5010 Inpatient THCIC 837 Technical Specifications

Version 10.3

December 1, 2023

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1 Introduction

Texas Health Care Information Collection's (THCIC) primary charge is to collect data and report on the quality performance and differences in charges of hospitals and health maintenance organizations operating in Texas. The goal is to provide information that will enable consumers to have an impact on the cost and quality of health care in Texas.

The Department of State Health Service's governing legislation, which includes collecting hospital inpatient discharge data for approximately 660 Texas hospitals, is contained within Chapter 108, Texas Health & Safety Code.

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

This guide is written to be complementary to the Hospital Discharge Data Collection and Release Rules:

TITLE - 25 Health Services
PART - 1 Department of State Health Services
CHAPTER - 421 Health Care Information
SUBCHAPTER - A - COLLECTION AND RELEASE OF HOSPITAL DISCHARGE DATA

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

2 General Information and Overview

THCIC's primary purpose is to provide data that will enable Texas consumers and health plan purchasers to make informed health care decisions.

General Overview

Submitters are required to use the THCIC 837 claim format (modified ANSI ASC X12N 837 Institutional claim format) to submit data on patients discharged from the hospital per Health and Safety Code Section 108.009(h) and Title 25 Texas Administrative Code, Chapter 421, Rule 421.2(b)(1-4).

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

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

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

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

For more detail on the file submission process as well as the use of the System13/THCIC system please see:

DSHS THCIC Hospital Reporting Requirements

Reference Information

The THCIC 837 claim format draws from the specifications for the ANSI 837 health care claim format from the American National Standards Institutes, Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional, 837, ASC X12N 837 (005010X223), May 2006 version, and the addenda published by the Washington Publishing Company in October 2007 (**ANSI 837 Institutional Guide,** 005010X223A2) which can be purchased and downloaded from the following website: X12 Product Licensing Program

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

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

The THCIC Business Associate - System13, Inc.

System13, Inc. provides a testing process to ensure that a hospital or vendor submits a HIPAA compatible ANSI 837 Institutional and Professional Guide formatted file with the additional required fields listed in this manual then that data file should pass the audits at System13, Inc. System13, Inc. (System13) located in Charlottesville, Virginia, is contracted to provide data collection, auditing, and warehousing of the data submitted by hospitals. System13, Inc. Contact Information:

E-mail	thcichelp@system13.com
Helpdesk Phone#	(888) 308-4953 Monday through Friday 8:00 a.m. to 5:00 p.m. (CT)
Fax	(434) 979-1047

Data Portal Web Site - https://thcic.system13.com/
This is for uploading data files and manually entering claims online (data submission), manual claim correction, and data reports.

THCIC Web Site

The THCIC web site contains the latest information about THCIC, the hospital discharge data reporting process, and other THCIC activities and publications. The site contains information about legislative mandates, instructions concerning the data reporting process, and THCIC staff contact information.

3 Definitions and Acronyms

Term	Definition
Accurate and Consistent Data	Data that has been edited by DSHS and subjected to provider validation and certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(1)
ANSI	American National Standards Institute
ANSI 837 Institutional Guide	American National Standards Institute, Accrediting Standards Committee electronic claims format for billing health care services [specifications can be obtained via the Internet at Washington Publishing Company and Title 25 Texas Administrative Code, Chapter 421, Rule 421.61(5)
Attending Physician	The individual licensed under the Medical Practice Act (Occupations Code, Chapter 151) or the licensed health professional primarily responsible for the care of the patient during the hospital episode as reported on the claim. For Skilled Nursing Facility (SNF) services, the attending physician is the individual who certifies the SNF plan of care. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(3)
Audit	For the purposes of this manual, a methodological examination and review of data. Audits are performed during data collection to identify errors or potential errors (warnings).
Certification Process	The process by which a provider confirms the accuracy and completeness of the encounter data set required to produce the public use data file as specified in §421.7 of this title (relating to Certification of Discharge Reports). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(4)
Charge	The amount billed by a provider for specific procedures or services provided to a patient before any adjustment for contractual allowances, government mandated fee schedules write-offs for charity care, bad debt or administrative courtesy. The term does not include co-payments charged to health maintenance organization enrollees by providers paid by capitation or salary in a health maintenance organization. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(5)
CHS	Texas Department of State Health Services, Center for Health Statistics.
CPT	Current Procedural Terminology – HCPCS Level 1 procedure codes
Comments	The notes or explanations submitted by the hospitals, physicians or other health professionals concerning the provider quality reports or the encounter data for public use as described in the Texas Health and Safety Code, §108.010(c) and (e) and §108.011(g) respectively. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(6)
Discharge	The formal release of a patient by a hospital; that is, the termination of a period of hospitalization by death or by disposition to a residence or another health care provider. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(9)

Discharge Claim	A computer record as specified in §421.9 of this title (relating to Discharge Reports--Records, Data Fields and Codes) relating to a specific patient. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(10)
Discharge Report	A computer file as defined in §421.9 of this title periodically submitted on or on behalf of a Hospital in compliance with the provisions of this chapter. "Discharge report" corresponds to the ANSI 837 Institutional Guide terms, "Communication Envelope" or "Interchange Envelope." Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(11)
DRG	Diagnosis Related Group. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(12)
EDI	Electronic Data Interchange. A method of sending data electronically from one computer to another. EDI helps providers and payers maintain a flow of vital information by enabling the transmission of claims and managed care transactions. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(13)
Edit	An electronic standardized process developed and implemented by the THCIC to identify potential errors and mistakes in data elements by reviewing data fields for the presence or absence of data, and the accuracy and appropriateness of data. (§108.002(8) Health and Safety Code) For the purposes of this manual: **1.** To make changes to a data file. **2.** The process of adding, deleting, or changing data. The THCIC edits the public use data file to protect the confidentiality of patients and physicians. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(14)
Electronic Filling	The submission of computer records in machine readable form by modem transfer from one computer to another (EDI) or by recording the records on a nine-track magnetic tape, computer diskette or other magnetic media acceptable to the executive director. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(15)
EMC	Electronic Media Claims (National Standard Format).
Encounter	An electronic record that contains information on all services rendered for a patient episode of care (admission through discharge) by a provider in a patient care setting (e.g., hospital, out-patient clinic, doctor's office).
Error	Data submitted in a discharge data file, which are not consistent with the format, data standards, or auditing criteria established by the director of CHS, or the failure to submit required data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(16)

Ethnicity	The status of patients relative to Hispanic background. Facilities shall report this data element according to the following ethnic types: Hispanic or Non- Hispanic. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(17)
Facility Type Indicators	An indicator that provides information to the data user as to the type of facility or the primary health services delivered at that facility (e.g., Teaching, Acute Care, Rehabilitation, Psychiatric, Pediatric, Cancer, Skilled Nursing, or other Long Term Care Facility). A facility may have more than one indicator. Hospitals may request updates to this field. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(18)
Geographic Identifiers	A set of codes indicating the public health region and county in which the patient resides. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(19)
HCDCS	Health Care Data Collection System
HCPCS	Healthcare Common Procedure Coding System
Healthcare Facility	A hospital, an ambulatory surgery center licensed under Chapter 243 of the Health and Safety Code, a chemical dependency treatment facility licensed under Chapter 464 of the Health and Safety Code, a renal dialysis center, a birthing center, a rural health clinic or a federally qualified health center as defined by 42 United States Code, §1396(1)(2)(B). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(21)
HIPPS	Health Insurance Prospective Payment System. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(22)
Hospital	A public, for-profit, or nonprofit institution licensed or owned by this state that is a general or special hospital, private mental hospital, chronic disease hospital, or other type of hospital. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(23)
ICD	International Classification of Disease. The *International Classification of Diseases, Clinical Modification* (ICD-CM) is a system used to code and classify mortality data from death certificates. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(24)
Inpatient	A patient, including a newborn infant, who is formally admitted to the inpatient service of a hospital, and who is subsequently discharged, regardless of status or disposition. Inpatients include patients admitted to medical/surgical, intensive care, nursery, sub-acute, skilled nursing, long- term, psychiatric, substance abuse, physical rehabilitation, and all other types of hospital units. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(25)
Institutional Review Board	The department's appointees or agent who have experience and expertise in ethics, patient confidentiality, and health care data who review and approve or disapprove requests for data or information other than the public use data as described in §421.10 of this title (relating to Institutional Review Board). The Institutional Review Board acts as the Scientific Review Panel described in the Health and Safety Code,

	§108.0135. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(26)
Insured	Services for which the provider expects payment from a third-party insuring Payer (e.g., Medicare, Medicaid, Blue Cross).
Non-insured	Services for which the Provider cannot bill a third-party insuring payer (e.g., self-pay, charity).
Operating or Other Physician	The "physician" licensed by the Texas Medical Board or "other health professional" licensed by the State of Texas who performed the principal procedure or performed the surgical procedure most closely related to the principal diagnosis. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(27)
Other Exempted Provider	A hospital exempt by rule Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(28) or by waiver (2014 Sunset Review Commission Waiver Recommendation) to be established in rule.
Other Health Professional	A person licensed to provide health care services other than a physician. An individual other than a physician who admits patients to hospitals, or who provides diagnostic or therapeutic procedures to inpatients. The term encompasses persons licensed under various Texas practice statutes, such as psychologists, chiropractors, dentists, nurse practitioners, nurse midwives, and podiatrists who are authorized by the hospital to admit or treat patients. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(29)
Patient Account Number	A number assigned to each patient by the hospital, which appears on each computer record in a patient discharge claim. This number is not consistent for a given patient from one hospital to the next, or from one admission to the next in the same hospital. The department deletes or encrypts this number to protect patient confidentiality prior to release of data. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(30)
Payer	The organization that pays for medical services. Payers usually are contractually responsible for adjudication and payment of provider claims for health care services rendered.
Physician	An individual licensed under the laws of this state to practice medicine under the Medical Practice Act, Occupations Code, Chapter 151. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(31)
Present on Admission (POA)	Diagnosis present on admission. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(32)
Provider	A hospital, physician, or other health professional that provides health care services to patients. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(33)
Provider Quality Data	A report or reports authored by the department on provider quality or outcomes of care, as defined in Health and Safety Code, Chapter 108, created from data collected by the department or obtained from other sources. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(34)

Public Use Data File	A data file composed of discharge claims with risk and severity adjustment scores which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of hospital discharge data imposed by statute. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(35)
Race	A division of patients according to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Hospitals shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(36)
Required Minimum Data Set	The list of data elements which hospitals are required to submit in a discharge claim for each inpatient stay in the hospital. The required minimum data set is specified in §421.9(d) of this title. This list does not include the data elements that are required by the ANSI 837 Institutional Guide to submit an acceptable discharge report. For example: Interchange Control Headers and Trailers, Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify which qualify as subsequent data elements). Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(37)
Research Data File	A customized data file, which includes the data elements in the public use file and may include data elements other than the required minimum data set submitted to the department, except those data elements that could reasonably identify a patient or physician. The data elements may be released to a requestor when the requirements specified in §421.8 of this title (relating to Hospital Discharge Data Release) are completed. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(38)
Risk Adjustment	A statistical method to account for a patient's severity of illness at the time of admission and the likelihood of development of a disease or outcome, prior to any medical intervention. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(39)
Service Unit Indicator	An indicator derived from submitted data (based on bill type or revenue codes), which represent the type of service unit or units (e.g., Coronary Care Unit, Detoxification Unit, Intensive Care Unit, Hospice Unit, Nursery, Obstetric Unit, Oncology Unit, Pediatric Unit, Psychiatric Unit, Rehabilitation Unit, Sub acute Care Unit, or Skilled Nursing Unit) where the patient received treatment. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(40)
Severity Adjustment	A method to stratify patient groups by degrees of illness and mortality. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(41)
Submission	The transfer of a set of computer records as specified in §421.9 of this title that constitutes the discharge report for one or more hospitals. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(42)
Submitter	The person or organization, which physically prepares discharge reports for one or more hospitals and submits them to THCIC. A submitter may

	be a hospital or an agent designated by a hospital or its owner. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(43)
Submitting Agent	An organization authorized by a health care provider to submit billing claims on behalf of the provider.
System13, Inc.	System13, Inc. The contractor that collects, audits, and warehouses the inpatient and outpatient health care claim data on behalf of THCIC.
THCIC	Texas Health Care Information Collection sub-unit in the Department of State Health Services, Center for Health Statistics Unit.
THCIC Identification Number	A string of six characters assigned by THCIC to identify health care facilities for reporting and tracking purposes. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(44)
Uniform Facility Identifier	A unique number assigned by the department to each health care facility licensed in the state. For hospitals, this will include the hospital's state license number. For hospitals operating multiple facilities under one license number and duplicating services, the department will assign a distinguishable uniform facility identifier for each separate facility. The relationship between facility identifier and the name and license number of the facility is public information. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(45)
Uniform Patient Identifier	A unique identifier assigned by the THCIC to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across hospitals and inpatient admissions. The relationship of the identifier to the patient-specific data elements used to assign it is confidential. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(46)
Uniform Physician Identifier	A unique identifier assigned by the THCIC to a physician or other health professional who is reported as attending or treating a hospital inpatient and which remains constant across hospitals. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(47)
User	For the purposes of this manual, Hospital or Submitter.
Validation	The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification. Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(48)

4 Technical Requirements Summary

Patient Inclusion Requirements

Hospitals must submit the required data elements for **all inpatients discharged** from the hospital. This includes patients for which the hospital may not generate an electronic claim, such as self-pay and charity (see Title 25 Texas Administrative Code, Chapter 421, Rule 421.2).

Communication Requirements

Data submission

Texas Administrative Code (TAC) rules require that all hospitals, in operation for any or all of the reporting periods described in Title 25 Texas Administrative Code, Chapter 421, Rule 421.1(a) and (b) relating to the Collection and release of Hospital Discharge Data, shall submit data on all discharged inpatients to the Texas Heath Care Information Collection program and are advised to reference Chapter 108, Health & Safety Code and the Texas Health Care Information Collection rules Title 25 Texas Administrative Code, Chapter 421, Rule 421.1 – 421.9 relating to data reporting.

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

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

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

System13 Enrollments

For more information, please see document:

THCIC Submitter and Provider Enrollment Guide

Data corrections

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

1. **Replacement of Errant Claim Data** - Submit "Replacement claims" (XX7) to System13, Inc.
   "Replacement claims" are required to have the following data elements match exactly to replace the claim data from System13, Inc.:

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

2. **Void or Cancel Errant Claim Data and Resubmit:**
   Submit "Void/Cancel claims" (XX8) to System13, Inc., then resubmit original bill type codes (XX0, XX1, XX2, XX3, XX4 or XX5) with the corrected data included.

   "Void/Cancel claims" are required to have the following data elements match exactly to delete the claim data from System13, Inc.:

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

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

Contact the System13, Inc. Help Desk:

E-mail	thcichelp@system13.com
Helpdesk Phone#	(888) 308-4953 Monday through Friday 8:00 a.m. to 5:00 p.m. (CT)
Fax#	(434) 979-1047

Required Data File Formats and Data Elements

Data file specifications

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

State required data elements

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

(1) Patient Name
  (A) Patient Last Name
  (B) Patient First Name
  (C) Patient Middle Initial
(2) Patient Address
  (A) Patient Address Line 1
  (B) Patient Address Line 2 (if applicable)
  (C) Patient City
  (D) Patient State
  (E) Patient ZIP
  (F) Patient Country (if address is not in United States of America, or one of its territories)
(3) Patient Birth Date
(4) Patient Sex
(5) Patient Race
(6) Patient Ethnicity
(7) Patient Social Security Number
(8) Patient Account Number
(9) Patient Medical Record Number
(10) Claim Filing Indicator Code (Payer Source – primary and secondary (if applicable for secondary payer source)
(11) Payer Name - Primary and secondary (if applicable, for both)
(12) National Plan Identifier - for primary and secondary (if applicable) payers (National Health Plan Identification number, if applicable and when assigned by the Federal Government)
(13) Type of Bill
(14) Statement Dates (replaces Statement From and Statement Thru dates)
(15) Admission / Start of Care
  (A) Admission / Start of Care Date
  (B) Admission / Start of Care Hour
(16) Admission Type
(17) Admission Source
(18) Patient (Discharge) Status
(19) Patient Discharge Hour
(20) Principal Diagnosis
(21) Admitting Diagnosis
(22) Principle External Cause of Injury (E-Code)

(23) Other Diagnosis Codes - up to 24 occurrences (all applicable)
(24) External Cause of Injury (E-Code) - up to 9 occurrences (if applicable)
(25) Principal Procedure Code (if applicable)
(26) Principal Procedure Date (if applicable)
(27) Other Procedure Codes - up to 24 occurrences (if applicable)
(28) Other Procedure Dates - up to 24 occurrences (if applicable)
(29) Occurrence Span Code - up to 4 occurrences (if applicable)
(30) Occurrence Span Code Associated Date – up to 4 occurrences (If applicable)
(31) Occurrence Code - up to 12 occurrences (if applicable)
(32) Occurrence Code Associated Date - up to 12 occurrences (if applicable)
(33) Value Code - up to 12 occurrences (if applicable)
(34) Value Code Associated Amount - up to 12 occurrences (if applicable)
(35) Condition Code - up to 8 occurrences (if applicable)
(36) Attending Physician or Practitioner Name
    (A) Attending Physician or Practitioner Last Name
    (B) Attending Physician or Practitioner First Name
    (C) Attending Physician or Practitioner Middle Initial
(37) Attending Physician or Practitioner Primary Identifier (National Provider Identifier, when HIPAA rule is implemented)
(38) Attending Physician or Practitioner Secondary Identifier (Texas state license number)
(39) Operating Physician Name (if applicable)
    (A) Operating Physician Last Name
    (B) Operating Physician First Name
    (C) Operating Physician Middle Initial
(40) Operating Physician Primary Identifier (National Provider Identifier, when HIPAA rule is implemented)
(41) Operating Physician Secondary Identifier (Texas state license number)
(42) Total Claim Charges
(43) Revenue Service Line Details (up to 999 service lines) (all applicable)
    (A) Revenue Code
    (B) Procedure Code
    (C) HCPCS/HIPPS Procedure Modifier 1
    (D) HCPCS/HIPPS Procedure Modifier 2
    (E) HCPCS/HIPPS Procedure Modifier 3
    (F) HCPCS/HIPPS Procedure Modifier 4
    (G) Charge Amount
    (H) Unit Code
    (I) Unit Quantity
    (J) Unit Rate
    (K) Non-covered Charge Amount
(44) Service Provider Name
(45) Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier (when HIPAA rule is implemented)
(46) Service Provider Address
    (A) Service Provider Address Line 1
    (B) Service Provider Address Line 2 (if applicable)

(C) Service Provider City
(D) Service Provider State
(E) Service Provider ZIP

(47) Service Provider Secondary Identifier - THCIC 6-digit Hospital ID assigned to each facility

Situational required data element

(48) Diagnosis Present on Admission (POA) – is required to be submitted for all hospitals which are not exempt from reporting Title 25 Texas Administrative Code, Chapter 421, Rule 421.9(e).

The following hospital types are exempt from the POA submission requirement:

(A) Critical Access Hospitals,
(B) Inpatient Rehabilitation Hospitals,
(C) Inpatient Psychiatric Hospitals,
(D) Cancer Hospitals,
(E) Children's or Pediatric Hospitals, or
(F) Long Term Care Hospitals

Data element locations

Data elements and their respective locations in the approved formats.

