# LOUISIANA HEALTH CARE DATA SPECIFICATIONS MANUAL

Louisiana Department of Health and Hospitals

November 2013

## Update Change Descriptions

The Louisiana Department of Health and Hospitals (DHH) will implement changes to this manual annually following the most current implementation schedules of the National Uniform Billing Committee and the American National Standards Institute, Accredited Standards Committee X12. The DHH Health Data Panel will be responsible for reviewing suggested new data elements and recommending changes to the Secretary for implementation. The one exception will be when state or federal law mandates immediate changes.

**October 23, 2013**

Based on consultation with national partners, the following changes were made to edit data specifications:

Required to Situational:

Subscriber's Address Line 1
Subscriber's City
Subscriber's State
Subscriber's ZIP Code
Subscriber Birth Date Qualifier
Subscriber's Birth Date
Subscriber's Sex Code
Subscriber's Race/Ethnicity Qualifier
Subscriber's Race
Subscriber's Ethnicity

Situational to Required:

Entity Identifier Code for Patient Name
Entity Qualifier for Patient Name
Patient's Last Name
Patient's First Name
Patient's Middle Name or Initial
Location Qualifier for Patient's County or Parish
Patient's County or Parish

**November 20, 2013**

Situational to Required:

Patient's County or Parish

## Table of Contents

Update Change Descriptions ..... 2

1. INTRODUCTION ..... 8

2. GENERAL INFORMATION AND OVERVIEW ..... 9

2.1 General Information ..... 9
2.2 Identifying Data Types ..... 10

3. GENERAL TECHNICAL REQUIREMENTS ..... 11

3.1 General Requirements ..... 11

3.2 Data Submittals ..... 11
3.3 Reporting Timeline ..... 11
3.4 Data Corrections ..... 12

4. INPUT DATA SPECIFICATIONS ..... 13

Patient Control Number ..... 13
Medical Record Number Qualifier ..... 14
Medical Record Number ..... 15
Mother's Medical Record Number Qualifier ..... 16
Mother's Medical Record Number ..... 17
Facility Type Code ..... 19
Facility Type Code Qualifier ..... 21
Statement Date Qualifier ..... 22
Statement Date Format Qualifier ..... 23
Statement From and Through Date ..... 24
Entity Identifier Code for Service Provider ..... 26
Entity Type Qualifier for Service Provider ..... 27
Service Provider Organization Name ..... 28
Service / Billing Provider Identification Qualifier Code ..... 29
Service / Billing Provider National Provider Identifier ..... 30
Reference Identification Qualifier for Service Provider Secondary ID ..... 31
State Facility Secondary Identifier Number ..... 32
Individual Relationship Code for Subscriber ..... 34
Claim Filing Indicator Code for Subscriber ..... 35
Entity Identifier Code for Subscriber Name ..... 37
Entity Qualifier for Subscriber Name ..... 38
Subscriber's Last Name ..... 39
Subscriber's First Name ..... 40
Subscriber's Middle Name or Initial ..... 41
Identification Code Qualifier for Subscriber ..... 42

Insured's Policy Number for Subscriber ..... 43
Subscriber's Address Line 1 ..... 45
Subscriber's Address Line 2 ..... 46
Subscriber's City ..... 47
Subscriber's State ..... 48
Subscriber's ZIP Code ..... 49
Location Qualifier for Subscriber's County or Parish ..... 51
Subscriber's County or Parish ..... 52
Subscriber Birth Date Qualifier ..... 53
Subscriber's Birth Date ..... 55
Subscriber's Sex Code ..... 56
Subscriber's Race/Ethnicity Qualifier ..... 57
Subscriber's Race ..... 58
Subscriber's Ethnicity ..... 60
Subscriber Secondary Identification Number Qualifier ..... 61
Subscriber Secondary Identification Number ..... 62
Entity Identifier Code for Payer Name ..... 63
Entity Type Qualifier for Payer Name ..... 64
Payer Name ..... 65
Payer Identification Code Qualifier ..... 66
Payer Identification Number ..... 67
Secondary Payer Identification Code Qualifier ..... 69
Secondary Payer Identification Number ..... 70
Entity Identifier Code for Patient Name ..... 72
Entity Qualifier for Patient Name ..... 73
Patient's Last Name ..... 74
Patient's First Name ..... 75
Patient's Middle Name or Initial ..... 76
Patient's Address Line 1 ..... 77
Patient's Address Line 2 ..... 78
Patient's City ..... 79
Patient's State ..... 80
Patient's ZIP Code ..... 81
Location Qualifier for Patient's County or Parish ..... 82
Patient's County or Parish ..... 83
Patient Birth Date Qualifier ..... 84
Patient's Birth Date ..... 85
Patient's Sex Code ..... 86
Patient's Race/Ethnicity Qualifier ..... 87
Patient's Race ..... 88
Patient's Ethnicity ..... 89
Patient Secondary Identification Number Qualifier ..... 90
Patient Secondary Identification Number ..... 91
Total Claim Charge Amount ..... 92
Discharge Hour Qualifier ..... 93
Discharge Hour Format Qualifier ..... 94

Discharge Hour ..... 95
Admission Date / Hour Qualifier ..... 96
Admission Date / Hour Format Qualifier ..... 97
Admission Date / Hour ..... 98
Priority (Type) of Visit ..... 99
Point of Origin ..... 100
Patient Status Code ..... 102
Source of Payment Typology I ..... 103
Source of Payment Typology II ..... 105
Source of Payment Typology III ..... 107
Preferred Language Spoken ..... 109
Principal Diagnosis Code ..... 110
Admitting Diagnosis Code List Qualifier ..... 112
Admitting Diagnosis Code ..... 113
Patient Reason For Visit Code List Qualifier ..... 115
Patient Reason For Visit Code ..... 116
External Cause of Injury Code List Qualifier ..... 118
External Cause of Injury Code ..... 119
Other Diagnosis Code List Qualifier 1 - 24 ..... 121
Other Diagnosis Code 1 - 24 ..... 122
Present on Admission Indicator ..... 124
Principal Procedure Code List Qualifier ..... 126
Principal Procedure Code ..... 127
Principal Procedure Date Format Qualifier ..... 129
Principal Procedure Date ..... 130
Other Procedure Code Qualifier 1-24 ..... 131
Other Procedure Codes 1 - 24 ..... 132
Other Procedure Dates Format Qualifier ..... 134
Principal Procedure Date 1 - 24 ..... 135
Occurrence Span Code List Qualifier ..... 137
Occurrence Span Code ..... 138
Occurrence Span Date Range Format Qualifier ..... 140
Occurrence Span Dates ..... 141
Occurrence Information Code List Qualifier ..... 142
Occurrence Information Code ..... 143
Occurrence Information Date Qualifier ..... 145
Occurrence Information Date ..... 146
Value Information Code Qualifier 1 - 12 ..... 147
Value Information Code ..... 148
Value Code Amount 1 - 12 ..... 150
Condition Information Code Qualifier 1 - 12 ..... 151
Condition Information Code ..... 152
Attending Provider Name Entity Identifier Code ..... 154
Attending Provider Name Entity Identifier Code ..... 155
Attending Provider Last Name ..... 156
Attending Provider First Name ..... 157

Attending Provider Middle Name or Initial ..... 158
Attending Provider Identification Qualifier Code ..... 159
Attending Provider National Provider Identifier ..... 160
Attending Provider Secondary Identification Qualifier Code ..... 161
Attending Provider Secondary Identifier ..... 162
Operating Physician Name Entity Identifier Code ..... 163
Operating Physician Name Entity Identifier Code ..... 164
Operating Physician Last Name ..... 165
Operating Physician First Name ..... 166
Operating Physician Middle Name or Initial ..... 167
Operating Physician Identification Qualifier Code ..... 168
Operating Physician National Provider Identifier ..... 169
Operating Physician Secondary Identification Qualifier Code ..... 170
Operating Physician Secondary Identifier Qualifier ..... 171
Other Operating Physician Name Entity Identifier Code ..... 172
Other Operating Physician Name Entity Identifier Code ..... 173
Other Operating Physician Last Name ..... 174
Other Operating Physician First Name ..... 175
Other Operating Physician Middle Name or Initial ..... 176
Other Operating Physician Identification Qualifier Code ..... 177
Other Operating Physician National Provider Identifier ..... 178
Other Operating Physician Secondary Identification Qualifier Code ..... 179
Other Operating Physician Secondary Identifier Qualifier ..... 180
Rendering Provider Name Entity Identifier Code ..... 181
Rendering Provider Name Entity Identifier Code ..... 182
Rendering Provider Last Name ..... 183
Rendering Provider First Name ..... 184
Rendering Provider Middle Name or Initial ..... 185
Rendering Provider Identification Qualifier Code ..... 186
Rendering Provider National Provider Identifier ..... 187
Rendering Provider Secondary Identification Qualifier Code ..... 188
Rendering Provider Secondary Identifier ..... 189
Payer Responsibility Sequence Number Code ..... 190
Individual Relationship Code ..... 191
Claim Filing Indicator Code for Other Subscriber ..... 192
Other Subscriber Name Entity Code Qualifier ..... 194
Other Subscriber Name Entity Type Qualifier ..... 195
Other Subscriber Last Name ..... 196
Other Subscriber Identification Code Qualifier ..... 197
Insured's Policy Number for Other Subscriber ..... 198
Other Subscriber Secondary Identification Qualifier ..... 200
Policy Number for Other Subscriber ..... 201
Other Payer Name Entity Code Qualifier ..... 202
Other Payer Name Entity Type Qualifier ..... 203
Other Payer Last Name ..... 204
Other Payer Name Identification Code Qualifier ..... 205

Other Payer Identification Number ..... 206
Other Payer Secondary Identification Qualifier ..... 208
Other Payer Secondary Identification Number ..... 209
Service Line Number ..... 210
Revenue Code ..... 211
HCPCS Procedure Code Qualifier ..... 214
CPT Procedure Code ..... 215
Procedure Modifier 1 ..... 216
Procedure Modifier 2 ..... 217
Procedure Modifier 3 ..... 218
Procedure Modifier 4 ..... 219
Line Item Charge Amount ..... 220
Measurement Code ..... 222
Service Unit Count ..... 223
Accommodations Rate ..... 225
Non-Covered Charges Amount ..... 226
Service Date Qualifier ..... 228
Service Date Format Qualifier ..... 229
Service Date ..... 230

APPENDICES ..... 231

Appendix A – Date Edit Validation Table ..... 232
Appendix B – Hour Reference Table ..... 233
Appendix C – Address Abbreviations ..... 234
Appendix D – State Edit Validation Table ..... 235
Appendix E – Louisiana Parish Edit Validation Table ..... 237

# 1. INTRODUCTION

Act 537 of the 2008 Regular Session of the Louisiana Legislature (R.S. 40:1300.111 et seq.) assigns to the Department of Health and Hospitals (DHH) the responsibility for the collection and dissemination of health care data. The legislative action was based upon a finding that, as a consequence of rising health care costs, the shortage of health professionals and health care services in many areas of the state, and the concerns expressed by consumers, health care providers, third-party payers, and others involved with making informed decisions regarding health care services, treatment, and coverage, there is a need to have access to provider specific health care cost, quality, and outcome data on health care facilities, health care providers, and health plans as well as continued access to global patterns and trends in the availability, use, and charges for health care services and the associated health circumstances. The statute requires that all state agencies and health professional licensing, certification, or registration boards and commissions, which collect, maintain, or distribute health data, shall provide the information necessary to carry out the purpose of this law.

By virtue of Act 537, DHH published a Notice of Intent in the September 20, 2013 edition of the *Louisiana Register* for an administrative rule providing procedures and guidelines for the reporting of statewide health care data (inpatient (IP), emergency-department (ED), and ambulatory-surgery (AS)), the protection of the confidentiality of certain data elements, and the use of data in research and public health practice. A Final Rule is scheduled for promulgation on December 20, 2013 and become effective January 1, 2014.

# 2. GENERAL INFORMATION AND OVERVIEW

## 2.1 General Information

This manual details the form and content for each required data element including:

- FILE ELEMENT DESCRIPTIONS

These elements are used within the American National Standards Institute (ANSI), Accredited Standards Committee (ASC) X12 837I file format to identify specific data elements submitted on the record.

- DATA ELEMENT DESCRIPTIONS

The data elements pertaining to the claim are named and defined. The specifications identify the required elements and the specific format/length.

- DATA EDIT SPECIFICATIONS

The following table describes whether an element is required for a particular data type (IP, ED, or AS). There are currently four one-letter codes to be used as follows:

| Data Edit | Data Edit Name | Description |
|---|---|---|
| **R** | Required | Data element must be submitted for the data type and must not be blank. |
| **S** | Situational | Required based upon values of other elements |
| **O** | Optional | This element is not required and may be blank, however, if submitted, it will be edited. |
| **N** | Not Needed | Not required, not edited, not collected. If submitted it will be ignored. |

- CODES AND VALUES.

Defines the specific codes and values for each data element in order to be accepted by DHH.

- EDIT APPLICATIONS.

Describes a series of edits that each input record must undergo in order for the data element to be accepted by DHH.

## 2.2 Identifying Data Types

The Louisiana Department of Health and Hospitals (DHH) accepts three distinct file types: inpatient (IP), emergency department (ED), and ambulatory surgery (AS). Each type of file must be submitted separately; that is, claims for distinct file types may not be contained within the same file.

Inpatient File: Within this file, only IP service type claims may be submitted. These are identified by the second digit of the Facility Type Code (formerly Type of Bill).

Emergency Department File: This file is also identified by the second digit of the Facility Type Code. In addition, ED records are identified by specific Revenue Codes as listed on page 214 of this manual.

Ambulatory Surgery File: This file is also identified by the second digit of the Facility Type Code. In addition, AS records are identified by specific Revenue Codes as listed on page 214 of this manual.

# 3. GENERAL TECHNICAL REQUIREMENTS

## 3.1 General Requirements

Licensed healthcare facilities must submit the required data elements for their respective discharges (IP, ED, AS) as specified in this manual.

## 3.2 Data Submittals

Once selection of a contracting vendor is complete, the system, transmission methods, and protocols through which DHH accepts data from facilities either directly or through their third-party intermediaries will be specified in this section.

## 3.3 Reporting Timeline

| Data System | Effective Date of Standards | Compliance Date to Begin Data Submittal | Deadline for Submittal of One Year's Worth of Data |
|---|---|---|---|
| Inpatient | January 1, 2014 | October 1, 2014 | August 1, 2015 |
| Emergency Department | January 1, 2015 | July 1, 2015 | February 15, 2016 |
| Ambulatory Surgery | January 1, 2016 | July 1, 2016 | February 15, 2017 |

Hospitals and ambulatory surgical centers must generate and submit their data quarterly. Facilities will be given 45 days from the end of the quarter to submit a file for that quarter. Edit checks and updates for data-improvement purposes will be allowed until the end of the data year. In addition, facilities will have a preview period prior to public reporting in which further modifications and edits may be submitted.

If the number of encounters each quarter changes by more than 1% by the end of the data year, DHH will request an explanation from the facility for the discrepancy. DHH's inquiry will not imply imposition of penalties.

| Quarter of Discharge | Deadline for Initial Submittal of Data | Deadline for Final Submittal of Revised/Updated Data for Quality Reporting |
|---|---|---|
| 1st | May 15 | June 1 |
| 2nd | August 14 | September 1 |
| 3rd | November 14 | December 1 |
| 4th | February 14 of the following year | March 1 of the following year |

## 3.4 Data Corrections

Once selection of a contracting vendor is complete, the reporting of errors and the mechanism for submitting corrections will be described in this section.

