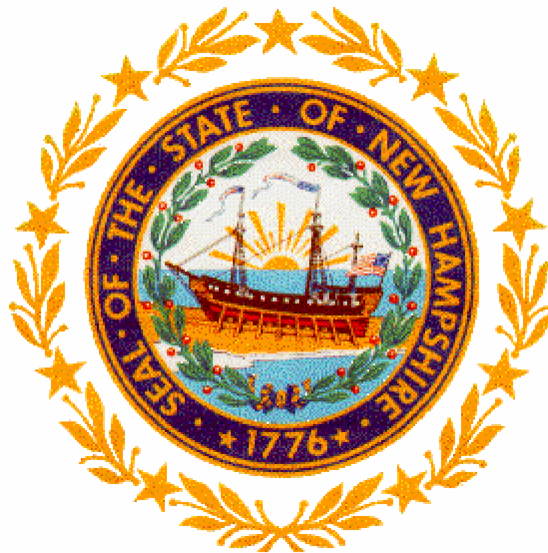
State of New Hampshire
Department of Health and Human Services
Division of Public Health Services
Health Statistics and Data Management

New Hampshire Uniform Health Facility Discharge Data Set Submission Manual
- Addendum -



Version 2

February 14, 2014

Department of Information Technology - Agency Software Division

Revision Log

Version	Date	Description
1	12/10/2013	Original Version
2	02/14/2014	Added 11.55 to table of contents Added paragraph "**Previously Submitted 5010 Files"** to section A1 Added Denise Towle as a contact in section A1 A11.3 - added comments A11.8 - added FX qualifier A11.9 - segment now optional A11.32 - CLM06 & CLM18 no longer required A11.37a - segment now optional A11.39a - added comment that POA is situational A11.39b - added comment on when segment is required A11.39c - segment now situational - added comment on when required A11.40 - added comment that POA is situational A11.48 - added comment on when required A11.50 - added comment on when required A11.54 - added total charges; removed accommodation rate; updated example and added comment A11.55 - segment now situational - added comment on when required

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A1. Introduction

This document is an addendum to Version 7 (6/30/2011) of the **New Hampshire Health Care Facility Discharge Data Submission Manual** prepared by Onpoint Health Data. It provides guidelines for creating an ANSI ASC X12-837 Version 5010 file as it is implemented for the New Hampshire CHAPTER He-C 1500 Data Submission and Release of Health Care Facility Discharge Data. The guidelines are based on the "**Institutional Side by Side 4010A1 to 5010"** document found on the following Centers for Medicare & Medicaid Services (CMS) website:

http://www.cms.gov/site-search/search-results.html?q=837%204010%205010

This addendum does not provide detailed instructions in the creation of the 837 file in 5010 format. Please refer to other documents for that information.

The 5010 guidelines, in this addendum, are presented in three sections.

- **Section A9. Data Elements to HIPAA Loop and Reference Designation Crosswalk**. This section is a repeat of Section 9 in the original submission manual from Onpoint. All modifications are highlighted in yellow and the word **"Change>"** appears in the first column.

- **Section A11. Segment Review and Submission Requirements.** This section is a repeat of Section 11 in the original submission manual from Onpoint. All modifications are highlighted in yellow. A brief summary of the changes, if any, follow each subsection and are highlighted in blue.

- **Section A12. Self-Pay Claims.** This section is a repeat of Section 12 in the original submission manual from Onpoint. All modifications are highlighted in yellow.

These three sections and all subsections are numbered the same as in the original submission manual, prefixed with an "A" (for addendum). For example, subsection A11.32 in this addendum corresponds to 11.32 in the original manual.

In addition to the 5010 guidelines, some error corrections and omissions in the original document have been included in this addendum (highlighted in yellow). For ease of reference, each UB-04 Form Locator in Section A9 includes the A11 subsection to which it refers. These references are highlighted in blue.

Please refer to the original submission manual from Onpoint, version 7, for detailed information regarding filing requirements, filing periods, registration, required data elements, and other important information.

ICD-10 Implementation

The State will follow the CMS guidelines and schedule for implementation of ICD-10 on October 1, 2014. Hospitals will need to migrate to the 5010 file format in order to submit diagnosis and procedure codes in ICD-10. Please note that ICD-9 codes are still

accepted in the 5010 formatted file. New qualifier codes are used to distinguish between an ICD-9 code and an ICD-10 code. Detailed information on the coding of each relevant segment is included in Sections A9 and A11.

5010 Testing

Hospitals are encouraged to submit test files in the 5010 format. Please inform Patty Thibeault, at the Division of Public Health Services, in advance that you wish to submit a test file. Insert the word "test" in the file name and submit the file in the same manner as Production files. Send the name of the file to Patty so it may be properly tracked. The State will validate the structure and format of the file as soon as possible and respond with the results.

Previously Submitted 5010 Files

For those hospitals who have been submitting their monthly/quarterly discharge data in 5010 formatted files, every effort will be made to process those files successfully. However, it is expected that these hospitals will review the guidelines in this addendum and compare them with the 5010 format that the hospital is currently using. Please note the discrepancies and then discuss them with the State. In some cases, the State may require a modification for your future submissions. The State will also use previously submitted 5010 files for test purposes and will then convey the results to you.

Contact Information

Questions and feedback regarding the contents of this addendum may be sent to the following contacts:

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A9. Data Elements to HIPAA Loop and Reference Designation Crosswalk

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes (section A11 references in blue)**
FL 01	Billing Provider Name, Address and Telephone Number					
	Line 1 – Name	2010AA	NM103	1035	85 in NM101; 2 in NM102	**A11.11**
	Line 2 - Street Address	2010AA	N301 and N302	166		**A11.12**
	Line 3 - City (positions 1-12)	2010AA	N401	19		**A11.13**
	Line 3 - State (positions 14-15	2010AA	N402	156		**A11.13**
	Line 3 - ZIP Code (positions 17-25)	2010AA	N403	116		**A11.13**
	Line 4 - Telephone	2010AA	PER04	364	TE in PER03	**A11.15**
FL 02	Pay-to Name and Address					
	Line 1 - Pay-to Name	2010AB	NM103	1035	87 in NM101; 2 in NM102	**A11.16**
Change>	Line 2 - Street Address or Post Office Box	2010AB	N301 **and N302**	166		**A11.17**
	Line 3 - State (positions 18-19)	2010AB	N402	156		**A11.18**
	Line 3 - ZIP Code (positions 21-25)	2010AB	N403	156		**A11.18**
FL 03a	Patient Control Number	2300	CLM01	1028		**A11.32**
FL 03b	Medical Record Number	2300	REF02	128	EA in REF01	**A11.37b**
FL 04	Type of Bill					**A11.32**
	Facility Code (positions 2-3 of 4 in FL 04)	2300	CLM05-1	1331		Leading zero in FL 04 is not reported on 837

UB-04 Form Locator		837 HIPAA 005010X223				
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes (section A11 references in blue)**
Change>	**Claim Frequency Code (position 4 of 4 in FL 04)**	**2300**	**CLM05-3**	**1331**		**Omitted in original spec**
FL 05	Federal Tax Number (Only NPI when available otherwise use FL 57 Other Billing Provider Identification)	2010AA	NM109	67	XX in NM108	**A11.11**
FL06	Statement Covers Period	2300	DTP03	1251	434 in DTPO1; RD8 in DTP02	**A11.34**
FL 08	Patient Name/Identifier					
Change>	b- Patient Name	2010BA	NM103-105	1035-1037	IL in NMI01; 1 in NM102 ; ~~**MI in NM108**~~	When FL59=18; **NM108 not needed;** **A11.21**
		2010CA	NM103-105		QC in NM101; 1 in NM102 ; ~~**MI in NM108**~~	When FL59 is not 18; **NM108 not needed;** **A11.28**