	THCIC 837 INSTITUTIONAL LOCATION	**THCIC 837 INSTITUTIONAL LOCATION**
DATA ELEMENT	***Loop***	***Ref. Des.***
Patient Last Name	2010BA or 2010CA	NM103
Patient First Name	2010BA or 2010CA	NM104
Patient Middle Initial	2010BA or 2010CA	NM105
Patient Street Address	2010BA or 2010CA	N301
Patient City	2010BA or 2010CA	N401
Patient State	2010BA or 2010CA	N402
Patient Zip	2010BA or 2010CA	N403
Patient Country Code	2010BA or 2010CA	N404
Patient Birth Date	2010BA or 2010CA	DMG02
Patient Sex	2010BA or 2010CA	DMG03
Patient Race	2300	K301
Patient Ethnicity	2300	K301
Subscriber/Patient Social Security Number	2010BA	REF02
Patient Social Security Number	2300	K301
Patient Control Number/Patient Account Number	2300	CLM01

	THCIC 837 INSTITUTIONAL LOCATION	THCIC 837 INSTITUTIONAL LOCATION
DATA ELEMENT	***Loop***	***Ref. Des.***
Medical Record Number	2300	REF02
Source of Payment Code (Standard)/ Claim Filing Indicator Code	2000B or 2320	SBR09
Payer Name	2010BB (and 2330B, if secondary payer)	NM103
National Plan Identifier (when implemented by Federal Government)	2010BB (and 2330B, if secondary payer)	NM109
Type of Bill	2300	CLM05
Statement Covers Period From	2300	DTP03
Statement Covers Period Through	2300	DTP03
Admission/Start of Care Date	2300	DTP03
*Admission Hour (Required when multiple bill types are sent)	2300	DTP03
Type of Admission (Priority (Type) of Admission)	2300	CL101
Source of Admission (Point of Origin for Admission or Visit	2300	CL102
Patient Status	2300	CL103
Patient Discharge Hour	2300	DTP03
Principal Diagnosis Code	2300	HI01
Admitting Diagnosis	2300	HI02
External Cause of Injury	2300	HI03-HI12
Other Diagnosis Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01-HI12
Diagnosis Present on Admission	2300	HInn-9 (nn = 01-12)
Principal Surgical Procedure Code (If applicable)	2300	HI01
Principal Surgical Procedure Date (If applicable)	2300	HI01
Other Surgical Procedure Codes (Up to 24 codes)	2300	HI01-HI12, plus a second segment HI01-HI12
Other Surgical Procedure Dates (If applicable)	2300	HI01-HI12, plus a second segment HI01-HI12
Procedure Coding Method Used/ Code List Qualifier Code	2300	HInn-1
Occurrence Span Code (Up to 4 codes will be used)	2300	HInn-2
Occurrence Span Code Associated Dates (up to 4 will be collected)	2300	HInn-4

	THCIC 837 INSTITUTIONAL LOCATION	THCIC 837 INSTITUTIONAL LOCATION
DATA ELEMENT	***Loop***	***Ref. Des.***
Occurrence Code (Up to 12 codes will be used)	2300	HInn-2
Occurrence Code Associated Dates (Up to 12 codes will be used)	2300	HInn-4
Value Code (Up to 12 codes will be used)	2300	HInn-2
Value Code Associated Amount (Up to 12 codes will be used)	2300	HInn-5
Condition Code (Up to 8 codes will be used)	2300	HInn-2
Attending Physician Name	2310A	NM103, NM104, and NM105
Attending Physician Number	2310A	NM109 (NPI) or REF02 (State License)
Operating or Other Physician Name	2310B	NM103, NM104, and NM105
Operating or Other Physician Number	2310B	NM109 (NPI) or REF02 (State License)
Total Claim Charges	2300	CLM02
Accommodations Revenue Codes or Revenue Codes	2400	SV201
HCPCS/HIPPS Procedure Codes	2400	SV202-2
HCPCS/HIPPS Procedure Code Modifiers	2400	SV202-3 to SV202-6
Accommodation Total Charges or Charge Amount	2400	SV203
Ancillary Charges Total or Charge Amount	2400	SV203
Unit Code	2400	SV204
Accommodations Days or Unit Quantity	2400	SV205
Units of Service or Unit Quantity	2400	SV205
Accommodations Rate or Unit Rate	2400	SV206
Provider Name	2010AA or 2310E	NM103
Provider Address	2010AA or 2310E	N301
Provider City	2010AA or 2310E	N401
Provider ZIP Code	2010AA or 2310E	N403
Provider National Provider Identification Number (NPI)	2010AA or 2310E	NM109
Provider Tax Identification (EIN)	2010AA or 2310E	REF02
Provider THCIC ID Identification (6 Digit) number assigned by THCIC	2010AA or 2010BB or 2310E	REF02

Billing Claims Validation and Acceptance

All submitted claims are audited and validated for adherence to the THCIC 837 specifications prior to being accepted for processing by System13, Inc. Audits required for validation include, at a minimum, those audits specified in the 5010 Inpatient and Outpatient Appendices found at https://www.dshs.texas.gov/texas-health-care-information-collection/facility-reporting-requirements/inpatient-data-reporting-requirements. Audits will be applied at the data element level or record level and without regard to other billing claim records previously received for a provider or a patient.

System Resources and Availability

The system is available to collect and accept data from submitters seven (7) days a week, twenty-four (24) hours a day.

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

System13, Inc. Technical Requirements – Enrollment and Submission

Provider enrollment / signature requirements

See the "THCIC Submitter and Provider Enrollment Guide".

Submission validations and audits summary

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

1. Each billing claims submission must contain at least one valid file, including valid file header /trailer records.
2. A file/Transaction Set must contain one valid claim for the file/Transaction Set to be accepted.
3. Claim file numbers may not be reused within six months of acceptance of the first use of the batch number.
4. Claim detail charges and claim counts must balance with batch and file totals.
5. Claims submission may contain only valid record types/Data segments as defined in the ANSI 837 specifications.
6. All fields defined as number must contain numerical data.
7. All fields designated as required date fields must contain valid dates. Dates must be submitted in CCYYMMDD format including the patient's birth date. All other date fields may contain a valid date or may be blank or zero filled.

Auditing of Data by System13, Inc.

Audits are listed in the 5010 Inpatient and Outpatient Appendices found on the THCIC website at https://www.dshs.texas.gov/thcic/hospitals/HospitalReportingRequirements.shtm.

5010_Inpatient_and_Outpatient_Appendices, Latest Version contains default codes, payer source codes, audit list, race/ethnicity documents, and other helpful information.

On page 19, we have available for your convenience:

APPENDIX - A5 INPATIENT & OUTPATIENT AUDIT ID'S THCIC

Table A Pre-Processing Audits (Format Check) (Example)

Audit MSG. ID	Audit Description
Example:	**Example:**
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.

And on page 28, we have available for your convenience:

Table B Claim Level Audit's (Example)

Audit	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	**Error**

5 THCIC 837 File Specifications

Reference Information

The THCIC 837 claim format draws from the specifications for the ANSI 837 health care claim format published in the American National Standards Institutes, Accredited Standards Committee X12, National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional, 837, ASC X12N 837 (005010X223), May 2006 version, and the addenda published by the Washington Publishing Company in October 2007 (**ANSI 837 Institutional Guide,** 005010X223A2) which can be purchased from the following website:

X12 Store ANSI 837 Institutional Guide

Only the sections and segments that are required or situational required by THCIC that are different from the ANSI 837 Institutional Guide sections are written in this manual. Following is a table of the data elements that have been modified from the ANSI 837 Institutional Guide to meet the THCIC requirements for data submission.

A rule of thumb: If a hospital or vendor submits a HIPAA compliant ANSI 837 Institutional Guide formatted file with the additional required fields listed below, that data file should pass the audits at System13, Inc.

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

Table 1: THCIC data elements where usage differs from ANSI 837 Institutional Guide

Data Elements	Loop	Ref. Des.	Difference from ANSI 837 Institutional Manual
National Provider Identification (NPI) number (*facility*)	2010AA or 2310E[1]	NM109	The Name segments in Loop 2310E are dependent upon who renders the service
Employer Identification Number	2010AA or 2310E[1]	REF02 (or NM109)	The REF segment in Loop 2010AA and 2310E are SITUATIONAL and would be required if the NPI is submitted in NM109 of the same loop
Facility ID Number (THCIC ID #)	2010AA or 2010BB[2] or 2310E	REF02	REF Segment is situational for all loops. Loop is dependent upon who renders the service to patient. Loop 2010BB usage is changed to "SITUATIONAL" from "REQUIRED" since this THCIC ID could be submitted in Loop 2010AA REF02
Claim Filing Indicator Code	2000B or 2320	SBR09	SBR09
Subscriber/Patient Social Security Number	2010BA	REF02	REF segment

Data Elements	Loop	Ref. Des.	Difference from ANSI 837 Institutional Manual
Patient Social Security Number	2300	K301	K3 segment (Required, if patient is not listed as the subscriber and SSN reported in 2010BA | REF02. SSN moves to 3rd -11th characters with change to new contract in response to HB 2641 84th Texas Legislature)
Patient Race	2300	K301	K3 segment second character (with change to new contract in response to HB 2641 84th Texas Legislature)
Principal and Admitting Diagnosis	2300	HI01–HI12	Bill Type 4XX and 5XX in the addenda were provided exemptions in the ANSI 837 Institutional guide.
Patient Ethnicity	2300	K301	K3 segment first character (with change to new contract in response to HB 2641 84th Texas Legislature)
Type of Admission (Priority (Type) of Admission)	2300	CL101	CL segment
Source of Admission (Point of Origin for Admission or Visit)	2300	CL101	CL segment
Patient Status	2300	CL101	CL segment
Medical Record Number	2300	REF02	REF segment
Attending Physician Number	2310A	NM109 REF02	NM1 segment REF segment
Attending Physician Name	2310A	NM103	NM segment
Subscriber Name	2010BA	NM103-Last NM104-First NM105-MI	Segment is situational for THCIC submissions, only required if Subscriber is Patient
External Cause of Injury[3]	2300	HI01–HI10	HI11 and HI12 excluded

1 Dependent on which facility is indicated as rendering the services to the patient
2 Loop 2010BB (REF Segment) would not be used if THCIC ID reported in Loop 2010AA
3 Allows for up to 10 External Cause of Injury codes

Basic Structure

The X12 standards define commonly used business transactions in a formal, structured manner called transaction sets. A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of: a unique segment ID; one or more logically related simple data elements or composite data structures, or both, each proceeded by a data element separator; and a segment terminator.

Composite data structures are composed of one or more logically related component data elements. Each composite data structure is followed by a component element separator with the exception of the last one element. The data segment directory entry referenced by the data segment ID defines the sequence of simple data elements and composite data structures in the segment, and any interdependencies that may exist. The composite data structure directory entry referenced by the composite data structure number defines the sequence of component data elements in the composite data structure.

A data element in the transaction set header identifies the type of transaction set. A functional group contains one or more related transaction sets preceded by a functional group header control segment and terminated by a functional group trailer control segment.

Control Segments

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

Delimiters

A delimiter (from Section B.1.1.2.5 of ANSI 837 Institutional Guides) is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered in implementations compliant with this guide to be a 105-byte fixed length record, followed by a segment terminator. The data element separator is byte number 4; the repetition separator is byte number 83; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in the Delimiters Table below for all examples of EDI transmissions.

Delimiter Examples

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element will result in errors in translation. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

Element Attributes

Attributes for each element include a Requirement Designator, Data Type, and Minimum Length/Maximum Length.

Requirement Designator

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

Data Type

AN	Alphanumeric
ID	Identifier
DT	Date
NO	Number
R	Decimal
TM	Time

Control Segment Elements Breakout

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

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

Repeat: 1

Notes:
1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange.

Example: Spaces in the example are represented by "." for clarity.
ISA*00*..........*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*YTH837.........*141031*1253*^*00501*000000905*1*T*:~

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** **Fixed Length Positions: Begin 5, End 6** Code to identify the type of information in the Authorization Information **THCIC will accept either code** **CODE DEFINITION** **00 NO AUTHORIZATION INFORMATION PRESENT** **03 ADDITIONAL DATA IDENTIFICATION**	**M ID 2/2**
REQUIRED	**ISA02**	**I02**	**Authorization Information** **Fixed Length Positions: Begin 8, End 17** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M AN 10/10**
REQUIRED	**ISA03**	**I03**	**Security Information Qualifier** **Fixed Length Positions: Begin 19, End 20** Code to identify the type of information in the Security Information **THCIC will accept either** **CODE DEFINITION** **00 NO SECURITY INFORMATION PRESENT** **01 PASSWORD**	**M ID 2/2**

REQUIRED **ISA04** **I04** **Security Information** **M AN 10/10**
Fixed Length Positions: Begin 22, End 31

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

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M ID 2/2**
Fixed Length Positions: Begin 33, End 34

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

THIS ID QUALIFIES THE SENDER IN ISA06.

CODE	DEFINITION
ZZ	MUTUALLY DEFINED

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M AN 15/15**
Fixed Length Positions: Begin 36, End 50

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

CODE	DEFINITION
SUBNNN	SYSTEM13, INC. SUBMITTER ID NUMBER

(Must be obtained from System13 Inc.)

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M ID 2/2**
Fixed Length Positions: Begin 52, End 53

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

THIS ID QUALIFIES THE RECEIVER IN ISA08.

CODE	DEFINITION
ZZ	MUTUALLY DEFINED

REQUIRED **ISA08** **I07** **Interchange Receiver ID** **M AN 15/15**
Fixed Length Positions: Begin 55, End 69

Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them.

CODE	DEFINITION
YTH837	Required for 837 claim submissions

REQUIRED **ISA09** **I08** **Interchange Date** **M DT 6/6**
Fixed Length Positions: Begin 71, End 76
Date of the interchange
The date format is YYMMDD.

REQUIRED **ISA10** **I09** **Interchange Time** **M TM 4/4**
Fixed Length Positions: Begin 78, End 81
Time of the interchange.
The time format is HHMM.

REQUIRED **ISA11** **I10** **Repetition Separator** **M ID 1/1**
Fixed Length Positions: Begin 83, End 83
Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator.

CODE	DEFINITION
^	**REPETITION SEPARATOR**

(Carat is THCIC RECOMMENDED)

REQUIRED **ISA12** **I11** **Interchange Control Version Number** **M ID 5/5**
Fixed Length Positions: Begin 85, End 89
This version number covers the interchange control segments

CODE	DEFINITION
00501	**APPROVED VERSION**

REQUIRED **ISA13** **I12** **Interchange Control Number** **M NO 9/9**
Fixed Length Positions: Begin 91, End 99
This version number covers the interchange control segments

The Interchange Control Number, ISA13, must be Identical to the associated Interchange Trailer

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M ID 1/1**
Fixed Length Positions: Begin 101, End 101
Code sent by the sender to request an interchange acknowledgment (TA1)
THCIC will accept either code

CODE	DEFINITION
0	**NO ACKNOWLEDGMENT REQUESTED**
1	**INTERCHANGE ACKNOWLEDGMENT REQUESTED**

Submitters will receive an Acknowledgement and a Claim Acceptance Response Report, regardless of which code is submitted

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

Fixed Length Positions: Begin 103, End 103

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

CODE	DEFINITION
P	**PRODUCTION DATA**

Submitters must be on the approved Submitter List at System13, Inc. prior to submitting Production Data

T	**TEST DATA**

Submitter must submit test to System13, Inc. and receive approval prior to submitting production data

REQUIRED	**ISA16**	**I15**	**Component Element Separator**	**M**	**ID 1/1**

Fixed Length Positions: Begin 105, End 105

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

RECOMMENDED CODE SEPARATORS

* - STAR
: - COLON
~ - TILDE

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

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

Repeat: 1

Example: **IEA*1*000000905~**

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M N0 1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender **NUMBER MUST MATCH NUMBER IN ISA13**	**M N0 9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

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

Repeat: 1

Example: **GS*HC*SENDER CODE*RECEIVER CODE* 19940331* 0802* 1*X* 005010X223~**

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **CODE DEFINITION** **HC HEALTH CARE CLAIM (837)**	**M ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **CODE DEFINITION** **SUBnnn SYSTEM13, INC. SUBMITTER ID NUMBER This is the same ID as in ISA06. The Submitter ID must be obtained from System13, Inc.**	**M AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission Codes agreed to by trading partners **CODE DEFINITION** **YTH837 REQUIRED FOR THCIC**	**M AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD SEMANTIC: GS04 is the group date **Use this date for the functional group creation date.**	**M DT 8/8**
REQUIRED	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00- 59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) SEMANTIC: GS05 is the group time. **Use this time for the functional group creation time.**	**M TM 4/8**
REQUIRED	**GS06**	**28**	**Group Control Number** Assigned number originated and maintained by the sender SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.	**M N0 1/9**

REQUIRED	**GS07**	**455**	**Responsible Agency Code** Code used in conjunction with Data Element 480 to identify the issuer of the standard	**M ID 1/2**
			CODE **DEFINITION** **X** **ACCREDITED STANDARDS COMMITTEE X12**	
REQUIRED	**GS08**	**480**	**Version / Release / Industry Identifier Code**	**M AN**
	1/12		Code indicating the version, release, sub release, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and sub release, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed	

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

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

Repeat: 1

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

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M N0 1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender SEMANTIC: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06. **MUST MATCH THE NUMBER IN GS06**	**M N0 1/9**

THCIC Transaction Set

Table 1 Header

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
0050	ST	Transaction Set Header	R	1	
0100	BHT	Beginning of Hierarchical Transaction	R	1	
		LOOP ID – 1000A SUBMITTER NAME	R		1
0200	NM1	Submitter Name	R	1	
		LOOP ID – 1000B RECEIVER NAME	R		1
0200	NM1	Receiver Name	R	1	

Table 2 Detail – Billing Provider Hierarchical Level

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000A Billing Provider HIERARCHICAL LEVEL	R		>1
0010	HL	Billing/ Provider Hierarchical Level	R	1	
		LOOP ID – 2010AA BILLING PROVIDER NAME	R		1
0150	NM1	Billing Provider Name	R	1	
0250	N3	Billing Provider Address	R	1	
0300	N4	Billing Provider City/State/ZIP Code	R	1	
0350	REF	Billing Provider Tax Identification	R	1	
0350	REF	Billing Provider THCIC Identification	S	1	
		LOOP ID – 2010AB PAY-TO PROVIDER NAME	S		1
0150	NM1	Pay-To Provider Name	S	1	
0250	N3	Pay-To Provider Address	R	1	
0300	N4	Pay-To Provider City/State/ZIP Code	R	1	

Table 2 Detail – Subscriber Hierarchical Level

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000B SUBSCRIBER HIERARCHICAL LEVEL	R		>1
0010	HL	Subscriber Hierarchical Level	R	1	
0050	SBR	Subscriber Information	R	1	
		LOOP ID – 2010BA SUBSCRIBER NAME **"Required" if the "Subscriber" is the "Patient" otherwise "Not Used"**	S		1
0150	NM1	Subscriber Name	R/N	1	
0250	N3	Subscriber Address	R/N	1	
0300	N4	Subscriber City/State/ZIP Code	R/N	1	
0320	DMG	Subscriber Demographic Information	R/N	1	
0350	REF	Subscriber Secondary Identification	R/N	1	
		LOOP ID - 2010BB PAYER NAME	R		1
0150	NM1	Payer Name	R	1	
0350	REF	Billing Provider Secondary Identification	S	1	