# 4. INPUT DATA SPECIFICATIONS

## Patient Control Number

**Data Element Name:** Patient Control Number

**Format-Length:** A/N – 20

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | CLI01 | 1028 | | Patient Control Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 03a | N/A | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the Individual account of services (accounts receivable) containing the financial billing records and any postings of payment.

**Codes and Values:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Edit Applications:**

Must equal patient control number.

**Data Element in Output Data Set:** Yes

**Note**: Providers may submit fewer characters depending upon their needs. However, the HIPAA maximum number of characters to be supported for this field is 20. Characters beyond 20 are not required to be stored nor returned by any receiving system or returned by any 837-receiving system.

## Medical Record Number Qualifier

**Data Element Name:** Medical Record Number

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | REF01 | 128 | EA | Qualifier Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the Reference Identification.

**Codes and Values:**

"EA" = Medical Record Identification Number

**Edit Applications:**

Must equal "EA".

**Data Element in Output Data Set:** No

## Medical Record Number

**Data Element Name:** Medical Record Number

**Format-Length:** A/N – 17

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | REF02 | 127 | | Medical Record Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 03b | N/A | |

---

**Definition:**

The number assigned to the patient's medical/health record by the provider. This number is **not** the same as the Patient Control Number.

**Codes and Values:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Edit Applications:**

Must equal Medical Record Number.

**Data Element in Output Data Set:** Yes

## Mother's Medical Record Number Qualifier

**Data Element Name:** Mother's Medical Record Number

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | REF01 | 128 | MRN | Qualifier Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the Reference Identification.

**Codes and Values:**

"MRN" = Medical Record Identification Number

**Edit Applications:**

Must equal "MRN".

**Data Element in Output Data Set:** No

## Mother's Medical Record Number

**Data Element Name:** Mother's Medical Record Number

**Format-Length:** A/N – 17

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | REF02 | 127 | | Mother's Medical Record Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | N/A | |

---

**Definition:**

The medical record number of the newborn child's mother, which links the newborn's hospital stay and the mother's stay.

**Codes and Values:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

3. If this field is not applicable, it must be blank

**Edit Applications:**

1. Must be present when a valid newborn diagnosis code is reported in the Principal Diagnosis Code.

2. Valid newborn codes are:

<u>ICD-9</u>

V3000 V3001 V301 V3100 V3101 V311 V3200 V3201 V321 V3300 V3301 V331 V3400 V3401 V341 V3500 V3501 V351 V3600 V3601 V361 V3700 V3701 V371

<u>ICD-10</u>

Z3800 Z3801 Z381 Z382 Z3830 Z3831 Z384 Z385 Z3861 Z3862 Z3863 Z3864 Z3865 Z3866 Z3868 Z3869 Z387 Z388

3. When a valid newborn diagnosis code is reported in the Principal Diagnosis Code and the mother is not admitted to the hospital, then report all 9's in the Mother's Medical Record Number for the newborn child.

**Data Element in Output Data Set:** Yes

## Facility Type Code

**Data Element Name:** Facility Type Code (formerly called Type of Bill)

**Format-Length:** A/N – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | CLM05-1 | 1331 | | Facility Code Value |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 04 | N/A | |

---

**Definition:**

A two-digit numeric code which identifies the specific type of facility bill (inpatient, emergency department, ambulatory surgical center). This code consists of the first two digits of a three-digit numeric data element called "Type of Bill" by National Uniform Billing Committee (NUBC). The first digit represents the type of facility, while the second digit represents the bill classification.

**Codes and Values:**

"11" = Hospital Inpatient (Including Medicare Part A)
"12" = Hospital Inpatient (Medicare Part B only)
"13" = Hospital Outpatient
"73" = Clinic – Freestanding
"75" = Clinic - Comprehensive Outpatient Rehab Facility (CORF)
"83" = Ambulatory Surgery Center
"85" = Critical Access Hospital

**CODING EXAMPLES:**

Hospital, IP, new claim: *CLM*2745331203128112806*0.00****11:A:1~*
Hospital, ED, void/cancel of prior claim: *LM*2745331203128112806*0.00****13:A:8~*
AS, new claim: *CLM*2745331203128112806*0.00****83:A:1~*

**Edit Applications:**

1. Must be entered. If not, the record will be rejected.

2. Must be a valid value. If not, the record will be rejected.

**Data Element in Output Data Set:** Yes, used to formulate “Type of Bill”.

## Facility Type Code Qualifier

**Data Element Name:** Facility Type Code Qualifier

**Format-Length:** ID – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | CLM05-2 | 1332 | A | Facility Code Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – Needed only for Electronic submission |

---

**Definition:**

.
A code identifying the type of code set used to identify facilities and claim submissions.

**Codes and Values:**

"A" = Uniform Billing Claim Form Bill Type

**CODING EXAMPLES:**

Hospital, IP, new claim: *CLM*2745331203128112806*0.00****11:A:1~*
Hospital, ED, void/cancel of prior claim: *LM*2745331203128112806*0.00****13:A:8~*
AS, new claim: *CLM*2745331203128112806*0.00****83:A:1~*

**Edit Applications:**

1. Must equal "A".

2. Must be entered. If not, the record will be rejected.

**Data Element in Output Data Set:** No

## Statement Date Qualifier

**Data Element Name:** Statement Date Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP01 | 374 | 434 | Date Time Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code specifying type of date or time, or both date and time.

**Codes and Values:**

"434" = Statement

**Edit Applications:**

Must equal "434".

**Data Element in Output Data Set:** No

## Statement Date Format Qualifier

**Data Element Name:** Statement Date Format Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP02 | 1250 | RD8 | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code indicating the data format, time format, or date and time format.

**Codes and Values:**

1. "RD8" = Range of Dates CCYYMMDD – CCYYMMDD (CCYYMMDD = Century Year Month Day)

2. Use RD8 to indicate the "from and through" date of statement. When the statement is for a single date of service, the "from and through" date is the same.

**Edit Applications:**

Must equal "RD8".

**Data Element in Output Data Set:** No

## Statement From and Through Date

**Data Element Name:** Statement From and Through Date

**Format-Length:** N – 8 Statement From
N – 8 Statement Through

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP03 | 1251 | | Statement Through and From Date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 06 | N/A | |

**Definition:**

The beginning and ending service dates of the period included in the bill.

**Codes and Values:**

1. Equals Statement From and Statement Through Date.

2. For all services received on a single day, use the same date for "From" and "Through".

**Edit Applications:**

1. Must equal Statement From and Statement Through Date in CCYYMMDD format.

2. Must be a valid date in accordance with the Date Edit Validation Table in Appendix A.

3. "Statement From Date" must be on or before the "Statement Through Date".

4. For IP records:

a. If the "Statement From" and "Statement Through" dates are the same, the record will be rejected.

b. If the "Statement From" and "Statement Through" dates cover a time period lasting more than 365 days, the record will be rejected.

c. If a newborn's date of birth does not fall between the "Statement From" and "Statement Through" dates, the record will be rejected.

5. For ED and AS records: If the "Statement From" and "Statement Through" dates are not the same, the record will be rejected.

6. If the patient's date of birth is after the "Statement Through Date", the record will be rejected.

**Notes:**

1. Enter both dates as month, day, and year (CCYYMMDD). For example: November 3, 2010 must be entered as: 20101103.

2. The "From" date should not be confused with the Admission Date. The Statement From Date in Form Locator 6 ("From" Date) is distinctly different from the Admission Date (Form Locator 12). The dates may coincide in some circumstances, but should not be confused. It is also not a requirement that the Admission Date fall in between the "From" Date and the Statement "Through" Date.

3. The Admission Date is merely the date the patient was admitted as an inpatient to the facility. It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.

4. The Statement Covers Period identifies the span of service dates included in a particular bill. The "From" Date is the earliest date of service on the bill.

<u>NUBC Examples of Correct Usage</u>

1. When Medicare patients receive outpatient services 72 hours prior to an inpatient admission, the outpatient charges are included on the inpatient bill. In this situation, the Statement Covers Period reflects the entire range of dates associated with the services on the billing statement. Therefore, the Admission Date and the "From" Date will differ. On an initial bill, the "From" Date would be prior to the Admission Date.

2. When a patient is treated in the Emergency Department and is subsequently admitted after midnight (the next day). The "From" Date and the ED Procedure Date would be the same, but the Admission Date would be the following day.

3. In a longer-term stay situation, it is necessary for the provider to issue an initial bill, one or more interim bills, and a final bill. The Admission Date is reported on each bill and will be the same on all of these bills. The Statement Covers Period will vary and reflects only the dates of services performed during the respective billing period.

**Data Element in Output Data Set:** Yes. Reported as two data elements: Statement Covers Period From Date and Statement Covers Period Through Date.

## Entity Identifier Code for Service Provider

**Data Element Name:** Entity Identifier Code for Service Provider

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010AA | NM101 | 98 | See Below | Entity Identifier Code for Service Provider |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying an organizational entity, a physical location or property for the Service Provider.

**Codes and Values:**

"SJ" = Service Provider
"85" = Billing Provider

**Edit Applications:**

Must equal "SJ" or "85".

**Data Element in Output Data Set:** No

Note: "85" is used in the 5010 Institutional Guide.

## Entity Type Qualifier for Service Provider

**Data Element Name:** Entity Type Qualifier for Service Provider

**Format-Length:** ID – 1

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010AA | NM102 | 1065 | 2 | Entity Type Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity for the Service Provider.

**Codes and Values:**

"2" = Non-person entity

**Edit Applications:**

Must equal "2".

**Data Element in Output Data Set:** No

## Service Provider Organization Name

**Data Element Name:** Service Provider Organization Name

**Format-Length:** AN - 60

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010AA | NM103 | 1035 | | Service Provider Organization Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 1 | N/A | |

---

**Definition:**

This may be the last name of the patient's service provider or the organization name.

**Codes and Values:**

Equals service provider organization name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

Note: Form Locator 1 on the UB-04 is for the Billing Provider information, which may or may not be the same as the service provider information state reporting systems require.

## Service / Billing Provider Identification Qualifier Code

**Data Element Name:** Service / Billing Provider Identification Qualifier Code

**Format-Length:** ID – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010AA | NM108 | 66 | XX | Identification Code Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code designating the system/method of code structure used for Identification Code. This code is required for service/billing providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.

**Codes and Values:**

"XX" = Centers for Medicare and Medicaid Services National Provider Identifier

**Edit Applications:**

Must equal "XX".

**Data Element in Output Data Set:** No

## Service / Billing Provider National Provider Identifier

**Data Element Name:** Service / Billing Provider National Provider Identifier

**Format-Length:** AN - 10

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010AA | NM109 | 67 | | Service Provider Identifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 56 | N/A | |

---

**Definition:**

The unique identification number assigned to the provider submitting the bill. Required for service/billing providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. Required when reporting for the Centers for Medicare and Medicaid Services.

**Codes and Values:**

Equal facility's National Provider Identifier.

**Edit Applications:**

1. Must contain no embedded blanks.

2. Must be entered if the Claim Filing Indicator Code is Blue Cross/Blue Shield (BL), Medicare (MA, MB, or 16), or Medicaid (MC).

3. Must be entered if the Source of Payment Typology I is:

   a. 1xxxx Medicare
   b. 2xxxx Medicaid

Example: Source of Payment Typology I has a value of '219' (Medicaid Managed Care); a valid entry for "Billing Provider ID" must be made.

**Data Element in Output Data Set:** Yes

## Reference Identification Qualifier for Service Provider Secondary ID

**Data Element Name:** Reference Identification Qualifier for Service Provider Secondary ID

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010AA | REF01 | 128 | 1J | Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the reference identification.

**Codes and Values:**

"1J" = Facility ID Number

**Edit Applications:**

Must equal "1J".

**Data Element in Output Data Set:** No

## State Facility Secondary Identifier Number

**Data Element Name:** State Facility Secondary Identifier Number

**Format-Length:** AN - 20

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010AA | REF02 | 127 | | Service Provider Secondary ID |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A state-issued secondary identifier for the service provider.

**Codes and Values:**

Equal the state issued service provider secondary identifier.

**Edit Applications:**

1. Must not equal zero or blanks.
2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Payer Responsibility Sequence Number Code for Subscriber

**Data Element Name:** Payer Responsibility Sequence Number Code for Subscriber

**Format-Length:** ID - 1

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2000B | SBR01 | 1138 | P | Payer Responsibility Sequence Number Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code identifying the insurance carrier's level of responsibility for a payment of a claim. Within a given claim, the value for the Payer Responsibility Sequence Number Code may occur no more than once.

**Codes and Values:**

"P" = Primary

**Edit Applications:**

1. Must equal "P".

2. Within a given claim, the various values for the payer responsibility sequence number code may occur no more than once.

**Data Element in Output Data Set:** No

**Note:** The SBR Subscriber Information Loop (Loop 2000B) is processed and stored when the subscriber is the patient.

## Individual Relationship Code for Subscriber

**Data Element Name:** Individual Relationship Code for Subscriber

**Format-Length:** ID - 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2000B | SBR02 | 1069 | 18 | Individual Relationship Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 59 | N/A | |

---

**Definition:**

A code indicating the relationship between two individuals or entities. It is required when the patient is the subscriber or is considered to be the subscriber. SBR02 specifies the relationship to the person insured.

**Codes and Values:**

"18" = Self

**Edit Applications:**

Must equal "18".

**Data Element in Output Data Set:** Yes

## Claim Filing Indicator Code for Subscriber

**Data Element Name:** Claim Filing Indicator Code for Subscriber

**Format-Length:** ID - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| O | O | O |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2000B | SBR09 | 1032 | See Below | Claim Filing Indicator Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code which indicates the type of payment. The code listing below was obtained from the ASC X12N Technical Report Guide. As many payers as needed may be reported within this loop. This loop is used when other payers are known to potentially be involved with paying on this claim.

**Codes and Values:**

"09" = Self-pay
"11" = Other Non-Federal Programs
"12" = Preferred Provider Organization (PPO)
"13" = Point of Service (POS)
"14" = Exclusive Provider Organization (EPO)
"15" = Indemnity Insurance
"16" = Health Maintenance Organization (HMO) Medicare Risk
"17" = Dental Maintenance Organization
"AM" = Automobile Medical
"BL" = Blue Cross/Blue Shield
"CH" = CHAMPUS
"CI" = Commercial Insurance Co.
"DS" = Disability
"FI" = Federal Employees Program
"HM" = Health Maintenance Organization
"LM" = Liability Medical
"MA" = Medicare Part A
"MB" = Medicare Part B
"MC" = Medicaid
"OF" = Other Federal Program (Use "OF" when submitting Medicare Part D Claims.)

"TV" = Title V
"VA" = Veterans Affairs Plan
"WC" = Workers' Compensation Health Claim
"ZZ" = Type of Insurance unknown

**Edit Applications:**

1. Must equal "09" , "11", "12", "13", "14", "15", "16", "17", "AM", "BL", "CH", "CI", "DS", "FI", "HM", "LM", "MA", "MB", "MC", "OF", "TV", "VA", "WC", or "ZZ".