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes (section A11 references in blue)**
FL81 **Change>**	c - Patient Race Ethnicity	2010BA	DMG05-3	67	~~**MI in NM108**~~; RET in DMG05-2	When FL59=18; Must equal Race or Ethnicity in ("R1", "R2", "R3", "R4", "R5", "R9", "E1", or "E2"). Multiple races are permitted. Both race and ethnicity shall be recorded; **NM108 not needed;** **A11.24**
Change>		2010CA	DMG05-3	67	~~**MI in NM108**~~; RET in DMG05-2	When FL59 **is not** 18; Must equal Race or Ethnicity in ("R1", "R2", "R3", "R4", "R5", "R9", "E1", or "E2"). Multiple races are permitted. Both race and ethnicity shall be recorded; **NM108 not needed;** **A11.31**
FL09	Patient Address					

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	Reference Designator	X12 Data Element #	Qualifier/Ref. Des./ Data Element	Notes (section A11 references in blue)
Change>	a - Street Address	2010BA	N301 **and N302**	166		When FL59=18; **A11.22**
		2010CA	N301 **and N302**	166		When FL59 is not 18; **A11.29**
	b - City	2010BA	N401	19		When FL59=18; **A11.23**
		2010CA	N401	19		When FL59 is not 18; **A11.30**
	c- State	2010BA	N402	156		When FL59=18; **A11.23**
		2010CA	N402	156		When FL59 is not 18; **A11.30**
	d - ZIP Code	2010BA	N403	116		When FL59=18; **A11.23**
		2010CA	N403	116		When FL59 is not 18; **A11.30**
FL 10 Change>	Patient Birth Date	2010BA	DMG02	1251	D8 in ~~DMG08~~ **DMG01**	When FL59=18; **correction to original spec**; **A11.24**
		2010CA	DMG02	1251	D8 in ~~DMG08~~ **DMG01**	When FL59 is not 18; **correction to original spec**; **A11.31**
FL 11	Patient Sex	2010BA	DMG03	1068	F,M,U in DMG03	When FL59=18; **A11.24**

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	Reference Designator	X12 Data Element #	Qualifier/Ref. Des./ Data Element	Notes (section A11 references in blue)
		2010CA	DMG03	1068	F,M,U in DMG03	When FL59 is not 18; A11.31
FL 12	Admission/Start of Care Date	2300	DTP03	1251	435 in DTPO1; DT in DTP02	A11.35
FL 13	Admission Hour	2300	DTP03	1251	435 in DTP01; DT in DTP02	A11.35
FL 14	Priority (Type) of Visit	2300	CL101	1315		A11.36
FL 15	Source of Admission/Point of Origin	2300	CL102	1314		A11.36
FL 16	Discharge Hour	2300	DTP03	1251	096 in DTP01; TM in DTP02	A11.33
FL 17	Patient Discharge Status	2300	CL103	1352		A11.36
FL 18-28	Condition Codes					Condition Codes HI line
	18	2300	HI01-2	1271	BG in HI01-1	02 = Condition is Employment-Related; and P1 = Do Not Resuscitate Order (DNR) shall be recorded/submitted where applicable. Other codes shall be submitted when available; A11.46
	19	2300	HI02-2	1271	BG in HI02-1	
	20	2300	HI03-2	1271	BG in HI03-1	
	21	2300	HI04-2	1271	BG in HI04-1	
	22	2300	HI05-2	1271	BG in HI05-1	
	23	2300	HI06-2	1271	BG in HI06-1	
	24	2300	HI07-2	1271	BG in HI07-1	
	25	2300	HI08-2	1271	BG in HI08-1	
	26	2300	HI09-2	1271	BG in HI09-1	
	27	2300	HI10-2	1271	BG in HI10-1	
	28	2300	HI11-2	1271	BG in HI11-1	
FL 31-34	Occurrence Codes and Dates					Occurrence Codes HI line
	31a – Code	2300	HI01-2	1271	BH in HI01-1	04 = Accident/employment related
	31a – Date	2300	HI01-4	1251	D8 in HI01-3	
	32a – Code	2300	HI02-2	1271	BH in HI02-1	

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	Reference Designator	X12 Data Element #	Qualifier/Ref. Des./ Data Element	Notes (section A11 references in blue)
	32a – Date	2300	HI02-4	1251	D8 in HI02-3	date shall be recorded/submitted where applicable. Other codes shall be submitted when available; **A11.44**
	33a – Code	2300	HI03-2	1271	BH in HI03-1	
	33a – Date	2300	HI03-4	1251	D8 in HI03-3	
	34a – Code	2300	HI04-2	1271	BH in HI04-1	
	34a – Date	2300	HI04-4	1251	D8 in HI04-3	
	31b – Code	2300	HI05-2	1271	BH in HI05-1	
	31b – Date	2300	HI05-4	1251	D8 in HI05-3	
	32b – Code	2300	HI06-2	1271	BH in HI06-1	
	32b - Date	2300	HI06-4	1251	D8 in HI06-3	
	33b - Code	2300	HI07-2	1271	BH in HI07-1	
	33b - Date	2300	HI07-4	1251	D8 in HI07-3	
	34b - Code	2300	HI08-2	1271	BH in HI08-1	
	34b - Date	2300	HI08-4	1251	D8 in HI08-3	
FL 39-41	Value Codes and Amounts					Value Codes HI line
	39a - Code	2300	HI01-2	1271	BE in HI01-1	54 = Newborn Birth Weight in Grams; and P0 = For newborns, mother's medical record number shall be recorded/submitted where applicable. Other codes shall be submitted when available; **A11.45**
	39a - Amount	2300	HI01-5	782		
	39b - Code	2300	HI02-2	1271	BE in HI02-1	
	39b - Amount	2300	HI02-5	782		
	39c - Code	2300	HI03-2	1271	BE in HI03-1	
	39c - Amount	2300	HI03-5	782		
	39d - Code	2300	HI04-2	1271	BE in HI04-1	
	39d - Amount	2300	HI04-5	782		
	40a - Code	2300	HI05-2	1271	BE in HI05-1	
	40a - Amount	2300	HI05-5	782		
	40b - Code	2300	HI06-2	1271	BE in HI06-1	
-	40b - Amount	2300	HI06-5	782		
	40c - Code	2300	HI07-2	1271	BE in HI07-1	
	40c - Amount	2300	HI07-5	782		
	40d - Code	2300	HI08-2	1271	BE in HI08-1	
	40d - Amount	2300	HI08-5	782		

