason for Visit Diagnosis.	Error
782	**I,Out/I,Out/P**	Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Other Diagnosis.	Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Other Diagnosis.	Error

APPENDIX - A6
PAYER SOURCE CODING GUIDE

(*Claim Filing Indicator Code*)
CATEGORY DESCRIPTIONS

11 Other non-federal program

Payment is made by a state or local program and most likely funded by tax dollars. This could include claims for which application to a program has been made but eligibility has not been determined. Can include, entities such as: The Texas Rehabilitation Commission, Texas Kidney Foundation, Non - Federal incarceration and Adoption Agencies

12 Preferred Provider Organization (PPO)

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

13 Point of Service (POS)

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

14 Exclusive Provider Organization (EPO)

EPO is a type of managed care and the category is new with the THCIC 837. An EPO is a more restrictive type of preferred provider organization plan under which beneficiaries must use providers from a specific network of physicians and healthcare facilities to receive coverage. In most cases, there is no coverage for care received from a non-network provider except in an emergency situation.

15 Indemnity Insurance

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

16 Health Maintenance Organization – Medicare Risk

Medicare risk is a contractual relationship between CMS and HMO managed care plans where the plan provides specific health care benefits to beneficiaries in exchange for a prepaid fixed monthly

amount from CMS. These benefits replace traditional Medicare benefits. Programs included in the Medicare managed care risk programs fall under the Medicare + Choice contract. These are called Coordinated Care Plans.

17 Dental Maintenance Organization

This is an organization of dental providers which provides services to its members.

AM Automobile Medical

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

BL Blue Cross (THCIC recommends that this category not be used.

This category refers to a specific insurance company. Blue Cross provides many different plan options (PPO, HMO).

CH CHAMPUS

CHAMPUS Civilian Health and Medical Program of the Uniformed Services,(also known as TRICARE) is a health benefits program offered through the Military Health Services System of the Department of Defense of inactive military, their spouses, beneficiaries, dependents of active-duty, retired and deceased military. CHAMPUS provides authorized in-patient and out-patient care from civilian sources, on a cost-sharing basis

CI Commercial Insurance (THCIC recommends that this category not be used.)

This category is misinterpreted as being any insurance that can be purchased on the open market (commercially). However, there are other categories that provide more specific categorization.

DS Disability

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

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

FI Federal Employees Program

Healthcare programs developed specifically for Federal Government employees.

HM Health Maintenance Organization (HMO)

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

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

LM Liability Medical

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

MA Medicare Part A

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

MB Medicare Part B

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

MC Medicaid

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

OF Other Federal Program

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

TV Title V

The Children with Special Health Care Needs (CSHCN) Services Program, funded through the Title V Block grant, provides services to children with extraordinary medical needs, disabilities, and chronic health conditions. The CSHCN Services Program's health care benefits include payments for medical care, family support services, and related services not covered by Medicaid, CHIP, private insurance, or other third party payers VA Veterans Administration Plan. The Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to its customers. Services are provided primarily in VHA facilities.

VA Veterans Administration Plan

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

WC Workers Compensation Health Plan

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

ZZ Charity or Unknown

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

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

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

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

Descending order of frequency

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

APPENDIX - A7
KEY DATA ELEMENTS FOR MATCHING INPATIENT CLAIMS

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

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

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

---

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

APPENDIX - A8
KEY DATA ELEMENTS FOR MATCHING OUTPATIENT CLAIMS

Key Data Elements to be added.

System 13 uses the following data elements to create a key for matching XX7 replacement, and XX8 Void/Cancel claims for THCIC 837 Institutional Claims:

- THCIC Number [2]
- PCN/PAN - Patient Control Number or Patient Account Number
- MRN – Medical Record Number
- Statement Covers Period From and Thru Date

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

System 13 uses the following data elements to create a key for matching XX7 replacement, and XX8 Void/Cancel claims for THCIC 837 Professional Claims:

- THCIC Number [3]
- PCN/PAN - Patient Control Number or Patient Account Number
- MRN – Medical Record Number
- Date – Service Date