2. The table below indicates the additional data items that are required, depending on the value in the Claim Filing Indicator Code for Other Subscriber:

| **Claim Filing Indicator Code for Other Subscriber** | **Payer ID** | **Insured's Policy Number** | **Billing NPI (Previously Provider ID)** |
|---|---|---|---|
| 09, 11, 13, 14, 15, 17, AM, CH, DS, FI, LM, OF, TV, VA, WC, ZZ | --------- | ---------- | -------- |
| 12, CI, HM, | Required | Required IP only | -------- |
| 16, BL, MA, MB, MC | Required | Required IP only | Required |

3. The Payer ID, Insured's Policy Number, and Billing NPI are required when the Claim Filing Indicator Code for Other Subscriber (and Source of Payment Typology) are reported with a Medicaid or Medicare payer type.

**Data Element in Output Data Set:** Yes

Note: This element could be replaced by the Source of Payment Typology.

## Entity Identifier Code for Subscriber Name

**Data Element Name:** Entity Identifier Code for Subscriber Name

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM101 | 98 | IL | Entity Identifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – Needed only for Electronic submission |

---

**Definition:**

A code identifying an organizational entity, physical location, property, or individual.

**Codes and Values:**

"IL" = Insured or Subscriber

**Edit Applications:**

1. Must equal "IL".

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then code "QC" must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** No

## Entity Qualifier for Subscriber Name

**Data Element Name:** Entity Qualifier for Subscriber Name

**Format-Length:** ID – 1

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM102 | 1065 | 1 | Entity Type Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – Needed only for Electronic submission |

---

**Definition:**

.
A code qualifying the type of entity.

**Codes and Values:**

"1" = Person

**Edit Applications:**

1. Must equal "1".

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the code must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** No

## Subscriber's Last Name

**Data Element Name:** Subscriber's Last Name

**Format-Length:** AN - 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM103 | 1035 | | Subscriber Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08 | N/A | |

---

### Definition:

The individual subscriber's last name or organizational name.

### Codes and Values:

Subscriber's Last Name.

### Edit Applications:

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

3. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

4. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** No

## Subscriber's First Name

**Data Element Name:** Subscriber's First Name

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM104 | 1036 | | Subscriber First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08 | N/A | |

---

**Definition:**

The individual subscriber's first name.

**Codes and Values:**

Subscriber's First Name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

3. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

4. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** No

## Subscriber's Middle Name or Initial

**Data Element Name:** Subscriber's Middle Name or Initial

**Format-Length:** AN – 25

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM105 | 1037 | | Subscriber First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08 | N/A | |

---

**Definition:**

The individual subscriber's middle name or initial.

**Codes and Values:**

Subscriber's Middle Name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

3. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

4. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

.

**Data Element in Output Data Set:** No

## Identification Code Qualifier for Subscriber

**Data Element Name:** Identification Code Qualifier for Subscriber

**Format-Length:** ID – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM108 | 66 | See Below | Identification Code Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code designating the system/method of code structure used for Identification Code. It is assigned by the payer.

**Codes and Values:**

"II" = Standard Unique Health Identifier for each individual in the United States

**Edit Applications:**

Must equal "II".

**Data Element in Output Data Set:** Yes

## Insured's Policy Number for Subscriber

**Data Element Name:** Insured's Policy Number for Subscriber

**Format-Length:** AN – 19

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM109 | 67 | | Subscriber Primary Identifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 60 | N/A | |

---

**Definition:**

The unique identification number assigned by the payer to identify the subscriber.

**Codes and Values:**

| Payer | Type of Number |
|---|---|
| Blue Cross | Enter the information depending on specific Blue Cross plan needs and contract requirements. |
| CHAMPUS | Enter information depending on CHAMPUS regulations. |
| Medicaid | Enter Medicaid Client Identification Number (CIN) of the insured or case head Medicaid number shown on the Medicaid Identification Card. |
| Medicare | Enter the patient's Medicare Health Insurance Claim (HIC) number as shown on the Medicare Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Administration. |

For all other payer types (for example, commercial insurers), enter the insured's unique number assigned by the payer.

**Edit Applications:**

1. (Inpatient only) Required if the first reported Claim Filing Indicator Code is 12, BL, CI, HM, Medicare (MA, MB, or 16), or Medicaid (MC).

2. (Inpatient only) Required if Source of Payment Typology I is Medicare (1xxxx) or Medicaid (2xxxx).

**Data Element in Output Data Set:** Yes

Note: The NM1 Subscriber Name Loop 2010BA is used and processed when the subscriber is the patient.

## Subscriber's Address Line 1

**Data Element Name:** Subscriber's Address Line 1

**Format-Length:** AN – 18

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | N301 | 166 | | Address Line 1 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09a | N/A | |

---

**Definition:**

The mailing address of the subscriber's principal residence at the time of admission/visit. Enter the street number, post office box number, or RFD.

**Codes and Values:**

1. Use standard abbreviations as listed in the "Official USPS Abbreviations" page of the United States Postal Service (USPS) website:

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

2. For homeless patients, "HOMELESS" should be coded.

**Edit Applications:**

1. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

2. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Subscriber's Address Line 2

**Data Element Name:** Subscriber's Address Line 2

**Format-Length:** AN – 18

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | N302 | 166 | | Address Line 2 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09a | N/A | |

---

**Definition:**

The continuation of the street mailing address of the subscriber's principal residence at the time of admission/visit.

**Codes and Values:**

Use standard abbreviations as listed in the "Official USPS Abbreviations" page of the USPS website:

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

**Edit Applications:**

1. Should be a valid entry.

2. If this field is applicable, it must be entered when the subscriber is not the patient. Otherwise, the record will be rejected.

3. If this field is applicable and the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

4. If this field is not applicable, it must be blank.

**Data Element in Output Data Set:** Yes

## Subscriber's City

**Data Element Name:** Subscriber's City

**Format-Length:** AN – 15

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | N401 | 19 | | City Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09b | N/A | |

---

**Definition:**

The name of the city, town, or village of the subscriber's address on the day of admission/visit.

**Codes and Values:**

1. Use standard city, town, or village names approved by USPS for mailing purposes.

2. For homeless patients, "HOMELESS" should be coded.

**Edit Applications:**

1. Must be entered when the subscriber is not the patient. Otherwise, the record will be rejected.

2. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Subscriber's State

**Data Element Name:** Subscriber's State

**Format-Length:** ID - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | N402 | 156 | | State or Province Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09c | N/A | |

---

**Definition:**

A two-letter/digit code for the subscriber's state of residence on the day of admission/visit.

**Codes and Values:**

1. Must be valid in accordance with the State Edit Validation Table in Appendix D. For a complete listing of state abbreviations, go to the "Official USPS Abbreviations" page of the USPS website:

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

2. "99" = Homeless or Unknown

"XX" = Other than United States

**Edit Applications:**

1. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

2. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Subscriber's ZIP Code

**Data Element Name:** Subscriber's Zip Code

**Format-Length:** AN - 9

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | N403 | 156 | | Postal Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09d | N/A | |

---

**Definition:**

The ZIP Code and Extension Code assigned by USPS to the subscriber's principal residence at the time of admission or date of visit.

**Codes and Values:**

1. For United States residences, this data element is divided into a five-digit ZIP Code and a four-digit Extension Code. For Canadian residences, this data element is defined as a six-character Postal Code and a three-character filler.

2. If the five-digit ZIP Code begins with 700 to 701, 703 to 708, or 710 to 714, then Patient's State (FL 09c) must equal "LA", and Patient's County or Parish must equal "01"-"64".

3. Must contain no embedded blanks.

4. "XXXXX" = Unknown

   "YYYYY" = Foreign Country (Other Than Canada)

5. Must be valid for the Patient County Code assigned to the patient's principal residence.

**Edit Applications:**

1. A five-digit ZIP Code is required as a minimum for United States residences.

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

Note: The N4 Patient City, State, ZIP Code Loop 2010BA is used and processed when the subscriber is the patient.

## Location Qualifier for Subscriber's County or Parish

**Data Element Name:** Location Qualifier for Subscriber's County or Parish

**Format-Length:** ID - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | N405 | 309 | CO | Location Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code identifying type of location.

**Codes and Values:**

"CO" = County / Parish.

**Edit Applications:**

1. Must equal "CO".

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** No

## Subscriber's County or Parish

**Data Element Name:** Patient's County or Parish

**Format-Length:** N - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | N406 | 310 | | Location Identifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A two-digit code assigned to the county/parish where the subscriber's principal residence is located on the day of admission or date of visit.

**Codes and Values:**

1. Must be a valid code in accordance with the Louisiana Parish Edit Validation Table in Appendix E.

**Edit Applications:**

1. Must be a valid county/parish code for the Patient's ZIP Code (FL 09d) assigned to the patient's principal residence. Otherwise, the record will be rejected.

2. Must be compatible with Patient's State (FL 09c). If Patient's County or Parish is in Louisiana ("01"-"64"), then Patient's State must equal "LA".

3. If Patient's County or Parish is outside Louisiana ("88"), then Patient's State must not equal "LA".

4. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

5. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Subscriber Birth Date Qualifier

**Data Element Name:** Subscriber Birth Date Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | DMG01 | 1250 | D8 | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code indicating the date format.

**Codes and Values:**

"D8" = Date expressed in the CCYYMMDD (Century Year Month Day) format.

**Edit Applications:**

1. Must equal "D8".

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

4. If the resulting age from the date of birth to the date of discharge is either less than 0 or greater than 115*, the record will be rejected.

**Data Element in Output Data Set:** No

---

*Based on current longevity data for Louisiana, 115 years is the maximum age to be accepted for a subscriber/patient.

## Subscriber's Birth Date

**Data Element Name:** Subscriber's Birth Date

**Format-Length:** N - 8

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | DMG02 | 1251 | | Patient Birth Date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 10 | N/A | |

---

**Definition:**

The date of the subscriber's birth.

**Codes and Values:**

Equals subscriber's date of birth in the CCYYMMDD (Century Year Month Day) format.

**Edit Applications:**

1. Must be in format CCYYMMDD in accordance with the Date Edit Validation Table in Appendix A.

2. Must not be after Admission Date / Start of Care.

3. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

4. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

5. If the resulting age from the date of birth to the date of discharge is either less than 0 or greater than 115*, the record will be rejected.

**Data Element in Output Data Set:** Yes

---

*Based on current longevity data for Louisiana, 115 years is the maximum age to be accepted for a subscriber/patient.

## Subscriber's Sex Code

**Data Element Name:** Subscriber's Sex Code

**Format-Length:** N - 8

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | DMG03 | 1068 | See Below | Subscriber Gender Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 11 | N/A | |

---

**Definition:**

The sex of the subscriber as recorded on the date of admission or start of care.

**Codes and Values:**

F = Female
M = Male
U = Unknown

**Edit Applications:**

1. There are multiple relationship edits between Patient Sex's and specific diagnosis and procedure codes, as defined by the ICD-9-CM and ICD-10-CM reference file edit flags. These edits are used to detect the inconsistencies between the patient's sex and diagnosis or procedure.

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

2. If the subscriber is the patient, then the information must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Subscriber's Race/Ethnicity Qualifier

**Data Element Name:** Subscriber's Race/Ethnicity Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | DMG05-2 | 1270 | RET | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission. |

---

**Definition:**

The DMG05 is a composite data element. Each composite section refers to a specific data element. The first element of the composite is the Component Element Separator. The Component Element Separator (ISA16 "^") must be used before and after the composite data element DMG05-2. In addition, the Repetition Separator (ISA11 ":") must be used between race and ethnicity. This is the code identifying a specific industry code list.

**Codes and Values:**

"RET" = Classification of Race or Ethnicity

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

where ISA16 = "^" and ISA11 = ":"

**Edit Applications:**

1. Must equal "RET".

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the race and ethnicity qualifier must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** No

## Subscriber's Race

**Data Element Name:** Subscriber's Race

**Format-Length:** AN - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | DMG05-3 | 1271 | See Below | Race or Ethnicity Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B1 | |

---

**Definition:**

A code which best describes the race of the subscriber. The DMG 05 is a composite data element. Each composite section refers to a specific data element. The first element is the Component Element Separator. This is the second element for race.

**Codes and Values:**

"R1" = American Indian or Alaska Native
"R2" = Asian
"R3" = Black or African-American
"R4" = Native Hawaiian or Pacific Islander
"R5" = White
"R9" = Other Race

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

**Edit Applications:**

1. Must equal one of the following: "R1", "R2", "R3", "R4", "R5", or "R9".

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the race and ethnicity qualifier must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

**Note:** DMG05 may repeat up to 10 times to accommodate state or federal requirements that allow individuals to report more than one race code along with the ethnicity code.

## Subscriber's Ethnicity

**Data Element Name:** Subscriber's Ethnicity

**Format-Length:** AN - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | DMG05-3 | 1271 | See Below | Race or Ethnicity Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B1 | |

---

**Definition:**

A code which best describes the ethnic origin of the subscriber. The DMG 05 is a composite data element. Each composite section refers to a specific data element. The first element is the Component Element Separator. This is the second element for ethnicity.

**Codes and Values:**

"E1" = Hispanic or Latino Ethnicity
"E2" = Non-Hispanic or Latino Ethnicity

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

**Edit Applications:**

1. Must equal either "E1" or E2" when using the DMG segment.

2. Must be entered when the subscriber is <u>not</u> the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the race and ethnicity qualifier must be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

Note: DMG05 may repeat up to 10 times to accommodate state or federal requirements that allow individuals to report more than one race code along with the ethnicity code.

## Subscriber Secondary Identification Number Qualifier

**Data Element Name:** Subscriber Secondary Identification Number Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | REF01 | 128 | See Below | Qualifier Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the Reference Identification.

**Codes and Values:**

"1W" = Member Identification Number (If NM108 = MI, this qualifier cannot be used.)

"ABB " = Personal ID Number (Used for state-specific linkage variables at the encounter.)

"IG" = Insurance Policy Number

"SY" = Social Security Number

**Edit Applications:**

1. Must equal one of the following: "1W", "ABB", "IG", or "SY".

2. Must be entered when the subscriber is not the patient. Otherwise, the record will be rejected.

3. If the subscriber is the patient, then the appropriate code must be entered in Loop 2010CA for the patient instead instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** No

## Subscriber Secondary Identification Number

**Data Element Name:** Subscriber Secondary Identification Number

**Format-Length:** A/N – 20

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | REF02 | 127 | | Subscriber Secondary Identification Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08a | N/A | |

---

**Definition:**

The number used to identify the subscriber.

**Codes and Values:**

Subscriber Secondary Identification Number.

**Edit Applications:**

1. Must equal Medical Record Number.

2. Must not equal zero or blanks.

3. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

4. Must be entered when the subscriber is not the patient. Otherwise, the record will be rejected.

5. If the subscriber is the patient, then the information will be entered in Loop 2010CA for the patient instead. Otherwise, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Entity Identifier Code for Payer Name

**Data Element Name:** Entity Identifier Code for Payer Name

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BB | NM101 | 98 | PR | Entity Identifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code identifying an organizational entity, physical location, property, or individual.

**Codes and Values:**

"PR" = Payer

**Edit Applications:**

Must equal "PR".

**Data Element in Output Data Set:** No

## Entity Type Qualifier for Payer Name

**Data Element Name:** Entity Type Qualifier for Payer Name

**Format-Length:** ID - 1

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BB | NM102 | 1065 | 2 | Entity Type Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"2" = Payer

**Edit Applications:**

Must equal "2".

**Data Element in Output Data Set:** No

## Payer Name

**Data Element Name:** Payer Name

**Format-Length:** A/N – 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BA | NM103 | 1035 | | Payer Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 50 | N/A | |

---

**Definition:**

The organization name of the payer.