Table 2 Detail – Patient Hierarchical Level

POS.#	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID – 2000C PATIENT HIERARCHICAL LEVEL	S		>1
0010	HL	Patient Hierarchical Level	S	1	
0070	PAT	Patient Information	R	1	
		LOOP ID – 2010CA PATIENT NAME	**S**		1
		Required" if "Subscriber" is the "Patient", otherwise "Not Used".			
0150	NM1	Patient Name	N/R	1	
0250	N3	Patient Address	N/R	1	
0300	N4	Patient City/State/ZIP Code	N/R	1	
0320	DMG	Patient Demographic Information	N/R	1	
		LOOP ID – 2300 CLAIM INFORMATION	**R**		100
1300	CLM	Claim Information	R	1	
1350	DTP	Discharge Hour	S	1	
1350	DTP	Statement Dates	R	1	
1350	DTP	Admission Date/Hour	R	1	
1400	CL1	Institutional Claim Code	R	1	
1800	REF	Medical Record Number	S	1	
1850	K3	State Required Data Elements (Patient Ethnicity, Race Codes and Patient SSN) File Information	S	10	
		SSN is "Not-Used" if "Subscriber" is the "Patient", otherwise "Required".	S		
2310	HI	Principal, Diagnosis	R	1	
2310	HI	Admitting Diagnosis	S	1	
2310	HI	External Cause of Injury	S	1	
2310	HI	Other Diagnosis Information	S	2	
2310	HI	Principal Procedure Information	S	1	
2310	HI	Other Procedure Information	S	2	
2310	HI	Occurrence Span Information	S	2	
2310	HI	Occurrence Information	S	2	
2310	HI	Value Information	S	2	
2310	HI	Condition Information	S	2	
		LOOP ID - 2310A ATTENDING PHYSICIAN NAME	R		1
2500	NM1	Attending Physician Name	R	1	
2710	REF	Attending Physician Secondary Identification	R	5	
		LOOP ID - 2310B OPERATING PHYSICIAN NAME	S		1
2500	NM1	Operating Physician Name	S	1	
2710	REF	Operating Physician Secondary Identification	S	5	
		LOOP ID - 2310E SERVICE FACILITY NAME	S		1
2500	NM1	Service Facility Name	S	1	
2650	N3	Service Facility Address	R	1	
2700	N4	Service Facility City/State/Zip Code	R	1	
2710	REF	Service Facility Secondary Identification	S	3	
		LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION	S		10
2900	SBR	Other subscriber Information	S	1	
		LOOP ID – 2330B OTHER PAYER NAME	S		1

3250	**NM1**	Other Payer Name	**R**	**1**	
		LOOP ID 2400 SERVICE LINE NUMBER	**R**		**999**
3650	**LX**	Service Line Number	**R**	**1**	
3750	**SV2**	Institutional Service Line	**R**	**1**	
5550	**SE**	Transaction Trailer	**R**	**1**	

Segment ID Breakout

IMPLEMENTATION

ST TRANSACTION SET HEADER

Usage: REQUIRED

Repeat: 1

Example **ST*837*987654*005010X223A2~**

ELEMENT SUMMARY

USAGE	REF.DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **CODE DEFINITION** **837 HEALTH CARE CLAIM**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Number in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could be sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.**	**M AN 4/9**
REQUIRED	**ST03**	**1705**	**Implementation Convention Reference** **This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (ST-SE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is used at translation time.**	**O AN 1/35**

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION

Usage: REQUIRED

Repeat: 1

Example **BHT*0019*00*0123*20141030*0932*CH~**

BHT Beginning of Hierarchical Transaction

ELEMENT SUMMARY

USAGE	REF.DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set **CODE DEFINITION** **0019 INFORMATION SOURCE, SUBSCRIBER, DEPENDENT**	**M ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set BHT02 is intended to convey the electronic transmission status of the 837, batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. **THCIC will accept either code and will treat both as an original submission.** **CODE DEFINITION** **00 ORIGINAL** **18 REISSUE**	**M ID 2/2**
REQUIRED	**BHT03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Originator Application Transaction Identifier SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system. **Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.** **The Reference Identification must not be duplicated or reused within 12 months.**	**O AN 1/50**

REQUIRED	**BHT04**	**373**	**Date** Date expressed as CCYYMMDD INDUSTRY: Transaction Set Creation Date SEMANTIC: BHT04 is the date the transaction was created within the business application system. Use this date to identify the date on which the submitter created the file.	**O**	**DT**	**8/8**
REQUIRED	**BHT05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) INDUSTRY: Transaction Set Creation Time SEMANTIC: BHT05 is the time the transaction was created within the business application system. **Use this time to identify the time of day that the submitter created the file.**	**O**	**TM**	**4/8**
REQUIRED	**BHT06**	**640**	**Transaction Type Code** Code specifying the type of transaction INDUSTRY: Claim or Encounter Identifier ALIAS: Claim or Encounter Indicator **THCIC WILL ACCEPT EITHER CODE.**	**O**	**ID**	**2/2**

CODE	DEFINITION
CH	**CHARGEABLE**
RP	**REPORTING**
31	**SUBROGATION DEMAND- THE SUBROGATION DEMAND CODE IS ONLY FOR USE BY STATE MEDICAID AGENCIES PERFORMING POST PAYMENT RECOVERY CLAIMING WITH WILLING TRADING PARTNERS.**

NOTE: AT THE TIME OF THIS WRITING, SUBROGATION DEMANDS IS NOT A HIPAA MANDATED USE OF THE 837 TRANSACTION SET.

IMPLEMENTATION

SUBMITTER NAME

Loop: 1000A — SUBMITTER NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. See ANSI 837 Institutional Claim Guide Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000.

Example: **NM1*41*2*ABC Submitter*****46*SUB###~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF.DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **CODE DEFINITION** **41 SUBMITTER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 **CODE DEFINITION** **1 PERSON** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization** **Individual last name or organizational name** **INDUSTRY: Submitter Last or Organization Name** **ALIAS: Submitter Name**	**O AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Submitter First Name ALIAS: Submitter Name **Required if NM102=1 (person).**	**O AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Submitter Middle Name ALIAS: Submitter Name **Required if NM102=1 and the middle name/initial of the person is known**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE** **DEFINITION** **46** **ELECTRONIC TRANSMITTER IDENTIFICATION NUMBER (ETIN) Established by a trading partner agreement**	**X**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Submitter Identifier ALIAS: Submitter Primary Identification Number **CODE** **DEFINITION** **SUBnnn** **SYSTEM13, INC. SUBMITTER ID NUMBER This must match ISA06 and GS02**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organizational Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

RECEIVER NAME

Loop: 1000B — RECEIVER NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. See ANSI 837 Institutional Claim Guide Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000.

Example: **NM1*40*2*THCIC*****46*YTH837~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an Individual **CODE DEFINITION** **40 RECEIVER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Receiver Name **CODE DEFINITION** **THCIC IDENTIFIES THCIC AS THE RECEIVER**	**X AN 1/60**
			Code designating the system/method of code structure used for Identification Code (67) INDUSTRY: Information Receiver Identification Number **CODE DEFINITION** **46 ELECTRONIC TRANSMITTER IDENTIFICATION NUMBER (ETIN)**	
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier**	**X ID 1/2**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Receiver Primary Identifier ALIAS: Receiver Primary Identification Number	**X**	**AN**	**2/80**
			CODE DEFINITION **YTH837 RECEIVER CODE FOR THCIC**			
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

BILLING PROVIDER HIERARCHICAL LEVEL

Loop: 2000A - BILLING PROVIDER HIERARCHICAL LEVEL Repeat: >1

Usage: REQUIRED

Repeat: 1

Notes:
1. Use the Billing Provider HL to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.
2. The Billing Provider Hierarchical Level may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.
3. If the Service Facility Provider is the same entity as the Billing or the Pay-to Provider then do not use Loop 2310E.
4. THCIC uses the provider HLs as base for batching claim submissions. Each set of claims for a provider HL results in one set of reports. Multiple provider HLs will result in multiple sets of reports. Thus, the number of provider HLs should be minimized where possible, to reduce the numbers of reports that must be reviewed.

Example: **HL*1**20*1~**

HL Hierarchical Level

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.**	**M AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O AN 1/12**

REQUIRED	**HL03**	**35**	**Hierarchical Level Code**	**M ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction.

CODE	DEFINITION
20	INFORMATION SOURCE

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

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

COMMENT: HL04 indicates whether there are subordinate (or child) HL segments related to the current HL segment.

The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).

CODE	DEFINITION
1	ADDITIONAL SUBORDINATE HL DATA SEGMENT IN THIS HIERARCHICAL STRUCTURE.

IMPLEMENTATION

BILLING PROVIDER NAME

Loop: 2010AA — BILLING PROVIDER NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.

Example: **NM1*85*2*JONES HOSPITAL*****XX*45609312~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM102**	**1065**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **CODE DEFINITION** **85 BILLING PROVIDER** **Use this code to indicate billing provider.**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **This is the name of the facility as reported to Bureau of Facility Licensing, Texas Department of Health** INDUSTRY: Billing Provider Last or Organizational Name ALIAS: Billing Provider Name	**O AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE DEFINITION** **XX CMS NATIONAL PROVIDER IDENTIFIER**	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** **This data element is REQUIRED by THCIC and shall be submitted here unless another facility is rendering the services in which case the information will be submitted in Loop 2310E NM109** **This data element is used in conjunction with the THCIC ID, and the 1st 15 characters of the address to identify the facility's data. The information in this field must be provided and on file with THCIC for data submissions to be identified** INDUSTRY: Billing Provider Identifier ALIAS: Billing Provider Primary ID **CODE DEFINITION** **XXXXXXXXXX NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI)** **nnnnnnnnnn Employer Identification Number - THCIC will allow for EIN to be submitted here for facility identification purposes.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**ID**	**1/60**

IMPLEMENTATION

BILLING PROVIDER ADDRESS

Loop: 2010AA — BILLING PROVIDER NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. The first 15 characters of N301 are used to validate the billing provider.

Example: **N3*225 MAIN STREET BARKLEY BUILDING~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information **No Post Office Box numbers are allowed** INDUSTRY: Billing Provider Address Line	**M AN 1/40**
SITUATIONAL	**N302**	**166**	**Address Information** **Address information** **No Post Office Box numbers are allowed** INDUSTRY: Billing Provider Address Line **Required if a second address line exists.**	**O AN 1/25**

IMPLEMENTATION

BILLING PROVIDER CITY/STATE/ZIP CODE

Loop: 2010AA — BILLING PROVIDER NAME

Usage: REQUIRED

Repeat: 1

Example: **N4*CENTERVILLE*PA*17111**~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name INDUSTRY: Billing Provider City Name	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Billing Provider State or Province Code CODE SOURCE 22: States and Outlying Areas of the U.S.	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (ZIP code for United States) INDUSTRY: Billing Provider Postal Zone or ZIP Code. CODE SOURCE 51: ZIP Code **WHEN REPORTING THE ZIP CODE FOR U.S. ADDRESSES, THE FULL NINE DIGIT ZIP CODE MUST BE PROVIDED for HIPAA compliant Claims. THCIC will not be requiring the full Nine-Digit Code.**	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**X ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X ID 1/3**

IMPLEMENTATION

BILLING PROVIDER TAX IDENTIFICATION

Loop: 2010AA — BILLING PROVIDER NAME
Usage: REQUIRED
Segment Repeat: 1
Notes:
1. This is the tax identification number (TIN) of the entity to be paid for the submitted services.
2. This is used as part of facility identification, if NPI is not provided in NM109 of this segment (2010AA – Billing Provider Name).

Example: **REF*EI*123456789~**

REF Reference

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE DEFINITION** **EI Employer's Identification Number** The Employer's Identification Number must be a string of exactly nine numbers with no separators. For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **CODE DEFINITION** **nnnnnnnnn Employer Identification Number**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

BILLING PROVIDER THCIC IDENTIFICATION

Loop: 2010AA — BILLING PROVIDER NAME

Usage: SITUATIONAL

Segment Repeat: 1 - (THCIC will allow a second REF segment, not allowed for billing translators)

Notes:
1. THCIC will allow for a second REF segment in Loop 2010AA. THCIC requires that the THCIC ID (6-digit number assigned by THCIC) and either NPI or whatever is placed in Loop 2010AA | NM109) and the 1st 15 characters of street address (Loop 2010AA | N301) be submitted to identify those facilities. If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310E.
2. ANSI X12N removed the other seven (7) REF segments in the ANSI X12N 837 5010 Institutional Guide and moved the Billing Provider Secondary Identification to Loop 2010BB (Payer Name) in the Subscriber Hierarchical Level. THCIC allows for either location to be used.

Example: **REF*1J*nnnnnn~**

(nnnnnn = THCIC ID assigned by THCIC staff)

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

REF Reference

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE** **DEFINITION** **1J** **Facility ID Number (THCIC ID);** ***Required by THCIC*** The Employer's Identification Number must be a string of exactly nine numbers with no separators. For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **CODE** **DEFINITION** **nnnnnn** **THCIC ID NUMBER (6-digit number assigned by THCIC)**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

PAY-TO ADDRESS NAME

Loop: 2010AB — PAY-TO ADDRESS NAME
Usage: SITUATIONAL
Repeat: 1
Notes:
1. Required by THCIC when the Pay-To Provider renders services for the patient.
5. Required if the Pay-to Provider is a different entity than the Billing Provider.
6. If this entity is the Service Facility Provider, it is not necessary to use the Service Facility Provider NM1 loop, loop 2310E.

Example: **NM1*87*2*ELLIS HOSPITAL*****24*123456789~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **87 PAY-TO PROVIDER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
NOT USED	**NM103**	**1035**	**Name Last or Organization Name**	**X AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X ID 1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X AN 2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X ID 2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O ID 2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O AN 1/60**

IMPLEMENTATION

PAY-TO ADDRESS - ADDRESS

Loop: 2010AB — PAY-TO PROVIDER NAME

Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required by THCIC when the Pay-To Provider renders services for the patient.
2. If Pay-To Provider is the service provider, the 1st 15 characters of N301 will be used to validate the provider.

Example: **N3*2216 N. MAIN STREET*COLDER BUILDING~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Pay-To Provider Address Line No Post Office Box numbers are allowed	**M AN 1/40**
SITUATIONAL	**N302**	**166**	**Address Information** Address information (No Post Office Box numbers are allowed) INDUSTRY: Pay-To Provider Address Line No Post Office Box numbers are allowed **Required if a second address line exists.**	**O AN 1/25**

IMPLEMENTATION

PAY-TO ADDRESS CITY/STATE/ZIP CODE

Loop: 2010AB — PAY-TO ADDRESS NAME

Usage: SITUATIONAL

Repeat: 1

Notes: **1.** Required by THCIC when the Pay-To Provider renders services for the patient.

Example: **N4*AUSTIN*TX*78701*~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name INDUSTRY: Pay-to Provider City Name	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Pay-to Provider State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Pay-to Provider Postal Zone or ZIP Code. CODE SOURCE 51: ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**X ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X ID 1/3**

IMPLEMENTATION

SUBSCRIBER HIERARCHICAL LEVEL

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL Repeat:

>1 Usage: REQUIRED

Repeat: 1

Notes:
1. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA).

Example: **HL*124*123*22*1~**

HL Hierarchical Level

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. **CODE** **DEFINITION** **22** **SUBSCRIBER**	**M ID 1/2**

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

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

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 = 0) or when HL04 has subordinate levels indicated (HL04 = 1).

In the first case (HL04 the subscriber is the patient and there are no dependent claims. The second case (HL04 = 1) happens when claims/encounters for a dependent is being sent under the same billing provider HL (e.g., a father has insurance and son is in an automobile accident).

CODE	DEFINITION
0	NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL STRUCTURE.
1	ADDITIONAL SUBORDINATE (DEPENDENT) HL DATA SEGMENT IN THIS HIERARCHICAL STRUCTURE.

IMPLEMENTATION

SUBSCRIBER INFORMATION

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL

Usage: REQUIRED

Repeat: 1

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

SBR Subscriber Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim **CODE — DEFINITION** **P — PRIMARY**	**M ID 1/1**
SITUATIONAL	**SBR02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities ALIAS: Patients Relationship to Insured SEMANTIC: SBR02 specifies the relationship to the person insured. **SITUATIONAL RULE: Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.** **CODE — DEFINITION** **18 — SELF**	**O ID 2/2**
NOT USED	**SBR03**	**127**	**Reference Identification**	**O AN 1/50**
NOT USED	**SBR04**	**93**	**Name**	**O AN 1/60**
NOT USED	**SBR05**	**1336**	**Insurance Type Code**	**O ID 1/3**
NOT USED	**SBR06**	**1143**	**Coordination of Benefits Code**	**O ID 1/1**
NOT USED	**SBR07**	**1073**	**Yes/No Condition or Response Code**	**O ID 1/1**
NOT USED	**SBR08**	**584**	**Employment Status Code**	**O ID 2/2**

SITUATIONAL SBR09 1032 Claim Filing Indicator Code O ID 1/2
Code identifying type of claim

CODE	DEFINITION
11	OTHER NON-FEDERAL PROGRAMS
12	PREFERRED PROVIDER ORGANIZATION (PPO)
13	POINT OF SERVICE (POS)
14	EXCLUSIVE PROVIDER ORGANIZATION (EPO)
15	INDEMNITY INSURANCE
16	HEALTH MAINTENANCE ORGANIZATION (HMO) MEDICARE RISK
17	DENTAL MAINTENANCE ORGANIZATION
AM	AUTOMOBILE MEDICAL
BL	BLUE CROSS/BLUE SHIELD
CH	CHAMPUS
CI	COMMERCIAL INSURANCE CO.
DS	DISABILITY
FI	FEDERAL EMPLOYEES PROGRAM
HM	HEALTH MAINTENANCE ORGANIZATION
LM	LIABILITY MEDICAL
MA	MEDICARE PART A
MB	MEDICARE PART B
MC	MEDICAID
OF	OTHER FEDERAL PROGRAM USE CODE "OF" WHEN SUBMITTING MEDICARD PART D CLAIMS OR HEALTH EXCHANGE INSURANCE PLANS (UNTIL OTHERWISE DIRECTED)
TV	TITLE V
VA	VETERAN ADMINISTRATION PLAN
WC	WORKERS' COMPENSATION HEALTH CLAIM
ZZ	MUTUALLY DEFINED, OR SELF-PAY, OR UNKNOWN, OR CHARITY. USE CODE "ZZ" WHEN TYPE OF INSURANCE IS SELF-PAY OR UNKNOWN AT TIME OF SUBMISSION TO THCIC.

IMPLEMENTATION

SUBSCRIBER NAME

Loop: 2010BA — SUBSCRIBER NAME
Usage: SITUATIONAL
Repeat: 1
Notes:
1. The Subscriber Name is REQUIRED when the subscriber is the patient.
2. Subscriber Name data segment is "NOT USED" if Subscriber is NOT the Patient.

Example: **NM1*IL*1*DOE*JOHN*T***MI*739004273~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE — DEFINITION** **IL — INSURED OR SUBSCRIBER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE — DEFINITION** **1 — PERSON** **2 — NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Subscriber Last Name **FOR PATIENTS THAT ARE COVERED BY 42 USC 290DD-2 OR 42 CFR PART2 AND FACILITIES THAT ARE PARTICIPATING WITH SAMHSA, USE THE FOLLOWING LAST NAME: DOE.**	**X AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **FOR PATIENTS THAT ARE COVERED BY 42 USC 290DD-2 OR 42 CFR PART2 AND FACILITIES THAT ARE PARTICIPATING WITH SAMHSA, USE ONE OF THE FOLLOWING NAMES: "JANE" IF FEMALE, OR "JOHN" IF MALE. HOSPITALS MAY INCLUDE A SEQUENTIAL NUMBER, E.G., JOHN1, JOHN2, JOHN3.**	**O AN 1/35**

INDUSTRY: Subscriber First Name
SITUATIONAL RULE: Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.

SITUATIONAL	**NM105**	**1037**	**Name Middle**	**O**	**AN**	**1/25**

Individual middle name or initial
INDUSTRY: Subscriber Middle Name
ALIAS: Subscriber's Middle Initial
SITUATIONAL RULE: Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.

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

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

This data element is required when NM102 equals one (1).

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

CODE	DEFINITION
II	**STANDARD UNIQUE HEALTH IDENTIFIER FOR EACH, INDIVIDUAL IN THE UNITED STATES- REQUIRED IF THE HIPAA INDIVIDUAL PATIENT IDENTIFIER IS MANDATED USE. IF NOT REQUIRED, USE VALUE `MI' INSTEAD.**
MI	**MEMBER IDENTIFICATION NUMBER MI:MEMBER IDENTIFICATION NUMBER- THE CODE MI IS INTENDED TO BE THE SUBSCRIBER'S IDENTIFICATION NUMBER AS ASSIGNED BY THE PAYER. (FOR EXAMPLE, INSURED'S ID, SUBSCRIBER'S ID, HEALTH INSURANCE CLAIM NUMBER (HIC), ETC.)**
	MI: IS ALSO INTENDED TO BE USED IN CLAIMS SUBMITTED TO THE INDIAN HEALTH SERVICE/CONTRACT HEALTH SERVICES (IHS/CHS) FISCAL INTERMEDIARY FOR THE PURPOSE, OF REPORTING THE TRIBE RESIDENCY CODE (TRIBE COUNTY STATE). IN THE EVENT, THAT A SOCIAL SECURITY NUMBER (SSN)

IS ALSO AVAILABLE ON AN IHS/CHS CLAIM, PUT THE SSN IN REF02.

