New Hampshire Health Care Facility Discharge Data Submission Manual

Prepared for the
New Hampshire Department of Health and Human Services
by
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Version 7

Contents

1. Introduction

This manual contains the instructions for submission of health care facility discharge data from acute care hospitals, specialty hospitals, freestanding hospital emergency facilities, and walk-in urgent care centers in New Hampshire in accordance with CHAPTER He-C 1500 Data Submission and Release of Health Care Facility Discharge Data. Up to date information on the rule can be found online at:

http://www.gencourt.state.nh.us/rules/he-c1500.html

The rule defines the data and the required submitting facilities as follows:

"Health care data" means information consisting of, or derived directly from patient discharge data. "Health care data" does not include analysis, reports, or studies containing information from health care data sets, if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by the department.

"Health care facility" means, in this chapter, a public or private, proprietary or not-for-profit entity or institution providing health services licensed under RSA 151:2 that is an:

(1) Acute care hospital;

(2) Specialty hospital;

(3) Freestanding hospital emergency facility; or

(4) Walk-in urgent care center.

Further definitions for each facility are as follows:

"Acute care hospital" means a health care facility that is licensed by the state of New Hampshire under RSA 151:2 as a general hospital.

"Specialty hospital" means a health care facility licensed by the state of New Hampshire under RSA 151:2 as a specialty hospital that is engaged in providing psychiatric, substance abuse, physical rehabilitation, long term acute care, or other services to patients under the supervision of a physician.

"Freestanding hospital emergency facility" means a health care facility that is licensed by the state of New Hampshire under RSA 151:2 as a freestanding hospital emergency facility.

"Walk-in urgent care center" means a health care facility licensed under RSA 151:2 by the state of New Hampshire as part of a larger general hospital, freestanding hospital emergency facility, or outpatient clinic that provides patients access to prompt medical care for minor illnesses or injury without an appointment.

Furthermore, this document is to provide guidelines for creating an ANSI ASC X12-837 Version 4010A file as it is implemented for the New Hampshire CHAPTER He-C 1500 Data Submission and Release of Health Care Facility Discharge Data. This format is based on the 837 Health Care Service Data Reporting implementation guide (X156). This document is to be used as an addendum document to the ANSI ASC X12 implementation guides and assumes the reader is familiar with the 837 Claim/Encounter Standard.

Note 1: Although this guide references discharge data as "claims" or "encounters", it must be noted that an X12-837 created with only the submission required segments will not be complete enough for payer submissions. Conversely, an X12-837 created with only the payer required segments will not be complete enough for these submissions. The additional data needed is noted in this document.

Note 2: Any data included in 837 submissions required by payer systems, but not necessary for this submission will be ignored by the processing system. Additional data submitted will NOT cause a rejection.

It is expected that the reader familiarize themselves with the ANSI ASC X12 837 standard and relevant implementation guides. Chapters One and Two and Appendices A and B of the ANSI ASC X12 implementation guides provide a detailed discussion regarding the X12-837 and its envelope. These implementation guides are available from the Washington Publishing Company Web site at www.wpc-edi.com.

The UB-04 and X12-837 are the standards governing New Hampshire Hospital discharge data submissions. As those standards change it is the intent to keep this submission manual current. If the manual is or becomes inconsistent with defined UB-04 and X12-837 standards users should submit data according to the standards.

The U.S. Centers for Disease Control and Prevention (CDC) maintains a code set for use in coding race and ethnicity. This code set is based on current federal standards for classifying race and ethnicity, specifically the minimum race and ethnicity categories defined by the U.S. Office of Management and Budget (OMB) and a more detailed set of race and ethnicity categories maintained by the U.S. Bureau of the Census (BC). These federal standards classify data on race and ethnicity exchanged, stored, retrieved, or analyzed in electronic form. The current federal code set for race and ethnicity can be found at:

http://www.cdc.gov/nedss/DataModels/Race_Ethnicity_CodeSet.pdf

2. Outpatient Hospital Data Submission Record Selection Requirements

New Hampshire Administrative Rule Chapter He-C 1500 specifies that the health care facilities that must submit discharge data to the state are: general acute care hospitals, specialty hospitals, freestanding hospital emergency facilities, and walk-in urgent care centers. The rule further specifies that all discharges shall be submitted. As hospital outpatient department billing methods have evolved for scheduled services, a clarification of what outpatient hospital discharges should be submitted to the state is required. At the time He-C 1500 was adopted there was no clear definition available. The below provides guidance as to what outpatient hospital records should be submitted.

Do Report:

- Outpatient hospital records that are typically billed on a UB-04 with a type of bill code of '013x' under the general acute care hospitals tax ID.
- Everything not on the Don't Report list. When in doubt, report the information, since the state will be further categorizing the data records received so that hospitals, public health, researchers, and others using the data set can be assured of consistent record sets across facilities.
    - Note: the technical component of professional claims and bundled technical/professional claim lines at Critical Access Hospitals, should be reported.

Don't Report:

- Professional claims (those typically billed on a CMS 1500) billed under the hospital tax ID or other tax IDs should not be reported.
- Lab specimen only records should not be reported.

3. Filing Requirements

Health care facilities shall submit standard claims transactions representing a completed data set for patients using the definitions outlined in this manual. Data will be submitted beginning with discharges occurring on January 1, 2010, and continuing at least quarterly thereafter. Data submissions must be in a format compliant with the Official UB-04 Data Specifications Manual published by the National Uniform Billing Committee consistent with the date of service. As codes are added or changed in the UB-04 they will be valid as of the effective date. Data may be submitted either monthly or quarterly, following the filing periods outlined below. Data submissions shall be made using the ANSI ASC X12N 837 electronic file format pursuant to 45 CFR 162 as specified later in this manual.

4. Filing Periods

The discharge data set shall be submitted 60 days after the close of a month or quarter.