**Codes and Values:**

Must equal organization name of payer.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Payer Identification Code Qualifier

**Data Element Name:** Payer Identification Code Qualifier

**Format-Length:** ID - 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BB | NM108 | 66 | See Below | Identification Code Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"PI" = Payer Identification

"XV" = Center for Medicare and Medicaid Services Plan ID (formerly Health Care Financing Administration Plan ID)

**Edit Applications:**

Must equal either "PI" or "XV".

**Data Element in Output Data Set:** No

## Payer Identification Number

**Data Element Name:** Payer Identification Number

**Format-Length:** A/N – 10

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BB | NM109 | 67 | See Below | Payer Identification Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 51 | N/A | |

---

**Definition:**

The number identifying the payer organization associated with this sequence for which the provider might expect some payment of the bill.

.

**Codes and Values:**

| Payer | Type of Number |
|---|---|
| Blue Cross | Plan Number |
| Commercial Insurers | National Association of Insurance Commissioners (NAIC) Number<br><br>Commercial insurance companies and Health Maintenance Organizations (HMOs) are regulated by the Louisiana Department of Insurance (DOI) and issued NAIC numbers. Additional information on these numbers and any other HMO-specific codes may be found on the DOI website at http://www.ldi.state.la.us. |
| Medicaid | 13-Digit Recipient Identification Number Assigned by the Louisiana Department of Health and Hospitals<br><br>Additional information on this number may be found on the Louisiana Medicaid website at http://www.lamedicaid.com. |
| Medicare | Blue Cross Number or Commercial Insurer NAIC Number Depending on Intermediary |

CHAMPUS NAIC Number

If this field is not applicable, it must be blank.

**Edit Applications:**

1. If Claim Filing Indicator Code is equal to “12”, “16”, “BL”, “CI”, “HM”, “MA”, “MB”, or “MC”, then Payer Identification is required and must be reported.

2. If Source of Payment Typology (SoP) is 21xxx (Medicaid Managed Care), then Payer Identification should equal a value from the most recent edition of the *Official UB-04 Data Specifications Manual* published by the National Uniform Billing Committee. Additional information is available in the *Users Guide for Source of Payment Typology* published by the Public Health Data Standards Consortium. An electronic copy may be accessed at:

http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion5.0_final.pdf

**Data Element in Output Data Set:** Yes

## Secondary Payer Identification Code Qualifier

**Data Element Name:** Secondary Payer Identification Code Qualifier

**Format-Length:** ID - 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BB | REF01 | 128 | See Below | Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

Code qualifying the Reference Identification.

**Codes and Values:**

"2U" = Payer Identification Number
"NF" = National Association of Insurance Commissioners (NAIC) Code

**Edit Applications:**

Must equal "2U" or "NF".

**Data Element in Output Data Set:** No

## Secondary Payer Identification Number

**Data Element Name:** Secondary Payer Identification Number

**Format-Length:** A/N – 10

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010BB | REF02 | 127 | | Secondary Payer Additional Identifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 51 | N/A | |

---

**Definition:**

The number identifying the secondary payer organization associated with this sequence for which the provider might expect some payment of the bill.

.

**Codes and Values:**

| Payer | Type of Number |
|---|---|
| Blue Cross | Plan Number |
| Commercial Insurers | National Association of Insurance Commissioners (NAIC) Number<br><br>Commercial insurance companies and Health Maintenance Organizations (HMOs) are regulated by the Louisiana Department of Insurance (DOI) and issued NAIC numbers. Additional information on these numbers and any other HMO-specific codes may be found on the DOI website at http://www.ldi.state.la.us. |
| Medicaid | 13-Digit Recipient Identification Number Assigned by the Louisiana Department of Health and Hospitals<br><br>Additional information on this number may be found on the Louisiana Medicaid website at http://www.lamedicaid.com. |
| Medicare | Blue Cross Number or Commercial Insurer NAIC Number Depending on Intermediary |

CHAMPUS NAIC Number

If this field is not applicable, it must be blank.

**Edit Applications:**

1. If Claim Filing Indicator Code is equal to “12”, “16”, “BL”, “CI”, “HM”, “MA”, “MB”, or “MC”, then Payer Identification is required and must be reported.

2. If Source of Payment Typology (SoP) is 21xxx (Medicaid Managed Care), then Payer Identification should equal a value from the most recent edition of the *Official UB-04 Data Specifications Manual* published by the National Uniform Billing Committee. Additional information is available in the *Users Guide for Source of Payment Typology* published by the Public Health Data Standards Consortium. An electronic copy may be accessed at:

http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion5.0_final.pdf

**Data Element in Output Data Set:** Yes

## Entity Identifier Code for Patient Name

**Data Element Name:** Entity Identifier Code for Patient Name

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | NM101 | 98 | QC | Entity Identifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – Needed only for Electronic submission |

---

**Definition:**

.

Code Identifying an organizational entity, a physical location, property or an individual.

**Codes and Values:**

"QC" = Patient

**Edit Applications:**

Must equal "QC".

**Data Element in Output Data Set:** No

## Entity Qualifier for Patient Name

**Data Element Name:** Entity Qualifier for Patient Name

**Format-Length:** ID – 1

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | NM102 | 1065 | 1 | Entity Type Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – Needed only for Electronic submission |

---

**Definition:**

.
A code qualifying the type of entity.

**Codes and Values:**

"1" = Person

**Edit Applications:**

Must equal "1".

**Data Element in Output Data Set:** No

## Patient's Last Name

**Data Element Name:** Patient's Last Name

**Format-Length:** AN - 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | NM103 | 1035 | | Patient Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08 | N/A | |

---

**Definition:**

The individual patient's last name or organizational name.

**Codes and Values:**

Patient Last Name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Patient's First Name

**Data Element Name:** Patient's First Name

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | NM104 | 1036 | | Patient First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08 | N/A | |

---

**Definition:**

The individual patient's first name.

**Codes and Values:**

Patient First Name.

**Edit Applications:**

1. Must not equal zero or blanks.
2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Patient's Middle Name or Initial

**Data Element Name:** Patient's Middle Name or Initial

**Format-Length:** AN – 25

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | NM105 | 1037 | | Patient First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08 | N/A | |

---

**Definition:**

The individual patient's middle name or initial.

**Codes and Values:**

Patient Middle Name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Patient's Address Line 1

**Data Element Name:** Patient's Address Line 1

**Format-Length:** AN – 18

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | N301 | 166 | | Address Line 1 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09a | N/A | |

---

**Definition:**

The mailing address of the patient's principal residence at the time of admission/visit. Enter the street number, post office box number, or RFD.

**Codes and Values:**

1. Use standard abbreviations as listed in the "Official USPS Abbreviations" page of the United States Postal Service (USPS) website:

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

2. For homeless patients, "HOMELESS" should be coded.

**Edit Applications:**

Should be a valid entry.

**Data Element in Output Data Set:** Yes

## Patient's Address Line 2

**Data Element Name:** Patient's Address Line 2

**Format-Length:** AN – 18

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | N302 | 166 | | Address Line 2 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09a | N/A | |

---

**Definition:**

The continuation of the street mailing address of the patient's principal residence at the time of admission/visit.

**Codes and Values:**

Use standard abbreviations as listed in the "Official USPS Abbreviations" page of the United States Postal Service (USPS) website:

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

**Edit Applications:**

1. Should be a valid entry.

2. If this field is not applicable, it must be blank.

**Data Element in Output Data Set:** Yes

## Patient's City

**Data Element Name:** Patient's City

**Format-Length:** AN – 15

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | N401 | 19 | | City Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09b | N/A | |

---

**Definition:**

The name of the city, town, or village of the patient's address on the day of admission/visit.

**Codes and Values:**

1. Use standard city, town, or village names approved by USPS for mailing purposes.

2. For homeless patients, "HOMELESS" should be coded.

**Data Element in Output Data Set:** Yes

## Patient's State

**Data Element Name:** Patient's State

**Format-Length:** ID - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | N402 | 156 | | State or Province Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09c | N/A | |

---

**Definition:**

A two-letter/digit code for the patient's state of residence on the day of admission/visit.

**Codes and Values:**

1. Must be valid in accordance with the State Edit Validation Table in Appendix D. For a complete listing of state abbreviations, go to the "Official USPS Abbreviations" page of the USPS website:

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

2. "99" = Homeless or Unknown

   "XX" = Other than United States

**Data Element in Output Data Set:** Yes

## Patient's ZIP Code

**Data Element Name:** Patient's Zip Code

**Format-Length:** AN - 9

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | N403 | 156 | | Postal Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 09d | N/A | |

---

**Definition:**

The ZIP Code and Extension Code assigned by USPS to the patient's principal residence at the time of admission or date of visit.

**Codes and Values:**

1. For United States residences, this data element is divided into a five-digit ZIP Code and a four-digit Extension Code. For Canadian residences, this data element is defined as a six-character Postal Code and a three-character filler.

2. If the five-digit ZIP Code begins with 700 to 701, 703 to 708, or 710 to 714, then Patient's State (FL 09c) must equal "LA", and Patient's County or Parish must equal "01"-"64".

3. Must contain no embedded blanks.

4. "XXXXX" = Unknown

   "YYYYY" = Foreign Country (Other Than Canada)

5. Must be valid for the Patient County Code assigned to the patient's principal residence.

**Edit Applications:**

A five-digit ZIP Code is required as a minimum for United States residences.

**Data Element in Output Data Set:** Yes

## Location Qualifier for Patient's County or Parish

**Data Element Name:** Location Qualifier for Patient's County or Parish

**Format-Length:** ID - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | N405 | 309 | CO | Location Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code identifying type of location.

**Codes and Values:**

"CO" = County / Parish

**Edit Applications:**

Must equal "CO".

**Data Element in Output Data Set:** No

## Patient's County or Parish

**Data Element Name:** Patient's County or Parish

**Format-Length:** N - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | N406 | 310 | | Location Identifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A two-digit code assigned to the county/parish where the patient's principal residence is located on the day of admission or date of visit.

**Codes and Values:**

Must be a valid code in accordance with the Louisiana Parish Edit Validation Table in Appendix E.

**Edit Applications:**

1. Must be a valid county/parish code for the Patient's ZIP Code (FL 09d) assigned to the patient's principal residence. Otherwise, the record will be rejected.

2. Must be compatible with Patient's State (FL 09c). If Patient's County or Parish is in Louisiana ("01"-"64"), then Patient's State must equal "LA".

3. If Patient's County or Parish is outside Louisiana ("88"), then Patient's State must not equal "LA".

**Data Element in Output Data Set:** Yes

## Patient Birth Date Qualifier

**Data Element Name:** Patient Birth Date Qualifier

**Format-Length:** ID - 3Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | DMG01 | 1250 | D8 | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code indicating the date format.

**Codes and Values:**

"D8" = Date expressed in the CCYYMMDD format

**Edit Applications:**

1. Must equal "D8".

2. If the resulting age from the date of birth to the "Statement Through" date is either less than 0 or greater than 115*, the record will be rejected.

**Data Element in Output Data Set:** No

---

*Based on current longevity data for Louisiana, 115 years is the maximum age to be accepted for a subscriber/patient.

## Patient's Birth Date

**Data Element Name:** Patient's Birth Date

**Format-Length:** N - 8

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | DMG02 | 1251 | | Patient Birth Date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 10 | N/A | |

---

**Definition:**

The date of the patient's birth.

**Codes and Values:**

Equals the patient's date of birth in the Century Year Month Day (CCYYMMDD) format

**Edit Applications:**

1. Should be in the CCYYMMDD format in accordance with the Data Edit Validation Table in Appendix A.

2. Must not be after Admission Date / Start of Care.

3. If the resulting age from the date of birth to the "Statement Through" date is either less than 0 or greater than 115*, the record will be rejected.

**Data Element in Output Data Set:** Yes

---

*Based on current longevity data for Louisiana, 115 years is the maximum age to be accepted for a subscriber/patient.

## Patient's Sex Code

**Data Element Name:** Patient's Sex Code

**Format-Length:** N - 8

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | DMG03 | 1068 | See Below | Patient Gender Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 11 | N/A | |

---

**Definition:**

The sex of the patient as recorded on the date of admission or start of care.

**Codes and Values:**

F = Female
M = Male
U = Unknown

**Edit Applications:**

There are multiple relationship edits between Patient Sex and specific diagnosis and procedure codes, as defined by the ICD-9-CM and ICD-10-CM reference file edit flags. These edits are used to detect the inconsistencies between the patient's sex and diagnosis or procedure.

**Data Element in Output Data Set:** Yes

## Patient's Race/Ethnicity Qualifier

**Data Element Name:** Patient's Race/Ethnicity Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | DMG05-2 | 1270 | RET | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission. |

---

**Definition:**

The DMG05 is a composite data element. Each composite section refers to a specific data element. The first element of the composite is the Component Element Separator. The Component Element Separator (ISA16 "^") must be used before and after the composite data element DMG05-2. In addition, the Repetition Separator (ISA11 ":") must be used between race and ethnicity. This is the code identifying a specific industry code list.

**Codes and Values:**

"RET" = Classification of Race or Ethnicity

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

where ISA16 = "^" and ISA11 = ":"

**Edit Applications:**

Must equal "RET".

**Data Element in Output Data Set:** No

## Patient's Race

**Data Element Name:** Patient's Race

**Format-Length:** AN - 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | DMG05-3 | 1271 | See Below | Race or Ethnicity Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B1 | |

---

**Definition:**

A code which best describes the race of the patient. The DMG 05 is a composite data element. Each composite section refers to a specific data element. The first element is the Component Element Separator. This is the second element for race.

**Codes and Values:**

"R1" = American Indian or Alaska Native
"R2" = Asian
"R3" = Black or African-American
"R4" = Native Hawaiian or Pacific Islander
"R5" = White
"R9" = Other Race

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

**Edit Applications:**

Must equal "R1", "R2", "R3", "R4", "R5", or "R9".

**Data Element in Output Data Set:** Yes

## Patient's Ethnicity

**Data Element Name:** Patient's Ethnicity

**Format-Length:** AN - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | DMG05-3 | 1271 | See Below | Race or Ethnicity Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B1 | |

---

**Definition:**

The code which best describes the ethnic origin of the patient. The DMG 05 is a composite data element. Each composite section refers to a specific data element. The first element is the Component Element Separator. This is the second element for ethnicity.

**Codes and Values:**

"E1" = Hispanic or Latino Ethnicity
"E2" = Non-Hispanic or Latino Ethnicity

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

**Edit Applications:**

Must equal "E1" or E2" when using the DMG segment.

**Data Element in Output Data Set:** Yes

Note: DMG05 may repeat up to 10 times to accommodate state or federal requirements that allow individuals to report more than one race code along with the ethnicity code.

## Patient Secondary Identification Number Qualifier

**Data Element Name:** Patient Secondary Identification Number

**Format-Length:** ID - 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | REF01 | 128 | See Below | Qualifier Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the Reference Identification.

**Codes and Values:**

"1W" = Member Identification Number (If NM108 = MI, this qualifier cannot be used.)

"ABB " = Personal ID Number (Used for state-specific linkage variables at the encounter.)

"IG" = Insurance Policy Number

"SY" = Social Security Number

**Edit Applications:**

Must equal "1W", "ABB", "IG", or "SY".

**Data Element in Output Data Set:** No

## Patient Secondary Identification Number

**Data Element Name:** Patient Secondary Identification Number

**Format-Length:** A/N – 20

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2010CA | REF02 | 127 | | Patient Secondary Identification Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 08a | N/A | |

---

**Definition:**

The number used to identify the patient.