WHEN SENDING THE SOCIAL SECURITY NUMBER AS THE MEMBER ID, SUBMIT SSN ALSO IN THE LOOP 2010BA SUBSCRIBER SECONDARY IDENTIFICATION SEGMENT (REF02). IT MUST BE A STRING OF EXACTLY NINE NUMBERS WITH NO SEPARATORS. FOR EXAMPLE, SENDING "111002222" WOULD BE VALID, WHILE SENDING "111-00-2222" WOULD BE INVALID.

NOT USED	NM109	67	Identification Code	X	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3
NOT USED	NM112	1035	Name Last or Organizational Name	O	AN	1/60

IMPLEMENTATION

SUBSCRIBER ADDRESS

Loop: 2010BA — SUBSCRIBER NAME
Usage: SITUATIONAL

Situational Rule: REQUIRED when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send. REQUIRED when Loop ID 2000B | SBR02 =18 (self).

Example: **N3*125 CITY AVENUE~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Subscriber Address Line	**M AN 1/40**
SITUATIONAL	**N302**	**166**	**Address Information** Address information INDUSTRY: Subscriber Address Line **SITUATIONAL RULE: Required when there is a second address line. If not required by this implementation guide, do not send.**	**O AN 1/25**

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP CODE

Loop: 2010BA — SUBSCRIBER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. This segment is REQUIRED when the Patient is the same person as the Subscriber. (REQUIRED when Loop ID 2000B | SBR02 =18 (self)).

Example: **N4*CENTERVILLE*PA*17111~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name INDUSTRY: Subscriber City Name	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Subscriber State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	**X ID 2/2**

CODE	DEFINITION
aa	**US STATE OR CANADIAN PROVINCE CODE (aa = state and province codes See Appendices for codes)**
FC	**FOREIGN COUNTRY (DEFAULT)**
XX	**FOREIGN COUNTRY**

THCIC will recognize either foreign country code

SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Subscriber Postal Zone or ZIP Code. CODE SOURCE 51: ZIP Code **THCIC: If the subscriber is the patient and the subscriber address and city are not in the U.S.A. or a Territory of U.S.A. the following codes should be used. Also, the Country Code in N404 will be required.** **CODE — DEFINITION** **00 — FOREIGN COUNTRY DEFAULT** **THCIC RECOMMENDED CODE** **XXXXX — FOREIGN COUNTRY DEFAULT** **SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country CODE SOURCE 5: Countries, Currencies and Funds **SITUATIONAL RULE: Required when the address is outside the United States of America. If not required by this implementation guide, do not send. Use the alpha-2 country codes from Part 1 of ISO 3166.** **See Appendices for Country Codes.**	**X**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**ID**	**1/3**

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: 2010BA — SUBSCRIBER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. This segment is REQUIRED when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B | SBR02 = 18 (self)).

Situational Rule: REQUIRED when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.

Example: **DMG*D8*19290730*M**5****~**

DMG Demographic Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X ID 2/3**
REQUIRED	**DMG02**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Subscriber Birth Date ALIAS: Date of Birth – Patient	**X AN 8/8**
REQUIRED	DMG03	1068	Gender Code Code indicating the sex of the individual INDUSTRY: Subscriber Gender Code ALIAS: Gender - Patient **CODE DEFINITION** **F FEMALE** **M MALE** **U UNKNOWN**	O ID 1/1
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O ID 1/1**
NOT USED	**DMG05**	**C056**	**Race Code**	**X ID 1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O ID 1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O ID 2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O ID 1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O R 1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X ID 1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X AN 1/3**

IMPLEMENTATION

SUBSCRIBER SECONDARY IDENTIFICATION

Loop: 2010BA — SUBSCRIBER NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. REQUIRED by THCIC when the subscriber is the patient (Loop ID 2000B SBR02=18 (self))

Situational Rule: REQUIRED when an additional identification number to that provided in **NM109** of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.

Example: **REF*SY*030385074~**

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE — DEFINITION** **SY — SOCIAL SECURITY NUMBER**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **CODE — DEFINITION** **nnnnnnnnn — SOCIAL SECURITY NUMBER THE SOCIAL SECURITY NUMBER MUST BE A STRING OF EXACTLY NINE NUMBERS WITH NO SEPARATORS. FOR EXAMPLE, SENDING "111002222" WOULD BE VALID, WHILE SENDING "111-00-2222" WOULD BE INVALID.** **999999999 — REQUIRED FOR: 1. NEWBORNS, WHOSE SSN IS UNKNOWN 2. FOREIGNERS WHO DO NOT HAVE A SOCIAL SECURITY NUMBER, 3. PATIENTS WHO CANNOT OR REFUSE TO PROVIDE A SOCIAL SECURITY NUMBER.** **INDUSTRY: Subscriber Supplemental Identifier**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

PAYER NAME

Loop: 2010BB — PAYER NAME
Usage: REQUIRED
Repeat: 1
Notes:
1. This is the destination payer.
2. For the purposes of this implementation the term payer is synonymous with several other terms, such as, reprise and third-party administrator.
3. This is the primary payer or only payer

Example: **NM1*PR*2*UNION MUTUAL OF TEXAS*****PI*43140~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE — DEFINITION** **PR — PAYER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE — DEFINITION** **2 — NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Payer Name **CODE — DEFINITION** **Self-Pay — USE FOR SELF- PAY CLAIMS (Loop 2000B | SBR09 = ZZ).** **Charity — USE FOR CHARITY CLAIMS (Loop 2000B | SBR09 = ZZ).** **Unknown — USE WHEN THE PAY SOURCE IS UNKNOWN (Loop 2000B | SBR09 = ZZ).**	**X AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

SITUATIONAL NM108 66 Identification Code Qualifier X ID 1/2

Code designating the system/method of code structure used for Identification Code (67)
On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent. Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent.

If a phase-in period is designated, PI must be sent unless:
1. Both the sender and receiver agree to use the National Plan ID,
2.The receiver has a National Plan ID, and
3.The sender has the capability to send the National Plan ID.
If all, of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.

CODE	DEFINITION
PI	**PAYER IDENTIFICATION** **Use for Payer Identification codes other than Self, Charity and Unknown**
XV	**HEALTH CARE FINANCING ADMINISTRATION NATIONAL PLAN ID** **Required when the National Plan ID is implemented.**
ZY	**USE FOR HEALTH PLAN IDENTIFIER (HPID), TEMPORARY IDENTIFICATION NUMBER, SELF PAY, CHARITY, OR UNKNOWN PAYER CLAIMS**

SITUATIONAL NM109 67 Identification Code X AN 2/80

Code identifying a party or other code
INDUSTRY: Payer Identifier
ALIAS: Primary Payer ID

Situational Rule: This is REQUIRED when Payer is Self-Pay, Charity Care or Payer is Unknown at the time of submission to THCIC.

CODE	DEFINITION
nnnnnnnnn	**NATIONAL HEALTH PLAN IDENTIFIER** **(CMS CURRENTLY HAS DELAYED THE IMPLEMENTATION DATE FOR ALL PLANS AND PROVIDERS UNTIL FURTHER NOTICE)**
SELF	**SELF-PAY CLAIMS** **(Loop 2000B | SBR09 = ZZ)**
CHARITY	**CHARITY CARE CLAIMS** **(Loop 2000B | SBR09 = ZZ)**

			UNKNOWN	**PAYER SOURCE IS UNKNOWN (Loop 2000B | SBR09 = ZZ)**		
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

BILLING PROVIDER SECONDARY IDENTIFICATION

Loop: 2010BB — BILLING PROVIDER NAME

Usage: SITUATIONAL

Repeat: 1

Notes:
1. If the THCIC ID is not submitted in a 2010AA REF segment REF01 (with qualifier "1J" in the REF02), then it is REQUIRED to be submitted here. THCIC REQUIRES that the THCIC ID (6-digit number assigned by THCIC) and NPI or whatever is submitted in in Loop 2010AA | NM109) and the 1st 15 characters of street address (Loop 2010AA | N301) be submitted to identify those facilities. If the Billing Provider is different than the facility rendering the services, this data is required to be submitted in Loop 2310E.

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

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **CODE** **DEFINITION** **1J** **FACILITY ID NUMBER**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Billing Provider Additional Identifier **CODE** **DEFINITION** **nnnnnn** **THCIC ID NUMBER (6 -DIGIT NUMBER ASSIGNED BY THCIC)**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

PATIENT HIERARCHICAL LEVEL

Loop: 2000C — PATIENT HIERARCHICAL LEVEL Repeat:

>1 Usage: SITUATIONAL

Repeat: 1

Notes: 1. This HL is required when the patient is a different person than the subscriber. There are no HLs subordinate to the Patient HL.

Situational Rule: Required when the patient is a dependent of the subscriber identified in Loop ID- 2000B and cannot be uniquely identified to the payer using the subscriber's identifier in the Subscriber Level. If not required by this implementation guide, do not send.

1. There are no HLs subordinate to the Patient HL.
2. If a patient is a dependent of a subscriber and can be uniquely identified to the payer by a unique Identification Number, then the patient is considered the subscriber and is to be identified in the Subscriber Level.

Example: **HL*125*124*23*0~**

HL Hierarchical Level

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction.	**M ID 1/2**

CODE	DEFINITION
23	DEPENDENT

23: Dependent- The code DEPENDENT conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.

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

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

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
0	NO SUBORDINATE HL SEGMENT IN THIS HIERARCHICAL

IMPLEMENTATION

PATIENT INFORMATION

Loop: 2000C — PATIENT HIERARCHICAL LEVEL

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required by THCIC when the Patient is a different person than the Subscriber.

Example: **PAT*19******01*145~**

PAT Patient Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PAT01**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities ALIAS: Patients Relationship to Insured **Use this code to specify the patient's relationship to the person insured.** **CODE — DEFINITION** **01 — SPOUSE** **18 — SELF** **19 — CHILD** **20 — EMPLOYEE** **21 — UNKNOWN** **39 — ORGAN DONOR** **40 — CADAVER DONOR** **53 — LIFE PARTNER** **G8 — OTHER RELATIONSHIP**	**O ID 2/2**
NOT USED	**PAT02**	**1384**	**Patient Location Code**	**O ID 1/1**
NOT USED	**PAT03**	**584**	**Employment Status Code**	**O ID 2/2**
NOT USED	**PAT04**	**1220**	**Student Status Code**	**O ID 1/1**
NOT USED	**PAT05**	**1250**	**Date, Time, Period Format Qualifier**	**X ID 2/3**
NOT USED	**PAT06**	**1251**	**Date, Time, Period**	**X AN 1/35**
NOT USED	**PAT07**	**355**	**Unit or Basis for Measurement Code**	**X ID 2/2**
NOT USED	**PAT08**	**81**	**Weight**	**X R 1/10**
NOT USED	**PAT09**	**1073**	**Yes/No Condition or Response Code**	**O ID 1/1**

IMPLEMENTATION

PATIENT NAME

Loop: 2010CA — PATIENT NAME
Usage: REQUIRED
Repeat: 1
Notes: 1. Required by THCIC when the Patient is a different person than the Subscriber.
Example: **NM1*QC*1*DOE*SALLY****MI*123456789~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **QC PATIENT**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Patient Last Name **FOR PATIENTS THAT ARE COVERED BY 42 USC 290DD-2 OR 42 CFR PART2 AND FACILITIES THAT ARE PARTICIPATING WITH SAMHSA, USE THE FOLLOWING LAST NAME: DOE.** **SITUATIONAL RULE: Required when the person has a first name. If not required by this implementation guide, do not send.**	**O AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Patient First Name **FOR PATIENTS THAT ARE COVERED BY 42 USC 290DD-2 OR 42 CFR PART2 AND FACILITIES THAT ARE PARTICIPATING WITH SAMHSA, USE ONE OF THE FOLLOWING NAMES: "JANE" IF FEMALE, OR "JOHN" IF MALE. HOSPITALS MAY INCLUDE A SEQUENTIAL NUMBER, E.G., JOHN1, JOHN2, JOHN3.**	**O AN 1/35**

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

IMPLEMENTATION

PATIENT ADDRESS

Loop: 2010CA — PATIENT NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. Required by THCIC when the Patient is a different person than the Subscriber.

Example: **N3*RFD 10*100 COUNTRY LANE~**

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Patient Address Line	**M AN 1/40**
SITUATIONAL	**N302**	**166**	**Address Information** Address information INDUSTRY: Patient Address Line **SITUATIONAL RULE: Required when there is a second address line. If not required by this implementation guide, do not send.**	**O AN 1/25**

IMPLEMENTATION

PATIENT CITY/STATE/ZIP CODE

Loop: 2010CA — PATIENT NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. Required by THCIC when the Patient is a different person than the Subscriber.

Example: **N4*CORNFIELD TOWNSHIP*IA*99999~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name INDUSTRY: Patient City Name	**O AN 2/30**
SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Patient State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S. **CODE — DEFINITION** **aa — US STATE OR CANADIAN PROVINCE CODE (aa = state and province codes See Appendices for codes)** **FC — FOREIGN COUNTRY (DEFAULT)** **XX — FOREIGN COUNTRY** **THCIC will recognize either foreign country code.** **SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.**	**X ID 2/2**
SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (ZIP code for United States) INDUSTRY: Patient Postal Zone or ZIP Code. CODE SOURCE 51: ZIP Code **If the subscriber is the patient and the subscriber address and city are not in the U.S.A. or a Territory of U.S.A the following codes should be used. Also, the Country Code in N404 will be required.**	**O ID 3/15**

				CODE DEFINITION 00000 FOREIGN COUNTRY (THCIC RECOMMENDED CODE) XXXXX FOREIGN COUNTRY **SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.**			
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country CODE SOURCE 5: Countries, Currencies, and Funds **SITUATIONAL RULE: Required when the address is outside the United States of America. If not required by this implementation guide, do not send.** Use the alpha-2 country codes from Part 1 of ISO 3166. **See Appendices for Country Codes.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**
NOT USED	**N407**	**1715**	**Country Subdivision Code**	**X**	**ID**	**1/3**

IMPLEMENTATION

PATIENT DEMOGRAPHIC INFORMATION

Loop: 2010CA — PATIENT NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. Required by THCIC when the Patient is a different person than the Subscriber.

Example: **DMG*D8*19290730*M**5****~**

DMG Demographic Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Patient Birth Date	**X ID 2/3**
REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Patient Birth Date	**X AN 8/8**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual INDUSTRY: Patient Gender Code **CODE DEFINITION** **F FEMALE** **M MALE** **U UNKNOWN**	**O ID 1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O ID 1/1**
NOT USED	**DMG05**	**C056**	**Race Code**	**X ID 1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O ID 1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O ID 2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O ID 1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O R 1/15**
NOT USED	**DMG10**	**1270**	**Code List Qualifier Code**	**X ID 1/3**
NOT USED	**DMG11**	**1271**	**Industry Code**	**X AN 1/30**

IMPLEMENTATION

CLAIM INFORMATION

Loop: 2300 — CLAIM INFORMATION Repeat: 100
Usage: REQUIRED
Repeat: 1
Notes:

1. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST- SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.
2. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this, the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, Loop ID- 2300, is placed following Loop ID-2010BB in the Subscriber Hierarchical Level (HL) when patient information is sent in Loop ID-2010BA of the Subscriber HL. Claim information is placed in the Patient HL when the patient information is sent in Loop ID-2010CA of the Patient HL. When the patient is the subscriber or considered to be the subscriber, Loop ID-2000C and Loop ID-2010CA are not sent. See Subscriber/Patient HL Segment explanation in section 1.4.3.2.2.1 for details.

Example: **CLM*01319300001*500***11:A:1*Y*A*Y*Y***02******N~**

CLM Health Claim

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CLM01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment INDUSTRY: Patient Account Number ALIAS: Patient Control Number **The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly**	**M AN 1/38**

recommend that submitters use unique numbers for this field for each individual claim.
When Loop ID-2010AC is present, CLM01 represents the subrogated Medicaid agency's claim number (ICN/DCN) from their original 835 CLP07 - Payer Claim Control Number. See Section 1.4.1.4 of the front matter for a description of post payment recovery claims for subrogated Medicaid agencies.
The maximum number of characters to be supported for this field is '20'. Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.

REQUIRED	**CLM02**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

Monetary amount
INDUSTRY: Total Claim Charge Amount
SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim.
The Total Claim Charge Amount must be greater than or equal to zero.
The total claim charge amount must balance to the sum of all service line charge amounts reported in the Institutional Service Line (SV2) segments for this claim

NOT USED	**CLM03**	**1032**	**Claim Filing Indicator Code**	**O**	**ID**	**1/2**
NOT USED	**CLM04**	**1343**	**Non-Institutional Claim Type Code**	**O**	**ID**	**1/2**
REQUIRED	**CLM05**	**C023**	**HEALTH CARE SERVICE LOCATION INFORMATION**	**O**		

To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered. ALIAS: Type of Bill

REQUIRED	**CLM05 - 1**	**1331**	**Facility Code Value**	**M**	**AN**	**1/2**

Code identifying the type of facility where services were performed. These are the first and second digits of the Uniform Billing Claim Form Bill Type.
INDUSTRY: Facility Type Code

CODE	DEFINITION
11	**HOSPITAL INPATIENT, INCLUDING MEDICARE A**
12	**HOSPITAL INPATIENT MEDICARE PART B**
18	**HOSPITAL SWING BEDS**
21	**SKILLED NURSING FACILITY INPATIENT, INCLUDING MEDICARE A**
28	**SKILLED NURSING FACILITY SWING BEDS**
32	**HOME HEALTH INPATIENT MEDICARE PART B**
41	**RELIGIOUS NON-MEDICAL HEALTH CARE - INPATIENT, INCLUDING MEDICARE A**
65	**INTERMEDIATE CARE – LEVEL I**
66	**INTERMEDIATE CARE – LEVEL II**

82	**SPECIAL FACILITY - HOSPICE (HOSPITAL BASED)**
85	**SPECIAL FACILITY – CRITICAL ACCESS HOSPITAL**
86	**SPECIAL FACILITY – RESIDENTIAL FACILITY**

REQUIRED **CLM05 - 21332** **Facility Code Qualifier** **O ID 1/2**
Code identifying the type of facility referenced

CODE	DEFINITION
A	**UNIFORM BILLING CLAIM FORM BILL TYPE**

CODE SOURCE 236: Uniform Billing Claim Form Bill Type

REQUIRED **CLM05 - 3 1325** **Claim Frequency Type Code** **O ID 1/1**
Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.

INDUSTRY: Claim Frequency Code

CODE	DEFINITION
0	**NON-PAYMENT/ZERO CLAIM**
1	**ADMIT THROUGH DISCHARGE CLAIM**
2	**INTERIM - FIRST CLAIM**
3	**INTERIM - CONTINUING CLAIM**
4	**INTERIM - LAST CLAIM**
5	**LATE CHARGE(S) - ONLY CLAIM**
7	**REPLACEMENT OF PRIOR CLAIM**
8	**VOID/CANCEL OF PRIOR CLAIM**

For interim claims, code 2 is reported first, then code 3 (if necessary, for as many claims as needed), then code 4 as the last/final interim claim. Code 2 must be sent before codes 3 or 4. Code 3, if sent, must be sent before code 4.