Monthly Data for:	Due Date:
January	March 31
February	April 30
March	May 31
April	June 30
May	July 31
June	August 31
July	September 30
August	October 31
September	November 30
October	December 31
November	January 31
December	February 28

Quarterly Data for:	Due Date:
January - March	May 31
April - June	August 31
July - September	November 30
October - December	February 28

Health care facilities may request up to 3 months additional time to file their first 2 submissions by submitting the request in writing to the department, including an explanation of the reason for the request. Please send requests to:

Andrew Chalsma
OMBP - NH DHHS
129 Pleasant St - Annex
Concord, NH 03301-6527

5. Registration

Each health care facility shall submit a registration to the department's agent by May 1, 2009 and annually thereafter, with the following information:

- Health care facility name and mailing address;
- Health care facility federal tax identification number;
- Health care facility national provider identification number(s); and
- Name, e-mail address, and mailing address of the person completing the registration.

Health care facilities becoming operational at a later date shall submit a registration within one month of becoming operational, and annually thereafter.

6. Initial Testing

Records submitted for testing should consist of one month's worth of discharge records. "Live" data will not be accepted until a facility has satisfactorily completed testing. Testing will also be required each time a facility changes information services vendors.

The following shows timeline for submission testing.

Test submission process available for use by facilities	11/1/2009
Submission of test data complete	2/28/2010
Quarter 1, 2010 data submission	5/31/2010
Quarter 2, 2010 data submission	8/31/2010
Quarter 3, 2010 data submission	11/30/2010

7. Electronic Transmissions:

Upon registration, the department's agent will provide facility contacts with the details regarding the following information:

- Encryption software to encrypt identified confidential data elements in place on submitter/facilities network;
- Secure ftp site for upload of encrypt and compressed (zipped) data submission;
- Security credentials (username and password) to access secure ftp site for file submissions.

The following guidelines are relevant for all submissions.

- Submission shall be made using the ANSI ASC X12N 837 institutional electronic file format pursuant to 45 CFR 162.
- Each encounter is represented by a separate CLM detail segment in the 837 electronic file.
- Without specific prior agreement, each facility must be submitted as a single file.
- Without specific prior agreement, separate facilities must submit separate files.

Details associated with transmittal record will be contained in transactional header sections of the 837 electronic file are in the following table. Sections 7, 8 and 10 of this manual detail the individual data elements and their requirements.

Transmittal Data Element	Descriptor Loop ID	HIPAA 837 Reference Designator
Submitting health care facility name	Submitter Name 1000A	NM103
Submitting health care facility tax id	Interchange Control Header; Submitter Name 1000A	ISA06; NM109
Submitting health care facility Medicare provider number	Functional Group Header	GS02
If different from submitting health care facility, the name and address of the location where discharges in the submitted records occurred;	Separate 837 file submission	
File name;	Beginning Hierarchal Transaction	BHT03
Contact person name;	Submitter EDI Contact Information 1000A	PER02
Contact person telephone number;	Submitter EDI Contact Information 1000A	PER03 = “TE” and PER04
Contact person e-mail address;	Submitter EDI Contact Information 1000A	PER05 = “EM” and PER06
Date processed;	Beginning Hierarchal Transaction	BHT04
Time processed;	Beginning Hierarchal Transaction	BHT05
Submission date;	Interchange Control Header	ISA09

8. Required Data Elements

CHAPTER He-C 1500 Data Submission and Release of Health Care Facility Discharge Data specifies Health care facilities shall submit data to the department, or its agent, as standard claims transactions in a format compliant with the Official UB-04 Data Specifications Manual published by the National Uniform Billing Committee. Please Note:

1. Unless otherwise specified in He-C 1503.04, the Official UB-04 Data Specifications Manual shall be the code source to be utilized for discharge data submission.
2. Unless otherwise specified in He-C 1503.04, data elements shall be required as defined by the UB-04 reporting standard in the Official UB-04 Data Specifications Manual.
3. Data submissions shall be made using the ANSI ASC X12N 837 electronic file format pursuant to 45 CFR 162.

8.1 UB-04 Specific Data Elements

The following elements from the UB-04 reporting standard shall be submitted as follows:

1. UB-04 Form Locator 01, “billing provider name, address and telephone number”;
2. UB-04 Form Locator 02, “pay-to name and address”;
3. UB-04 Form Locator 03a, “patient control number”;
4. UB-04 Form Locator 03b, “medical/health record number”, which shall be required on all claims;
5. UB-04 Form Locator 04, “type of bill”;
6. UB-04 Form Locator 05, “federal tax ID number”;
7. UB-04 Form Locator 06, “statement covers period”;
8. UB-04 Form Locator 08, “patient name/identifier”, which shall:
    a. Be encrypted using a standard methodology and software provided by the department or its agent before submission to the department or its agent; and
    b. Be divided into 4 distinct components of patient last name, patient first name, patient middle name, and patient generational identifier suffix, all provided in upper case prior to encryption;
9. UB-04 Form Locator 09, “patient address”;

10. UB-04 Form Locator 10, “patient birth date”;

11. UB-04 Form Locator 11, “patient sex”;

12. UB-04 Form Locator 12, “admission/start of care date”, which shall be required on all claims;

13. UB-04 Form Locator 13, “admission hour”, which shall be required on all claims;

14. UB-04 Form Locator 14, “priority (type) of visit”;

15. UB-04 Form Locator 15, “point of origin for admission or visit”;

16. UB-04 Form Locator 16, “discharge hour”, which shall be required on all inpatient and observation stay claims;

17. UB-04 Form Locator 17, “patient discharge status”;

18. UB-04 Form Locator 18 through 28, “condition codes”, which shall:

    a. Be submitted as recorded; and
    b. Be collected, recorded, and submitted where applicable for:

        i. 02 = Condition is Employment-Related; and
        ii. P1 = Do Not Resuscitate Order (DNR);