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

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

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

<div style="border:2px solid black; text-align:center">

APPENDIX - A9
CHANGES MADE SINCE THE PREVIOUS VERSION(S)

</div>

Changes are from Version 3.1 to 3.2

Under section: STATE REQUIRED ETHNICITY AND RACE QUESTIONS, pages #12 and 13 of this document: **Paragraph: Question #1:   Ethnic Background,** we have removed the five digit (xxxxx) ethnic background (example: (1) Hispanic/Latino ~~(21352)~~ and **Paragraph: Question #2: Race**   (1) American Indian/Eskimo/Aleut ~~(10025)~~ and so on

Minor modifications (Additions) to Table A, Pre-Processing Audits (Format Check) From Version 3.1 to   Version 3.2 (Dec. 7, 2015).

<u>**Appendix – A5,**</u>

1) **RJ029** – It used to have a value of (SE01=0000?) and SE=0000?).

And now the Error Message is: **RJ029 -** Value (SE01=???) not equal num of segments counted in Transaction Set (actual cnt ST thru SE=???).

2) **RJ32** - RJ032 - RJ032 - Value (GE01=000?) not equal number of transaction sets included in Functional Group (actual count=000?).

And now the Error Message is: **RJ032** - Value (GE01=???) not equal number of transaction sets included in Functional Group (actual count=???).

3) **RJ033** - GS06 (Group Control Number=??????) value not equal segment GE02 (Group Control Number=??????}) Value.

And now the Error Message is: **RJ033 -** RJ033 - GS06 (Group Control Number=?) value not equal segment GE02 (Group   Control Number=?) value.

4) **RJ035** - Value (IEA01=000?) not equal number of Functional Groups included in Interchange (actual count=000?).

And now the Error Message is: RJ035 - Value (IEA01=?) not equal number of Functional Groups included in Interchange (actual count=?).

5) **RJ042** – RJ042 - Element NM109, provider NPI num validation failed.
   Your #: ?????????? Our #: ??????????

And now the Error Message is: RJ042 Element NM109, provider NPI num validation failed.
   Your #: ??????????
   Our #: ??????????

6) **RJ043** - Element N3 (street addr) validation on provider failed. Your addr 123 Some street. Our addr 456 Another St (1st 15 characters only)

And now the Error Message is: RJ043 - Element N3 (street addr) validation on provider failed.

Your addr: ???

Our addr: ???

(1st 15 characters only)

7) **RJ052 -** Element REF*EI, provider EIN num validation failed. Your #: ????????? Our #: ?????????

And now the Error Message is: RJ052 - Element REF*EI, provider EIN num validation failed.

Your #: ?????????

Our #: ?????????

8) RJ060 - Facility not ASC, Institutional 5010 version format required

And now the Error Message is: RJ060 - Facility not ASC, Institutional 5010 version format required

(ver# 005010X223A2), your ver#??????????

And the Audit Description now read as: RJ060 - All non-ASC facilities MUST submit claims in Institutional format. Our system validates institutional format by examining the version number in the 8th element of the GS segment (GS08).

9) New Addition - **RJ061 – RJ061** - SBR (subscriber) segment missing in HL (hierarchical level). The Subscriber SBR segment is required in order to properly identify the patient. The SBR segment (along with its associated fields) normally appears immediately after an HL (hierarchical level) segment.

10) Audit 733 Out/P Invalid Reason for visit Code is removed

11) New Audit Id's have been added: **765 - 782**

Changes are from the THCIC Data Collection Healthcare Facility Procedures and Technical Specifications 5010 Inpatient and Outpatient Appendices - from Version 2 to Version 3.1

a) **Appendix – A1   Country Codes - ISO 3166**
   i. Remove the old display table codes of Country Codes and replace it with new display table. ISO 3166 is the International Standard for country codes and codes for their subdivisions. https://www.iso.org/obp/ui/#search. The codes in ISO 3166 are available on the Online Browsing Platform. (OBP) is always up to date.