**Codes and Values:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Edit Applications:**

Must equal Medical Record Number.

**Data Element in Output Data Set:** Yes

## Total Claim Charge Amount

**Data Element Name:** Total Claim Charge Amount

**Format-Length:** N - 12

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | CLM02 | 782 | | Total Claim Charge Amount |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 47 | N/A | |

---

**Definition:**

Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non-covered charges. The total amount of all submitted charges of service segments for this claim.

**Codes and Values:**

The amount must be entered in dollars and cents including the decimal point.

Example: *$125.24 would be entered as: 125.24*

Note: There are 7 positions for dollars and 2 positions or cents separated by a decimal point. Amounts greater than or equal to zero are acceptable values in this element.

**Edit Application:**

Must equal the total of all submitted charges of service segments for this claim.

**Data Element in Output Data Set:** Yes

Note: The total charges should equal the sum of both covered and non-covered charges of each service line.

## Discharge Hour Qualifier

**Data Element Name:** Discharge Hour Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP01 | 374 | 096 | Date Time Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code specifying type of date or time, or both date and time.

**Codes and Values:**

"096" = Discharge

**Edit Applications:**

Must equal "096".

**Data Element in Output Data Set:** No

## Discharge Hour Format Qualifier

**Data Element Name:** Discharge Hour Format Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP02 | 1250 | TM | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code indicating the date format, time format, or date and time format.

**Codes and Values:**

"TM" = Time Expressed in Hour Minute (HHMM) Format

**Edit Applications:**

Must equal "TM".

**Data Element in Output Data Set:** No

## Discharge Hour

**Data Element Name:** Discharge Hour

**Format-Length:** AN - 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP03 | 1251 | | |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 16 | N/A | |

---

**Definition:**

The hour when the patient was discharged or death occurred.

For ED patients, this would be the hour in which the patient was discharged from the ED to home or to another health care provider.

**Codes and Values:**

Equals Discharge Hour.

**Edit Applications:**

1. Must equal Discharge Hour.

2. Discharge Hour should be reported in the HHMM format, as defined by the X12-837 standards. Louisiana currently only edits and collects the first 2 characters (HH). Please refer to the Admission/Discharge Hour Code Table in Appendix B for details.

**Data Element in Output Data Set:** Yes

## Admission Date / Hour Qualifier

**Data Element Name:** Admission Date / Hour Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP01 | 374 | 435 | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code indicating the data format, time format, or date and time format.

**Codes and Values:**

"435" = Admission

**Edit Applications:**

Must equal "435".

**Data Element in Output Data Set:** No

## Admission Date / Hour Format Qualifier

**Data Element Name:** Admission Date / Hour Format Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP02 | 1250 | DT | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code indicating the data format, time format, or date and time format.

**Codes and Values:**

"DT" = Date and Time expressed in the CCYYMMDDHHMM format

**Edit Applications:**

Must equal "DT".

**Data Element in Output Data Set:** No

## Admission Date / Hour

**Data Element Name:** Admission Date / Hour

**Format-Length:** AN - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | DTP03 | 1251 | | |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 13 | N/A | |

---

**Definition:**

The hour when the patient was either admitted for IP care or was provided outpatient (ED or AS) service.

For ED patients, this would be the hour in which the patient was registered or triaged, whichever occurred first.

**Codes and Values:**

Equals Discharge Hour

**Edit Applications:**

1. Must equal Discharge Hour.

2. Discharge Hour should be reported in the HHMM format, as defined by the ANSI/ASC X12-837I standards. Louisiana currently only edits and collects the first 2 characters (HH). Please refer to the Admission/Discharge Hour Code Table in Appendix B for details.

**Data Element in Output Data Set:** Yes

## Priority (Type) of Visit

**Data Element Name:** Priority (Type) of Visit (formerly Type of Admission)

**Format-Length:** AN - 1

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | CL101 | 1315 | | Admission Type Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 14 | N/A | |

---

**Definition:**

A code indicating the priority of this admission.

**Codes and Values:**

1 = Emergency - The patient requires immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions.

2 = Urgent - The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.

3 = Elective - The patient's condition permits adequate time to schedule the admission based on the availability of a suitable accommodation.

4 = Newborn - Use of this code necessitates the use of special codes in the Source of Admission.

5 = Trauma - Visit to a trauma center as certified by the Louisiana Department of Health and Hospitals.

9 = Information not available - The provider cannot classify the type of admission.

**Edit Applications:**

Must equal a valid code.

**Data Element in Output Data Set:** Yes

## Point of Origin

**Data Element Name:** Point of Origin (formerly Source of Admission)

**Format-Length:** AN - 1

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | CL102 | 1314 | | Admission Source Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 15 | N/A | |

---

**Definition:**

A code indicating the point of patient origin for the admission/visit.

**Codes and Values:**

1 = Non-Health Facility Point of Origin (includes patients coming from home or workplace). IP: The patient was admitted to the facility upon an order of a physician. ED/AS: The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g. mammography). Includes non-emergent self-referrals.

2 = Clinic or Physician's Office. IP: The patient was referred to this facility as a transfer from a freestanding or non-freestanding clinic. ED/AS: The patient was referred to this facility for outpatient or referenced diagnostic services.

4 = Transfer From a Hospital (Different Facility). IP: The patient was admitted to this facility as a hospital transfer from an acute-care facility where he or she was an inpatient or outpatient. ED/AS: The patient was transferred to this facility as an outpatient from an acute-care facility.

5 = Transfer From a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). IP: The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident. ED/AS: The patient was referred to this facility for outpatient or referenced diagnostic services for a SNF or ICF where he or she was a resident.

6 = Transfer From Another Health Care Facility. IP: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. ED/AS: The patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.

8 = Court/Law Enforcement. IP: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. ED/AS: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.

9 = Information Not Available. IP: The means by which the patient was admitted to the hospital is not known. ED/AS: The means by which the patient was referred to the ED or AS center is not known.

D = Transfer from One Distinct Unit of the Facility to another Distinct Unit of the Same Facility Resulting in a Separate Claim to the Payer. IP: The patient was admitted to the hospital as a transfer from hospital inpatient within the same facility resulting in a separate claim to the payer. ED/AS: The patient received outpatient services in this facility as a transfer from within this same facility resulting in a separate claim to the payer.

E = Transfer from Ambulatory Surgical Center (ASC). IP: The patient was admitted to the facility as a transfer from an ASC. ED/AS: The patient was referred to the facility for outpatient or referenced diagnostic services from an ASC.

F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program. IP: The patient was admitted to the facility as a transfer from a hospice. ED/AS: The patient was referred to the facility for outpatient or referenced diagnostic services from a hospice.

Note: If the Priority (Type) of Visit is "4" (Newborn), the following coding scheme must be used for Point of Origin:

5 = Born Inside Hospital – A baby born inside the hospital.

6 = Born Outside Hospital - A baby born outside of the hospital.

**Edit Applications:**

Must equal a valid code.

**Data Element in Output Data Set:** Yes

## Patient Status Code

**Data Element Name:** Patient Status Code (also known as Patient Discharge Status)

**Format-Length:** AN - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | CL103 | 1352 | | Patient Status Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 17 | N/A | |

---

**Definition:**

A code indicating the patient status as of the "Statement Through Date" upon discharge.

**Codes and Values:**

Equals Patient Status Code.

**Edit Applications:**

Must be a valid code in accordance with the Patient Status or Disposition Codes listed in the most recent edition of the *Official UB-04 Data Specifications Manual* published by the National Uniform Billing Committee.

**Data Element in Output Data Set:** Yes

## Source of Payment Typology I

**Data Element Name:** Source of Payment Typology I

**Format-Length:** AN – 5

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | K3 | 449 | | Source of Payment Typology I |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B4 | |

---

**Definition:**

Source of Payment Typology (SoP) I is a hierarchical code list used to identify the payer expected to pay the major portion of the patient's bill. This data element provides a range of codes from broad categories to related sub-categories that are more specific. The expected payer should be reported using the greatest level of detail without sacrificing accuracy of the information.

Specific attention should be given to types of payment using Managed Care Plans (MCPs). MCPs operate multiple products (HMO and PPO). Medicare (federal) and Medicaid (state) fund different HMO programs/products within the Managed Care Plans companies. In order to determine the appropriate funding, the MCP should advise on the state or federal funding to accurately determine the source of payment.

**Codes and Values:**

1. Equals a valid code in accordance with the Source of Payment Typology Codes listed in the most recent edition of the *Official UB-04 Data Specifications Manual* published by the National Uniform Billing Committee.

2. Additional information is available in the *Users Guide for Source of Payment Typology* published by the Public Health Data Standards Consortium. An electronic copy may be accessed at:

http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion5.0_final.pdf

**Edit Applications:**

1. Must be a valid Source of Payment Typology Code.

2. Must be left-justified and space-filled right.

**Data Element in Output Data Set:** Yes

Note: Positions 4 – 8 of K3 String used to Submit Source of Payment Typology. It is important to enter the trailing blanks if the Source of Payment Typology Code entered is less than 5 characters in length.

Example: *K3**121* ~

## Source of Payment Typology II

**Data Element Name:** Source of Payment Typology II

**Format-Length:** AN – 5

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | K3 | 449 | | Source of Payment Typology II |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B5 | |

---

**Definition:**

Source of Payment Typology II (SoP II) is used to identify the secondary payer expected to pay a portion of the patient's bill if applicable.

Source of Payment Typology II is a hierarchical code list. This data element provides a range of codes from broad categories to related subcategories that are more specific. The expected payer should be reported using the greatest level of detail without sacrificing accuracy of the information.

Specific attention should be given to types of payment using Managed Care Plans (MCPs). MCPs operate multiple products (HMO and PPO). Medicare (federal) and Medicaid (state) fund different HMO programs/products within the Managed Care Plans companies. In order to determine the appropriate funding, the MCP should advise on the state or federal funding to accurately determine the source of payment.

**Codes and Values:**

1. Equals a valid code in accordance with the Source of Payment Typology Codes listed in the most recent edition of the *Official UB-04 Data Specifications Manual* published by the National Uniform Billing Committee.

2. Additional information is available in the *Users Guide for Source of Payment Typology* published by the Public Health Data Standards Consortium. An electronic copy may be accessed at:

http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion5.0_final.pdf

**Edit Applications:**

1. Must be a valid Source of Payment Typology Code.

2. Must be left-justified and space-filled right.

**Data Element in Output Data Set:** Yes

Note: Positions 9 – 13 of K3 String used to Submit Source of Payment Typology. It is important to enter the trailing blanks if the Source of Payment Typology Code entered is less than 5 characters in length.

Example: *K3*121* ***62*** ~

## Source of Payment Typology III

**Data Element Name:** Source of Payment Typology III

**Format-Length:** AN – 5

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | K3 | 449 | | Source of Payment Typology III |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B6 | |

---

**Definition:**

Source of Payment Typology III (SoPIII) is used to identify the third payer expected to pay a portion of the patient's bill if applicable.

Source of Payment Typology III is a hierarchical code list. This data element provides a range of codes from broad categories to related subcategories that are more specific. Report the expected payer using the greatest level of detail without sacrificing accuracy of the information.

Specific attention should be given to types of payment using Managed Care Plans (MCPs). MCPs operate multiple products (HMO and PPO). Medicare (federal) and Medicaid (state) fund different HMO programs/products within the Managed Care Plans companies. In order to determine the appropriate funding, the MCP should advise on the state or federal funding to accurately determine the source of payment.

**Codes and Values:**

1. Equals a valid code in accordance with the Source of Payment Typology Codes listed in the most recent edition of the *Official UB-04 Data Specifications Manual* published by the National Uniform Billing Committee.

2. Additional information is available in the *Users Guide for Source of Payment Typology* published by the Public Health Data Standards Consortium. An electronic copy may be accessed at:

http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion5.0_final.pdf

**Edit Applications:**

1. Must be a valid Source of Payment Typology Code.

2. Must be left-justified and space-filled right.

**Data Element in Output Data Set:** Yes

Note: Positions 13 – 17 of K3 String used to Submit Source of Payment Typology. It is important to enter the trailing blanks if the Source of Payment Typology Code entered is less than 5 characters in length.

Example: *K3*121 62* ***52*** *~*

## Preferred Language Spoken

**Data Element Name:** Preferred Language Spoken

**Format-Length:** A/N – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | K3 | 449 | | Preferred Language Spoken |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 81 | B7 | |

---

**Definition:**

A code used to identify the language the subscriber prefers for discussing health care information with those in the health care community.

**Codes and Values:**

Must be a valid ISO 639-2* Language Code.

**Edit Applications:**

Must equal Patient Preferred Language Spoken.

**Data Element in Output Data Set:** Yes

Note: Positions 18 – 20 of K3 String used to Submit Preferred Language Spoken. It is important that the Preferred Language Spoken Code begin in Column 19 of the K3 string. It also should be noted that the use of the K3 segment for reporting the Preferred Language Spoken will only be necessary in the 5010 version of the ANS ASC X12 implementation guides. For any subsequent ANSI ASC X12 versions, the Preferred Language Spoken will be reported in the LUI segment, which is part of the Subscriber Loop (2010BA) or the Patient Loop (2010CA) depending on whether the Subscriber is the patient or not. No matter where in the ANSI ASC X12 standard the Preferred Language Spoken is reported, the ISO 639-2 codes will be reported.

Example: *K3*121 62 52* ***SPA*** ~

---

*ISO 639-2 is a code set of the International Organization for Standardization. Information about the Library of Congress as the ISO 639-2 Registration Authority is available at http://www.loc.gov/standards/iso639-2/.

## Principal Diagnosis Code

**Data Element Name:** Principal Diagnosis Code

**Format-Length:** AN – 7

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 | 1271 | | Principal Diagnosis Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 67 | N/A | |

---

**Definition:**

Overall, the Principal Diagnosis is the condition established after study to be chiefly responsible for occasioning the patient's visit for care. For discharge dates before October 1, 2014, the ICD-9-CM coding rules for inpatient services will apply. For discharge dates on or after October 1, 2014, ICD-10 coding rules must be used. Discharge date, not admission date, dictate which coding must be applied when the change from the ICD-9 to ICD-10 occurs.

In the case of an inpatient (IP) stay, the Principal Diagnosis represents the reason for the patient's care, though it may not necessarily be the diagnosis which represents the greatest length of stay, the greatest consumption of resources, or the most life-threatening condition. Since the Principal Diagnosis reflects clinical findings discovered during the patient's care, it may differ from Admitting Diagnosis.

In the case of admission for ambulatory-surgery (AS) services, the Principal Diagnosis is that diagnosis established to be chiefly responsible for occasioning the admission for the service.

In the case of emergency-department (ED) visits, the Principal Diagnosis Code is that diagnosis established to be chiefly responsible for occasioning the visit to the ED.

**Codes and Values:**

1. Equals a valid ICD code. To be valid, ICD codes must be entered at the most specific level to which they are classified in the ICD-9 or ICD-10 Tabular List. Failure to enter all required digits in the diagnosis codes will cause the record to be rejected.

2. Must be entered exactly as shown in the ICD coding reference.

3. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Edit Applications:**

1. Must equal a valid Principal Diagnosis Code. If missing, the record will be rejected.

2. If the Principal Diagnosis Code is inconsistent with the patient's sex, the record will be rejected.

3. If a *neonatal* Principal Diagnosis Code is inconsistent with the patient's age, the record will be rejected.

4. If a *maternal* Principal Diagnosis Code is reported for a patient younger than 10 years of age or older than 55 years of age, the record will be rejected.