19. UB-04 Form Locator 31 through 34, “occurrence codes and dates 1 – 4”, which shall:

    a. Be submitted as recorded; and
    b. Be collected, recorded, and submitted where applicable for 04 = Accident/employment related date;

20. UB-04 Form Locator 39 through 41, “value codes and amounts”, which shall:

    a. Be submitted as recorded; and
    b. Be collected, recorded, and submitted where applicable for:

        i. 54 = Newborn Birth Weight in Grams; and
        ii. P0 = For newborns, mother’s medical record number;

21. UB-04 Form Locator 42, “revenue code”;

22. UB-04 Form Locator 44, “HCPCS or CPT/accommodation rates/HIPPS rate codes”, except the length limit shall not apply;

23. UB-04 Form Locator 45, “service date”;

24. UB-04 Form Locator 46, “service units”;

25. UB-04 Form Locator 47, “total charges”;

26. UB-04 Form Locator 50, “payer name”, except the length limit shall not apply;

27. UB-04 Form Locator 51, “health plan identification number”;

28. UB-04 Form Locator 56, “national provider identifier – billing provider”;

29. UB-04 Form Locator 57, “other (billing) provider identifier”;

30. UB-04 Form Locator 59, “patient’s relationship to insured”;

31. UB-04 Form Locator 64, “document control number”;

32. UB-04 Form Locator 65, “employer”, which shall:

    a. When the employer is not known, be recorded as “UNKNOWN”; and
    b. When not employed, be recorded as “NA”;

33. UB-04 Form Locator 66, “diagnosis and procedure code qualifier”;

34. UB-04 Form Locator 67, “principal diagnosis code and present on admission indicator” which for the present on admission (POA) element shall only be recorded on inpatient acute care discharges;

35. UB-04 Form Locator 67A-Q, “other diagnosis codes and present on admission indicator” which for the POA element shall only be recorded on inpatient acute care discharges;

36. UB-04 Form Locator 69, “admitting diagnosis code”;

37. UB-04 Form Locator 70A-C, “patient’s reason for visit”;

38. UB-04 Form Locator 72A-C, “external cause of injury code (ECI) and present on admission indicator”, which shall be reported in order for every applicable principal and other diagnoses;

39. UB-04 Form Locator 74, “principal procedure code and date”;

40. UB-04 Form Locator 74A-E, “other procedure codes and dates”;

41. UB-04 Form Locator 76, “attending provider name and identifiers”;

42. UB-04 Form Locator 77, “operating physician name and identifiers”;

43. UB-04 Form Locator 78 and 79, “other provider (individual) names and identifiers”;

44. UB-04 Form Locator 81A-D, “code-code field”, shall: be collected, recorded, and submitted where applicable for B1 (race and ethnicity); and submitted in

837 electronic transaction in conjunction with FL 08 patient demographic qualifier

8.2 Non UB-04 Specific Data Elements.

The health care facility shall also submit information regarding primary language spoken as the health care facility has coded it.

8.3 Race and Ethnicity Data Element Reference

Race and ethnicity codes will follow the standard associated with the U.S. Centers for Disease Control and Prevention (CDC) code set for use in coding race and ethnicity (see http://www.cdc.gov/nedss/DataModels/Race_Ethnicity_CodeSet.pdf). This hierarchical code set consists of two tables: (1) Race and (2) Ethnicity. The Race and Ethnicity tables include the U.S. Office of Management and Budget (OMB) minimum categories, 5 races and 2 ethnicities, along with a sixth race category, Other race.

October 9, 2009 Update: The Foundation for Health Communities Cultural Diversity Project Director and several NH Hospitals have provided feedback and additional advice on how to expand these code sets to encourage and permit the use of the 'refused/declined to provide' and 'unknown' codes for Race and Ethnicity. The hope is that this will allow for improved collection of the race and ethnicity information. For facilities that choose to use these codes, NH will monitor them over time and work with hospitals showing high rates of use relative to other hospitals to discover possible reasons for the variation. We encourage facilities to use this expanded code set and to avoid the use of null values as these codes will also provide more information than the use of null will provide.

Race

The OMB minimum categories for data on race are American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. The standard requires the recording multiple races for the same individual. Health care facilities must allow for recording and submittal of multiple codes.

The highest level codes representing the race code set are as follows:

R1 = American Indian / Alaskan Native
R2 = Asian
R3 = Black or African American
R4 = Native Hawaiian or Pacific Islander
R5 = White
R7=Refused/declined to provide
R8=Unknown
R9 = Other Race

Race codes are further detailed (if available) by building on the R1-R9 code set as in the following example:

R1 = American Indian or Alaska Native
R1.01 = American Indian
R1.02 = Alaska Native

R2 = Asian
R2.01 = Asian Indian
R2.02 = Bangladeshi
R2.03 = Bhutanese
R2.04 = Burmese
R2.05 = Cambodian
R2.06 = Chinese
R2.07 = Taiwanese
R2.08 = Filipino
R2.09 = Hmong
…

Ethnicity

There are two OMB minimum categories for data on ethnicity: Hispanic or Latino, and Not Hispanic or Latino. The highest level codes representing the ethnicity code set are as follows:

E1 = Hispanic or Latino
E2 = Not Hispanic or Latino
E7=Refused/declined to provide
E8=Unknown

Ethnicity codes are also further detailed (if available) by building on the E1 and E2 code set as follows:

E1 = Hispanic or Latino
E1.01 = Spaniard
E1.02 = Mexican
E1.03 = Central American
E1.04 = South American
E1.05 = Latin American
E1.06 = Puerto Rican
E1.07 = Cuban
E1.08 = Dominican

While additional detail can further segment race and ethnicity beyond the second level, no additional qualifiers are required nor will they be saved and processed with the discharge submission. Sections 10.23 and 10.29 of this manual detail how race and ethnicity are to be submitted in conjunction with other subscriber/patient demographic information.