UB-04 Form Locator			**837 HIPAA 005010X223**			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes** **(section A11 references in blue)**
	41a - Code	2300	HI09-2	1271	BE in HI09-1	
	41a - Amount	2300	HI09-5	782		
	41b - Code	2300	HI10-2	1271	BE in HI10-1	
	41b - Amount	2300	HI10-5	782		
	41c - Code	2300	HI11-2	1271	BE in HI11-1	
	41c - Amount	2300	HI11-5	782		
	41d - Code	2300	HI12-2	1271	BE in HI12-1	
	41d - Amount	2300	HI12-5	782		
FL 42	Revenue Code	2400	SV201	234		**A11.54**
FL 44	HCPCS or CPT/Accommodation Rates/HIPPS Rates Codes					**A11.54**
	HCPCS or CPT Procedure Code	2400	SV202-2	234	HC in SV202-1	
	HCPCS Modifiers	2400	SV202-3, 4, 5, 6	1339	HC in SV202-1	
FL 45 **Change>**	Service Date**(s)**	2400	DTP03	1251	472 in DTP01; D8 **or RD8** in DTP02	**Omitted in original spec**; **A11.55**
FL 46	Service Units	2400	SV205	380	DA, UN in SV204	**A11.54**
FL 47	Total Charges	2300	CLM02	782		**A11.32**
FL 50 **Change>**	Payer Name	~~**2010BC**~~ **2010BB**	NM103	1035	PR in NM101; 2 in NM102	**Loop change**; **A11.25**
FL 51 **Change>**	Health Plan Identifier	~~**2010BC**~~ **2010BB**	NM109	67	PI or XV in NM108	**Loop change**; **A11.25**
FL 56	National Provider Identifier - Billing Provider	2010AA	NM109	67	XX in NM108	**A11.11**
FL 57 **Change>**	Other (Billing) Provider Identifier	2010AA	REF02	127	~~**0B, 1G, G2 in REF01**~~ **EI in REF01**	**New code**; **A11.14**
FL 59	Patient's Relationship to Insured	2000B	SBR02	1069		When FL59= 18; **A11.20**

UB-04 Form Locator			837 HIPAA **005010X223**			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes** **(section A11 references in blue)**
	Patient's Relationship to Insured	2000C	PAT01	1069		When FL59 not 18; **A11.27**
FL 64	Document Control Number	2300	REF02	127	F8 in REF01	**A11.37a**
FL 65	Employer Name (of the Insured)				TBD	When the employer is not known, shall be recorded as "UNKNOWN"; When not employed, record as "NA"
FL 66 **Change>**	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)				~~**TBD**~~	**Do not need this code for 5010**
FL 67	Principal Diagnosis Code					Primary Dx HI line; **A11.39a**
Change>	Code	2300	HI01-2	1271	BK **or ABK** in HI01-1	
Change>	POA Indicator	2300	HI01-9	449	BK **or ABK** in HI01-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
FL67A-Q **Change>**	Other Diagnosis Codes					~~**Secondary**~~ **Other** Dx HI line; **A11.40**
Change>	A - Code	2300	HI01-2	1271	BF **or ABF** in HI01-1	
Change>	A - POA Indicator	2300	HI01-9	449	BF **or ABF** in HI01-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N",

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	Reference Designator	X12 Data Element #	Qualifier/Ref. Des./ Data Element	Notes (section A11 references in blue)
						"U", "Y" "W" or "1")
Change>	B - Code	2300	HI02-2	1271	BF **or ABF** in HI02-1	
Change>	B - POA Indicator	2300	HI02-9	449	BF **or ABF** in HI02-1	Must equal ~~Onset of Diagnosis~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	C - Code	2300	HI03-2	1271	BF **or ABF** in HI03-1	
Change>	C - POA Indicator	2300	HI03-9	449	BF **or ABF** in HI03-1	Must equal ~~Onset of Diagnosis~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	D - Code	2300	HI04-2	1271	BF **or ABF** in HI04-1	
Change>	D - POA Indicator	2300	HI04-9	449	BF **or ABF** in HI04-1	Must equal ~~Onset of Diagnosis~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	E - Code	2300	HI05-2	1271	BF **or ABF** in HI05-1	
Change>	E - POA Indicator	2300	HI05-9	449	BF **or ABF** in HI05-1	Must equal ~~Onset of Diagnosis~~ Present on Admission

UB-04 Form Locator			837 HIPAA **005010X223**			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes** **(section A11 references in blue)**
						Indicator ("N", "U", "Y" "W" or "1")
Change>	F - Code	2300	HI06-2	1271	BF **or ABF** in HI06-1	
Change>	F - POA Indicator	2300	HI06-9	449	BF **or ABF** in HI06-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	G - Code	2300	HI07-2	1271	BF **or ABF** in HI07-1	
Change>	G - POA Indicator	2300	HI07-9	449	BF **or ABF** in HI07-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	H - Code	2300	HI08-2	1271	BF **or ABF** in HI08-1	
Change>	H - POA Indicator	2300	HI08-9	449	BF **or ABF** in HI08-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	I - Code	2300	HI09-2	1271	BF **or ABF** in HI09-1	
Change>	I - POA Indicator	2300	HI09-9	449	BF **or ABF** in HI09-1	Must equal ~~**Onset of Diagnosis**~~ Present on

UB-04 Form Locator			837 HIPAA **005010X223**			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes** **(section A11 references in blue)**
						Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	J - Code	2300	HI10-2	1271	BF **or ABF** in HI10-1	
Change>	J - POA Indicator	2300	HI10-9	449	BF **or ABF** in HI10-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	K - Code	2300	HI11-2	1271	BF **or ABF** in HI11-1	
Change>	K - POA Indicator	2300	HI11-9	449	BF **or ABF** in HI11-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
Change>	L - Code	2300	HI12-2	1271	BF **or ABF** in HI12-1	
Change>	L - POA Indicator	2300	HI12-9	449	BF **or ABF** in HI12-1	Must equal ~~**Onset of Diagnosis**~~ Present on Admission Indicator ("N", "U", "Y" "W" or "1")
FL69 **Change>**	Admitting Diagnosis Code	2300	~~HI02-2~~ HI01-2	1271	BJ **or ABJ in ~~HI02-1~~ HI01-1**	~~**Primary**~~ **Admitting** Dx HI line; **must be ICD Code;**

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes (section A11 references in blue)**
						A11.39b
FL 70**a-c** **Change>**	Patient's Reason for Visit	2300	~~HI02-2~~		~~**ZZ in HI02-1**~~	~~**Primary**~~ **Reason** Dx HI line; **A11.39c**
Change>	a - Code		HI01-2	1271	PR or APR in HI01-1	Must be ICD Code
Change>	b - Code		HI02-2	1271	PR or APR in HI02-1	Must be ICD Code
Change>	c - Code		HI03-2	1271	PR or APR in HI03-1	Must be ICD Code
FL 72a-c **Change>**	External Cause of Injury Code	2300				~~**Primary**~~ **ECI** Dx HI line; **A11.39d**
Change>	a - Code	2300	~~**HI04-2**~~ **HI01-2**	1271	~~**BK in HI04-1**~~ **BN or ABN in HI01-1**	ECI code shall be recorded/ submitted for each injury/poisoning diagnosis (ICD9 800 to 999.9) in order diagnosis code is listed.
Change>	b - Code	2300	~~**HI05-2**~~ **HI02-2**	1271	~~**BK in HI05-1**~~ **BN or ABN in HI02-1**	
Change>	c - Code	2300	~~**HI06-2**~~ **HI03-2**	1271	~~**BK in HI06-1**~~ **BN or ABN in HI03-1**	
FL 74	Principal Procedure Code and Date					Principal Procedure HI line; **A11.41**
Change>	Code	2300	HI01-2	1271	BR **or BBR** in HI01-1	
	Date	2300	HI01-4	1251	D8 in HI01-3	
74a-e **Change>**	Other Procedure Codes and Dates					~~**Principal**~~ **Other** Procedure HI line; **A11.42**
Change>	a Code	2300	~~**HI02-2**~~ **HI01-2**	1271	BQ **or BBQ in** ~~**HI02-1**~~ **HI01-1**	
Change>	a Date	2300	~~**HI02-4**~~ **HI01-4**	1251	D8 in ~~**HI02-3**~~ **HI01-3**	