5. Diagnosis codes reported in the range of 800.00-999.99 (ICD-9) or S00.00xx-T88.99XXS (ICD-10) require the reporting of a valid External Cause-of-Injury Code.

6. IP and AS Only: E-codes are not valid as Principal Diagnosis Codes. E-codes are reported in External Cause-of-Injury Code and Place-of-Injury Code.

7. If the Principal Diagnosis Code is repeated in Other Diagnosis Codes 1 – 24, the record will be rejected.

8. If the Principal Diagnosis Code is trauma-related but External Cause of Injury Code is not reported, the record will be rejected.

9. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Data Element in Output Data Set:** Yes

Note: HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

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

## Admitting Diagnosis Code List Qualifier

**Data Element Name:** Admitting Diagnosis Code List Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 | 1270 | See Below | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for admitting diagnosis.

**Codes and Values:**

"BJ" = International Classification of Diseases Clinical Modification (ICD-9-CM) Admitting Diagnosis

"ABJ" = International Classification of Diseases Clinical Modification (ICD-10-CM) Admitting Diagnosis (start date for reporting on or after October 1, 2014)

**Edit Applications:**

Must equal "BJ" or "ABJ".

**Data Element in Output Data Set:** No

## Admitting Diagnosis Code

**Data Element Name:** Admitting Diagnosis Code

**Format-Length:** AN – 7

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 | 1271 | | Admitting Diagnosis Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 69 | N/A | |

---

**Definition:**

The diagnosis provided by the practitioner at the time of admission which describes the patient's condition upon admission to the hospital. The ICD-CM diagnosis code describing the admitting diagnosis as a significant finding representing patient distress, an abnormal finding on examination, a possible diagnosis based on significant findings, a diagnosis established from a previous encounter of admission, an injury, a poisoning, or a reason or condition (not an illness or injury) such as a follow-up or pregnancy in labor. Report only one admitting diagnosis. Since the Admitting Diagnosis is formulated before all tests and examinations are complete, it may be stated in the form of a problem or symptom and it may differ from any of the final diagnoses recorded in the medical record.

For discharge dates before October 1, 2014, the ICD-9-CM coding rules for inpatient services will apply. For discharge dates on or after October 1, 2014, ICD-10-CM coding rules must be used. Discharge date, not admission date, dictate which coding must be applied when the change from the ICD-9 to ICD-10 occurs.

**Codes and Values:**

1. Equals a valid ICD code. To be valid, ICD codes must be entered at the most specific level to which they are classified in the ICD-9 or ICD-10 Tabular List. Failure to enter all required digits in the diagnosis codes will cause the record to be rejected.

2. Must be entered exactly as shown in the ICD coding reference.

3. E-codes are not valid as Admitting Diagnosis Codes. E-codes are reported in External Cause-of-Injury Code and Place-of-Injury Code.

4. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Edit Applications:**

1. Must be valid Admitting Diagnosis Code.

2. If the Admitting Diagnosis Code is inconsistent with the patient's sex, the record will be rejected.

3. If a *neonatal* Admitting Diagnosis Code is inconsistent with the patient's age, the record will be rejected.

4. If a *maternal* Admitting Diagnosis Code is reported for a patient younger than 10 years of age or older than 55 years of age, the record will be rejected.

5. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Data Element in Output Data Set:** Yes

## Patient Reason For Visit Code List Qualifier

**Data Element Name:** Patient Reason For Visit Code List Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 Thru HI02-1 | 1270 | See Below | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for patient reason for visit.

**Codes and Values:**

"PR" = International Classification of Diseases Clinical Modification (ICD-9-CM) Patient Reason for Visit.

"APR" = International Classification of Diseases Clinical Modification (ICD-10-CM) Patient Reason for Visit (start date for reporting on or after October 1, 2014).

**Edit Applications:**

Must equal "PR" or "APR".

**Data Element in Output Data Set:** No

## Patient Reason For Visit Code

**Data Element Name:** Patient Reason For Visit Code

**Format-Length:** AN – 7

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI03-2 | 1271 | | Patient Reason for Visit Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 70a-c | N/A | |

---

**Definition:**

The diagnosis describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report the diagnosis code(s) describing the patient's primary reason for seeking care. Reporting the decimal between the third and fourth digits is unnecessary because it is implied. In the 5010R Version, you can repeat up to three reasons.

For discharge dates before October 1, 2014, the ICD9-CM coding rules for inpatient services will apply: For discharge dates on or after October 1, 2014, ICD-10 coding rules must be used. Discharge date, not admission date, dictate which coding must be applied when the change from the ICD9 to ICD10 occurs.

**Codes and Values:**

1. Equals a valid ICD code. To be valid, ICD codes must be entered at the most specific level to which they are classified in the ICD-9 or ICD-10 Tabular List. Failure to enter all required digits in the diagnosis codes will cause the record to be rejected.

2. Must be entered exactly as shown in the ICD coding reference.

3. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Edit Applications:**

1. If the Patient Reason for Visit Code is inconsistent with the patient's sex, the record will be rejected.

3. If a *neonatal* Patient Reason for Visit Code is inconsistent with the patient's age, the record will be rejected.

4. If a *maternal* Patient Reason for Visit Code is reported for a patient younger than 10 years of age or older than 55 years of age, the record will be rejected.

5. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Data Element in Output Data Set:** Yes

## External Cause of Injury Code List Qualifier

**Data Element Name:** External Cause of Injury Code List Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 Thru HI12-1 | 1270 | See Below | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for external cause of injury.

**Codes and Values:**

"BN" = International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury

"ABN" = International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury (start date for reporting on or after October 1, 2014).

**Edit Applications:**

Must equal "BN" or "ABN".

**Data Element in Output Data Set:** No

Note: HI01-HI12 are composite data elements. Component Element Separator (ISA16) must be used between segment data elements. See HI segment example below.

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

## External Cause of Injury Code

**Data Element Name:** External Cause of Injury Code

**Format-Length:** AN – 7

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI12-2 | 1271 | | External Cause-of-Injury (ECI)/Place-of-Injury Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 72a-c | N/A | |

---

**Definition:**

The ICD diagnosis code pertaining to the external cause of injury (ECI), poisoning, or adverse effect. Practitioners should complete this item whenever there is a diagnosis of an injury, poisoning, or adverse effect. Assign your ECI based on the priority of: (1) having a principal diagnosis of an injury or poisoning, (2) other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis, and (3) other diagnosis with an external cause. The place of injury code further identifies the place where the injury reported in the ECI code occurred.

For discharge dates before October 1, 2014, the ICD9-CM coding rules for inpatient services will apply. For discharge dates on or after October 1, 2014, ICD-10 coding rules must be used. Discharge date, not admission date, dictate which coding must be applied when the change from the ICD-9 to ICD-10 occurs.

**Codes and Values**:

1. ICD-9-CM

a. A valid ICD-9-CM "E" code. To be valid, the code must be entered at the most specific level classified in the ICD-9-CM Tabular List and include the prefix letter "E". Failure to enter the prefix "E" and all required digits will cause the record to be rejected.

b. Must include the prefix letter "E" and all digits entered exactly as shown in the ICD-9-CM coding reference.

c. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

2. ICD-10-CM

a. A valid ICD-10-CM code beginning with the "V", "W", "X", or "Y" prefix. To be valid, the code must be entered at the most specific level classified in the ICD-10-CM Tabular List and include the prefix letter "V", "W", "X", or "Y". Failure to enter any of the four "V"-"Y" prefixes and all required digits will cause the record to be rejected.

b. Must include the prefix letter "V", "W", "X", or "Y" and all digits entered exactly as shown in the ICD-10-CM coding reference.

c. Additional information may be obtained from:

*ICD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Edit Applications:**

1. Must equal "External Cause of Injury Code" or "External Place of Injury".

2. ICD-9-CM

a. A valid entry is required in this field when either the Principal Diagnosis Code or Other Diagnosis Code 1-24 reported is in the range 800.00-999.99.

b. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

3. ICD-10-CM

a. A valid entry is required in this field when either the Principal Diagnosis Code or Other Diagnosis Code 1-24 reported is in the range S00.00XA-T88.9XXS.

b. Additional information may be obtained from:

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

4. If the Principal Diagnosis Code is trauma-related but External Cause of Injury Code is not reported, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Other Diagnosis Code List Qualifier 1 - 24

**Data Element Name:** Other Diagnosis Code List Qualifier 1 - 24

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 Thru HI12-1 | 1270 | See Below | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for other diagnosis.

**Codes and Values:**

1. "BF" = International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis

2. "ABF" = International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis (start date for reporting on or after October 1, 2014)

**Edit Applications:**

Must equal "BF" or "ABF".

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

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

## Other Diagnosis Code 1 - 24

**Data Element Name:** Other Diagnosis Code 1 - 24

**Format-Length:** AN – 7

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI12-2 | 1271 | | Other Diagnosis Code 1-24 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 67a-q | N/A | |

---

**Definition:**

Other Diagnoses include all conditions that coexist at the time of admission or service, or develop subsequently, which affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current stay are to be excluded.

Conditions should be coded that affect patient care in terms of requiring: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of stay, or increased nursing care and/or monitoring.

For discharge dates before October 1, 2014, the ICD9-CM coding rules for inpatient services will apply: For discharge dates on or after October 1, 2014, ICD-10 coding rules must be used. Discharge date, not admission date, dictate which coding must be applied when the change from the ICD9 to ICD10 occurs.

**Codes and Values:**

1. Equals a valid ICD code. To be valid, ICD codes must be entered at the most specific level to which they are classified in the ICD-9 or ICD-10 Tabular List. Failure to enter all required digits in the diagnosis codes will cause the record to be rejected.

2. E-codes are valid as Other Diagnosis Codes.

3. Code as entered exactly in the ICD coding reference.

4. If this field is not applicable, it must contain blanks.

5. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Edit Applications:**

1. Must equal Other Diagnosis Code.

2. Diagnosis codes reported in the range of 800.00-999.99 (ICD-9) or S00.00XA-T88.9XXS (ICD-10) require the reporting of a valid External Cause-of-Injury Code.

3. If any of the Other Diagnosis Codes 1 – 24 is inconsistent with the patient's sex, the record will be rejected.

4. If a *neonatal* Other Diagnosis Code 1 – 24 is inconsistent with the patient's age, the record will be rejected.

5. If a *maternal* Other Diagnosis Code 1 – 24 is reported for a patient younger than 10 years of age or older than 55 years of age, the record will be rejected.

6. If the Principal Diagnosis Code is repeated in Other Diagnosis Codes 1- 24, the record will be rejected.

7. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Data Element in Output Data Set:** Yes

**Notes:**

1. HI01-HI12 are required composite data elements. HI02-HI12 are used for claims that have a second through twelfth Other Diagnosis Code, respectively. Component Element Separator (ISA16) must be used between segment data elements.

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

## Present on Admission Indicator

**Data Element Name:** Present on Admission Indicator

**Format-Length:** ID – 1

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-9 Thru HI12-9 | 1270 | See Below | Present on Admission Indicator |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | 67 | N/A | |

---

**Definition:**

The Present on Admission Indicator Code is used to identify the diagnosis onset as it relates to the diagnosis reported in the Principal Diagnosis Code, External Cause of Injury Codes, and Other Diagnosis Codes. The Present on Admission Indicator on each of these Diagnoses indicates whether the onset of the diagnosis preceded or followed admission to the hospital.

**Codes and Values:**

"Y" = Yes. Present at the time of inpatient admission.

"N" = No. Not present at the time of inpatient admission.

"U" = Unknown. The documentation is insufficient to determine if condition is present on admission.

"W" = Clinically Undetermined. The provider is unable to clinically determine whether condition was present on admission or not.

"1" or blank = Exempt from POA reporting for selected ICD-CM codes (a value of "1" is preferred over a blank).

**Edit Applications:**

1. Must equal "Y", "N", "U", "W", "1", or blank.

2. If an Other Diagnosis Code 1-24 is reported, there must be a corresponding Present on Admission Indicator coded appropriately, except for E-codes.

3. If Present on Admission Indicator is entered, Other Diagnosis Code 1-24 must also be reported.

4. If Present on Admission Indicator is equal to "1" or blank, the associated Other Diagnosis Code 1-24 must be listed as an exempt code according to the ICD-CM Reporting Guidelines.

5. If any diagnosis code (Principal, Admitting, Other 1- 24) is inconsistent with the patient's sex, the record will be rejected.

**Data Element in Output Data Set:** Yes

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

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

## Principal Procedure Code List Qualifier

**Data Element Name:** Principal Procedure Code List Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 | 1270 | See Below | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

Code identifying a specific industry code list for principal procedure.

**Codes and Values:**

"BR" = International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure.

"ABR" = International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis (start date for reporting on or after October 1, 2014).

**Edit Application:**

Must equal "BR" or "ABR".

**Data Element in Output Data Set:** No

**Note:**

HI01 is a required composite data element. Component Element Separator (ISA16) must be used between segment data element.

## Principal Procedure Code

**Data Element Name:** Principal Procedure Code

**Format-Length:** AN – 7

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 | 1271 | | Principal Procedure Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 74 | N/A | |

---

**Definition:**

The principal procedure is one that is performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. A significant procedure is one that is surgical in nature, carries a procedural risk, carries an anesthetic risk, or requires specialized training. Surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation.

If there appear to be two procedures that are principal, then the one most related to the Principal Diagnosis should be selected as the principal procedure. When more than one procedure is reported, the principal procedure is to be designated. For discharge dates before October 1, 2014, the ICD9-CM coding rules for inpatient services will apply. For discharge dates on or after October 1, 2014, ICD-10 coding rules must be used. Discharge date, not admission date, dictate which coding must be applied when the change from the ICD-9 to ICD-10 occurs.

**Codes and Values:**

1. A valid ICD Principal Procedure Code.

2. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Edit Applications:**

1. Must equal Principal Procedure Code.

2. If this field is not applicable, it must be blank.

3. If the Principal Procedure Code is entered, the Operating Physician State License Number and Principal Procedure Date must also be reported.

4. If the Principal Procedure Code is inconsistent with the patient's sex, the record will be rejected.

5. If a *maternal* Principal Procedure Code is reported for a patient younger than 10 years of age or older than 55 years of age, the record will be rejected.

6. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Data Element in Output Data Set:** Yes

Note: HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

## Principal Procedure Date Format Qualifier

**Data Element Name:** Principal Procedure Date Format Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-3 | 1250 | See Below | Principal Procedure Date Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code indicating the date format.

**Codes and Values:**

"D8" = Date Expressed in Format "CCYYMMDD"

**Edit Applications:**

1. Must equal "D8".

2. If the Principal Procedure Code is inconsistent with the patient's sex, the record will be rejected.

**Data Element in Output Data Set:** No

**Note:**

HI01 is a required composite data element. Component Element Separator (ISA16) must be used between segment data element.

## Principal Procedure Date

**Data Element Name:** Principal Procedure Date
**Format-Length:** N – 8

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-4 | 1251 | | Principal Procedure Date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 74 | N/A | |

---

**Definition:**

The date the Principal Procedure was performed.

**Codes and Values:**

A valid date.