NOT USED	**CLM06**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM07**	**1359**	**Provider Accept Assignment Code**	**O**	**ID**	**1/1**
NOT USED	**CLM08**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM09**	**1363**	**Release of Information Code**	**O**	**ID**	**1/1**
NOT USED	**CLM10**	**1351**	**Patient Signature Source Code**	**O**	**ID**	**1/1**
NOT USED	**CLM11**	**C024**	**RELATED CAUSES INFORMATION**	**O**		
NOT USED	**CLM12**	**1366**	**Special Program Code**	**O**	**ID**	**2/3**
NOT USED	**CLM13**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM14**	**1338**	**Level of Service Code**	**O**	**ID**	**1/3**
NOT USED	**CLM15**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM16**	**1360**	**Provider Agreement Code**	**O**	**ID**	**1/1**
NOT USED	**CLM17**	**1029**	**Claim Status Code**	**O**	**ID**	**1/2**
NOT USED	**CLM18**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM19**	**1383**	**Claim Submission Reason Code**	**O**	**ID**	**2/2**
NOT USED	**CLM20**	**1514**	**Delay Reason Code**	**O**	**ID**	**1/2**

IMPLEMENTATION

DISCHARGE HOUR

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Situational Rule: Required on all final inpatient claims. If not required by this implementation guide, do not send.

Example: **DTP*096*TM*1130~**

DTP Date or Time or Period

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier **CODE DEFINITION** **096 DISCHARGE**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **CODE DEFINITION** **TM TIME EXPRESSED IN FORMAT HHMM**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times NDUSTRY: Discharge Time	**M AN 1/35**

IMPLEMENTATION

STATEMENT DATES

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

Example: **DTP*434*RD8*19981209-19981214~**

DTP Date or Time or Period

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier **CODE DEFINITION** **434 STATEMENT**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **CODE DEFINITION** **RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Statement From and To Date	**M AN 1/35**

IMPLEMENTATION

ADMISSION DATE/HOUR

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL
Repeat: 1

Situational Rule: Required on inpatient claims.
If not required by this implementation guide, do not send.

Example: **DTP*435*DT*199610131242~**

DTP Date or Time or Period

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier **CODE DEFINITION** **435 ADMISSION**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **CODE DEFINITION** **DT DATE AND TIME EXPRESSED IN FORMAT CCYYMMDDHHMM** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD SELECTION OF THE APPROPRIATE QUALIFIER IS DESIGNATED BY THE NUBC BILLING MANUAL.**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Admission Date and Hour **EXAMPLES:** **CCYYMMDD – 20150120 (JANUARY 20, 2015)** **CCYYMMDDHHMM – 201501200830 (JANUARY 20, 2015 8:30 AM)**	**M AN 1/35**

IMPLEMENTATION

INSTITUTIONAL CLAIM CODE

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

Notes: 1. This segment is REQUIRED when reporting hospital-based admissions.

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

CL1 Claim Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**CL101**	**1315**	**Admission Type Code** Code indicating the priority of this admission CODE SOURCE: Priority (Type) of Visit, National Uniform Billing Committee UB-04 Manual **SITUATIONAL RULE: Required when patient is being admitted for inpatient services. If not required by this implementation guide, do not send.**	**O ID 1/1**
SITUATIONAL	**CL102**	**1314**	**Admission Source Code** Code indicating the source of this admission CODE SOURCE: Point of Origin for Admission or Visit, National Uniform Billing Committee UB–04 Manual **SITUATIONAL RULE: Required for all inpatient and outpatient services. If not required by this implementation guide, do not send.**	**O ID 1/1**
REQUIRED	**CL103**	**1352**	**Patient Status Code** Code indicating patient status as of the "statement covers through date" CODE SOURCE: Patient Discharge Status code, National Uniform Billing Committee UB-04 Manual **This element is required for inpatient claims/encounters.**	**O ID 1/2**
NOT USED	**CL104**	**1345**	**Nursing Home Residential Status Code**	**O ID 1/1**

IMPLEMENTATION

MEDICAL RECORD NUMBER

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

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

Example: **REF*EA*1230484376R~**

REF Reference Identification

ELEMENT SUMMARY

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

IMPLEMENTATION

K3 – STATE REQUIRED DATA ELEMENTS

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 10

Notes:
1. Required to report PATIENT SOCIAL SECURITY NUMBER if the subscriber is not the patient and Social Security Number is not submitted in Loop 2010BA REF02.
2. THCIC requires that the Patient's Social Security Number be submitted to be used in conjunction with other submitted data elements to generate the uniform patient identification for longitudinal studies and epidemiological studies.
3. Per the requirements of Texas Government Code, Title 4, Section 531.0162, to meet national standard reporting requirements, the "Patient Ethnicity" and "Patient Race" is collected in the K3 segment. The adopted location for "Patient Ethnicity" is the 1st character of the K301 data field, the "Patient Race" is the 2nd character, and the "Patient's Social Security Number" is in the 3rd through 11th character slots.

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

Example:

K3*25999999999

Example of a "Non- Hispanic/Latino" and "Other or multiple race", with no known SSN.

K3*14999999999

Example of "Hispanic/Latino" of "White" race, with no known SSN.

Required Rule:
1. Required to report ETHNICITY code (Patient or Subscriber).
2. Required to report RACE code (Patient or Subscriber).
3. In order to obtain RACE and ETHNICITY data, the facility staff retrieves the patient's response from a written form or asks the patient, or the person speaking for the patient, to classify the patient. If the patient, or person speaking for the patient, declines to answer, the facility staff is to use its best judgment to make the correct classification based on available data.
4. THCIC requires that the patient's Social Security Number (SSN) be submitted to be used in conjunction with other submitted data elements to generate the uniform patient identification for longitudinal studies and epidemiological studies.
5. Situational to report patient SSN as "Not Used" if Subscriber is the patient since the SSN would be submitted in REF02 of the Subscriber Loop 2010BA.

K3 State Required Data Elements

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**K301**	**449**	**Fixed Format Information** A free-form description to clarify the related data elements and their content	**M AN 1/80**

N ETHNICITY CODE **POSITION (1)**

CODE	DEFINITION
1	HISPANIC OR LATINO
2	NOT HISPANIC OR LATINO

N RACE CODE **POSITION (2)**

CODE	DEFINITION
1	AMERICAN INDIAN/ESKIMO/ALEUT
2	ASIAN OR NATIVE HAWAIIAN OR PACIFIC ISLANDER
3	BLACK OR AFRICAN AMERICAN
4	WHITE
5	OTHER RACE OR MULTIPLE RACES

SOCIAL SECURITY NUMBER **POSITIONS (3 - 11)**

CODE	DEFINITION
NNNNNNNNN	SOCIAL SECURITY NUMBER
999999999	1. Newborn that have no social security number 2. Foreigners who do not have a social security number 3. Patients who cannot or refuse to provide a social security number

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

IMPLEMENTATION

PRINCIPAL DIAGNOSIS

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

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

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

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**
			CODE **DEFINITION** **ABK** **INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) PRINCIPAL DIAGNOSIS**	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list CODE SOURCE 897: International Classification of Diseases Clinical Modification (ICD-10-CM).	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date, Time, Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
SITUATIONAL	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code** IMPLEMENTATION NAME: Present on Admission Indicator	**X ID 1/1**
			CODE **DEFINITION** **N** **NO** **U** **UNKNOWN** **W** **NOT APPLICABLE** **Y** **YES**	
			SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement	

			(1) Critical Access Hospitals; (2) Inpatient Rehabilitation Hospitals; (3) Inpatient Psychiatric Hospitals; (4) Cancer Hospitals; (5) Children's or Pediatric Hospitals; and (6) Long Term Care Hospitals	
NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O

IMPLEMENTATION

ADMITTING DIAGNOSIS

Loop: 2300 — CLAIM INFORMATION

Usage: REQUIRED

Repeat: 1

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

Example: **HI*ABJ:S98141A~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **ABJ** **INTERNATIONAL CLASSIFICATION DISEASES CLINICALMODIFICATION (ICD-10-CM) ADMITTING DIAGNOSIS CODE**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list Implementation Name: Admitting Diagnosis Code	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date, Time, Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
NOT USED	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**
NOT USED	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**

IMPLEMENTATION

EXTERNAL CAUSE OF INJURY

Loop: 2300 CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when an External Cause of Injury/Morbidity is needed to describe an injury, poisoning, or adverse effect. If not required by this implementation guide, do not send.

Notes:
1. Do not transmit the decimal point for ICD codes. The decimal point is implied.
2. In order to fully describe an injury using ICD-10-CM, it will be necessary to report a series of 3 external cause of injury/morbidity codes. The ICD-10-CM External Cause of Morbidity codes are in the V00-Y99 code group.

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

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **ABN** **INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list IMPLEMENTATION NAME: External Cause of Injury Code Code Source 897: International Classification of Diseases Clinical Mod. (ICD-10-CM).	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date, Time, Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**

SITUATIONAL	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts and quantities
SITUATIONAL RULE: Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.

REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)

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

Code indicating a code from a specific industry code list
IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI02 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**

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

Code indicating a code from a specific industry code list
IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI03 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**

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

Code indicating a code from a specific industry code list
IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI04 - 3**	**1250**	**Date, TimePeriod Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)

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

Code indicating a code from a specific industry code list

IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI05 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)

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

Code indicating a code from a specific industry code list

IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI06 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**

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

Code indicating a code from a specific industry code list
IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI07 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)

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

Code indicating a code from a specific industry code list

IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI08 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

SITUATIONAL	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SITUATIONAL RULE: Required as directed by the NUBC billing manual. IMPLEMENTATION NAME: Present on Admission Indicator **CODE DEFINITION** **N NO** **U UNKNOWN** **W NOT APPLICABLE** **Y YES** **SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement** **(1) Critical Access Hospitals;** **(2) Inpatient Rehabilitation Hospitals;** **(3) Inpatient Psychiatric Hospitals;** **(4) Cancer Hospitals;** **(5) Children's or Pediatric Hospitals; and** **(6) Long Term Care Hospitals**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities SITUATIONAL RULE: Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.	**O**		
REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**	**M**	**ID**	**1/3**
REQUIRED	**HI09 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list IMPLEMENTATION NAME: External Cause of Injury Code	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**

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

Code indicating a code from a specific industry code list

IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI10 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts and quantities
SITUATIONAL RULE: Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.

REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**

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

Code indicating a code from a specific industry code list
IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI11 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

To send health care codes and their associated dates, amounts and quantities SITUATIONAL RULE: Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.

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

Code identifying a specific industry code list

CODE	DEFINITION
ABN	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)**

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

Code indicating a code from a specific industry code list

IMPLEMENTATION NAME: External Cause of Injury Code

NOT USED	**HI12 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

IMPLEMENTATION

OTHER DIAGNOSIS INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 2

Situational Rule: Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment. If not required by this implementation guide, do not send.

Notes:
1. Required when other condition(s) coexist(s) with the principal diagnosis, coexist(s) at the time of admission, or develop(s) subsequently during the patient's treatment.
2. Do not transmit the decimal point for ICD codes. The decimal point is implied.

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

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **ABF** **INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date, Time, Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**

SITUATIONAL	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS

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

Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis

NOT USED	**HI02 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**

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

Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis

NOT USED	**HI01 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS

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

Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis

NOT USED	**HI04 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
NOT USED	**HI05 - 2**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SITUATIONAL RULE: Required as directed by the NUBC billing manual. IMPLEMENTATION NAME: Present on Admission Indicator	**X**	**ID**	**1/1**

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;

(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION			
			ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS			
REQUIRED	**HI06 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis			
NOT USED	**HI06 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
			Code indicating a Yes or No condition or response SITUATIONAL RULE: Required as directed by the NUBC billing manual. IMPLEMENTATION NAME: Present on Admission Indicator			
			CODE DEFINITION			
			N NO			
			U UNKNOWN			
			W NOT APPLICABLE			
			Y YES			
			SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement **(1) Critical Access Hospitals;** **(2) Inpatient Rehabilitation Hospitals;** **(3) Inpatient Psychiatric Hospitals;** **(4) Cancer Hospitals;** **(5) Children's or Pediatric Hospitals; and** **(6) Long Term Care Hospitals**			
SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION **ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**			
REQUIRED	**HI07 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis			
NOT USED	**HI07 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
			Code indicating a Yes or No condition or response SITUATIONAL RULE: Required as directed by the NUBC billing manual. IMPLEMENTATION NAME: Present on Admission Indicator			
			CODE DEFINITION **N NO** **U UNKNOWN** **W NOT APPLICABLE** **Y YES**			
			SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement **(1) Critical Access Hospitals;** **(2) Inpatient Rehabilitation Hospitals;** **(3) Inpatient Psychiatric Hospitals;** **(4) Cancer Hospitals;** **(5) Children's or Pediatric Hospitals; and** **(6) Long Term Care Hospitals**			
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE DEFINITION **ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**			

REQUIRED	**HI08 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis	**M**	**AN**	**1/30**
NOT USED	**HI08 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response SITUATIONAL RULE: Required as directed by the NUBC billing manual. IMPLEMENTATION NAME: Present on Admission Indicator	**X**	**ID**	**1/1**

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**

REQUIRED	**HI09 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**

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

Code indicating a code from a specific industry code list
INDUSTRY: Other Diagnosis

NOT USED	**HI10 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

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

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	**NO**
U	**UNKNOWN**
W	**NOT APPLICABLE**
Y	**YES**

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**

Code identifying a specific industry code list

CODE	DEFINITION
ABF	**INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS**

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

Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis

NOT USED	**HI11 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

Code indicating a Yes or No condition or response
SITUATIONAL RULE: Required as directed by the NUBC billing manual.
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities				
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list				

CODE	DEFINITION
ABF	INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS

REQUIRED	**HI12 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list			
			INDUSTRY: Other Diagnosis			
NOT USED	**HI12 - 3**	**1250**	**Date, Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
SITUATIONAL	**HI12 – 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
			Code indicating a Yes or No condition or response			
			SITUATIONAL RULE: Required as directed by the NUBC billing manual.			
			IMPLEMENTATION NAME: Present on Admission Indicator			

CODE	DEFINITION
N	NO
U	UNKNOWN
W	NOT APPLICABLE
Y	YES

SITUATIONAL RULE: The following hospitals are exempt from this POA submission requirement
(1) Critical Access Hospitals;
(2) Inpatient Rehabilitation Hospitals;
(3) Inpatient Psychiatric Hospitals;
(4) Cancer Hospitals;
(5) Children's or Pediatric Hospitals; and
(6) Long Term Care Hospitals

IMPLEMENTATION

PRINCIPAL PROCEDURE INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required on inpatient claims or encounters when a procedure was performed.
2. Do not transmit the decimal point for ICD codes. The decimal point is implied.

Example: **HI*BBR:009U0ZZ:D8:20160321~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **BBR** **INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-PCS) PRINCIPAL PROCEDURE CODES**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Principal Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M AN 1/30**
REQUIRED	**HI01 - 3**	**1250**	**Date Time, Period, Format Qualifier** Code indicating the date format, time format, or date and time format **CODE** **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD Use code D8 when the value in data element HI01-1 equals "BBR"**	**X ID 2/3**
REQUIRED	**HI01 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times **Required when HI01-3 is used**	**X AN 1/35**

NOT USED	HI01 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI01 - 6	380	Quantity	O	R	1/15
NOT USED	HI01 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI01 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O		

IMPLEMENTATION

OTHER PROCEDURE INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 2

Notes:
1. Required on inpatient claims or encounters when additional procedures must be reported.
2. Do not transmit the decimal point for ICD codes. The decimal point is implied

Example: **HI*BBQ:009R0ZX:D8:20160321~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE — DEFINITION** **BBQ — INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-PCS) OTHER PROCEDURE CODES**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M AN 1/30**
REQUIRED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE — DEFINITION** **D8 — DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**	**X ID 2/3**
REQUIRED	**HI01 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**

NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing**			
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			
REQUIRED	**HI02 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System **Code Source 897: International Classification of Diseases Procedural Coding System (ICD-10-PCS).**	**M**	**AN**	**1/30**
REQUIRED	**HI02 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
REQUIRED	**HI02 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing**			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			

REQUIRED	**HI03 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE** **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI03 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**	**M**	**ID**	**1/3**
REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI04 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE** **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI04 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			
REQUIRED	**HI05 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI05 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
			CODE **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**			
REQUIRED	**HI05 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			

REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI06 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI06 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI07C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BBQ INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**	**M**	**ID**	**1/3**
REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI07 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI07 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**

NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE **DEFINITION**			
			BBQ **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			
REQUIRED	**HI08 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System **Code Source 897: International Classification of Diseases Procedural Coding System (ICD-10-PCS).**			
REQUIRED	**HI08 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format			
REQUIRED	**HI08 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date			
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			
REQUIRED	**HI09 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI09 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
			CODE **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**			
REQUIRED	**HI09 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**O**		
			Used when necessary to report multiple additional co-existing conditions			
REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			
REQUIRED	**HI10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**

REQUIRED	**HI10 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE** **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI10 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions**	**O**		
REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASESPROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODE**	**M**	**ID**	**1/3**
REQUIRED	**HI11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI11 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE** **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI11 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE **DEFINITION** **BBQ** **INTERNATIONAL CLASSIFICATION OF DISEASES PROCEDURAL CODING SYSTEM (ICD-10-PCS) OTHER PROCEDURE CODES**			
REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Procedure Code CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System	**M**	**AN**	**1/30**
REQUIRED	**HI12 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
			CODE **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD - CCYYMMDD**			
REQUIRED	**HI12 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Procedure Date	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

OCCURRENCE SPAN INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when occurrence span information applies to the claim or encounter.
2. THCIC will collect a maximum of 4 occurrence span

Example: **HI*BI:70:RD8:20131202-20131212~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE — DEFINITION** **BI — OCCURRENCE SPAN**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
REQUIRED	**HI01 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE — DEFINITION** **RD8 — RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD**	**X ID 2/3**
REQUIRED	**HI01 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Span Code Associated Date	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**

SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE **DEFINITION**			
			BI **OCCURRENCE SPAN**			
REQUIRED	**HI02 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI02 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format			
			CODE **DEFINITION**			
			RD8 **RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD**			
REQUIRED	**HI02 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence or Occurrence Span Code Associated Date			
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE **DEFINITION**			
			BI **OCCURRENCE SPAN**			
REQUIRED	**HI03 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			

REQUIRED	**HI03 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format			
			CODE **DEFINITION** **RD8** **RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD**			
REQUIRED	**HI03 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence or Occurrence Span Code Associated Date			
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list			
			CODE **DEFINITION** **BI** **OCCURRENCE SPAN**			
REQUIRED	**HI04 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Span Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI04 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format			
			CODE **DEFINITION** **RD8** **RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD**			
REQUIRED	**HI04 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence or Occurrence Span Code Associated Date			
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
NOT USED	**HI05 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI05 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI05 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI06 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI06 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI06 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI07 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI07 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI08- 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI08 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI09 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI09- 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	HI09 - 6	380	Quantity	O	R	1/15
NOT USED	HI09 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O		
REQUIRED	HI10 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list CODE DEFINITION BI OCCURRENCE SPAN	M	ID	1/3
NOT USED	HI10- 2	1271	Industry Code	M	AN	1/30
NOT USED	HI10 - 3	1250	Date, Time, Period Format Qualifier	X	ID	2/3
NOT USED	HI10 - 4	1251	Date, Time, Period	X	AN	1/35
NOT USED	HI10 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI10 - 6	380	Quantity	O	R	1/15
NOT USED	HI10 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI10 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI11- 1	1270	Code List Qualifier Code	M	ID	1/3
NOT USED	HI11- 2	1271	Industry Code	M	AN	1/30
NOT USED	HI11 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI11 - 4	1251	Date, Time, Period	X	AN	1/35
NOT USED	HI11 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI11 - 6	380	Quantity	O	R	1/15
NOT USED	HI11 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI12 - 1	1270	Code List Qualifier Code	M	ID	1/3
NOT USED	HI12- 2	1271	Industry Code	M	AN	1/30
NOT USED	HI12 - 3	1250	Date, Time, Period Format Qualifier	X	ID	2/3
NOT USED	HI12 - 4	1251	Date, Time, Period	X	AN	1/35
NOT USED	HI12 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI12 - 6	380	Quantity	O	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

IMPLEMENTATION

OCCURRENCE INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required when occurrence information applies to the claim or encounter.
2. THCIC will collect a maximum of 12 occurrences.