UB-04 Form Locator			837 HIPAA **005010X223**			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes** **(section A11 references in blue)**
Change>	b - Code	2300	**~~HI03-2~~ HI02-2**	1271	BQ **or BBQ in ~~HI03-1~~ HI02-1**	
Change>	b - Date	2300	**~~HI03-4~~ HI02-4**	1251	D8 in **~~HI03-3~~ HI02-3**	
Change>	c - Code	2300	**~~HI04-2~~ HI03-2**	1271	BQ **or BBQ in ~~HI04-1~~ HI03-1**	
Change>	c - Date	2300	**~~HI04-4~~ HI03-4**	1251	D8 in **~~HI04-3~~ HI03-3**	
Change>	d - Code	2300	**~~HI05-2~~ HI04-2**	1271	BQ **or BBQ in ~~HI05-1~~ HI04-1**	
Change>	d - Date	2300	**~~HI05-4~~ HI04-4**	1251	D8 in **~~HI05-3~~ HI04-3**	
Change>	e - Code	2300	**~~HI06-2~~ HI05-2**	1271	BQ **or BBQ in ~~HI06-1~~ HI05-1**	
Change>	e - Date	2300	**~~HI06-4~~ HI05-4**	1251	D8 in **~~HI06-3~~ HI05-3**	
FL 76	Attending Provider Name and Identifiers					**A11.47 & A11.48**
	NPI	2310A	NM109	67	71 in NM101; XX in NM108	
	Secondary Identifier	2310A	REF02	127	71 in NM101; 0B, 1G, G2 in REF01	
	Last Name	2310A	NM103	1035	71 in NM101; 1 in NM102	
	First Name	2310A	NM104	1036	71 in NM101; 1 in NM102	
FL 77	Operating Physician Name and Identifiers					**A11.49 & A11.50**
	NPI	2310B	NM109	67	72 in NM101; XX in NM108	
	Secondary Identifier	2310B	REF02	127	72 in NM101; 0B, 1G, G2 in REF01	

UB-04 Form Locator			837 HIPAA 005010X223			
		Loop ID	Reference Designator	X12 Data Element #	Qualifier/Ref. Des./ Data Element	Notes (section A11 references in blue)
	Last Name	2310B	NM103	1035	72 in NM101; 1 in NM102	
	First Name	2310B	NM104	1036	72 in NM101; 1 in NM102	
FL 78 **Change>**	Other ~~**Provider (Individual)**~~ **Operating Physician** Names and Identifiers					**A11.51 & A11.52**
Change>	NPI	2310C	NM109	67	~~73~~ **ZZ** in NM101; XX in NM108	
Change>	Secondary Identifier	2310C	REF02	127	~~73~~ **ZZ** in NM101; 0B, 1G, G2 in REF01	
Change>	Last Name	2310C	NM103	1035	~~73~~ **ZZ** in NM101; 1 in NM102	
Change>	First Name	2310C	NM104	1036	~~73~~ **ZZ** in NM101; 1 in NM102	
No FL	Primary Language	2300	NTE02	352	UPI in NTE01	Submit as coded in facility system until further notice; **A11.38**

A11. Segment Review and Submission Requirements

A11.1 Introduction

The Segment Review Section lists segments in the order they must appear in the X12-837 submission file. The segment section includes instructions on how to implement the data elements that will make up the segment. The data element instructions will either:

* Demonstrate how to implement the segment data elements as indicated in the ANSI ASC X12 Implementation Guides

* Display with format (length/type) and/or data values specific to the data elements required for the New Hampshire Health Care Facility Discharge Data Submission implementation.

Note: The Data Type column will be an AN, N, R, ID, DT, or TM (Alpha Numeric, Numeric, Decimal, Identifier, Date, or Time) and carry the following meanings.

* AN data type allows all alpha numeric characters and is left justified

* N data type allows only numeric characters (no decimals) and is right justified

* R data type allows only numeric characters (with decimals) and is right justified

* ID data type allows all alpha numeric characters and is left justified

* DT data type allows only eight (8) digital dates as CCYYMMDD

* TM data type allows only four (4) digital times as HHMM

Generic Segment Note: This document does not list all data elements in each segment if they are not required for X12 syntax or for this submission. Any data reported in unlisted data elements will not be processed or stored.

A11.2 ISA Interchange Control Header (Header) - Required

ISA01 ID 2/2 Must equal "00"
ISA03 ID 2/2 Must equal "00"
ISA05 ID 2/2 Must equal "ZZ"
ISA06 AN 15/15 Must equal facility federal Tax ID (with no leading zeros)
ISA07 ID 2/2 Must equal "ZZ"
ISA08 AN 15/15 Must equal "DHHS-NHHDD"
ISA09 DT 6/6 Must equal Submission Date - YYMMDD format
ISA13 AN 9/9 Must equal Interchange Control Number (same value as Interchange Control Trailer, IEA02, and Functional Group Header, GS06, and Functional Group Trailer, GE02)
ISA16 AN 1/1 Must equal Component Element Separator, ":"

==> A11.2 - No Change

A11.3 GS Functional Group Header (Header) - Required

GS01 ID 2/2 Must equal "HC"
GS02 AN 2/15 Must equal Medicare Provider Number (with no leading zeros)
GS03 AN 2/15 Must equal "DHHS-NHHDD"
GS06 AN 1/9 Must equal Interchange Control Number (same value as Functional Group Trailer, GE02 and Interchange Control Number, ISA13)
GS07 ID 1/2 Must equal "X"
GS08 AN 1/12 Must equal "~~004010X096A1~~" "005010X223"

==> A11.3 - GS08 Changed; will accept 005010X223A1; the important part of GS08 is the first 6 digits, which will be either 004010 or 005010

A11.4 ST Transaction Set Header (Header) - Required

ST01 ID 3/3 Must equal "837"
ST02 AN 4/9 Must equal Transaction Set Control Number (same value as SE02)

==> A11.4 - No Change

A11.5 BHT Beginning of Hierarchical Transaction (Header) - Required

BHT01	ID	4/4	Must equal "0019"
BHT02	ID	2/2	Must equal "00" or "18"
BHT03	AN	1/50	Must equal File Sequence and Serial Number
BHT04	DT	8/8	Must equal Processing Date - CCYYMMDD format
BHT05	N	4/8	Must equal Processing Time

==> A11.5 - No Change

~~A11.6 REF Transaction Type Identification (Header) - Required~~

~~REF01~~	~~ID~~	~~2/3~~	~~Must equal "87"~~
~~REF02~~	~~AN~~	~~1/30~~	~~Must equal Transmission Type Code~~

==> A11.6 - Segment deleted in 5010

A11.7 NM1 Submitter Name (1000A) - Required

NM101	ID	2/3	Must equal "41"
NM102	ID	1/1	Must equal "2"
NM103	AN	1/60	Must equal Submitter/Facility Organization Name
NM108	ID	1/2	Must equal "46"
NM109	AN	2/80	Must equal facility federal Tax ID

==> A11.7 - No Change

A11.8 PER Submitter EDI Contact Information (1000A) - Required

Data elements below are required for X12 syntax.