**Edit Applications:**

1. Must equal Principal Procedure Date.

2. Must be in format CCYYMMDD = Century Year Month Day.

3. Must be a valid date in accordance with the Date Edit Validation Table in Appendix A.

4. The date must be no more than three (3) days prior to the Admission Date <u>and</u> before (or the same as) Statement-Through Date.

5. If Principal Procedure Date is entered, the Operating Physician State License Number and Principal Procedure Code must also be reported.

**Data Element in Output Data Set:** Yes

Note: HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

## Other Procedure Code Qualifier 1-24

**Data Element Name:** Other Procedure Code Qualifier 1-24

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 | 1270 | See Below | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for other procedure.

**Codes and Values:**

1. "BQ" = International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure

2. "ABQ" = International Classification of Diseases Clinical Modification (ICD-10-CM) Other Diagnosis (start date for reporting on or after October 1, 2014).

**Edit Applications:**

Must equal "BQ" or "ABQ".

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. 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.

2. A second repeat of these segments may be used to report Other Procedure Codes 13 and 14. Although all other procedure codes for a claim may be entered on two iterations of this composite segment, Louisiana currently only processes the first fourteen (14) Other Procedure Codes.

## Other Procedure Codes 1 - 24

**Data Element Name:** Other Procedure Codes 1 - 24

**Format-Length:** AN – 7

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI12-2 | 1271 | | Other Procedure Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 74 a-e | N/A | |

---

**Definition:**

All significant procedures other than the Principal Procedure Code are to be reported here, as space allows. They are reported in order of significance, starting with the most significant.

A significant procedure is one that is surgical in nature, carries a procedural risk, carries an anesthetic risk, or requires specialized training. Surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation.

For discharge dates before October 1, 2014, the ICD9-CM coding rules for inpatient services will apply. For discharge dates on or after October 1, 2014, ICD-10 coding rules must be used. Discharge date, not admission date, dictate which coding must be applied when the change from the ICD-9 to ICD-10 occurs.

**Codes and Values:**

1. A valid ICD Procedure Code.

2. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Edit Applications:**

1. Must equal a valid ICD Procedure Code to report Other Procedure.

2. Must be entered exactly as shown in the ICD-9-CM or ICD-10-CM coding reference.

3. If this field is not applicable, it must be blank.

4. If Other Procedure Code 1-24 is entered, the corresponding Other Procedure Date 1-24 must also be reported.

5. If any of the Other Procedure Codes 1 – 24 is inconsistent with the patient's sex, the record will be rejected.

6. If a *maternal* Other Procedure Codes 1 – 24 is reported for a patient younger than 10 years of age or older than 55 years of age, the record will be rejected.

7. Additional information may be obtained from:

*ICD-9-CM Official Guidelines for Coding and Reporting*
*(*http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)

I*CD-10-CM Official Guidelines for Coding and Reporting*
(http://www.cdc.gov/nchs/data/icd9/icd10cm_guidelines_2014.pdf).

**Data Element in Output Data Set:** Yes

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. A second repeat of these segments may be used to report Other Procedure Codes 13 through 24. Although all other procedure codes for a claim may be entered on two iterations of this composite segment, Louisiana currently only processes the first fourteen (14) Other Procedure Codes.

## Other Procedure Dates Format Qualifier

**Data Element Name:** Other Procedure Dates Format Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-3 thru HI12-3 | 1250 | See Below | Other Procedure Date Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code indicating the date format for Other Procedures.

**Codes and Values:**

"D8" = Date Expressed in Format "CCYYMMDD"

**Edit Applications:**

Must equal "D8".

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. A second repeat of these segments may be used to report Other Procedure Codes 13 and 14. Although all other procedure codes for a claim may be entered on two iterations of this composite segment, Louisiana currently only processes the first fourteen (14) Other Procedure Codes.

## Principal Procedure Date 1 - 24

**Data Element Name:** Principal Procedure Date 1 - 24

**Format-Length:** N – 8

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-4 Thru HI12-4 | 1251 | | Other Procedure Date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 74a-e | N/A | |

---

**Definition:**

The date the Other Procedures were performed.

**Codes and Values:**

A valid date principal procedure date.

**Edit Applications:**

1. Must equal Other Procedure Date.

2. Must be in format CCYYMMDD = Century Year Month Day.

3. Must be a valid date in accordance with the Date Edit Validation Table in Appendix A.

4. If Other Procedure Date 1-24 is entered, the corresponding Other Procedure Code 1-24 must also be entered.

5. Date must be no more than three (3) days prior to the Admission Date and before (or the same as) Statement-Through Date.

**Data Element in Output Data Set:** Yes

**Notes:**

1. HI01-HI12 are required composite data elements. 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.

2. A second repeat of these segments may be used to report Other Procedure Codes 13 through 24. Although all other procedure codes for a claim may be entered on two iterations of this composite segment, Louisiana currently only processes the first fourteen (14) Other Procedure Codes.

## Occurrence Span Code List Qualifier

**Data Element Name:** Occurrence Span Code List Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 Thru HI12-1 | 1270 | BI | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for Occurrence Span Codes.

**Codes and Values:**

"BI" = Occurrence Span

**Edit Applications:**

Must equal "BI"

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements. Louisiana allows a maximum of 30 Occurrence Spans.

2. Reportable Occurrence Span Code conditions may be coded in any order, and may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

## Occurrence Span Code

**Data Element Name:** Occurrence Span Code

**Format-Length:** AN – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI12-2 | 1271 | See Below | Occurrence Span Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 35 – 36 | N/A | |

---

**Definition:**

The code which identifies the specific Type of Alternate Level of Care (ALC) required for a patient determined to need a level of care other than acute during their hospitalization and the corresponding from and through span dates; **or** the span dates that identify when a patient was in Leave of Absence (LOA) status.

**Codes and Values:**

| | |
|---|---|
| "74" = Non-covered Level of Care / Leave of Absence Dates | The from/through dates of a period at a non-covered care or leave of absence in an otherwise covered stay. |
| "75" = Skilled Nursing Facility (SNF) Level of Care Dates | The from/through dates of a period of SNF Level of care during an inpatient hospital stay. |

**Edit Applications:**

1. Must equal "74", or "75".

2. If an Occurrence Span Code is reported, then a valid Occurrence Span Code From and Through Date must also be reported.

3. The Occurrence Span Code From Date must be on or before the Occurrence Span Code Through Date for each Occurrence Span Code that is reported.

4. The Occurrence Span Code From and Through dates must be within the stay as defined by the Admission Date/Start of Care and the Statement Through Date.

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements. Louisiana allows a maximum of 30 Occurrence Spans.

2. Reportable Occurrence Span Code conditions may be coded in any order, and may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

## Occurrence Span Date Range Format Qualifier

**Data Element Name:** Occurrence Span Date Range Format Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-3<br>Thru<br>HI12-3 | 1250 | See Below | Date Time Period Format Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code indicating the date format for Occurrence Span Codes.

**Codes and Values:**

"RD8" = Date range expressed in format CCYYMMDD - CCYYMMDD

**Edit Applications:**

Must equal "RD8".

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. A second repeat of this segment may be used to report Other Occurrence Span Dates.

## Occurrence Span Dates

**Data Element Name:** Occurrence Span Dates for ALC and LOA

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-4 Thru HI12-4 | 1251 | | Occurrence Span Code and associated date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 35-36 | N/A | |

---

**Definition:**

An expression of a range of dates, or date for Alternate Level of Care (ALC) and Leave of Absence (LOA).

**Codes and Values:**

Enter the Occurrence Span Dates

**Edit Applications:**

1. Must equal Occurrence Span Date Range.

2. Must be entered in "CCYYMMDD-CCYYMMDD" format.

3. The Dates must be valid in accordance with the Date Edit Validation Table in Appendix A.

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

*2.* Reportable Occurrence Span dates may be coded in any order and may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

## Occurrence Information Code List Qualifier

**Data Element Name:** Occurrence Information Code List Qualifier

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 Thru HI12-1 | 1270 | BH | Code List Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for Occurrence information.

**Codes and Values:**

"BH" = Occurrence

**Edit Applications:**

Must equal "BH"

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. Reportable Occurrence Information may be coded in any order and may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

## Occurrence Information Code

**Data Element Name:** Occurrence Information Code

**Format-Length:** AN – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI12-2 | 1271 | See Below | Occurrence Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | 31-34 | N/A | |

---

**Definition:**

A code which identifies the specific significant event relating to the bill that may affect payer processing.

**Codes and Values:**

| | |
|---|---|
| "01" Accident /Medical Coverage | Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury. |
| "02" No Fault Insurance Involved – Including Auto Accident/Other | Code indicating the date of an accident including auto or other where state has applicable no fault liability laws (i.e., legal basis for settlement without admission of proof of guilt). |
| "03" Accident /Tort Liability | Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability. |
| "04" Accident /Employment Related | Code indicating the date of an accident allegedly relating to the patient's employment. |
| "05" Accident /No Medical or Liability Coverage | Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of accident /injury. |
| "06" Crime Victim | Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties |

**Edit Applications:**

Must equal “01”, “02”, “03”, “04”, “05” or “06”

**Data Element in Output Data Set:** Yes

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. Reportable Occurrence Information may be coded in any order and may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

## Occurrence Information Date Qualifier

**Data Element Name:** Occurrence Information Date Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-3 Thru HI12-3 | 1250 | D8 | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code indicating the date format for Occurrence Information.

**Codes and Values:**

"D8" = Date range expressed in format CCYYMMDD

**Edit Applications:**

Must equal "D8".

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. Reportable Occurrence Information may be coded in any order and may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

## Occurrence Information Date

**Data Element Name:** Occurrence Information Date

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-4 Thru HI12-4 | 1251 | | Occurrence Code and Associated date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 31-34 | N/A | |

---

**Definition:**

An expression of a date for the corresponding significant event relating to the bill that may affect payer processing.

**Codes and Values:**

Enter the Occurrence Span Dates.

**Edit Applications:**

1. May equal Occurrence Information Date in CCYYMMDD format.

2. The dates must be valid in accordance with the Date Edit Validation Table in Appendix A.

**Data Element in Output Data Set:** Yes

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. Reportable Occurrence Information may be coded in any order and may be reported multiple times. This HI segment may be reported 2 times as indicated in the 837 Implementation Guides.

## Value Information Code Qualifier 1 - 12

**Data Element Name:** Value Information Code Qualifier 1 - 12

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 Thru HI12-1 | 1270 | BE | Value Code List Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for Value information.

**Codes and Values:**

"BE" = Value Code

**Edit Applications:**

Must equal "BE".

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. Component Element Separator (ISA16) must be used between segment data elements.

2. Reportable Value Code conditions may be reported multiple times. This HI segment may be reported 2 times as indicated in the 837 Implementation Guides.

## Value Information Code

**Data Element Name:** Value Information Code

**Format-Length:** AN – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI12-2 | 1271 | | Value Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 39-41 | N/A | |

---

**Definition:**

A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization. Only specific value codes and their associated amounts. The list below details the specific value codes collected for each data set.

**Codes and Values:**

Inpatient (IP) Only:

14 = No-Fault, Including Auto/Other Amount shown is that portion from a higher priority no-fault insurance, including auto/other made on behalf of the patient or insured.

15 = Worker's Compensation Amount shown is that portion from a higher priority no-fault insurance, including auto/other made on behalf of the patient or insured.

21 = Catastrophic Medicaid eligibility requirements to be determined at state level.

22 = Surplus Medicaid eligibility requirements to be determined at state level.

23 = Recurring Monthly Income Medicaid eligibility requirements to be determined at state level.

37 = Units of Blood Furnished The total number of units of whole blood or packed red cells furnished to the patient, regardless of whether the hospital charges for the blood or not.

54 = Newborn Birth Weight in Grams Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with Type of Admission of 4 and on other claims as required by state law.

80 = Covered Days The number of days covered by the primary payer as qualified by the payer.

81 = Non-Covered Days Days of care not covered by the primary payer.

Emergency Department (ED) and Ambulatory Surgery (AS) Only:

45 = Accident Hour. The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below right justified to the left of the dollar/cents delimiter. Refer to Appendix B for reporting hour.

**Edit Applications:**

1. Must equal "14", "15", "21", "22", "23", "37", "54", "80", or "81" for IP only.

2. Must equal "45" for ED and AS only.

3. If no entry is made in the value code or amount, the record will be accepted.

4. If submitted, the record must contain the appropriate value and corresponding amount.

**Data Element in Output Data Set:** Yes

**Notes:**

1. 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.

2. Reportable Value Code conditions may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

3. Do not zero fill the positions to the left of the delimiter.

4. Enter value codes in alphanumeric sequence.

## Value Code Amount 1 - 12

**Data Element Name:** Value Code Amount 1 - 12

**Format-Length:** R – 9

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-5 Thru HI12-5 | 782 | | Value Code Amount |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 39-41 | N/A | |

---

**Definition:**

The amount associated with a corresponding value code.

**Codes and Values:**

Equals the amount associated with a corresponding value code.

**Edit Applications:**

If entered, the amount must be greater than zero. May equal value amount information.

**Data Element in Output Data Set:** Yes

**Notes:**

1. 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.

2. Reportable Value Code conditions may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

3. For reporting Medicaid Rate codes: The Medicaid rate code is acceptable with a decimal reporting. For example, rate code 1400 is accepted as “1400”, “1400.00”, “14.00”, or 14.0.

## Condition Information Code Qualifier 1 - 12

**Data Element Name:** Condition Information Code Qualifier 1 - 12

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-1 Thru HI12-1 | 1270 | BG | Condition Code List Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying a specific industry code list for Condition information.

**Codes and Values:**

"BG" = Condition

**Edit Applications:**

Must equal "BG".

**Data Element in Output Data Set:** No

**Notes:**

1. HI01-HI12 are required composite data elements. HI02-HI2 are used for claims that have additional reportable Condition Codes. Component Element Separator (ISA16) must be used between segment data elements.

2. Condition Codes may be reported multiple times. This HI segment may be reported twice as indicated in the 837 Implementation Guides.

## Condition Information Code

**Data Element Name:** Condition Information Code

**Format-Length:** AN – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2300 | HI01-2 Thru HI12-2 | 1271 | See Below | Condition Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL18-28 | N/A | |

---

**Definition:**

A code used to identify conditions or events related to a bill that may affect processing.

**Codes and Values:**

Inpatient (IP) Only:

"25" = Patient is Non-U.S. Resident. The patient is not a resident of the United States.

"A2" = Physically Handicapped Children's Program. Services provided under this program receive special funding through Title VII of the Social Security Act or the CHAMPUS/TRICARE program for the Handicapped.

"A3" = Special Federal Funding. The code which indicates if the patient is entitled to Medicaid Special Funding Project (SFP) benefits due to a specified physical impairment or treatment under SFP.

"A4" = Family Planning. The code which indicates if the patient is entitled to Medicaid Family Planning (FP) benefits due to a specified physical impairment or treatment for FP procedures.

"A5" = Disability. The code which indicates if the patient is entitled to Medicaid benefits due to a specified physical impairment or treatment for a condition of a disabling nature. A disabling condition means the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"P7" = Direct Inpatient Admission from Emergency Room. This code indicates that the patient was directly admitted from the facility's Emergency Room/Department.

Inpatient (IP), Emergency Department (ED), or Ambulatory Surgery (AS):

"17" = Patient is Homeless. The patient is homeless at time of discharge. Patients discharged to a shelter should be considered homeless.

**Edit Applications:**

1. Must equal "17", "25", "A2", "A3", "A4", "A5", or "P7" for IP file.

2. Must equal "17" only on ED or AS file.

**Data Element in Output Data Set:** Yes

**Notes:**

1. 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.