9. Data Elements to HIPAA Loop and Reference Designation Crosswalk

UB-04 Form Locator		837 HIPAA 00410X096/004010X096A1				
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
FL 01	Billing Provider Name, Address and Telephone Number					
	Line 1 – Name	2010AA	NM103	1035	85 in NM101; 2 in NM102	
	Line 2 - Street Address	2010AA	N301 and N302	166		
	Line 3 - City (positions 1-12)	2010AA	N401	19		
	Line 3 - State (positions 14-15	2010AA	N402	156		
	Line 3 - ZIP Code (positions 17-25)	2010AA	N403	116		
	Line 4 - Telephone	2010AA	PER04	364	TE in PER03	
FL 02	Pay-to Name and Address					
	Line 1 - Pay-to Name	2010AB	NM103	1035	87 in NM101; 2 in NM102	
	Line 2 - Street Address or Post Office Box	2010AB	N301	166		
	Line 3 - State (positions 18-19)	2010AB	N402	156		
	Line 3 - ZIP Code (positions 21-25)	2010AB	N403	156		
FL 03a	Patient Control Number	2300	CLM01	1028		
FL 03b	Medical Record Number	2300	REF02	128	EA in REF01	
FL 04	Type of Bill					
	Facility Code (positions 2-3 of 4 in FL 04))	2300	CLM05-1	1331		Leading zero in FL 04 is not reported on 837
FL 05	Federal Tax Number (Only NPI when available otherwise	2010AA	NM109	67	XX in NM108	

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
	use FL 57 Other Billing Provider Identification)					
FL06	Statement Covers Period	2300	DTP03	1251	434 in DTPO1; RD8 in DTP02	
FL 08	Patient Name/Identifier					
	b- Patient Name	2010BA	NM103-105	1035-1037	IL in NMI01; 1 in NM102 ; MI in NM108	When FL59=18
		2010CA	NM103-105		QC in NM101; 1 in NM102 ; MI in NM108	When FL59 is not 18
FL81	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

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
		2010CA	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
FL09	Patient Address					
	a - Street Address	2010BA	N301	166		When FL59=18
		2010CA	N301	166		When FL59 is not 18
	b - City	2010BA	N401	19		When FL59=18
		2010CA	N401	19		When FL59 is not 18
	c- State	2010BA	N402	156		When FL59=18
		2010CA	N402	156		When FL59 is not 18
	d - ZIP Code	2010BA	N403	116		When FL59=18
		2010CA	N403	116		When FL59 is not 18
FL 10	Patient Birth Date	2010BA	DMG02	1251	D8 in DMG08	When FL59=18
		2010CA	DMG02	1251	D8 in DMG08	When FL59 is not 18

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
FL 11	Patient Sex	2010BA	DMG03	1068	F,M,U in DMG03	When FL59=18
		2010CA	DMG03	1068	F,M,U in DMG03	When FL59 is not 18
FL 12	Admission/Start of Care Date	2300	DTP03	1251	435 in DTPO1; DT in DTP02	
FL 13	Admission Hour	2300	DTP03	1251	435 in DTP01; DT in DTP02	
FL 14	Priority (Type) of Visit	2300	CL101	1315		
FL 15	Source of Admission/Point of Origin	2300	CL102	1314		
FL 16	Discharge Hour	2300	DTP03	1251	096 in DTP01; TM in DTP02	
FL 17	Patient Discharge Status	2300	CL103	1352		
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
	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/empl
	31a – Date	2300	HI01-4	1251	D8 in HI01-3	

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
	32a – Code	2300	HI02-2	1271	BH in HI02-1	oyment related date shall be recorded/submitted where applicable. Other codes shall be submitted when available
	32a – Date	2300	HI02-4	1251	D8 in HI02-3	
	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
	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		
	41a - Code	2300	HI09-2	1271	BE in HI09-1	

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
	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		
FL 44	HCPCS or CPT/Accommodation Rates/HIPPS Rates Codes					
	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	Service Date	2400	DTP03	1251	472 in DTP01; D8 in DTP02	
FL 46	Service Units	2400	SV205	380	DA, UN in SV204	
FL 47	Total Charges	2300	CLM02	782		
FL 50	Payer Name	2010BC	NM103	1035	PR in NM101; 2 in NM102	
FL 51	Health Plan Identifier	2010BC	NM109	67	PI or XV in NM108	
FL 56	National Provider Identifier - Billing Provider	2010AA	NM109	67	XX in NM108	
FL 57	Other (Billing) Provider Identifier	2010AA	REF02	127	0B, 1G, G2 in REF01	
FL 59	Patient's Relationship to Insured	2000B	SBR02	1069		When FL59= 18
	Patient's Relationship to Insured	2000C	PAT01	1069		When FL59 not 18
FL 64	Document Control Number	2300	REF02	127	F8 in REF01	
FL 65	Employer Name (of the Insured)				TBD	When the employer is not known, shall

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
						be recorded as "UNKNOWN"; When not employed, record as "NA"
FL 66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)				TBD	
FL 67	Principal Diagnosis Code					Primary Dx HI line
	Code	2300	HI01-2	1271	BK in HI01-1	
	POA Indicator	2300	HI01-9	449	BK in HI01-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y" "W" or "1")
FL 67A-Q	Other Diagnosis Codes					Secondary Dx HI line
	A - Code	2300	HI01-2	1271	BF in HI01-1	
	A - POA Indicator	2300	HI01-9	449	BF in HI01-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or "1")
	B - Code	2300	HI02-2	1271	BF in HI02-1	
	B - POA Indicator	2300	HI02-9	449	BF in HI02-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or "1")
	C - Code	2300	HI03-2	1271	BF in HI03-1	
	C - POA Indicator	2300	HI03-9	449	BF in HI03-1	Must equal