PER01 ID 2/2 Must equal "IC"
PER02 AN 1/60 Must equal Submitter Contact Person Name
PER03 ID 2/2 Must equal "TE"
PER04 AN 1/256 Must equal Submitter Contact Person Telephone Number
PER05 ID 2/2 Must equal "EM" **or "FX"**
PER06 AN 1/256 Must equal Submitter Contact Person Email Address **or Fax #**

==> A11.8 - Will accept fax # in place of email address

A11.9 NM1 Receiver Name (1000B) - ~~Required~~ Optional

Data elements below are required for X12 syntax.

NM101 ID 2/3 Must equal "40"
NM102 ID 1/1 Must equal "2"
NM103 AN 1/60 Must equal "DHHS-NHHDD"

==> A11.9 - Segment is now Optional

A11.10 HL Billing/Service Provider Hierarchical Level (2000A) – Required

HL01 N 1/12 Must begin with 1 for the first HL01 in the transaction and be incremented by 1 each time an HL is used within the transaction. Only numeric values are allowed in HL01. The same value should also be reported in every subordinate Subscriber Hierarchical Level HL02.
HL03 ID 1/2 Must equal "20"
HL04 ID 1/1 Must equal "1"

==> A11.10 - No Change

A11.11 NM1 Billing/Service Provider Name (2010AA) - Required

NM101 ID 2/3 Must equal "85"
NM102 ID 1/1 Must equal "2"
NM103 AN 1/60 Must equal Billing/Service Provider Organization Name
NM108 ID 1/2 Must equal "XX"
NM109 AN 2/80 Must equal National Provider Identification (when available)

==> A11.11 - No Change

A11.12 N3 Billing/Service Provider Address (2010AA) - Required

N301	AN	1/55	Address Line 1
N302	AN	1/55	Address Line 2

==> A11.12 - No Change

A11.13 N4 Billing/Service City/State/Zip (2010AA) - Required

N401	AN	2/30	City
N402	ID	2/2	State
N403	ID	3/15	Zip Code

==> A11.13 - No Change

A11.14 REF Billing/Service Provider Secondary Identification (2010AA) - Situational

REPEAT 1

REF01	**ID**	**2/3**	**Must equal ~~"0B", "1G" or "G2"~~ "EI"**
REF02	AN	1/50	Must equal corresponding Identification Number

==> A11.14 - REF01 Changed - EI is the only valid code in 5010, replacing all others.

A11.15 PER Billing/Service Provider Contact Information (2010AA) - Situational

PER01	ID	2/2	Must equal "IC"
PER03	ID	2/2	Must equal "TE"
PER04	**AN**	**1/256**	**Billing/Service Provider Telephone Number**

==> A11.15 - PER04 Changed - Length changed from 1/80 to 1/256

A11.16 NM1 Pay-To ~~Provider~~ Address Name (2010AB) - Situational

NM101	ID	2/3	Must equal "87"
NM102	ID	1/1	Must equal "2"
NM103	AN	1/60	Must equal Pay-To Provider Organization Name
~~**NM108**~~	~~**ID**~~	~~**1/2**~~	~~**Must equal "XX"**~~
NM109	AN	2/80	Must equal National Provider Identification (when available)

==> A11.16 - NM1 Name Changed; NM108 no longer required - no valid codes in 5010

A11.17 N3 Pay-To Provider Address (2010AB) - Required

N301	AN	1/55	Address Line 1
N302	AN	1/55	Address Line 2

==> A11.17 - No Change

A11.18 N4 Pay-To Provider City/State/Zip (2010AB) - Required

N402	ID	2/2	State
N403	ID	3/15	Zip Code

==> A11.18 - No Change

A11.19 HL Subscriber Hierarchical Level (2000B) – Required

Note: If the subscriber is not the same as the patient, Loop 2000C must be used for the patient information. If the subscriber is the same as the patient, Loop 2000C is not sent.

HL01 AN 1/12 Must begin with 1 for the first HL01 in the transaction and be incremented by 1 each time an HL is used within the transaction. Only numeric values are allowed in HL01. The same value should also be reported in every subordinate Patient Hierarchical Level HL02.
HL02 AN 1/12 Must contain the same value as the parent Service Provider Hierarchical Level HL01
HL03 ID 1/2 Must equal "22"
HL04 ID 1/1 Must equal "0" for subscriber as patient or "1" patient different than subscriber

==> A11.19 - No Change

A11.20 SBR Subscriber Information (2000B) - Required

Note: Will only processes and store the subscriber information when the subscriber IS the patient.

SBR01 ID 1/1 Must equal "P"
SBR02 ID 2/2 Must equal "18" if the subscriber IS the patient, otherwise not required.
~~**SBR09 ID 1/2 Must equal "09" if Self Pay claim, otherwise not required.**~~

==> A11.20 - SBR09 no longer required - 09 not valid in 5010

A11.21 NM1 Subscriber Name (2010BA) – Required if subscriber IS the patient

The following are data values for this segment if the subscriber IS the patient.

NM101	ID	2/3	Must equal "IL"
NM102	ID	1/1	Must equal "1"
NM103	AN	1/60	Must equal Subscriber's Last Name (encrypted)
NM104	AN	1/35	Must equal Subscriber's First Name (encrypted)
NM105	AN	1/25	Must equal Subscriber's Middle Name (encrypted)

==> A11.21 - No Change

A11.22 N3 Subscriber Address (2010BA) – Required if subscriber IS the patient

N301 AN 1/55 Must equal Subscriber's Street Address
N302 AN 1/55 Must equal Subscriber's Street Address Line 2, if applicable

==> A11.22 - No Change

A11.23 N4 Subscriber City/State/Zip (2010BA) – Required if subscriber IS the patient

N401 AN 2/30 Must equal Subscriber's City
N402 ID 2/2 Must equal Subscriber's State or Province if in U.S. or Canada. If outside the U.S. or Canada, must equal “XX”.
N403 ID 3/15 Must equal Subscriber's Postal Code. **If no fixed residence, must equal "XXXXX".**
N404 ID 2/3 Must equal Subscriber’s Country Code if outside the U.S.

==> A11.23 - N403 Changed

A11.24 DMG Subscriber Demographic Information (2010BA) - Required if subscriber IS the patient

DMG01	ID	2/3	Must equal "D8"
DMG02	AN	1/35	Must equal Birth Date in CCYYMMDD format
DMG03	ID	1/1	Must equal Patient Sex ("F", "M", or "U")

DMG05 is a composite data element. The Component Element Separator (ISA16) must be used before and after the composite data element DMG05-2, "RET". Below is a DMG segment example.
DMG05-2 ID 1/3 Must equal "RET"
DMG05-3 ID 1/30 Must equal all defined Race and Ethnicity ("R1", "R2", "R3", "R4", "R5", "R9", "E1", or "E2")

Example: DMG*D8*19880208*F**:RET:R5^:RET:E2~

==> A11.24 - No Change

A11.25 NM1 Payer Name (~~2010BC~~ 2010BB) - Required

NM101 ID 2/3 Must equal "PR"
NM102 ID 1/1 Must equal "2"
NM103 AN 1/60 Must equal Payer Name or "SELF PAY" for Self Pay claims
NM108 ID 1/2 Must equal "PI" or "XV", must be "PI" for Self Pay claims
NM109 AN 2/80 Must equal National Plan ID when available, or "009" for Self Pay claims

==> A11.25 - NM1 loop changed

A11.26 HL Patient Hierarchical Level (2000C) - Required if subscriber IS NOT the patient

Note: If the subscriber is not the same as the patient, Loop 2000C must be used for the patient information. If the subscriber is the same as the patient, Loop 2000C is not sent.