Example: **HI*BH:42:D8:19981208~**

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
REQUIRED	**HI01 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X ID 2/3**
REQUIRED	**HI01 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**

SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE DEFINITION **BH OCCURRENCE**			
REQUIRED	**HI02 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI02 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
			CODE DEFINITION **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI02 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE DEFINITION **BH OCCURRENCE**			
REQUIRED	**HI03 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**

REQUIRED	**HI03 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
			CODE DEFINITION **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI03 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE DEFINITION **BH OCCURRENCE**			
REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI04 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
			CODE DEFINITION **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI04 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI05 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI05 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI05 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**

REQUIRED	**HI06 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format			
			CODE DEFINITION **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date			
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**			
REQUIRED	**HI07 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI07 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI07 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence or Occurrence Span Code Associated Date			
NOT USED	**HI07 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**

NOT USED	**HI07- 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**	**M**	**ID**	**1/3**
REQUIRED	**HI08 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI08 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI08 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **Used when necessary to report multiple additional co-existing conditions.**	**M**	**ID**	**1/3**

REQUIRED	**HI09 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI09 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI09 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date			
NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
			Code identifying a specific industry code list **CODE DEFINITION** **BH OCCURRENCE**			
REQUIRED	**HI10 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
			Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI10 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format **CODE DEFINITION** **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI10 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date			
NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE DEFINITION **BH OCCURRENCE**			
REQUIRED	**HI11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI11 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
			CODE DEFINITION **D8 DATE EXPRESSED IN FORMAT CCYYMMDD**			
REQUIRED	**HI11 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE DEFINITION **BH OCCURRENCE**			

REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Occurrence Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
REQUIRED	**HI12 - 3**	**1250**	**Date, Time, Period Format Qualifier** Code indicating the date format, time format, or date and time format **CODE** **DEFINITION** **D8** **DATE EXPRESSED IN FORMAT CCYYMMDD**	**X**	**ID**	**2/3**
REQUIRED	**HI12 - 4**	**1251**	**Date, Time, Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Occurrence Code Associated Date	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

VALUE INFORMATION[1]

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when value information applies to the claim or encounter.
2. THCIC will collect a maximum of 12 occurrences.

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

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date, Time, Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Value Code Amount**	**O R 1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O R 1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O AN 1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X AN 1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X ID 1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M ID 1/3**

REQUIRED	**HI02 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI02 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M**	**ID**	**1/3**
REQUIRED	**HI03 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI03 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M**	**ID**	**1/3**

REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI04 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI05 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M**	**ID**	**1/3**
REQUIRED	**HI05 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI05 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M**	**ID**	**1/3**
REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code	**M**	**AN**	**1/30**

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

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

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

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

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

CODE	DEFINITION
BE	**Value**

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

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

NOT USED	**HI07 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		

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

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

REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BE	**Value**

REQUIRED	**HI08 – 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI08 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI09 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M**	**ID**	**1/3**
REQUIRED	**HI09 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI09- 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BE Value**	**M**	**ID**	**1/3**

REQUIRED	**HI10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI10 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **BE** **Value**	**M**	**ID**	**1/3**
REQUIRED	**HI11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI11 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI11 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI11 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI12 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE** **DEFINITION** **BE** **Value**	**M**	**ID**	**1/3**

REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Value Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI12 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12- 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI12 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI12 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

IMPLEMENTATION

CONDITION INFORMATION

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required when condition information applies to the claim or encounter.
2. THCIC will collect a maximum of 8 occurrences.

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

HI Health Care Information Codes

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M ID 1/3**
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M AN 1/30**
NOT USED	**HI01 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X ID 2/3**
NOT USED	**HI01 - 4**	**1251**	**Date, Time, Period**	**X AN 1/35**
NOT USED	**HI01 - 5**	**782**	**Value Code Amount**	**O R 1/18**

NOT USED	**HI01 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI01 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI01 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**			
REQUIRED	**HI02 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI02 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI02 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI02 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	HI03	C022	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI03 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI03 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI03 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI03 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI03 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**

SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI04 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI04 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI04 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI04 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI04 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI05 – 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI05 - 2**	**1271**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/30**
NOT USED	**HI05 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI05- 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI05 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts, and quantities			
			Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI06 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI06 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI06 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI06 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI06 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		
REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI07 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI07 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI07 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts, and quantities **Used when necessary to report multiple additional co-existing conditions.**	**O**		

REQUIRED	**HI08 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **CODE DEFINITION** **BG CONDITION**	**M**	**ID**	**1/3**
REQUIRED	**HI08 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: Condition Code CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	**M**	**AN**	**1/30**
NOT USED	**HI08 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI08- 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI08 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI08 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI09 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI09 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI09 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI09 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI09 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI10 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI10 - 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI10 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI10 - 8**	**1271**	**Industry Code**	**X**	**AN**	**1/30**
NOT USED	**HI10 - 9**	**1073**	**Yes/No Condition or Response Code**	**X**	**ID**	**1/1**
NOT USED	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
NOT USED	**HI11 - 1**	**1270**	**Code List Qualifier Code**	**M**	**ID**	**1/3**
NOT USED	**HI11- 2**	**1271**	**Industry Code**	**M**	**AN**	**1/30**
NOT USED	**HI11 - 3**	**1250**	**Date, Time, Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date, Time, Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Value Code Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O		
NOT USED	HI12 - 1	1270	Code List Qualifier Code	M	ID	1/3
NOT USED	HI12 - 2	1271	Industry Code	M	AN	1/30
NOT USED	HI12 - 3	1250	Date, Time, Period Format Qualifier	X	ID	2/3
NOT USED	HI12 - 4	1251	Date, Time, Period	X	AN	1/35
NOT USED	HI12 - 5	782	Value Code Amount	O	R	1/18
NOT USED	HI12 - 6	380	Quantity	O	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

IMPLEMENTATION

ATTENDING PHYSICIAN OR PRACTITIONER NAME

Loop: 2310A — ATTENDING PHYSICIAN OR PRACTITIONER NAME

Usage: REQUIRED

Repeat: 1

Notes: 1. Required on all inpatient claims or encounters.
2. Must use physician or practitioner individual NPI, not group practice NPI and not institutional NPI.

Example: **NM1*71*1*JONES*JOHN****XX*1234567890~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** **CODE DEFINITION** **71 Attending Physician**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last** Individual last name INDUSTRY: Attending Physician or Practitioner Last Name	**X AN 1/35**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: Attending Physician or Practitioner First Name	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: Attending Physician or Practitioner Middle Name **Required if the middle name/initial of the person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name INDUSTRY: Attending Physician or Practitioner Name Suffix **Required if known.**	**O AN 1/10**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE** **DEFINITION** **XX** **CMS NATIONAL PROVIDER IDENTIFIER Required if NO State License Number Submitted in 2310A REF02** Note: Must use physician or practitioner individual NPI, not group practice NPI and not institutional NPI.	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Attending Physician or Practitioner Primary Identifier	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**ID**	**1/60**

IMPLEMENTATION

ATTENDING PHYSICIAN OR PRACTITIONER NAME

Loop: 2310A — ATTENDING PHYSICIAN OR PRACTITIONER NAME

Usage: SITUATIONAL

Repeat: 4

Notes: 1. REQUIRED by THCIC to report the Practitioner's state license or if the National Provider Identification Number is NOT submitted in Loop 2310A NM109.

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

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification Required if National Provider Identifier is NOT Submitted in Loop 2310A, NM109 **CODE DEFINITION** **0B STATE LICENSE NUMBER**	**M ID 2/3**
SITUATIONAL	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Attending Physician or Practitioner Secondary Identifier Required if National Provider Identifier is NOT Submitted in Loop 2310A, NM109	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

OPERATING PHYSICIAN NAME

Loop: 2310B — OPERATING PHYSICIAN NAME

Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required by THCIC when any surgical procedure code is listed on this claim.
2. For THCIC reporting, the operating physician name is that of the individual that performed the principal procedure.
3. Must use physician or practitioner individual NPI, not group practice NPI and not institutional NPI.

Example: **NM1*72*1*MEYERS*JANE****XX*1234567890~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	ATTRIBUTES	NAME		
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** **CODE DEFINITION** **72 OPERATING PHYSICIAN**	**M**	**ID**	**2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **CODE DEFINITION** **1 PERSON**	**M**	**ID**	**1/1**
REQUIRED	**NM103**	**1035**	**Name Last** Individual last name **INDUSTRY**: Operating Physician Last Name	**X**	**AN**	**1/35**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name **INDUSTRY:** Operating Physician First Name	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **INDUSTRY:** Operating Physician Middle Name **This data element is required when NM102 equals one (1) and the Middle Name or Initial of the person is known by the provider.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name **INDUSTRY:** Operating Physician Name Suffix **Required if known**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE** **DEFINITION** **XX** **NATIONAL PROVIDER IDENTIFIER** **Required if no State License Number or NPI is submitted when applicable in Loop 2310B REF02** Note: Must use physician or practitioner individual NPI, not group practice NPI and not institutional NPI	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **INDUSTRY:** Operating Physician Primary Identifier **Required if no State License Number or NPI is submitted when applicable in Loop 2310B REF02**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O**	**ID**	**1**

IMPLEMENTATION

OPERATING PHYSICIAN SECONDARY IDENTIFICATION

Loop: 2310B — OPERATING PHYSICIAN NAME

Usage: SITUATIONAL

Repeat: 4

Notes: 1. REQUIRED by THCIC to report the Operating Practitioner's state license or if the National Provider Identification Number is NOT submitted in Loop 2310B NM109.

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

REF Reference Identification

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **Required by THCIC to report if the National Provider Identification Number is NOT submitted in Loop 2310B NM109** **CODE DEFINITION** **0B STATE LICENSE NUMBER**	**M ID 2/3**
SITUATIONAL	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Operating Physician Secondary Identifier **Required by THCIC to report if the National Provider Identification Number is NOT submitted in Loop 2310B NM109**	**X AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

SERVICE FACILITY LOCATION NAME

Loop: 2310E — SERVICE FACILITY LOCATION NAME
Usage: SITUATIONAL
Repeat: 1
Notes:
1. Required by THCIC when the Service Facility Provider is different than the Billing Provider or the Pay-To Provider.
2. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.

Example: **NM1*FA*2*Rehab Facility*****XX*1234567890~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE DEFINITION** **FA FACILITY**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE DEFINITION** **2 NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Laboratory or Facility Name	**O AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **CODE DEFINITION** **24 EMPLOYER'S IDENTIFICATION NUMBER Required by THCIC** **XX CMS NATIONAL PROVIDER IDENTIFIER (*FACILITY*)**	**X ID 1/2**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier	**X**	**AN**	**2/80**

CODE	**DEFINITION**
nnnnnnnnnn	**EMPLOYER IDENTIFICATION NUMBER**
xxxxxxxxx	**NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI)**

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

IMPLEMENTATION

SERVICE FACILITY LOCATION ADDRESS

Loop: 2310E — SERVICE FACILITY LOCATION NAME

Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required by THCIC if the Service Facility Provider is different than the Billing Provider or the Pay-To Provider.
2. Required if Service Facility Name segment is used.
3. If the Service Facility is used, THCIC requires that the THCIC ID (Loop 2310E | REF01), the Employer Identification Number (EIN / Tax ID, in Loop 2310E | NM109), and the first **15** characters of street address (Loop 2310E | N301) be submitted to identify those facilities.

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

N3 Address Information

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information INDUSTRY: Laboratory or Facility Address Line **Do not use PO Box**	**M AN 1/ 40**
SITUATIONAL	**N302**	**166**	**Address Information** Address information INDUSTRY: Laboratory or Facility Address Line **Do not use PO Box** **Required if a second address line exists**	**M AN 1/ 40**

IMPLEMENTATION

SERVICE FACILITY LOCATION CITY/STATE/ZIP CODE

Loop: 2310E — SERVICE FACILITY LOCATION NAME

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required by THCIC if the Service Facility Provider is different than the Billing Provider or the Pay-To Provider.

Example: **N4*ANY TOWN*TX*75123~**

N4 Geographic Location

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name	**O AN 2/30**
REQUIRED	**N402**	**156**	**INDUSTRY: Laboratory or** Facility City Name State or Province Code Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Laboratory or Facility State or Province Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	**X ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (ZIP code for United States) INDUSTRY: Laboratory or Facility Postal Zone or ZIP Code. CODE SOURCE 51: ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**X ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**
SITUATIONAL	**N407**	**1715**	**Country Subdivision Code**	**X ID 1/3**

IMPLEMENTATION

SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

Loop: 2310E — SERVICE FACILITY LOCATION NAME

Usage: SITUATIONAL

Repeat: 3

Notes:
1. Required by THCIC if the Service Facility Provider is different than the Billing Provider.

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

REF Reference Identification

ELEMENT SUMMARY

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

IMPLEMENTATION

OTHER SUBSCRIBER INFORMATION

Loop: 2320 — OTHER SUBSCRIBER INFORMATION Repeat:

10 Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required if other payers are known to potentially be involved in paying on this claim.
2. THCIC collects secondary payer data for only the first secondary payer reported.
3. All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is reported, run the 2320 Loop again with its respective 2330 Loops.

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

SBR Subscriber Information

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim **CODE DEFINITION** **S SECONDARY**	**M ID 1/1**
NOT USED	**SBR02**	**1069**	**Individual Relationship Code**	**O ID 2/2**
NOT USED	**SBR03**	**127**	**Reference Identification**	**O AN 1/50**
NOT USED	**SBR04**	**93**	**Name**	**O AN 1/60**
NOT USED	**SBR05**	**1336**	**Insurance Type Code**	**O ID 1/3**
NOT USED	**SBR06**	**1143**	**Coordination of Benefits Code**	**O ID 1/1**
NOT USED	**SBR07**	**1073**	**Yes/No Condition or Response Code**	**O ID 1/1**
NOT USED	**SBR08**	**584**	**Employment Status Code**	**O ID 2/2**
REQUIRED	**SBR09**	**1032**	**Claim Filing Indicator Code** Code identifying type of claim **CODE DEFINITION** **11 OTHER NON-FEDERAL PROGRAMS** **12 PREFERRED PROVIDER ORGANIZATION (PPO)** **13 POINT OF SERVICE (POS)** **14 EXCLUSIVE PROVIDER ORGANIZATION (EPO)**	**O ID 1/2**

15	INDEMNITY INSURANCE
16	HEALTH MAINTENANCE ORGANIZATION (HMO) MEDICARE RISK
17	DENTAL MAINTENANCE ORGANIZATION
AM	AUTOMOBILE MEDICAL
BL	BLUE CROSS/BLUE SHIELD
CH	CHAMPUS
CI	COMMERCIAL INSURANCE CO
DS	DISABILITY
FI	FEDERAL EMPLOYEES PROGRAM
HM	HEALTH MAINTENANCE ORGANIZATION
LM	LIABILITY MEDICAL
MA	MEDICARE PART A
MB	MEDICARE PART B
MC	MEDICAID
OF	OTHER FEDERAL PROGRAM USE CODE OF WHEN SUBMITTING MEDICARE PART D CLAIMS OR HEALTH EXCHANGE INSURANCE PLANS (UNTIL OTHERWISE DIRECTED)
TV	TITLE V
VA	VETERAN ADMINISTRATION PLAN
WC	WORKERS' COMPENSATION HEALTH CLAIM
ZZ	MUTUALLY DEFINED, OR SELF-PAY, OR UNKNOWN, OR CHARITY, USE CODE "ZZ" WHEN TYPE OF INSURANCE IS SELF - PAY OR UNKNOWN AT TIME OF SUBMISSION TO THCIC

IMPLEMENTATION

OTHER PAYER NAME

Loop: 2330B — OTHER PAYER NAME Repeat: 1
Usage: SITUATIONAL
Repeat: 1
Notes:
1. REQUIRED when more than one payer is paying on claim.
2. Submitters are required to send all known information on other payers in this Loop ID - 2330.

Example: **NM1*PR*2*MUTUAL OF TEXAS*****PI*43140~**

NM1 Individual or Organizational Name

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property, or an individual **CODE — DEFINITION** **PR — PAYER**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **CODE — DEFINITION** **2 — NON-PERSON ENTITY**	**M ID 1/1**
REQUIRED	**NM103**	**103**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: Other Payer Last or Organization Name. ALIAS: Payer Name **CODE — DEFINITION** **SELF PAY — USE FOR SELF PAY CLAIMS (Loop 2320 | SBR09 = ZZ).** **CHARITY — USE FOR CHARITY CLAIMS (Loop 2320 | SBR09 = ZZ).** **UNKNOWN — USE FOR UNKNOWN CLAIMS (Loop 2320 | SBR09 = ZZ).**	**X AN 1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**

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

CODE	DEFINITION
PI	**PAYER IDENTIFICATION**
XV	**HCFA NATIONAL PLAN ID Required when the National Plan ID is implemented**
ZY	**TEMPORARY IDENTIFICATION NUMBER, OR CHARITY, OR UNKNOWN, OR SELF-PAY CLAIMS**

CODE SOURCE 540: Health Care Financing Administration National Plan ID

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: Other Payer Primary Identifier ALIAS: Payer Primary ID	**X**	**AN**	**2/80**

CODE	DEFINITION
xxxxxxxxxx	**NATIONAL PLAN IDENTIFIER (When implemented)**
SELF	**SELF-PAY CLAIMS, (Loop 2320 | SBR09 = "ZZ")**
CHARITY	**CHARITY CARE CLAIMS (LOOP 2320 | SBR09 = "ZZ")**
UNKNOWN	**PAYER SOURCE IS UNKNOWN (LOOP 2320 | SBR09 = "ZZ")**

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

IMPLEMENTATION

SERVICE LINE NUMBER

Loop: 2400 — SERVICE LINE NUMBER Repeat: 999

Usage: REQUIRED

Repeat: 1

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

Example: **LX*1~**

LX Assigned Number

ELEMENT SUMMARY

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

IMPLEMENTATION

INSTITUTIONAL SERVICE LINE

Loop: 2400 — SERVICE LINE NUMBER

Usage: REQUIRED

Repeat: 1

Notes: 1. This segment is required for inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication.

Example 1: **SV2*0300*HC:48000*73.42*UN*1~**
Example 2: **SV2*0120**1500*DA*5~**

SV2 Institutional Service

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SV201**	**234**	**Product/Service ID** See Code Source 132: National Uniform Billing Committee (NUBC) Codes.	**X AN 1/48**

SITUATIONAL SV202 C003 COMPOSITE MEDICAL PROCEDURE IDENTIFIER X

To identify a medical procedure by its standardized codes and applicable modifiers
ALIAS: Service Line Procedure Code
This data element is required for all Outpatient claims.

REQUIRED SV202 – 1 235 Product/Service ID Qualifier M ID 2/2

Code identifying the type/source of the descriptive number used in Product/Service ID (234) INDUSTRY Product or Service ID Qualifier

CODE	DEFINITION
HC	**COMMON PROCEDURAL CODING SYSTEM (HCPCS) CODES (CPT codes are reported under HC).**

CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System

HP	**Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code**

CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS)
Rate Code for Skilled Nursing Facilities

REQUIRED SV202 – 2 234 Product/Service ID M AN 1/48

Identifying number for a product or service INDUSTRY Procedure Code
ALIAS: HCPCS Procedure Code

SITUATIONAL SV202 – 3 1339 Procedure Modifier O AN 2/2

This identifies special circumstances related to the performance of the service, as defined by trading partners
ALIAS: HCPCS Modifier 1

Use this modifier for the first procedure code modifier.

This data element is required when the Provider needs to convey additional clarification for the associated procedure code.