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
						Onset of Diagnosis Indicator ("N", "U", "Y", "W" or "1")
	D - Code	2300	HI04-2	1271	BF in HI04-1	
	D - POA Indicator	2300	HI04-9	449	BF in HI04-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or "1")
	E - Code	2300	HI05-2	1271	BF in HI05-1	
	E - POA Indicator	2300	HI05-9	449	BF in HI05-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or "1")
	F - Code	2300	HI06-2	1271	BF in HI06-1	
	F - POA Indicator	2300	HI06-9	449	BF in HI06-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or "1")
	G - Code	2300	HI07-2	1271	BF in HI07-1	
	G - POA Indicator	2300	HI07-9	449	BF in HI07-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or "1")
	H - Code	2300	HI08-2	1271	BF in HI08-1	
	H - POA Indicator	2300	HI08-9	449	BF in HI08-1	Must equal Onset of Diagnosis

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
						Indicator ("N", "U", "Y", "W" or “1”)
	I - Code	2300	HI09-2	1271	BF in HI09-1	
	1 - POA Indicator	2300	HI09-9	449	BF in HI09-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or “1”)
	J - Code	2300	HI10-2	1271	BF in HI10-1	
	J - POA Indicator	2300	HI10-9	449	BF in HI10-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or “1”)
	K - Code	2300	HI11-2	1271	BF in HI11-1	
	K - POA Indicator	2300	HI11-9	449	BF in HI11-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or “1”)
	L - Code	2300	HI12-2	1271	BF in HI12-1	
	L - POA Indicator	2300	HI12-9	449	BF in HI12-1	Must equal Onset of Diagnosis Indicator ("N", "U", "Y", "W" or “1”)
FL69	Admitting Diagnosis Code	2300	HI02-2	1271	BJ in HI02-1	Primary Dx HI line
FL 70a	Patient's Reason for Visit	2300	HI02-2	1271	ZZ in HI02-1	Primary Dx HI line
FL 72a-c	External Cause of Injury Code	2300				Primary Dx HI line

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
	a - Code	2300	HI04-2	1271	BK in HI04-1	ECI code shall be recorded/submitted for each injury/poisoning diagnosis (ICD9 800 to 999.9) in order diagnosis code is listed.
	b - Code	2300	HI05-2	1271	BK in HI05-1	
	c - Code	2300	HI06-2	1271	BK in HI06-1	
FL 74	Principal Procedure Code and Date					Principal Procedure HI line
	Code	2300	HI01-2	1271	BR in H101-1	
	Date	2300	HI01-4	1251	D8 in HI01-3	
74a-e	Other Procedure Codes and Dates					Principal Procedure HI line
	a Code	2300	HI02-2	1271	BQ in HI02-1	
	a Date	2300	HI02-4	1251	D8 in HI02-3	
	b - Code	2300	HI03-2	1271	BQ in HI03-1	
	b - Date	2300	HI03-4	1251	D8 in HI03-3	
	c - Code	2300	HI04-2	1271	BQ in HI04-1	
	c - Date	2300	HI04-4	1251	D8 in HI04-3	
	d - Code	2300	HI05-2	1271	BQ in HI05-1	
	d - Date	2300	HI05-4	1251	D8 in HI05-3	
	e - Code	2300	HI06-2	1271	BQ in HI06-1	
	e - Date	2300	HI06-4	1251	D8 in HI06-3	
FL 76	Attending Provider Name and Identifiers					
	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;	

UB-04 Form Locator			837 HIPAA 00410X096/004010X096A1			
		Loop ID	**Reference Designator**	**X12 Data Element #**	**Qualifier/Ref. Des./ Data Element**	**Notes**
					1 in NM102	
	First Name	2310A	NM104	1036	71 in NM101; 1 in NM102	
FL 77	Operating Physician Name and Identifiers					
	NPI	2310B	NM109	67	72 in NM101; XX in NM108	
	Secondary Identifier	2310B	REF02	127	72 in NM101; 0B, 1G, G2 in REF01	
	Last Name	2310B	NM103	1035	72 in NM101; 1 in NM102	
	First Name	2310B	NM104	1036	72 in NM101; 1 in NM102	
FL 78	Other Provider (Individual) Names and Identifiers					
	NPI	2310C	NM109	67	73 in NM101; XX in NM108	
	Secondary Identifier	2310C	REF02	127	73 in NM101; 0B, 1G, G2 in REF01	
	Last Name	2310C	NM103	1035	73 in NM101; 1 in NM102	
	First Name	2310C	NM104	1036	73 in NM101; 1 in NM102	
No FL	Primary Language	2300	NTE02	352	UPI in NTE01	Submit as coded in facility system until further notice

10. 837 Loop Diagram for DHHS-NHHDD

The diagram below is an outline representing the hierarchical structure of the X12-837 loops and segments. This hierarchical looping structure, we strongly suggest you study Appendix A in any of the published 837 contains the primary and secondary loop descriptions and the segment IDs. The indentations in the outline are intended to represent hierarchical relationships. The numbers in parenthesis in the right hand margin represent permissible repeats of that loop.

HEADER
ST Transaction Set Header
BHT Beginning of Hierarchical Transaction
REF Transmission Type Identification

- **LOOP ID 1000A SUBMITTER NAME (1)**
- NM1 Submitter Name
- REF Submitter Secondary Identification
- PER Submitter EDI Contact Information

- **LOOP ID 1000B RECEIVER NAME (1)**
- NM1 Receiver Name

    - Detail - Provider

    - **LOOP ID 2000A SERVICE PROVIDER HIERARCHICAL LEVEL (1)**
    - HL Service Provider Hierarchical Level

    - **LOOP ID 2010AA SERVICE PROVIDER NAME (1)**
    - NM1 Service Provider Name
    - REF Service Provider Secondary Identification

        - Detail - Subscriber

        - **LOOP ID 2000B SUBSCRIBED HIERARCHICAL LEVEL (>1)**
        - HL Subscriber Hierarchical Level
        - SBR Subscriber Information
        - PAT Patient Information