HL01 AN 1/12 Must begin with 1 for the first HL01 in the transaction and be incremented by 1 each time an HL is used within the transaction. Only numeric values are allowed in HL01.
HL02 AN 1/12 Must contain the same value as the parent Subscriber Hierarchical Level HL01
HL03 ID 1/2 Must equal "23"
HL04 ID 1/1 Must equal "0"

==> A11.26 - No Change

A11.27 PAT Patient Information (2000C) - Required if subscriber IS NOT the patient

The following are data values for this segment if the subscriber IS NOT the patient.

PAT01 ID 2/2 Must equal Individual Relationship Code

==> A11.27 - No Change

A11.28 NM1 Patient Name (2010CA) - Required if subscriber IS NOT the patient

The following are data values for this segment if the subscriber IS NOT the patient.

NM101 ID 2/3 Must equal "QC"
NM102 ID 1/1 Must equal "1"
NM103 AN 1/60 Must equal Patient's Last Name (encrypted)
NM104 AN 1/35 Must equal Patient's First Name (encrypted)
NM105 AN 1/25 Must equal Patient's Middle Name (encrypted)

==> A11.28 - No Change

A11.29 N3 Patient Address (2010CA) - Required if subscriber IS NOT the patient

N301 AN 1/55 Must equal Patient's Street Address
N302 AN 1/55 Must equal Patient's Street Address Line 2, if applicable

==> A11.29 - No Change

A11.30 N4 Patient City/State/Zip Code (2010CA) - Required if subscriber IS NOT the patient

N401 AN 2/30 Must equal Patient's City
N402 ID 2/2 Must equal Patient's State or Province if in U.S. or Canada. If outside the U.S. or Canada, must equal “XX”.
N403 ID 3/15 Must equal Patient's Postal Code. **If no fixed residence, must equal "XXXXX".**
N404 ID 2/3 Must equal Country Code if outside the U.S.

==> A11.30 - N403 Changed

A11.31 DMG Patient Demographic Information (2010CA) - Required if subscriber IS NOT the patient

DMG01 ID 2/3 Must equal "D8"
DMG02 AN 1/35 Must equal Birth Date in CCYYMMDD format
DMG03 AN 1/1 Must equal Patient Sex ("F", "M", or "U")

DMG05 is a composite data element. The Component Element Separator (ISA16) must be used before and after the composite data element DMG05-2, "RET". Below is a DMG segment example.

DMG05-2 ID 1/3 Must equal "RET"
DMG05-3 ID 1/30 Must equal all defined Race and Ethnicity ("R1", "R2", "R3", "R4", "R5", "R9", "E1", or "E2")

Example: DMG*D8*19880208*F**:RET:R5^:RET:E2~

==> A11.31 - No Change

A11.32 CLM Claim Information (2300) - Required

CLM01	AN	1/38	Must equal Patient Control Number
CLM02	R	1/18	Must equal Total Claim Charges

CLM05 is a composite data element. The Component Element Separator (ISA16) must be used before and after the composite data element, below is a CLM segment example.

CLM05-1	AN	1/2	Must equal Bill Type Facility Code Value
CLM05-2	ID	1/2	Must equal Uniform Billing Claim Form Bill Type
CLM05-3	ID	1/1	Must equal Bill Type Claim Frequency Code
~~**CLM06**~~	~~**ID**~~	~~**1/1**~~	~~**Must equal Provider Signature on File, Yes (Y) or No (N)**~~
CLM08	ID	1/1	Must equal Assignment of Benefits Indicator, Yes (Y) or No (N)
CLM09	ID	1/1	Must equal Release of Information Code
~~**CLM18**~~	~~**ID**~~	~~**1/1**~~	~~**Must equal Explanation of Benefits (EOB) Indicator**~~

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

==> A11.32 - CLM06 & CLM18 no longer required - not used in 5010

A11.33 DTP Discharge Hour (2300) – Situational (Inpatient)

DTP01	ID	3/3	Must equal "096"
DTP02	ID	2/3	Must equal "TM"
DTP03	**AN**	**1/35**	**Must equal Discharge ~~Hour~~ Time (HHMM format)**

==> A11.33 - DTP03 Changed

A11.34 DTP Statement Dates (2300) - Required

DTP01	ID	3/3	Must equal "434"
DTP02	ID	2/3	Must equal "RD8"
DTP03	AN	1/35	Must equal Statement Period From and Through Dates (CCYYMMDD-CCYYMMDD format)

==> A11.34 - No Change

A11.35 DTP Admission Date/Hour (2300) – Situational (Inpatient)

DTP01	ID	3/3	Must equal "435"
DTP02	ID	2/3	Must equal "DT"
DTP03	AN	1/35	Must equal Admission Date/Hour (CCYYMMDDHHMM format)

==> A11.35 - No Change

A11.36 CL1 Institutional Claim Code (2300) – Situational

CL101 ID 1/1 Must equal Type of Admission Code
CL102 ID 1/1 Must equal Source of Admission Code
CL103 ID 1/2 Must equal Patient Status / Disposition Code

==> A11.36 - No Change

A11.37a REF Payer Claim Control Number (2300) - ~~Situational~~ Optional

REF01	ID	2/3	Must equal "F8"
REF02	AN	1/50	Must equal Document Control Number

==> A11.37a - Omitted in original submission manual; but not really needed

A11.37b REF Medical Record Number (2300) - Required

REF01	ID	2/3	Must equal "EA"
REF02	AN	1/50	Must equal Medical Record Number

==> A11.37b - Re-numbered - used to be A11.37

A11.38 NTE Claim Note (2300) – Situational with note

NTE01	ID	3/3	Must equal "UPI"
NTE02	AN	1/30	See below for NTE requirements

Note: Spaces equaling the data element length must be used if a data element cannot be supplied. Below are NTE segments examples:

NTE*UPI*FRENCH~

==> A11.38 - No Change

A11.39a HI Principal Diagnosis (2300) - Required

HI01 is a required composite data element. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1	ID	1/3	Must equal "BK" **or "ABK"**
HI01-2	AN	1/30	Must equal Principal Diagnosis Code
HI01-9	ID	1/1	Must equal **Present on Admission** Indicator Y (Yes), N (No), U (Unknown/No information on the Record), W (Clinically Undetermined) or 1 (Diagnosis code exempt from POA reporting)

Example of ICD-9 Principal Diagnosis Code: HI*BK:63491:::::::Y~

==> A11.39a - Re-numbered - used to be A11.39; re-named to "Principal Diagnosis" and is now required; HI01-1 includes a new code of ABK; BK is used for ICD-9 and ABK is used for ICD-10; HI01-9 is "Present on Admission (POA)" and is situational for inpatient and specialty; it is not used for outpatient.

A11.39b HI Admitting Diagnosis (2300) - Situational

HI01 is a required composite data element. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1	ID	1/3	Must equal "BJ" or "~~ZZ~~" or "ABJ"
HI01-2	AN	1/30	Must equal Admitting Diagnosis Code (ICD Code)

Example of ICD-9 Admitting Diagnosis Code: HI*BJ:30000~

==> A11.39b - New situational segment; BJ is used for ICD-9 and ABJ is used for ICD-10. Segment is required for inpatient and specialty hospitals.