   ii. **USPS State Codes, Military and Canadian Provinces,**
   You can find the official USPS (USA) and Canadian abbreviation in the following web sites:
   For United States postal abbreviation codes:
    https://www.usps.com/send/official-abbreviations.htm and for Postal Abbreviations for **Provinces and Territories in Canada:**

http://canadaonline.about.com/od/postalservices/a/abbreviations-provinces-canada.htm
Note: Official USPS, Military "State" abbreviations codes colored each section with
different color: Red for Military "State", and Green for Canada

b) **Appendix – A3** Race and Ethnicity Questionnaire Documents Note below the title of
   "Instructions for State Ethnicity and Race Questionnaire" is added to specify the documents are
   for: Hospitals and Ambulatory Surgery Centers **USE Only.**

c) **Appendix – A5,**
   a. Title of Appendix changed to INPATIENT & OUTPATIENT AUDIT ID'S from
      INPATIENT AND OUTPATIENT AUDIT ID'S AND AUDIT MESSAGES
   b. Table- A - Pre Processing Audits Format and Claim Construction Checks**.**
      i.   Table A is reformatted Audit Message ID and Message are Merged
      ii. Inpatient and Outpatient Audit ID's and Audit Messages have been revised to:
           a. Updated and clarified the audit list messages, providing a Text explanation for
              each "RJ000" messages.
           b. Modify existing table with clear definitions and add new Audit Messages from
              RJ048 –RJ059
           c. Added RJ060 for Emergency Department data submission in Institutional format.

   c. **Table- B -Claim Level Audits and Error Messages :**
      THCIC Inpatient Outpatient Audit Comparison to Table - Containing Audits and Error
      Messages: (Moved the old Table B Claim Level Audits from website
      http://www.dshs.state.tx.us/thcic/hospitals/HospitalReportingRequirements.shtm in
      Microsoft Excel file and incorporated into a table under Appendix – A-5, Table - B -Claim
      Level Audits
           1. Table B Claim Level Audit's Updated the following Audits:
              a. Audit code 646 for Inpatient claims is modified adding the new code name
                 "Point of Origin" (Admission Source).
           2. Audit code 646 Outpatient Institutional is added as "Missing Point of Origin
              (Admission Source) Code for Outpatient ED".
           3. Audit code 647 added Missing Patient Status Code for Outpatient ED (Outpatient
              Institutional claims only).
           4. Audit code 655 Invalid Point of Origin (Admission Source) code for inpatient
              claims the Audit Message and Audit Description are updated from " Invalid
              Admission Source" and " The Admission Source Code is a required field and must
              contain a valid value of 1 - 9, A." to "Invalid Point of Origin (Admission Source)" and
              "The Point of Origin (Admission Source) Code is required and must contain one of the
              following values: 1, 2, 4, 5, 6, 8, 9, D, E, F.", respectively.
           5. Audit code 655 Invalid Point of Origin (Admission Source) code for outpatient
              institutional claims is added
           6. Audit code 656 Invalid Admission Type code for outpatient ED claims is added
           7. Audit code 657 Invalid Facility Type code for Outpatient Institutional claims, the
              Audit Description is updated to " The Facility Type Code field contains an invalid
              Outpatient-I unique allowable value. The Facility Type Code is the first two characters
              of the claim's bill type" from "Outpatient-I unique allowable values".
           8. Audit code 657 Invalid Facility Type code for Outpatient Professional claims, the
              Audit Description is updated to " The Facility Type Code field contains an invalid

Outpatient-I unique allowable value. The Facility Type Code is the first two characters of the claim's bill type" from "Outpatient-P unique allowable values".

9. Audit code 658 Invalid Claim Frequency Type code for Outpatient Institutional claims, the Audit Description is updated to "The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type." from "Outpatient-I unique allowable values".

10. Audit code 658 Invalid Claim Frequency Type code for Outpatient Professional claims, the Audit Description is updated to "The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type." from" from "Outpatient-P unique allowable values".

11. Audit code 666 Invalid Patient Discharge Status code for outpatient ED claims is added

12. Audit code 675 Invalid Unit code the description field has the "F2" code removed from the listing for Inpatient and Outpatient Institutional claims.