        - **LOOP ID 2010BA SUBSCRIBER NAME (1)**
        - NM1 Subscriber Name
        - N3 Subscriber Address
        - N4 Subscriber City/State/Zip Code
        - DMG Subscriber Demographic Information
        - REF Subscriber Secondary Identification

        - **LOOP ID 2010BC PAYER NAME (1)**
        - NM1 Payer Name

- REF Payer Secondary Identification

  - Detail – Patient/Subscriber

  - **LOOP ID 2000C PATENT HIERARCHICAL LEVEL (>1)**
  - HL Patient Hierarchical Level

  - **LOOP ID 2010CA PATIENT NAME (1)**
  - NM1 Patient Name
  - N3 Patient Address
  - N4 Patient City/State/Zip Code
  - DMG Patient Demographic Information
  - REF Patient Secondary Identification

    - Detail - Claim

    - **LOOP ID 2300 CLAIM INFORMATION (100)**
    - CLM Claim Information
    - DTP Statement Dates
    - DTP Discharge Hour
    - DTP Admission Date / Hour
    - CL1 Claim Codes
    - PWK Claim Supplemental Information
    - AMT Payer Estimated Amount Due
    - AMT Patient Estimated Amount Due
    - REF Medical Record Number
    - REF Mother's Medical Record Number
    - K3 File Information
    - NTE Claim Note
    - HI Principal Dx, Admitting Dx, and E-code
    - HI Diagnosis Related Group (DRG) Information
    - HI Other Diagnosis Information
    - HI Principal Procedure Information
    - HI Other Procedure Information
    - HI Occurrence Span Code Information
    - HI Occurrence Code Information
    - HI Value Code Information
    - HI Condition Code Information
    - QTY Claim Quantity

    - **LOOP ID 2310A ATTENDING PHYSICIAN NAME (1)**
    - NM1 Attending Physician Name
    - REF Attending Physician Secondary Information

    - **LOOP ID 2310B OPERATING PHYSICIAN NAME (1)**
    - NM1 Operating Physician Name
    - REF Operating Physician Secondary Information

    - **LOOP ID 2310C OTHER PHYSICIAN NAME (1)**
    - NM1 Other Physician Name

- REF Other Physician Secondary Information

- **LOOP ID 2310D REFERRING PHYSICIAN NAME (1)**
- NM1 Referring Physician Name
- REF Referring Physician Secondary Information

- **LOOP ID 2320 OTHER SUBSCRIBER INFO (10)**
- SBR Other Subscriber Information
- AMT Payer Prior Payment

- **LOOP ID 2330A OTHER SUBSCRIBER NAME (1)**
- NM1 Other Subscriber Name
- REF Other Subscriber Secondary Information

- **LOOP ID 2330B OTHER PAYER NAME (1)**
- NM1 Other Payer Name
- REF Other Payer Secondary Information

- **LOOP ID 2330C OTHER PAYER PATIENT INFO (1)**
- NM1 Other Payer Patient Information
- REF Other Payer Patient Identification Number

  → **LOOP ID 2400 SERVICE LINE NUMBER (1)**
  → LX Service Line Number
  → SV2 Institutional Service Line Information
  → DTP Service Line Date

SE Transaction Set Trailer
TRAILER

11. Segment Review and Submission Requirements

11.1 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.

11.2 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, ":"

11.3 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"

11.4 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)

11.5 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

11.6 REF Transaction Type Identification (Header) - Required

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

11.7 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

11.8 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"
PER06	AN	1/256	Must equal Submitter Contact Person Email Address

11.9 NM1 Receiver Name (1000B) - Required

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"

11.10 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"

11.11 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)

11.12 N3 Billing/Service Provider Address (2010AA) - Required

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

11.13 N4 Billing/Service City/State/Zip (2010AA) - Required

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

11.14 REF Billing/Service Provider Secondary Identification (2010AA) - Situational

REPEAT 1			
REF01	ID	2/3	Must equal "0B", “1G” or “G2”
REF02	AN	1/50	Must equal corresponding Identification Number

11.15 PER Billing/Service Provider Contact Information (2010AA) - Situational

PER01	ID	2/2	Must equal “IC”
PER03	ID	2/2	Must equal “TE”
PER04	AN	1/80	Billing/Service Provider Telephone Number

11.16 NM1 Pay-To Provider 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)

11.17 N3 Pay-To Provider Address (2010AB) - Required

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

11.18 N4 Pay-To Provider City/State/Zip (2010AB) - Required

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

11.19 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

11.20 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.

11.21 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)

11.22 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

11.23 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
N404	ID	2/3	Must equal Subscriber’s Country Code if outside the U.S.

11.24 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~

11.25 NM1 Payer Name (2010BC) - 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

11.26 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"

11.27 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

11.28 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)

11.29 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

11.30 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
N404	ID	2/3	Must equal Country Code if outside the U.S.

11.31 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~

11.32 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~

11.33 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 (HHMM format)

11.34 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)

11.35 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)

11.36 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

11.37 REF Medical Record Number (2300) - Required

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

11.38 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~

11.39 HI Principal, Admitting, and E-Codes (2300) - Situational

HI01-HI06 are required 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 "BK"
HI01-2 AN 1/30 Must equal Principal Diagnosis Code
HI01-9 ID 1/1 Must equal Onset of Diagnosis Indicator Y (Yes), N (No), U (Unknown/No information on the Record), W (Clinically Undetermined) or 1 (Diagnosis code exempt from POA reporting)

HI02-1 ID 1/3 Must equal "BJ" or “ZZ”
HI02-2 AN 1/30 Must equal Admitting Diagnosis Code

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

HI04-1 ID 1/3 Must equal "BN"
HI04-2 AN 1/30 Must equal External Cause of Injury Code (E-Code)

HI05-1	ID	1/3	Must equal "BN"
HI05-2	AN	1/30	Must equal External Cause of Injury Code (E-Code)
HI06-1	ID	1/3	Must equal "BN"
HI06-2	AN	1/30	Must equal External Cause of Injury Code (E-Code)