A11.39c HI Patient Reason For Visit (2300) - ~~Required~~ Situational

HI01 - HI03 are composite data elements. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1	ID	1/3	Must equal "PR" or "APR"
HI01-2	AN	1/30	Must equal Patient Reason for Visit Code (ICD Code)
HI02-1	ID	1/3	Must equal "PR" or "APR"
HI02-2	AN	1/30	Must equal Patient Reason for Visit Code (ICD Code)
HI03-1	ID	1/3	Must equal "PR" or "APR"
HI03-2	AN	1/30	Must equal Patient Reason for Visit Code (ICD Code)

Example of two ICD-9 Reason for Visit Codes: HI*PR:29420*PR:29622~

==> A11.39c - New situational segment; Required on outpatient; Patient Reason for Visit omitted in original submission manual; PR is used for ICD-9; APR is used for ICD-10.

A11.39d HI External Cause of Injury (2300) - Situational

HI01 - HI03 are composite data elements. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1	ID	1/3	Must equal "BN" or "ABN"
HI01-2	AN	1/30	Must equal External Cause of Injury Code (E-Code)
HI02-1	ID	1/3	Must equal "BN" or "ABN"
HI02-2	AN	1/30	Must equal External Cause of Injury Code (E-Code)
HI03-1	ID	1/3	Must equal "BN" or "ABN"
HI03-2	AN	1/30	Must equal External Cause of Injury Code (E-Code)

Example of three ICD-9 ECodes: HI*BN:E8786*BN:E8800*BN:E9586~

==> A11.39d - New situational segment; BN is used for ICD-9; ABN is used for ICD-10.

A11.40 HI Other Diagnosis Information (2300) - Situational

HI01-HI12 are required composite data elements that have a **~~second~~ first** through twelfth Other Diagnosis Code, respectively. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1	ID	1/3	Must equal "BF" **or "ABF"**
HI01-2	AN	1/30	Must equal Other Diagnosis Code
HI01-9	ID	1/1	Must equal **Present on Admission** Indicator Y (Yes), N (No), U (Unknown/No information on the Record) or W (Clinically Undetermined) or 1 (Diagnosis code exempt from POA reporting)

HI02-1 thru HI12-1	ID	1/3	Must equal "BF" **or "ABF"**
HI02-2 thru HI12-2	AN	1/30	Must equal Other Diagnosis Code
HI02-9 thru HI12-9	ID	1/1	Must equal **Present on Admission** Indicator Y (Yes), N (No), U (Unknown/No information on the Record) or W (Clinically Undetermined) or 1 (Diagnosis code exempt from POA reporting)

Note: A second repeat of these segments may be used to report Other Diagnosis Codes 13 through 24.

Example reporting **five other ICD-9 diagnosis codes: HI01 thru HI05**:
HI*BF:99591:::::::N*BF:5789:::::::N*BF:2851:::::::N*BF:5849:::::::N*BF:40391:::::::Y*~

==> A11.40 - BF is used for ICD-9; ABF is used for ICD-10; "Onset of Diagnosis Indicator" changed to "Present on Admission Indicator (POA)". POA is situational for inpatient and specialty; it is not used for outpatient.

A11.41 HI Principal Procedure Information (2300) - Situational

HI01 is a required composite data element. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1	ID	1/3	Must equal "BR" or ~~**"BP"**~~ **"BBR"**
HI01-2	AN	1/30	Must equal Principal Procedure Code
~~**HI01-3**~~	~~**ID**~~	~~**2/3**~~	~~**Must equal "D8"**~~
~~**HI01-4**~~	~~**AN**~~	~~**1/35**~~	~~**Must equal Principal Procedure Date (CCYYMMDD format)**~~

~~**Example: HI*BR:3614:D8:20060413~**~~
Example: HI*BR:3614~

==> A11.41 - BR is used for ICD-9; BBR is used for ICD-10; HI01-3 & HI01-4 are not used in 5010.

A11.42 HI Other Procedure Information (2300) - Situational

HI01-HI12 are used for claims that have a ~~**second**~~ **first** through twelfth Other Procedure Code, respectively. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1 thru HI12-1	ID	1/3	Must equal "BQ" or ~~**"BO"**~~ **"BBQ"**
HI01-2 thru HI12-2	AN	1/30	Must equal Other Procedure Code
HI01-3 thru HI12-3	ID	2/3	Must equal "D8"
HI01-4 thru HI12-4	AN	1/35	Must equal Other Procedure Date (CCYYMMDD format)

Example of two ICD-9 Other Procedure Codes:
HI*BQ:3963:D8:20060413*BQ:3964:D8:20060413~

==> A11.42 - BQ is used for ICD-9; BBQ is used for ICD-10; segment begins with HI01 rather than HI02 as stated in original submission manual.

A11.43 HI Occurrence Span Information (2300) - Situational

Required when occurrence span information applies to the claim or encounter.

HI01-1 thru HI12-1	ID	1/3	Must equal "BI"
HI01-2 thru HI12-2	AN	1/30	Must equal Occurrence Span Code
HI01-3 thru HI12-3	ID	2/3	Must equal "RD8"
HI01-4 thru HI12-4	AN	1/35	Must equal Occurrence Span Period From and Through Dates (CCYYMMDD-CCYYMMDD format)

Example: HI*BI:70:RD8:19981202-19981212~

==> A11.43 - Segment begins with HI01 rather than HI02 as stated in original submission manual.

A11.44 HI Occurrence Information (2300) - Situational

HI01-HI12 are required composite data elements. HI02-HI12 are used for claims that have additional reportable Occurrence Code conditions. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1 ID 1/3 Must equal "BH"
HI01-2 AN 1/30 Must equal valid UB-04 occurrence codes; sample values are as follows: "01", "02", "03", "04", "05", or "06"
HI01-3 ID 2/3 Must equal "D8"
HI01-4 AN 1/35 Must equal Occurrence Associated Date (CCYYMMDD format)

HI02-1 thru HI12-1 ID 1/3 Must equal "BH"
HI02-2 thru HI12-2 AN 1/30 Must equal valid UB-04 occurrence codes; sample values are as follows: "01", "02", "03", "04", "05", or "06"
HI02-3 thru HI12-3 ID 2/3 Must equal "D8"
HI02-4 thru HI12-4 AN 1/35 Must equal Occurrence Associated Date (CCYYMMDD format)

Note: Reportable Occurrence Code conditions may be reported multiple times.

Example of two Occurrence Codes: HI*BH:01:D8:20130914*BH:17:D8:20130921~

==> A11.44 - No change except to update the example.

A11.45 HI Value Information (2300) - Situational

HI01-HI12 are required composite data elements. HI02-HI12 are used for claims that have additional reportable Value Code conditions. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1 ID 1/3 Must equal "BE"
HI01-2 AN 1/30 Must equal valid UB-04 value codes sample values are as follows: "14", "15", "21", "22", "23", "37", "45", "54" or “P0”
HI01-5 R 1/18 Must equal Value Information

HI02-1 thru HI12-1 ID 1/3 Must equal "BE"
HI02-2 thru HI12-2 AN 1/30 Must equal valid UB-04 value codes sample values are as follows: "14", "15", "21", "22", "23", "37", "45", "54" or “P0”
HI02-5 thru HI12-5 R 1/18 Must equal Value Information

Note: Reportable Value Code conditions may be reported multiple times.
Example **of a value code of 45 and a value amount of $6.00**: HI*BE:45:::6.00~

==> A11.45 - No change except to add a comment to the example.