13. Audit Code 710 Description the phrase "Primary Practitioner" is replaced by "Other Provider".

14. Audit Code 742 Description the phrase "Primary Practitioner" is replaced by "Rendering Provider".

15. Audit code 759 Invalid Procedure through Date for Outpatient Institutional and Outpatient Professional claims was removed since it is duplicated.

16. Audit code 733 - Out/P - Invalid Reason for visit code is deleted from the table.

Data Reporting Requirements in section: Data Correction -We had a section: Audit List, that contain audits and messages used by THCIC for auditing inpatient and outpatient data we made it available in this documentation

1 Appendix B1 and B2 are renumbered to Appendix A7 and A8 respectively
2 New Appendix A7 KEY DATA ELEMENTS FOR MATCHING INPATIENT CLAIMS Footnote - language regarding UB92 electronic file structure deleted.
3 New Appendix A8 KEY DATA ELEMENTS FOR MATCHING OUTPATIENT CLAIMS Footnote - language regarding UB92 electronic file structure deleted.
4 Appendix - A9 PAST VERSION CHANGES THAT HAVE BEEN MADE TO THIS DOCUMENT is added new. It is the listing of all past changes to the different 5010_Inpatient_and_Outpatient-Appendices manual versions is added to the end of the document.

Changes are from the THCIC Data Collection Healthcare Facility Procedures and Technical Specifications 5010 Inpatient and Outpatient Appendices – from Version 1 to Version 2

1. Appendix – A1 Valid Country Codes the following updates are made
   a. Webpage Hyperlink updated to
      http://www.iso.org/iso/country_codes/iso_3166_code_lists.htm from
      http://www.iso.org/iso/en/prods-services/iso3166ma/02iso-3166-code-lists/list-en1.html
   b. AX- ÅLAND ISLANDS is added
   c. BO - BOLIVIA, PLURINATIONAL STATE OF is changed from "BOLIVIA"
   d. CW – CURAÇAO is added
   e. GG- GUERNSEY is added
   f. IM- ISLE OF MAN is added

g. JE- JERSEY is added
h. LY- LIBYA is changed from "LIBYAN ARAB JAMAHIRIYA"
i. ME – MONTENEGRO is added
j. AN - NETHERLANDS ANTILLES is deleted
k. BL - SAINT BARTHÉLEMY is added
l. SH - SAINT HELENA, ASCENSION AND TRISTAN DA CUNHA is changed from "SAINT HELENA"
m. MF - SAINT MARTIN (FRENCH PART) is added
n. RS – SERBIA is changed from "CS - SERBIA AND MONTENEGRO"
o. SX - SINT MAARTEN (DUTCH PART) is added
p. SS - SOUTH SUDAN is added
q. VE - VENEZUELA, BOLIVARIAN REPUBLIC OF is changed from "VENEZUELA"

2. Appendix – A2 Default or Missing Data Values
    a. Unknown Social Security Number
        i. Removed reference to UB92 Record.Field
        ii. Updated segment references for Loop 2010CA to K301 from REF02
    b. Unknown ZIP Code - Removed reference to UB92 Record.Field
    c. Temporary Licenses
        i. Removed reference to UB92 Record.Field
        ii. INPATIENT CLAIMS DATA

    1. Title added
    2. Segment references are updated NM109 for NPI and REF02 for State License numbers
        iii. OUTPATIENT CLAIMS DATA tables added
    1. INSTITUTIONAL Guide Loops and Segments added
    2. PROFESSIONAL Guide Loops and Segments added.

    a. Alcohol, Drug Use and HIV Conditions – Table – Patient SSN – Loop 2300 with K301 replaces Loop 2010CA with REF02.

3. Appendix – A5 Inpatient and Outpatient Audit ID's and Audit Messages – Table B Claim Level Audits – Audit 677 is deleted.

4. Appendix – A6 Payer Source Coding Guide – Table –

    a. Self/Private Pay, Code "09" is deleted
    b. Self-Pay moved to "ZZ" code
    c. Liability Code "LI" is deleted.