Example: HI*BK:63491*BJ:63491~

11.40 HI Other Diagnosis Information (2300) - Situational

HI01-HI12 are required composite data elements that have a second 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"
HI01-2	AN	1/30	Must equal Other Diagnosis Code
HI01-9	ID	1/1	Must equal Onset of Diagnosis 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"
HI02-2 thru HI12-2	AN	1/30	Must equal Other Diagnosis Code
HI02-9 thru HI12-9	ID	1/1	Must equal Onset of Diagnosis 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 HI01 thru HI12:
HI*BF:99591:::::::N*BF:5789:::::::N*BF:2851:::::::N*BF:5849:::::::N*BF:40391:::::::Y*~

11.41 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”
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~

11.42 HI Other Procedure Information (2300) - Situational

HI02-HI12 are used for claims that have a second through twelfth Other Procedure Code, respectively. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

HI02-1 thru HI12-1	ID	1/3	Must equal "BQ" or “BO”
HI02-2 thru HI12-2	AN	1/30	Must equal Other Procedure Code

HI02-3 thru HI12-3 ID 2/3 Must equal "D8"
HI02-4 thru HI12-4 AN 1/35 Must equal Other Procedure Date (CCYYMMDD format)

Example: HI*BQ:3963:D8:20060413*BQ:3964:D8:20060413~

11.43 HI Occurrence Span Information (2300) - Situational

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

HI02-1 thru HI12-1 ID 1/3 Must equal "BI"
HI02-2 thru HI12-2 AN 1/30 Must equal Occurrence Span Code
HI02-3 thru HI12-3 ID 2/3 Must equal "RD8"
HI02-4 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~

11.44 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: HI*BH:01:D8:20061124~

11.45 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: HI*BE:45:::6.00~

11.46 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~

11.47 NM1 Attending Physician 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 Last Name
NM104	AN	1/35	Must equal Attending Physician First Name
NM105	AN	1/25	Must equal Attending Physician Middle Name
NM108	ID	2/2	Must equal “XX”
NM109	AN	2/80	Must equal Attending Provider National Provider ID

11.48 REF Attending Physician Secondary Identification (2310A) – Situational (on Inpatient)

REF01	ID	2/3	Must equal "0B”, “1G”, or ”G2”
REF02	AN	1/30	Must equal Attending Physician Secondary Identifier

11.49 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 Provider National Provider ID

11.50 REF Operating Physician Secondary Identification (2310A) – Situational (on Surgical)

REF01	ID	2/3	Must equal "0B”, “1G”, or ”G2”
REF02	AN	1/30	Must equal Operating Physician Secondary Identifier

11.51 NM1 Other Provider Name (2310C) – Required if Other declared

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

11.52 REF Other Provider Secondary Identification (2310A) – Situational (if Other declared)

REF01	ID	2/3	Must equal "0B”, “1G”, or ”G2”
REF02	AN	1/30	Must equal Other Provider Secondary Identifier

11.53 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.

11.54 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”
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

11.55 DTP Service Line Date (2400) – Required

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)

11.56 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)

11.57 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)

11.58 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)

12. 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:

SBR01	Must equal “P”
SBR02	Must equal “18” for self
SBR09	Must equal “09” for Self Pay claims

Example: SBR*P*18*******09~

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 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.

13. Previous Data Layout to New Data Layout Cross-Walk

FILETYPE	NAME	STARTPOS	ENDPOS	New Rule	Form Locator	Notes
A	Birth Date	1	8	Y	FL10	
A	Sex	9	9	Y	FL11	
A	Zip Code	10	14	Y	FL09d	
A	Admission Date	15	20	Y	FL12	
A	Admission Hour	21	22	Y	FL13	
A	Discharge Date	23	28	Y	FL45	Max. service dt
A	Discharge Hour	29	30	Y	FL16	
A	Principal Diagnosis	31	35	Y	FL67	
A	Secondary Diagnosis 1	36	40	Y	FL67A	
A	Secondary Diagnosis 2	41	45	Y	FL67B	
A	Secondary Diagnosis 3	46	50	Y	FL67C	
A	Secondary Diagnosis 4	51	55	Y	FL67D	
A	Secondary Diagnosis 5	56	60	Y	FL67E	
A	Secondary Diagnosis 6	61	65	Y	FL67F	
A	Secondary Diagnosis 7	66	70	Y	FL67G	
A	Secondary Diagnosis 8	71	75	Y	FL67H	
A	Secondary Diagnosis 9	76	80	Y	FL67I	
A	Principal Procedure	81	84	Y	FL74	
A	Secondary Procedure 1	85	88	Y	FL74a	
A	Secondary Procedure 2	89	92	Y	FL74b	
A	Secondary Procedure 3	93	96	Y	FL74c	
A	Secondary Procedure 4	97	100	Y	FL74d	
A	Secondary Procedure 5	101	104	Y	FL74e	
A	E-code	105	110	Y	FL72a-c	
A	Principal Procedure Date	111	116	Y	FL74	
A	Secondary Procedure Date 1	117	122	Y	FL74a	
A	Secondary Procedure Date 2	123	128	Y	FL74b	
A	Secondary Procedure Date 3	129	134	Y	FL74c	