A11.46 HI Condition Information (2300) - Situational

HI01-HI12 are required composite data elements. HI02-HI12 are used for claims that have additional reportable Condition Codes. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI01-1 ID 1/3 Must equal "BG"
HI01-2 AN 1/30 Must equal valid UB-04 condition codes sample values are as follows: “02”, “P1”, "17", "25", "A2", "A3", "A4", or "A5"

HI02-1 thru HI12-1 ID 1/3 Must equal "BG”
HI02-2 thru HI12-2 AN 1/30 Must equal valid UB-04 condition codes sample values are as follows: “02”, “P1”, "17", "25", "A2", "A3", "A4", or "A5"

Note: Condition Codes may be reported multiple times.
Example: HI*BG:17~

==> A11.46 - No Change

A11.47 NM1 Attending ~~Physician~~ Provider Name (2310A) – Required (on Inpatient)

NM101	ID	2/3	Must equal "71"
NM102	ID	1/1	Must equal "1"
NM103	AN	1/60	Must equal Attending **~~Physician~~ Provider** Last Name
NM104	AN	1/35	Must equal Attending **~~Physician~~ Provider** First Name
NM105	AN	1/25	Must equal Attending **~~Physician~~ Provider** Middle Name
NM108	ID	2/2	Must equal “XX”
NM109	AN	2/80	Must equal Attending Provider National Provider ID

==> A11.47 - Name changed from Physician to Provider

A11.48 REF Attending ~~Physician~~ Provider Secondary Identification (2310A) – Situational (on Inpatient)

REF01 ID 2/3 Must equal "0B”, “1G”, or ”G2”
REF02 AN **1/50** Must equal Attending **~~Physician~~ Provider** Secondary Identifier

==> A11.48 - Name changed from Physician to Provider; length changed from 1/30 to 1/50. Required when NPI is unavailable.

A11.49 NM1 Operating Physician Name (2310B) – Required (on Surgical)

NM101 ID 2/3 Must equal "72"
NM102 ID 1/1 Must equal "1"
NM103 AN 1/60 Must equal Operating Physician Last Name
NM104 AN 1/35 Must equal Operating Physician First Name
NM105 AN 1/25 Must equal Operating Physician Middle Name
NM108 ID 2/2 Must equal "XX"
NM109 AN 2/80 Must equal Operating Physician National Provider ID

==> A11.49 - No Change

A11.50 REF Operating Physician Secondary Identification (~~2310A~~ 2310B) – Situational (on Surgical)

REF01 ID 2/3 Must equal "0B", "1G", or "G2"
REF02 AN **1/50** Must equal Operating Physician Secondary Identifier

==> A11.50 - REF loop corrected from original submission manual; length changed from 1/30 to 1/50. Required when NPI is unavailable.

A11.51 NM1 Other ~~Provider~~ Operating Physician Name (2310C) – Required if Other declared

NM101 ID 2/3 Must equal **~~"73"~~ ZZ**
NM102 ID 1/1 Must equal "1"
NM103 AN 1/60 Must equal Other **~~Provider~~ Operating Physician** Last Name
NM104 AN 1/35 Must equal Other **~~Provider~~ Operating Physician** First Name
NM105 AN 1/25 Must equal Other **~~Provider~~ Operating Physician** Middle Name
NM108 ID 2/2 Must equal "XX"
NM109 AN 2/80 Must equal Other **~~Provider~~ Operating Physician** National Provider ID

==> A11.51 - Name changed from Provider to Operating Physician; code changed from 73 to ZZ.

A11.52 REF Other ~~Provider~~ Operating Physician Secondary Identification (~~2310A~~ 2310C) – Situational (if Other declared)

REF01 ID 2/3 Must equal "0B", "1G", or "G2"
REF02 AN **1/50** Must equal Other **~~Provider~~ Operating Physician** Secondary Identifier

==> A11.52 - REF loop corrected from original submission manual; length changed from 1/30 to 1/50; name changed from Provider to Operating Physician.

A11.53 LX Service Line ~~Number~~ (2400) - Required

LX01 N 1/6 This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.

==> A11.53 - Segment name changed to remove the word "Number".

A11.54 SV2 Institutional Service Line (2400) - Required

SV201	AN	1/48	Must equal UB Revenue Code
SV202-1	ID	2/2	Must equal "HC", "IV" ~~or "ZZ"~~**, "ER", "HP", or "WK"**
SV202-2	AN	1/48	Must equal HCPCS/CPT Procedure Code
SV202-3	AN	2/2	Must equal Modifier 1
SV202-4	AN	2/2	Must equal Modifier 2
SV202-5	AN	2/2	Must equal Modifier 3
SV202-6	AN	2/2	Must equal Modifier 4
SV203	**R**	**1/18**	**Must equal Total Line Item Charge Amount**
SV204	**ID**	**2/2**	**Must equal "DA" or "UN"**
SV205	**R**	**1/15**	**Must equal Service Units/Days**

Example of a revenue code 0202; HCPCS code 77052; modifiers XX and YY; total charge 154, and service units 2: SV2*0202*HC:77052:XX:YY*154*UN*2~

==> A11.54 - Added new codes - ZZ deleted; added SV203, SV204, and SV205, which were omitted from the original submission manual. Data element for accommodation rate removed as it is not used in 5010; accommodation rate can be computed by dividing total charge (SV203) by number of units (SV205).

A11.55 DTP Date - Service ~~Line~~ Date (2400) – ~~Required~~ Situational

DTP01 ID 3/3 Must equal "472"
DTP02 ID 2/3 Must equal "D8" for format CCYYMMDD or "RD8" for format CCYYMMDD-CCYYMMDD
DTP03 AN 1/35 Must equal Service Date(s)

==> A11.55 - Segment name changed. Required for outpatient.

A11.56 SE Transaction Set Trailer (Trailer) - Required

SE01 N 1/10 Must equal Total number of segments included in a transaction set including ST and SE segments
SE02 AN 4/9 Must equal Transaction Set Control Number (same value as ST02)

==> A11.56 - No Change

A11.57 GE Functional Group Trailer (Trailer) - Required

GE01 AN 1/6 Must equal Number of Transaction Sets
GE02 AN 1/9 Must equal Interchange Control Number (same value as Functional Group Header, GS06, ISA13 and IEA02)

==> A11.57 - No Change

A11.58 IEA Interchange Control Trailer (Trailer) - Required

IEA01 AN 1/5 Must equal Number of Included Functional Groups
IEA02 AN 9/9 Must equal Interchange Control Number (same value as Interchange Control Header, ISA13, GS06 and GE02)

==> A11.58 - No Change

A12. Self Pay Claims

Self Pay claims will be handled by treating the patient as the Subscriber, although some data elements have specific values. The SBR segment of the 2000B loop for Self Pay claims is defined below. **Note that SBR09 is no longer required**:

SBR01 Must equal "P"
SBR02 Must equal "18" for self
~~**SBR09 Must equal "09" for Self Pay claims**~~

Example: SBR*P*18~

The additional sections of the 2010BA loop, NM1, N3, N4, and DMG, will be submitted as usual for a Subscriber as patient situation.

Payer Information (NM1 segment in the ~~**2010BC**~~ **2010BB** loop) for Self Pay claims is defined below:

NM101 Must equal "PR"
NM102 Must equal "2"
NM103 Must equal "SELF PAY"
NM108 Must equal "PI"
NM109 Must equal "009" for Self Pay claims

Example: NM1*PR*2*SELF PAY*****PI*009~

All additional loops required for a Subscriber remain required for Self Pay claims.