CODE SOURCE 130: See NUBC UB04 manual or CMS website http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html and http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html for valid HIPPS and http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html for HCPCS Level II and III codes

SITUATIONAL	**SV202 - 4**	**1339**	**Procedure Modifier**	**O**	**AN**	**2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners
ALIAS: HCPCS Modifier 2

See SV202-3
https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html for modifier codes

SITUATIONAL	**SV202 – 5**	**1339**	**Procedure Modifier**	**O**	**AN**	**2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners
ALIAS: HCPCS Modifier 3

See SV202-3

SITUATIONAL	**SV202 - 6**	**1339**	**Procedure Modifier**	**O**	**AN**	**2/2**

This identifies special circumstances related to the performance of the service, as defined by trading partners
ALIAS: HCPCS Modifier 3

See SV202-3

SITUATIONAL	**SV202 – 7**	**352**	**Description**	**O**	**AN**	**1/80**
REQUIRED	**SV203**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

Monetary amount
Negative charges must have a "minus" (-) leading the numbers. INDUSTRY
Line Item Charge Amount
ALIAS: Service Line Charge Amount
SEMANTIC:SV203 is a submitted charge amount
Use this amount to indicate the submitted charge amount. Zero may be a valid amount

REQUIRED	**SV204**	**355**	**Unit or Basis for Measurement Code**	**X**	**ID**	**2/2**

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

CODE	DEFINITION
DA	**DAYS**
F2	**INTERNATIONAL UNIT** **Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g. blood factors).**
UN	**UNIT**

REQUIRED	**SV205**	**380**	**Quantity** Numeric value of quantity Negative amounts must have a "minus" (-) leading the numbers INDUSTRY: Service Unit Count ALIAS: Service Line Units	**X**	**R**	**1/15**
NOT USED	**SV206**	**137**	**Unit Rate**	**O**	**R**	**1/10**
SITUATIONAL	**SV207**	**782**	**Monetary Amount** Monetary amount Negative charges must have a "minus" (-) leading the numbers INDUSTRY Line Item Denied Charge or Non-Covered Charge Amount ALIAS: Service Line Non-Covered Charge Amount SEMANTIC:SV207 is a non-covered charge amount. **Use this amount if needed to report line specific non-covered charge amount.**	**O**	**R**	**1/18**
NOT USED	**SV208**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV209**	**1345**	**Nursing Home Residential Status Code**	**O**	**ID**	**1/1**
NOT USED	**SV210**	**1337**	**Level of Care Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: REQUIRED

Repeat: 1

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

TRANSACTION SET TRAILER

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments INDUSTRY: Transaction Segment Count	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set SE02 must match ST02. **Must match number in ST02**	**M AN 4/9**

6 Past Version Changes to this Document

Changes to the THCIC Data Collection Healthcare Facility Procedures and Technical Specifications 5010 Inpatient THCIC 837 Technical Specifications

Inpatient THCIC 837 Technical Specifications Updates of Version 2 from Version 1

a. Table of Contents added, inadvertently deleted.
b. Section 5.5.1 Interchange Control Header, ISA12 code is updated from 00401 to 00501.
c. Section 5.12 Loop 2300, Other Diagnosis Information added, inadvertently deleted.

Inpatient THCIC 837 Technical Specifications Updates of Version 3 from Version 2

1. Section 2.2 – Reference Information – Versions and dates are updated.
2. Section 4.3.1 Data File Specifications – Version is updated.
3. Section 4.3.2 State Required Data Elements (Table)
    a. Payer Name Loop is updated from 2010BC to 2010BB.
    b. National Plan Identifier is updated from 2010BC to 2010BB.
4. Section 5.1 Reference Information – Versions and dates are updated.
5. Section 5.7 Loop Labeling and Use – Loop 2010BC is deleted.
6. Section 5.11 THCIC Transaction Set – Table 2 Detail – Subscriber Hierarchical Level – Loop 2010BC changed to 2010BB.
7. Section 5.12 Segment ID Breakout
    a. 2000A Billing Provider Hierarchical Level – Note the Loop ID 2010BC is updated to 2010BB.
    b. 2300 External Cause of Injury – HInn-9 (nn = 01-12) Yes/No Condition or Response Code - Situational Rule is added.
    c. 2300 Other Diagnosis Information –
        i. Hinn-8 (nn – 01-12) – Industry Code is added
        ii. HInn-9 (nn – 01-12) - Yes/No Condition or Response Code is added
    d. 2320 Other Subscriber Information – SBR09 codes update to match codes in Loop 2000B.

Inpatient THCIC 837 Technical Specifications Updates of Version 4 from Version 3

1. Section 2.2 – Reference Information
    a. Versions and dates are updated
    b. A conditional approval to reproduce or cite ANSI 837 Institution Guide information is inserted.

2. Section 4.3.1 Data File Specifications – Version is updated
3. Section 4.3.2 State Required Data Elements (Table)
    a. Payer Name Loop is updated from 2010BC to 2010BB.
    b. National Plan Identifier is updated from 2010BC to 2010BB.
4. Section 5.1 Reference Information –
    a. Versions and dates are updated.
    b. A conditional approval to reproduce or cite ANSI 837 Institution Guide information is inserted.
5. Section 5.7 Loop Labeling and Use – Loop 2010BC is deleted.
6. Section 5.11 THCIC Transaction Set – Table 2 Detail – Subscriber Hierarchical Level – Loop 2010BC changed to 2010BB.
7. Section 5.12 Segment ID Breakout
    a. 2000A Billing Provider Hierarchical Level – Note the Loop ID 2010BC is updated to 2010BB.
    b. 2300 External Cause of Injury – HInn-9 (nn = 01-12) Yes/No Condition or Response Code - Situational Rule is added.
    c. 2300 Other Diagnosis Information –
        i. Hinn-8 (nn – 01-12) – Industry Code is added
        ii. HInn-9 (nn – 01-12) - Yes/No Condition or Response Code is added
    d. 2320 Other Subscriber Information – SBR09 codes update to match codes in Loop 2000B.

Inpatient THCIC 837 Technical Specifications Updates of Version 5 from Version 4

1. Section 1 Introduction – Updated URL for link to Hospital Procedures and Technical Specifications guides.
2. Section 2.2 Reference Information
    a. Second Paragraph – Removed Copyright information statement.
    b. Third Paragraph now second paragraph modified language to state only segments that are different from the ANSI 837 Institutional are included in this manual.
3. Section 4.3.2 Data Element Table with THCIC 837 Institutional Location: Patient Social Security Number Loop 2300 and data field K301 replace Loop 2010CA REF02.
4. Section 5.1 Reference Information
    a. Second Paragraph – Removed Copyright information statement.
    b. Third Paragraph now second paragraph modified language to state only segments that are different from the ANSI 837 Institutional are included in this manual.
    c. Added table title "THCIC DATA ELEMENTS WHERE USAGE DIFFERS FROM ANSI 837 INSTITUTIONAL GUIDE"
    d. Patient Social Security Number Loop 2300 and data element K301 replaces Loop 2010CA REF02.

   e. PRV data segment row is deleted from the Table "THCIC DATA ELEMENTS WHERE USAGE DIFFERS FROM ANSI 837 INSTITUTIONAL GUIDE".
5. Section 5.2 Basic Structure is deleted.
6. Old Section 5.3 ANSI Terminology section is deleted.
7. Old Section 5.4 Interchange Overview is deleted.
8. Section 5.5 Control Segments becomes Section 5.2.
   a. Interchange Control Trailer is deleted.
   b. Functional Group Trailer is deleted.
9. New Section 5.2.1 Control Segment Elements Breakout – Function Group Header
   a. Example updated with Addendum reference – 005010X223A1.
   b. GS08 Code is updated with Addendum reference - 005010X223A1
10. Section 5.6 Overall Data Architecture for ANSI Form 837 is deleted.
11. Section 5.7 Loop Labeling and Use is deleted.
12. Section 5.8 required and Situational Loops is deleted.
13. Section 5.9 Use of Data Segments and Elements Marked Situational is deleted.
14. Section 5.10 Limitations to the Size of a Claim/Encounter (837) Transaction is deleted.
15. Section 5.11 THCIC Transaction Set is renumbered to Section 5.3.
   a. Table 1 and Table 2 Position #s are updated
   b. Table 2 Patient Hierarchical Level State Required Data Elements – "K3" State Required Data Elements (Patient SSN) is added.
16. Section 5.12 Segment ID Breakout is renumbered to Section 5.4.
   a. NM1 Payer Name – NM108 Identification Code Qualifier usage changed to "Situational" from "Required"
   b. K3 State Required Data Elements (Patient Social Security Number) is added
   c. NM1 Other Payer Name – NM108 Identification Code Qualifier usage changed to "Situational" from "Required".

Inpatient THCIC 837 Technical Specifications Updates of Version 6 from Version 5

1. Section 4.3.2 State Required Data Elements – Table listing Data Elements and Locations – THCIC ID – Loop 2010BB replaces 2010AA and 2010AB is deleted.
2. Section 5.1. Reference Information – THCIC DATA ELEMENTS WHERE USAGE DIFFERS FROM ANSI 837 INSTITUTIONAL GUIDE – Facility ID Number (THCIC ID#) - Loop 2010BB replaces 2010AA and 2010AB is deleted.
3. Section 5.2 – Control Segments – Information added about Delimiters.
4. Section 5.2.1 - CONTROL SEGMENT ELEMENTS BREAKOUT- Interchange Control Header
   a. Example is updated in ISA11.
   b. ISA11 Repetition Separator replaces Interchange Control Standards Identifier

Inpatient THCIC 837 Technical Specifications Updates of Version 7 from Version 6

1. Section 2.2 Reference Information version updated to 005010X223A2 from 005010X223A1.
2. Section 4.3.2 State Required Data Elements – The list of the data elements and their respective locations in the approved formats
    a. Type of Admission text added to identify new UB-04 name "Priority (Type) of Admission".
    b. Source of Admission text added to identify new UB-04 name "Point of Origin for Admission or Visit".
3. Section 5.1 Reference Information
    a. First paragraph last sentence the version updated to 005010X223A2 from 005010X223A1.
    b. List of THCIC Data Elements Where Usage Differs From ANSI 837 Institutional Guide
        i. Type of Admission text added to identify new UB-04 name "Priority (Type) of Admission".
        ii. Source of Admission text added to identify new UB-04 name "Point of Origin for Admission or Visit".
4. Section 5.2.1 Control Segment Elements Breakout – Interchange Control Header
    a. Note 1 – the phrase "fixed record length segment" is underlined.
    b. Boxes noting the fixed length record beginning and ending positions are added for each data element.
    c. ISA14 – note referencing Section A.1.5.1 is removed.
5. Section 5.2.1 Control Segment Elements Breakout – Functional Group Header
    a. Example is updated to 005010X223A2 from 005010X223A1.
    b. GS08 Version/Release/Industry Identifier Code is updated to 005010X223A2 from 005010X223A1 and description updated to A2 from A1.
6. Section 5.3 THCIC Transaction Set – Table 2 Detail – Subscriber Hierarchical Level – Loop ID 2010BA Subscriber Name – The "Usage" is changed to "R/N" for Subscriber Name, Subscriber Address, Subscriber City/State/ZIP Code, Subscriber Demographic Information and Subscriber Secondary Identification and boxed note added stating "Required" if "Subscriber" is the "Patient" otherwise "Not Used".
7. Section 5.3 THCIC Transaction Set – Table 2 Detail – Patient Hierarchical Level
    a. Loop ID 2010CA Patient Name – The "Usage" is changed to "N/R" for Patient Name, Patient Address, Patient City/State/ZIP Code and Patient Demographic Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".
    b. Loop ID 2300 K3 State Required Data Elements (Patient SSN) File Information and boxed note added stating "Not Used" if "Subscriber" is the "Patient" otherwise "Required".
8. Section 5.4 Segment ID Breakout – ST Transaction Set Header – Example changed to ST*837*987654*005010X223A2~ from ST*837*987654*005010X223~
9. Section 5.4 Segment ID Breakout – Loop 2010BA Subscriber Name – Note changed to "The Subscriber Name is REQUIRED when the subscriber is the

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

10. Section 5.4 Segment ID Breakout – Loop 2010BB Payer Name – NM103- SELF PAY code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).
11. Section 5.4 Segment ID Breakout – Loop 2010BB Billing Provider Secondary Identification – REF02 Reference Identification – Length changed to 50 from 30.
12. Section 5.4 Segment ID Breakout – Loop 2300 Institutional Claim Code
    a. Note is shortened to "This segment is REQUIRED when reporting hospital based admissions".
    b. CL102 - Code Source name changed to "Point of Origin for Admission or Visit, , National Uniform Billing Committee UB –04 Manual." from "Source of Referral for Admission or Visit, National Uniform Billing Committee UB – 04 Manual."
13. Section 5.4 Segment ID Breakout – Loop 2310A Attending Physician Secondary Identification – REF02 – Reference Identification - Length change to 50 from 30.
14. Section 5.4 Segment ID Breakout – Loop 2310B Operating Physician Secondary Identification – REF02 – Reference Identification - Length change to 50 from 30.
15. Section 5.4 Segment ID Breakout – Loop 2310E Service Facility Secondary Identification – REF02 – Reference Identification - Length change to 50 from 30.
16. Section 5.4 Segment ID Breakout – Loop 2330B Other Payer Name
    a. NM103- SELF PAY code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).
    b. NM109- SELF code example is changed to (Loop 2000B | SBR09 = ZZ) from (Loop 2000B | SBR09 = 09).

Inpatient THCIC 837 Technical Specifications Updates of Version 8 from Version 7

1. Section 5.2.1 Control Segment Elements Breakout
    a. Interchange Control Trailer segment information was added.
    b. Functional Group Trailer segment information was added.
2. Section 5.4 Segment ID Breakout – Loop 2300 – Claim Information - CLM05-1 – Facility Code Value – "89" the descriptions is amended by adding the phrase "(NOT APPLICABLE FOR INPATIENT CLAIMS BEGINNING 7/1/13)"
3. Section 5.4 Segment ID Breakout – Loop 2300 – Claim Information
    a. HI - Principal Diagnosis – HI01-2 The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
    b. HI - Admitting Diagnosis – HI01-2 The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1,

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

c. HI - External Cause of Injury
    i. HInn-1 (nn = 01 through 12) the description under Code "BN" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM E-Codes will be required on data submitted to THCIC."
    ii. HInn-1 (nn = 02 through 12) The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10- CM E-Codes will be required on data submitted to THCIC."
d. HI – Other Diagnosis Information – HInn-2 (nn = 02 through 12) The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10-CM Diagnosis Codes will be required on data submitted to THCIC."
e. HI – Principal Procedure Information
    i. HI01-1 the description under Code "BR" is amended by adding the phrase "Procedure"
    ii. HI01-2 The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure"
f. HI – Other Procedure Information
    i. HInn-1 (nn = 01 through 12). The description under Code "BQ" is amended by adding the phrase "Procedure"
    ii. HInn-2 (nn = 01 through 12) The description under the "CODE SOURCE 131: International Classification of Diseases Clinical Modification (ICD-9-CM)" is amended by adding the phrase "Procedure Beginning October 1, 2015, ICD-10- PCS Procedure Codes will be required on data submitted to THCIC."
    iii. HInn-2 (nn = 01 through 12). The grey note is amended by adding the phrase "Procedure"
g. HI –Value Information - HI08-8 and HI08-9 were added from previous missed data fields in Version 7
h. HI – Principal Procedure Information duplicate page of 100 was removed from page 131.
i. HI – Other Procedure Information duplicate pages of 101- 108 were removed from pages 132- 109.
j. HI - Occurrence Span Information duplicate pages of 109-111 were removed from pages 140- 142.
k. HI - Occurrence Information duplicate pages of 112-118 were removed from pages 143 - 149.
l. HI - Value Information duplicate pages of 119-124 were removed from pages 150 - 155.
m. HI - Other Procedure Information duplicate pages of 125-127 were removed from pages 156 - 158.

4. Section 5.4 Segment ID Breakout – Loop 2310B – Operating Physician Name – All data elements added back due to inadvertent deletion.

Inpatient THCIC 837 Technical Specifications Updates of Version 9 from Version 8

1 Section 1-Introduction –
   a. First Paragraph is separated in to two paragraphs,
   b. New second paragraph (previously 3rd sentence of first paragraph) the approximate number of hospitals is updated and a hyperlink is added to the statutory reference
   c. New third paragraph (previously 2nd paragraph) the file URL and hyperlink to this manual is updated.
   d. New fourth paragraph, the rule reference with hyperlink is added and link to the Secretary of State's website for the rules is updated.

2 Section 2.1 – General Overview
   a. First Paragraph – the phrase "discharged patients" is changed to "discharged from the hospital per Health and Safety Code (HSC) §108.009(h)) and (25 TAC §421.2(b) (1- 4))" and hyperlinks are added to the statute and rules.
   b. Second Paragraph – Second sentence the first word "Once" is replaced by "When"

3 Section 2.2 – Reference Information
   a. New Second Paragraph is added regarding the copyright statement with Washington Publishing Company.
   b. New Third Paragraph (previous 2nd Paragraph) – the phrase "that are different from the ANSI 837 Institutional Guide sections is replaced by "in the ANSI 837 Institutional Guide sections"

4 Section 3 – Definition and Acronyms –
   a. The following terms, acronyms and descriptions were added:
      i. "Accurate and Consistent Data", "Certification Process", "Comments", "Discharge", "Discharge claim", "Discharge report" "DRG", "Electronic Filling", "Ethnicity", "Geographic identifiers", "HCPCS--HCFA's", "Health care facility", "HIPPS", "Institutional Review Board", "Operating or Other Physician", "Other exempted provider", "Patient account number", "Present on admission (POA)", "Provider quality data", "Public use data file", "Race", "Research data file", "Risk adjustment", "Rural provider", "Submission", "Uniform facility identifier", and "Validation".
   b. The following terms were modified:
      i. "Required minimum data set"

5 Section 4.2.1 – Data Submission
   a. Two paragraphs were added before the first paragraph to clarify that all hospitals are required to submit data under Health and Safety Code, Chapter 108 and the rules 25 TAC §§ 421.1 – 421.10 and that each

facility needs to provide contact information for as a liaison between the facility and THCIC.

b. Old paragraph two, (New paragraph four) the first sentence
   i. Clarifying language (which is enclosed in parentheses) is added.
   ii. Website URL is updated

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

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

7 Section 4.3.2 State Required Data Elements – language is added to the bottom of the list regarding the submission of diagnosis present on admission (POA) and which facilities are exempt from having to report the POA indicator.

8 Section 4.6.1 Provider Enrollment / Signature Requirements – the document title and hyperlink are updated

9 Section 4.7 - Auditing of Data by System13, Inc. The link to the website is updated and replaced.

10 Section 5.1 – Reference Information – First paragraph the website link is update

11 Section 5.2.1 = Control Segment Elements Breakout Interchange Control Header
   a. Example is corrected and updated
   b. ISA03 – "Statement "THCIC WILL ACCEPT EITHER CODE" is added

12 Section 5.4 Segment ID Breakout
   a. Beginning of Hierarchical Transaction (BHT) segment – Example – Date is updated
   b. Loop 2010AA
      a. Billing Provider City/State/ZIP Code – N4 Segment - Data Field N404 Country Code the URL link to the Appendices is updated
      b. Billing Provider THCIC Identification – REF Segment –Example Corrected Updated and Generic Example added
   c. Loop 2010AB
      a. Pay-To Provider City/State/ZIP Code – N4 Segment - Data Field N404 Country Code the URL link to the Appendices is updated
   d. Loop 2010BA
      a. Subscriber City/State/ZIP Code – N4 Segment –

1. Data Field N402 State or Province Code, a note added regarding "aa" code to see the Appendices for the codes.
2. Data Field N404 Country Code the URL link to the Appendices is updated

e. Loop 2010BB –Payer Name – NM1 Segment – Data Field NM109 Identification Code for National Health Plan Identifier note about implementation is updated.

f. Loop 2010CA

a. Patient City/State/ZIP Code – N4 Segment –

1. Data Field N402 State or Province Code, a note added regarding "aa" code to see the Appendices for the codes.
2. Data Field N404 Country Code the URL link to the Appendices is updated

g. Loop 2300 –Claim Information

a. Claim Information - CLM Segment – Data Field CLM05-1 Facility Value – the note is removed
b. Principal Diagnosis - HI Segment – Data Field H101-1 Code List Qualifier Code – Qualifying Code "ABK" is added for ICD-10-CM **Principal Diagnosis** and a noted about the implementation dates is added.
c. Admitting Diagnosis HI Segment – Data Field

1. H101-1 Code List Qualifier Code – Qualifying Code "ABJ" is added for ICD-10-CM **Admitting Diagnosis** and a note is added about the implementation dates is added.
2. HI01-2 Industry Code – The implementation note is updated

d. External Cause of Injury - HI Segment – Data Field

1. H1nn-1 (nn=01-12) Code List Qualifier Code – Qualifying Code "ABN" is added for ICD-10-CM **External Cause of Injury** and a note is added about the implementation dates is added.
2. HInn-2 (nn=01-12) Industry Code – The implementation note is updated

e. Other Diagnosis Information - HI Segment – Data Field

1. H1nn-1 (nn=01-12) Code List Qualifier Code –
   a. Qualifying Code "BF" description updated to include the code is for ICD-9-CM Other Diagnosis
   b. Qualifying Code "ABF" is added for ICD-10-CM **Other Diagnosis Information** and a note is added about the implementation dates is added.
2. HInn-2 (nn=01-12) Industry Code – The implementation note is updated

a. Principal Procedure - HI Segment – Data Field

3. H101-1 Code List Qualifier Code –
   a. Qualifying Code "BR" description Note on implementation date is deleted

b. Qualifying Code "BBR" is added for ICD-10-CM **Principal Procedure** and a note is added about the implementation dates is added.