A	Secondary Procedure Date 4	135	140	Y		FL74d	
A	Secondary Procedure Date 5	141	146	Y		FL74e	
A	Patient Disposition	147	148	Y		FL17	
A	Primary Payer Source	149	150	Y		FL50	
A	Length of Stay	151	153	N			
A	Total Charges	154	160	Y		FL47	
A	Total Charges Net Professional Services	161	167	N			
A	Medical Record Number - Patient Account Number	168	176	Y		FL03b	
A	Unique Patient ID number	177	186		Y	FL03 and FL08	
A	Hospital Medicare Prov Number	187	192	N			
A	Attending Physician	193	198	Y		FL76	
A	Surgeon 1	199	204	Y		FL77	Operating
A	Surgeon 2	205	210	Y		FL78	Other
A	Surgeon 3	211	216	Y		FL79	Other
A	Surgeon 4	217	222	N			
A	Surgeon 5	223	228	N			
A	Surgeon 6	229	234	N			
A	CCTT	235	239	N			
A	Filler	240	274	N			
A	Record Type	275	275	N			
A	Attending Physician NPI	276	290	Y		FL76	
A	Surgeon 1 NPI	291	305	Y		FL77	Operating
A	Surgeon 2 NPI	306	320	Y		FL78	Other
A	Surgeon 3 NPI	321	335	Y		FL79	Other
A	Surgeon 4 NPI	336	350	N			
A	Surgeon 5 NPI	351	365	N			
A	Surgeon 6 NPI	366	380	N			
I	Birth Date	1	8	Y		FL10	
I	Sex	9	9	Y		FL11	
I	Race	10	10	Y		FL81c	

I	Zip Code	11	15	Y		FL09d	
I	Town/County Code	16	20	N			
I	Admission Date	21	26	Y		FL12	
I	Admission Hour	27	28	Y		FL13	
I	Discharge Date	29	34	Y		FL45	Max. service dt
I	Discharge Hour	35	36	Y		FL16	
I	Principal Diagnosis	37	41	Y		FL67	
I	Secondary Diagnosis 1	42	46	Y		FL67A	
I	Secondary Diagnosis 2	47	51	Y		FL67B	
I	Secondary Diagnosis 3	52	56	Y		FL67C	
I	Secondary Diagnosis 4	57	61	Y		FL67D	
I	Secondary Diagnosis 5	62	66	Y		FL67E	
I	Secondary Diagnosis 6	67	71	Y		FL67F	
I	Secondary Diagnosis 7	72	76	Y		FL67G	
I	Secondary Diagnosis 8	77	81	Y		FL67H	
I	Secondary Diagnosis 9	82	86	Y		FL67I	
I	Principal Procedure	87	90	Y		FL74	
I	Secondary Procedure 1	91	94	Y		FL74a	
I	Secondary Procedure 2	95	98	Y		FL74b	
I	Secondary Procedure 3	99	102	Y		FL74c	
I	Secondary Procedure 4	103	106	Y		FL74d	
I	Secondary Procedure 5	107	110	Y		FL74e	
I	E-code	111	116	Y		FL72a-c	
I	Principal Procedure Date	117	122	Y		FL74	
I	Secondary Procedure Date 1	123	128	Y		FL74a	
I	Secondary Procedure Date 2	129	134	Y		FL74b	
I	Secondary Procedure Date 3	135	140	Y		FL74c	
I	Secondary Procedure Date 4	141	146	Y		FL74d	
I	Secondary Procedure Date 5	147	152	Y		FL74e	
I	Patient Disposition	153	154	Y		FL17	
I	Primary Payer Source	155	156	Y		FL50	
I	Admission Type	157	157		Y	FL14	Priority (Type) of Visit
I	Admission Source	158	158	Y		FL15	

I	Length of Stay	159	161	N			
I	Total Charges	162	168	Y		FL47	
I	Total Charges Net Professional Services	169	175	N			
I	Medical Record Number - Patient Account Number	176	184	Y		FL03b	
I	Unique Patient ID number	185	193		Y	FL03 and FL08	
I	Filler	194	194	N			
I	Hospital Medicare Prov Number	195	200	N			
I	Attending Physician	201	206	Y		FL76	
I	Surgeon 1	207	212	Y		FL77	Operating
I	Surgeon 2	213	218	Y		FL78	Other
I	Surgeon 3	219	224	Y		FL79	Other
I	Surgeon 4	225	230	N			
I	Surgeon 5	231	236	N			
I	Surgeon 6	237	243	N			
I	Filler	244	274	N			
I	Record Type	275	275	N			
I	Attending Physician NPI	276	290	Y		FL76	
I	Surgeon 1 NPI	291	305	Y		FL77	Operating
I	Surgeon 2 NPI	306	320	Y		FL78	Other
I	Surgeon 3 NPI	321	335	Y		FL79	Other
I	Surgeon 4 NPI	336	350	N			
I	Surgeon 5 NPI	351	365	N			
I	Surgeon 6 NPI	366	380	N			
S	Hospital ID Number	1	4	N			
S	Medical Record Number - Patient Account Number	5	13	Y		FL03b	
S	Unique Patient ID number	14	23		Y	FL03 and FL08	
S	Admission Date	24	29	Y		FL12	

S	Discharge Date	30	35	Y	FL45	Max. service dt
S	Sex	36	36	Y	FL11	
S	Birth Date	37	44	Y	FL10	
S	Race	45	45	Y	FL81c	
S	Zip Code	46	50	Y	FL09d	
S	Principal Diagnosis	51	55	Y	FL67	
S	Secondary Diagnosis 1	56	60	Y	FL67A	
S	Secondary Diagnosis 2	61	65	Y	FL67B	
S	Secondary Diagnosis 3	66	70	Y	FL67C	
S	Secondary Diagnosis 4	71	75	Y	FL67D	
S	Secondary Diagnosis 5	76	80	Y	FL67E	
S	Secondary Diagnosis 6	81	85	Y	FL67F	
S	Secondary Diagnosis 7	86	90	Y	FL67G	
S	Secondary Diagnosis 8	91	95	Y	FL67H	
S	Secondary Diagnosis 9	96	100	Y	FL67I	
S	E-code	101	106	Y	FL72a-c	
S	Primary Payer Source	107	108	Y	FL50	
S	Total Charges	109	115	Y	FL47	
S	Total Charges Net Professional Services	116	122	N		
S	Length of Stay	123	127	N		
S	Patient Disposition	128	129	Y	FL17	
S	Referral Source	130	131	N		
S	Filler	132	149	N		
S	Record Type	150	150	N		