4. HI01-2 Industry Code – The implementation note is updated

f. Other Procedure Information - HI Segment – Data Field

1. H1nn-1 (nn=01-12) Code List Qualifier Code –
   a. Qualifying Code "BQ" description updated to include the code is for ICD-9-CM Other Procedure and note on implementation deleted
   b. Qualifying Code "BBQ" is added for ICD-10-CM **Other Procedure Codes** and a note is added about the implementation dates is added.
2. HInn-2 (nn=01-12) Industry Code – The implementation note is updated

g. HI Segment – Occurrence Span Information – Example updated

h. Loop 2400 — Institutional Service Line – SV2 Segment –
   a. Data Field SV202-3 Procedure Modifier- Webpage links updated Data Field SV202-4 Procedure Modifier- Webpage links updated

13 Section 5.4 SEGMENT ID BREAKOUT
Loop: 2300 CLAIM INFORMATION
Loop: 2010AA —- BILLING PROVIDER CITY/STATE/ZIP CODE N4 segment: Modify attributes:
N401 19 City Name OAN 2/ From 2/20 to 2/30 N402 156 State or Province Code from O to X

Loop:2010AB — PAY-TO PROVIDER CITY/STATE/ZIP CODE- N4 Segment Modify attributes: N403 116 Postal Code O ID From 3/ 9 to 3/ 15

Loop: 2000B SUBSCRIBER INFORMATION- SBR Segment: Modify Usage from NOT USED to SITUATIONAL SBR03 127 and Required to SITUATIONAL for SBR04 93 and SITUATIONAL REQUIRED SBR09 1032**: Page # 161**

Loop:2010BA — SUBSCRIBER CITY/STATE/ZIP CODE - N4 Segment -Modify N403 26
Country Code Attributes: 3/9 to 3/15 and Postal Code from O to X ID, and N404 26 Country Code from O to X

Loop: 2010CA – PATIENT DEMOGRAPHIC INFORMATION – DMG Segment – DMG021251
Date Time Period X AN Modify Attributes from 1/ 25 to 1/35

Loop:2300 — CLAIM INFORMATION - CLM Segment- Modify Usage: From NOT USED to REQUIRED CLM07 1359, and From NOT USED to REQUIRED CLM08 1073, and From NOT USED to REQUIRED CLM09 1363, and From NOT USED to SITUATIONAL CLM20 1514
Delay Reason Code

Loop: 2300 — CLAIM INFORMATION: STATEMENT DATES - DTP Segment - Modify the
Date/Time format from CCYYMMDD to DTP01 374 Date/Time Qualifier **RD8 RANGE OF DATES EXPRESSED IN FORMAT CCYYMMDD-CCYYMMDD**

Loop: 2300 — CLAIM INFORMATION - INSTITUTIONAL CLAIM CODE Modify: From **to SITUATIONAL** CL101 1315 Admission Type Code

CLAIM INFORMATION Modify: **to SITUATIONAL** CL101 1315 Admission Type Code and **to SITUATIONAL** CL102 1314 Admission Source Code

Modify all the description under the "October 1, 2014 to reflect the new date October 1, 2015". "CODE SOURCE 131: International Classification of Diseases Clinical Mod. (ICD-9-CM)

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

Loop: 2300 — CLAIM INFORMATION **-** PRINCIPAL PROCEDURE INFORMATION - HI
Segment **add the following lines: NOT USED HI01 – 8 1271 Industry Code X AN 1/30 and NOT USED HI01 – 9 1073** Yes/No Condition or Response Code X ID 1/1

Loop: 2300 — CLAIM INFORMATION OCCURANCE SPAN INFORMATION: Repeat ad from 1 to 2 and Ad sections from HI05 – 1- 9, HI06 – 1- 9, HI07 – 1- 9, HI08 – 1- 9, HI09 – 1- 9, HI10 – 1-
9, HI11 – 1- 9, HI12

Loop: 2310A — ATTENDING PHYSICIAN NAME ATTENDING PHYSICIAN SECONDARY
IDENTIFICATION - REF Segment Modify Repeat: **4**

Loop: 2310B — OPERATING PHYSICIAN NAME - NM1 Segment - **NM112 was added NOT**
USED NM1121035 Name Last or Organization Name O ID 1/60

Loop: 2330B — OTHER PAYER NAME- NM1 Segment - NM108 was corrected
From SITUATIONAL to REQUIRED since the segment is situational, the data field would be required if there was a secondary payer otherwise the segment is not needed thus the data field would not be used either.

Inpatient THCIC 837 Technical Specifications Updates of Version 9.1 from 9

1. The format of Tables, headings, section numbers, when uploaded to Adobe Acrobat format from a Word Document written in MS Word 2007 or 2010 and 2013 of Version 10.1, created compatibility issues. All have been verified and fixed.
2. Modifications made to all the Texas administration rules 25 TAC §421.xx from the old link:
   http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1

   To the new link:
   http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tlo c=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=421&rl=1
3. In 5.2 Control Segments section we were referring: (The ISA segment can be considered in implementations compliant with this guide (see Appendix C, ISA Segment Note 1) to be a 105 byte fixed length record, followed by a segment terminator. We removed because in the x223 documentation they were referring without having Section C either.
4. We removed "From Commonwealth to reflect the present company SYSTEM13, Inc.

REQUIRED **GS02 142 Application Sender's Code** **MAN 2/15**
Code identifying party sending transmission; codes agreed to by trading partners

CODE	DEFINITION
SUBnnn	SYSTEM13 SUBMITTER ID NUMBER

This is the same ID as in ISA06.
The Submitter ID must be obtained from System13, Inc.

Inpatient THCIC 837 Technical Specifications Updates of Version 9.2 from 9.1

Modifications in version 9.1 are made to clarify certain specifications: Specifically, page 159 to 163, (where the changes between version 8 and 9 and between 9 and 9.1) comparison of the old specs (Version 8.1) to the new specs (Version 9.1).

The following modifications are made:

1 In section 13 from version 8 to Version 9 page # 162, Loop: 2000B — SUBSCRIBER INFORMATION- SBR Segment: Modify Usage from NOT USED to SITUATIONAL SBR03 127 and Required to SITUATIONAL for SBR04 93 and SITUATIONAL REQUIRED SBR09 1032

This text is removed from the manual as it was not changed.

2 However, in version 9.1 specs field SBR03 is still NOT USED (page 49). Correct it is Not Used and is not changed from 8.1 version

3 Version 9.1 specs, field SBR03 is still NOT USED (page 49).
[DSHS response] correct it is Not Used and is not changed from 8.1 version

4 Loop: 2300 — CLAIM INFORMATION OCCURANCE SPAN INFORMATION: Another example is 2300/HI (Occurrence Span Information). The following description of the changes is made on page 162:
Loop: 2300 — CLAIM INFORMATION OCCURANCE SPAN INFORMATION:
[DSHS response] Sections HI01 and HI02 remain the same and sections from HI05 – 1- 9, HI06 – 1- 9, HI07 – 1- 9, HI08 – 1- 9, HI09 – 1- 9, HI10 – 1- 9, HI11 – 1- 9, HI12.
[DSHS response] – 1- 9 are added to the manual, but are marked "Not Used" which effectively is no change for the formatting of the data.

[DSHS response] Besides the misspellings of Occurrence as Occurrence and add as ad, the new version 9.1 specs still say that the Occurrence Span Information segment repeats 1 time (page 112). The following description of the changes is made on page 162:

The web site for Inpatient Reporting Requirements:
http://www.dshs.state.tx.us/thcic/hospitals/HospitalReportingRequirements.shtm
Now sows the correct version from 9 to 9.1. THCIC Inpatient 5010 Technical Specifications Version 9.1, revised December 3, 2015 (PDF, 735 KB) Under Technical Specifications the wrong version of the document

5 In page # 63 of this Inpatient manual under PATIENT INFORMATION we added in the Individual Relationship Code "20 - Employee" that was missing

Inpatient THCIC 837 Technical Specifications Updates of Version 9.2.1 from 9.2

CMS switched to the NPI and does not support UPIN any longer. Therefore, THCIC has removed the references to UPIN from this document.

Inpatient THCIC 837 Technical Specifications Updates of Version 10.0 from 9.2.1

1. Changed the examples for Principal Diagnosis code for ICD-10-CM/PCS and removed ICD-9-CM examples.
2. Changed the examples for Admitting Diagnosis code for ICD-10-CM/PCS and removed ICD-9-CM examples.
3. Changed the examples in Loop 2300, External Causes of Injury/Morbidity, for ICD-10-CM/PCS and removed ICD-9-CM examples. Modified the definition to describe ICD-10 code ranges of V00-Y99.
4. Changed the examples for Other Diagnosis code for ICD-10-CM/PCS and removed ICD-9-CM examples.
5. Changed the examples for Principal Procedure code for ICD-10-CM/PCS and removed ICD-9-CM examples.
6. Created page break between Principal Procedure code and Other Procedure codes.
7. Changed the examples for Other Procedure code for ICD-10-CM/PCS and removed ICD-9-CM examples.
8. Changed the Condition Code example to use the asterisk.
9. Changed the Attending Physician example to have a 10-digit NPI number.
10. Changed the Operating Physician example to have a 10-digit NPI number.
11. Changed the Service Facility example to have a 10-digit NPI number.
12. Changed the example in segment SV2 to have 0300, not 300 as the revenue code. Modified the HCPCS example.
13. Removed "IV" as a HCPCS qualifier for segment SV2. The only valid value for the HCPCS qualifier is "HC".
14. Added language to Section 5.1 Table on "THCIC Data Element where usage differs from ANSI 837 Institutional Guide" regarding K3 segment and the collection of Patient Ethnicity and Race, in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data collection efforts.
15. Added language to Section 5.2 Table 2 regarding K3 segment and the collection of Patient Ethnicity and Race, in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data collection efforts.
16. Added language to Loop 2010BA Subscriber Name (Subscriber Demographic Information) notes and in DMG05 data field notes regarding K3 segment and the collection of Patient Ethnicity and Race, in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data collection efforts.
17. Deleted outdated language from Loop 2010BB Payer Name NM109 regarding National Plan Identifier and updated.

18. Added language to Loop 2010CA Patient Name (Subscriber Demographic Information) notes and in DMG05 data field notes regarding K3 segment and the collection of Patient Ethnicity and Race, in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data collection efforts.
19. Added language to Loop 2300 K3 segment regarding and the collection of Patient Ethnicity, Race, and Social Security Number in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data collection efforts. The new locations are listed in the notes for the K3 as adopted in rules 25 TAC §§421.9 (c)(1) & (2).
20. Added language to Loop 2300 Claim Note segment regarding and the collection of Patient Ethnicity in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data collection efforts. The new locations are listed in the notes for the K3 as adopted in rules 25 TAC §§421.9 (c)(2).
21. Language is modified to clarify which facilities are exempt from reporting "Diagnosis Present on Admission (POA) for each of the diagnosis data fields including "Principal Diagnosis", "External Cause of Injury" and "Other Diagnosis Information" data fields.
22. Added CODE and DEFINITION to Loop 2300 K3 segment regarding Ethnicity, Race, and Social Security Number in response to HB 2641 (84th Texas Legislature) requirement to meet national standards for electronic data collection efforts.
23. Inspected accessibility results and removed the errors.

Inpatient THCIC 837 Technical Specifications Updates of Version 10.1 from 10.0 – 9/12/2019

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

Inpatient THCIC 837 Technical Specifications Updates of Version 10.2 from 10.1 – 5/10/2022

1. Changed formatting throughout document for readability including removing italics, matching font, and setting consistent tabs for element detail lines (did not affect implementation).
2. Fixed incorrect and inconsistent spelling, grammar, capitalization, and punctuation throughout document (did not affect implementation).
3. Removed "THCIC Hospital Discharge Data Collection" from document title.
4. Changed WebCorrect to Claim Correction in all locations.
5. Reworded website links to match destination page titles.
6. Updated all "Appendices" web links to https://www.dshs.texas.gov/thcic/hospitals/5010_InpatientandOutpatientAppendices.pdf.

7. Section 2.1 - added paragraph with the definition and description of the THCIC HCDCS. Moved or reworded phrases for a clearer and more accurate description of file processing (did not affect implementation).
8. Sections 2.3 and 2.4 - clarified definitions of Data Portal Web Site and THCIC Web Site.
9. Section 4.2.2 - list item 3, moved System13 contact information and clarified data deletion tabs.
10. Section 4.3.2 - updated items 36, 37, 38, 39, 40 and 41 to read "Attending Physician or Practitioner" (added Physician or") and "Operating Physician" (removed "or Other Practitioner").
11. Section 4.3.2 - updated items 29-35 with correct maximum number of occurrences.
12. Section 4.3.3 – in the data element table, removed "Outpatient Ancillary Revenue Code or" from "Outpatient Ancillary Revenue Code or HCPCS/HIPPS Procedure Codes".
13. Section 5.1 - updated the sentence regarding "Situational" and "Not Used" use for clarification; labeled the table as "Table 1"; corrected the footnote reference marks in Table 1; and added Attributes definition, Requirement Designator acronyms, glossary, and Data Type acronyms (did not affect implementation).
14. Section 5.2 -
    a. INTERCHANGE CONTROL HEADER, ISA10, changed time format from YYMMDD to HHMM.
    b. INTERCHANGE CONTROL HEADER, ISA11, changed data element from I65 to I10.
15. Section 5.3 - Table 2 - updated 1850 K3 to include Ethnicity and Race Codes and removed 1900 NTE.
16. Section 5.4 -
    a. 1000A — SUBMITTER NAME, NM109, added Data Type AN.
    b. 2000A - BILLING PROVIDER HIERARCHICAL LEVEL, HL01, added to end of comment "numeric values are allowed in HL01."
    c. 2010AB — PAY-TO PROVIDER -ADDRESS, title changed to 2010AB — PAY-TO ADDRESS -ADDRESS and Loop Name changed.
    d. 2010AB — PAY-TO PROVIDER - CITY/STATE/ZIP CODE, title changed to 2010AB — PAY-TO ADDRESS - CITY/STATE/ZIP CODE and Loop Name changed
    e. PAY-TO PROVIDER CITY/STATE/ZIP CODE. 2010AB — PAY-TO PROVIDER NAME, N404, removed Alias and Code Source text.
    f. SUBSCRIBER NAME, 2010BA — SUBSCRIBER NAME, NM103 and NM 104: add "AND FACILITIES THAT ARE PARTICIPATING WITH SAMHSA", and NM105: changed "Name First" to "Name Middle".

g. SUBSCRIBER DEMOGRAPHIC INFORMATION, 2010BA — SUBSCRIBER NAME, removed notes 2 and 3 regarding Race and Ethnicity information, and removed DMG05 details, due to implementation of K3.

h. SUBSCRIBER SECONDARY IDENTIFICATION, 2010BA — SUBSCRIBER NAME, REF02, changed CODE "99999999" to "999999999".

i. 2010BB — PAYER NAME, NM108, CODE "ZY", moved "USE FOR" to beginning of definition and added Health Plan Identifier acronym (HPID).

j. PATIENT NAME, 2010CA — PATIENT NAME, NM103 and NM 104: add "AND FACILITIES THAT ARE PARTICIPATING WITH SAMHSA", and changed "NM10" to "NM101".

k. PATIENT DEMOGRAPHIC INFORMATION, 2010CA — PATIENT NAME, removed notes 2 and 3 regarding Race and Ethnicity information, and removed DMG05 details, due to implementation of K3.

l. CLAIM INFORMATION, 2300 — CLAIM INFORMATION, CLM05-1, removed "32 HOME HEALTH INPATIENT MEDICARE PART B" and "64 INTERMEDIATE CARE – OTHER (EFFECTIVE BEGINNING MARCH 1, 2007)".

m. CLAIM INFORMATION, 2300 — CLAIM INFORMATION, CLM05-3, added interim claim instructions.

n. K3, 2300 — STATE REQUIRED DATA ELEMENTS, 2300 -CLAIM INFORMATION, removed anticipated begin date in Note 3, reworded Required Rule, removed K301 paragraph regarding House Bill 2641 requirements and anticipated begin date, and changed RACE CODE 5 definition from "OTHER Race" to "OTHER RACE OR MULTIPLE RACES".

o. PRINCIPAL DIAGNOSIS, 2300 — CLAIM INFORMATION, HI01-2, updated the CODE SOURCE from 131 to 897.

p. PRINCIPAL PROCEDURE INFORMATION, 2300 — CLAIM INFORMATION, removed example 1 (old ICD-9-CM code).

q. OTHER PROCEDURE INFORMATION, 2300 — CLAIM INFORMATION, removed example 1 (old ICD-9-CM code); removed ICD-9-CM-related industry notes; added industry notes to HI01-4; removed notes for all HInn-3 in this data segment; changed Usage of HI03-4 through HI08-4 from "NOT USED" to "REQUIRED"; replaced " ABN INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) EXTERNAL CAUSE OF INJURY CODE (E-CODES)" with "ABF INTERNATIONAL CLASSIFICATION OF DISEASES CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS"; removed industry note from HI11-3 and HI12-3; and changed "CLINICAL MODIFICATION" to "PROCEDURAL CODING SYSTEM".

r. CONDITION INFORMATION, 2300 — CLAIM INFORMATION, HI09 – HI12, clarified at the element level that HI09 – HI12 are not collected by THCIC and removed unnecessary detail text.

s. 2310A — ATTENDING PHYSICIAN NAME, added "or Practitioner" to all reverences of "Physician", removed all references to an entity or organization, and added NPI note.

t. 2310B — OPERATING PHYSICIAN NAME, removed all references to an entity or organization and added NPI note.

u. 2310E — SERVICE FACILITY NAME, changed "SERVICE FACILITY" TO "SERVICE FACILITY LOCATION" in all Segment and Loop titles.

v. 2400 — SERVICE LINE NUMBER, SV202-3, added "and" between two website links.

Changes from Version 10.2 to 10.3 on 12/1/2023

1. Section 2 Reference Information – updated X12 Product link.
2. Section 4 – updated 5010 IP and OP Appendices link in multiple locations.
3. Section 5 Basic Structure – added the entire Basic Structure section.
4. Section 5 – removed unnecessary details from NOT USED data elements including but not limited to references, codes, definitions, INDUSTRY name, SEMANTIC information, etc.
5. K3 – Grammar fix in Note 1, grammar update in Note 3, and deleted Note 4 "Per requirements of House Bill (HB) 2641 (84th Texas Legislature) to meet national standard reporting requirements the "Patient Ethnicity" and "Patient Race" will be collected on the K3 segment. The adopted location for "Patient Ethnicity" is the first character and "Patient Race" will be the second character of the K301 data field with the "Patient's Social Security Number" being located in the 3rd through 11th character slots."