2. Condition Codes may be reported multiple times. This HI segment may be reported twice times as indicated in the 837 Implementation Guides.

## Attending Provider Name Entity Identifier Code

**Data Element Name:** Attending Provider Name Entity Identifier Code

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM101 | 98 | 71 | Attending Provider |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

A code identifying an organizational entity, physical location, property, or individual.

**Codes and Values:**

"71" = Attending Provider

**Edit Applications:**

Must equal "71".

**Data Element in Output Data Set:** No

## Attending Provider Name Entity Identifier Code

**Data Element Name:** Attending Provider Name Entity Identifier Code

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM102 | 1065 | 1 | Person |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"1" = Person

**Edit Applications:**

Must equal "1".

**Data Element in Output Data Set:** No

## Attending Provider Last Name

**Data Element Name:** Attending Provider Last Name

**Format-Length:** AN – 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM103 | 1035 | | Attending Provider Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 76 | N/A | |

---

**Definition:**

Individual last name.

**Codes and Values:**

Equals attending provider last name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Attending Provider First Name

**Data Element Name:** Attending Provider First Name

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM104 | 1036 | | Attending Provider First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 76 | N/A | |

---

**Definition:**

Individual first name.

**Codes and Values:**

Equals attending provider first name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Attending Provider Middle Name or Initial

**Data Element Name:** Attending Provider Middle Name or Initial

**Format-Length:** AN – 25

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM105 | 1037 | | Attending Provider Middle Name or Initial |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 76 | N/A | |

---

**Definition:**

Individual middle name or initial.

**Codes and Values:**

Equals attending provider middle name or initial.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Attending Provider Identification Qualifier Code

**Data Element Name:** Attending Provider Identification Qualifier Code

**Format-Length:** ID – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM108 | 66 | XX | Attending Provider Id Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the National Provider Identifier for the Attending Provider.

**Codes and Values:**

"XX" = Centers for Medicare and Medicaid Services National Provider Identifier

**Edit Applications:**

Must equal "XX".

**Data Element in Output Data Set:** No

## Attending Provider National Provider Identifier

**Data Element Name:** Attending Provider National Provider Identifier

**Format-Length:** AN - 10

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM109 | 67 | | Attending Provider NPI |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | 76 | N/A | |

---

**Definition:**

The attending provider National Provider Identifier (NPI).

**Codes and Values:**

Equals the attending provider NPI.

**Edit Applications:**

Must equal the attending provider NPI.

**Data Element in Output Data Set:** Yes

## Attending Provider Secondary Identification Qualifier Code

**Data Element Name:** Attending Provider Secondary Identification Qualifier Code

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | REF01 | 128 | OB | Attending Provider State License Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the State License Number for the Attending Provider.

**Codes and Values:**

"OB" = State License Number

**Edit Applications:**

Must equal "OB".

**Data Element in Output Data Set:** No

## Attending Provider Secondary Identifier

**Data Element Name:** Attending Provider Secondary Identifier

**Format-Length:** AN - 50

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | REF02 | 127 | | Attending Provider NPI |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 76 | N/A | |

---

**Definition:**

Attending Provider Secondary Identifier number assigned by the appropriate state licensing authority.

**Codes and Values:**

Equals attending provider secondary identifier.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Operating Physician Name Entity Identifier Code

**Data Element Name:** Operating Physician Name Entity Identifier Code

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | NM101 | 98 | 72 | Operating Physician |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

The Operating Physician is the individual with primary responsibility for performing the surgical procedure(s).

For ED visits, if there is more than one physician or health care professional responsible for the care of the patient, then additional physician or health care processional's license numbers should be reported here. When reporting multiple providers of care, report the license numbers in the order in which the care was provided.

A code identifying an organizational entity, physical location, property, or individual.

**Codes and Values:**

"72" = Operating Physician

**Edit Applications:**

Must equal "72".

**Data Element in Output Data Set:** No

## Operating Physician Name Entity Identifier Code

**Data Element Name:** Operating Physician Name Entity Identifier Code

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | NM102 | 1065 | 1 | Person |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"1" = Person

**Edit Applications:**

Must equal "1".

**Data Element in Output Data Set:** No

## Operating Physician Last Name

**Data Element Name:** Operating Physician Last Name

**Format-Length:** AN – 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | NM103 | 1035 | | Operating Physician Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 77 | N/A | |

---

**Definition:**

Individual last name.

**Codes and Values:**

Equals operating physician last name.

**Edit Applications:**

1. Must not equal zero or blanks.
2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Operating Physician First Name

**Data Element Name:** Operating Physician First Name

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | NM104 | 1036 | | Operating Physician First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 77 | N/A | |

---

**Definition:**

Individual first name.

**Codes and Values:**

Equals operating physician first name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Operating Physician Middle Name or Initial

**Data Element Name:** Operating Physician Middle Name or Initial

**Format-Length:** AN – 25

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | NM105 | 1037 | | Operating Physician Middle Name or Initial |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 77 | N/A | |

---

**Definition:**

Individual middle name or initial.

**Codes and Values:**

Equals operating physician middle name or initial.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Operating Physician Identification Qualifier Code

**Data Element Name:** Operating Physician Identification Qualifier Code

**Format-Length:** ID – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | NM108 | 66 | XX | Operating Physician Id Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the National Provider Identifier for the Operating Physician.

**Codes and Values:**

"XX" = Centers for Medicare and Medicaid Services National Provider Identifier

**Edit Applications:**

Must equal "XX".

**Data Element in Output Data Set:** No

## Operating Physician National Provider Identifier

**Data Element Name:** Operating Physician National Provider Identifier

**Format-Length:** AN - 10

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | NM109 | 67 | | Operating Physician NPI |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 77 | N/A | |

---

**Definition:**

The operating physician National Provider Identifier (NPI).

**Codes and Values:**

Equals the operating physician NPI.

**Edit Applications:**

Must equal the operating physician NPI.

**Data Element in Output Data Set:** Yes

## Operating Physician Secondary Identification Qualifier Code

**Data Element Name:** Operating Physician Secondary Identification Qualifier Code

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | REF01 | 128 | OB | Operating Physician State License Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the State License Number for the Operating Physician.

**Codes and Values:**

"OB" = State License Number

**Edit Applications:**

Must equal "OB".

**Data Element in Output Data Set:** No

## Operating Physician Secondary Identifier Qualifier

**Data Element Name:** Operating Physician Secondary Identifier Qualifier

**Format-Length:** AN - 50

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310B | REF02 | 127 | | Operating Physician Secondary ID |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 77 | N/A | |

---

**Definition:**

Operating Physician Secondary Identifier number assigned by the appropriate state licensing authority.

**Codes and Values:**

Equals operating physician secondary identifier.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Other Operating Physician Name Entity Identifier Code

**Data Element Name:** Other Operating Physician Name Entity Identifier Code

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | NM101 | 98 | ZZ | Mutually Defined |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

The Other Operating Physician is the individual performing a secondary surgical procedure or assisting the Operating Physician.

A code identifying an organizational entity, physical location, property, or individual.

**Codes and Values:**

"ZZ" = Mutually Defined as Other Operating Physician

**Edit Applications:**

Must equal "ZZ".

**Data Element in Output Data Set:** No

## Other Operating Physician Name Entity Identifier Code

**Data Element Name:** Other Operating Physician Name Entity Identifier Code

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | NM102 | 1065 | 1 | Person |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"1" = Person

**Edit Applications:**

Must equal "1".

**Data Element in Output Data Set:** No

## Other Operating Physician Last Name

**Data Element Name:** Other Operating Physician Last Name

**Format-Length:** AN – 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | NM103 | 1035 | | Other Operating Physician Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

Individual last name.

**Codes and Values:**

Equals other operating physician last name.

**Edit Applications:**

1. Must not equal zero or blanks.
2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Other Operating Physician First Name

**Data Element Name:** Other Operating Physician First Name

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | NM104 | 1036 | | Other Operating Physician First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

Individual first name.

**Codes and Values:**

Equals other operating physician first name.

**Edit Applications:**

1. Must not equal zero or blanks.
2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Other Operating Physician Middle Name or Initial

**Data Element Name:** Other Operating Physician Middle Name or Initial

**Format-Length:** AN – 25

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | NM105 | 1037 | | Other Operating Physician Middle Name or Initial |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

Individual middle name or initial.

**Codes and Values:**

Equals other operating physician middle name or initial.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Other Operating Physician Identification Qualifier Code

**Data Element Name:** Other Operating Physician Identification Qualifier Code

**Format-Length:** ID – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | NM108 | 66 | XX | Other Operating Physician Id Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the National Provider Identifier for the Other Operating Physician.

**Codes and Values:**

"XX" = Centers for Medicare and Medicaid Services National Provider Identifier

**Edit Applications:**

Must equal "XX".

**Data Element in Output Data Set:** No

## Other Operating Physician National Provider Identifier

**Data Element Name:** Other Operating Physician National Provider Identifier

**Format-Length:** AN - 10

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | NM109 | 67 | | Other Operating Physician NPI |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

The other operating physician National Provider Identifier (NPI).

**Codes and Values:**

Equals the other operating physician NPI.

**Edit Applications:**

Must equal the other operating physician NPI.

**Data Element in Output Data Set:** Yes

## Other Operating Physician Secondary Identification Qualifier Code

**Data Element Name:** Other Operating Physician Secondary Identification Qualifier Code

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | REF01 | 128 | OB | Other Operating Physician State License Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the State License Number for the Other Operating Physician.

**Codes and Values:**

"OB" = State License Number

**Edit Applications:**

Must equal "OB".

**Data Element in Output Data Set:** No

## Other Operating Physician Secondary Identifier Qualifier

**Data Element Name:** Other Operating Physician Secondary Identifier Qualifier

**Format-Length:** AN - 50

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310C | REF02 | 127 | | Other Operating Physician Secondary ID |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78 -79 | N/A | |

---

**Definition:**

Other Operating Physician Secondary Identifier number assigned by the appropriate state licensing authority.

**Codes and Values:**

Equals other operating physician secondary identifier.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Rendering Provider Name Entity Identifier Code

**Data Element Name:** Rendering Provider Name Entity Identifier Code

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310A | NM101 | 98 | 82 | Rendering Provider |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

The Rendering Provider is the health care professional who delivers or completes a particular medical service or non-surgical procedure.

A code identifying an organizational entity, or physical location, property or an individual.

**Codes and Values:**

"82" = Rendering Provider

**Edit Applications:**

Must equal "82".

**Data Element in Output Data Set:** Yes

## Rendering Provider Name Entity Identifier Code

**Data Element Name:** Rendering Provider Name Entity Identifier Code

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | NM102 | 1065 | 1 | Person |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"1" = Person

**Edit Applications:**

Must equal "1".

**Data Element in Output Data Set:** No

## Rendering Provider Last Name

**Data Element Name:** Rendering Provider Last Name

**Format-Length:** AN – 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | NM103 | 1035 | | Rendering Provider Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

Individual last name.

**Codes and Values:**

Equals rendering provider last name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Rendering Provider First Name

**Data Element Name:** Rendering Provider First Name

**Format-Length:** AN – 35

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | NM104 | 1036 | | Rendering Provider First Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

Individual first name.

**Codes and Values:**

Equals rendering provider first name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Rendering Provider Middle Name or Initial

**Data Element Name:** Rendering Provider Middle Name or Initial

**Format-Length:** AN – 25

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | NM105 | 1037 | | Rendering Provider Middle Name or Initial |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

Individual middle name or initial.

**Codes and Values:**

Equals rendering provider middle name or initial.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Rendering Provider Identification Qualifier Code

**Data Element Name:** Rendering Provider Identification Qualifier Code

**Format-Length:** ID – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | NM108 | 66 | XX | Rendering Provider Id Qualifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the National Provider Identifier for the Rendering Provider.

**Codes and Values:**

"XX" = Centers for Medicare and Medicaid Services National Provider Identifier

**Edit Applications:**

Must equal "XX".

**Data Element in Output Data Set:** No

## Rendering Provider National Provider Identifier

**Data Element Name:** Rendering Provider National Provider Identifier

**Format-Length:** AN - 10

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | NM109 | 67 | | Rendering Provider NPI |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

The rendering provider National Provider Identifier (NPI).

**Codes and Values:**

Equals the rendering provider NPI.

**Edit Applications:**

Must equal the rendering provider NPI.

**Data Element in Output Data Set:** Yes

## Rendering Provider Secondary Identification Qualifier Code

**Data Element Name:** Rendering Provider Secondary Identification Qualifier Code

**Format-Length:** ID – 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | REF01 | 128 | OB | Rendering Provider State License Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying the State License Number for the Rendering Provider.

**Codes and Values:**

"OB" = State License Number

**Edit Applications:**

Must equal "OB".

**Data Element in Output Data Set:** No

## Rendering Provider Secondary Identifier

**Data Element Name:** Rendering Provider Secondary Identifier

**Format-Length:** AN - 50

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2310D | REF02 | 127 | | Rendering Provider Secondary ID |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 78-79 | N/A | |

---

**Definition:**

Rendering Provider Secondary Identifier number assigned by the appropriate state licensing authority.

**Codes and Values:**

Equals rendering provider secondary identifier.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Payer Responsibility Sequence Number Code

**Data Element Name:** Payer Responsibility Sequence Number Code

**Format-Length:** ID - 1

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2320 | SBR01 | 1138 | See Below | Payer Responsibility Sequence Number Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code identifying the insurance carrier's level of responsibility for payment of a claim.

**Codes and Values:**

"S" = Secondary

"T" = Tertiary

**Edit Applications:**

1. Must equal "S" or "T".

2. Within a given claim, the various values for the payer responsibility sequence number code may occur no more than once.

**Data Element in Output Data Set:** No

## Individual Relationship Code

**Data Element Name:** Individual Relationship Code

**Format-Length:** ID - 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2320 | SBR02 | 1069 | See Below | Individual Relationship Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 59 | N/A | |

---

**Definition:**

A code indicating the relationship between two individuals or entities. SBR02 specifies the relationship to the person insured.

**Codes and Values:**

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

**Edit Applications:**

Must equal "01" , "18", "19", "20", "21", "39", "40", "53", or "G8".

**Data Element in Output Data Set:** Yes

## Claim Filing Indicator Code for Other Subscriber

**Data Element Name:** Claim Filing Indicator Code for Other Subscriber

**Format-Length:** ID - 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2320 | SBR09 | 1032 | See Below | Claim Filing Indicator Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code which indicates the type of payment. The code listing below was obtained from the ASC X12N Technical Report Guide. You may report as many payers as needed within this loop. This loop is used when other payers are known to potentially be involved with paying on this claim.

**Codes and Values:**

"09" = Self-pay "11" = Other Non-Federal Programs
"12" = Preferred Provider Organization (PPO)
"13" = Point of Service (POS)
"14" = Exclusive Provider Organization (EPO)
"15" = Indemnity Insurance
"16" = Health Maintenance Organization (HMO) Medicare Risk
"17" = Dental Maintenance Organization
"AM" = Automobile Medical
"BL" = Blue Cross/Blue Shield
"CH" = CHAMPUS
"CI" = Commercial Insurance Co.
"DS" = Disability
"FI" = Federal Employees Program
"HM" = Health Maintenance Organization
"LM" = Liability Medical
"MA" = Medicare Part A
"MB" = Medicare Part B
"MC" = Medicaid
"OF" = Other Federal Program (Use "OF" when submitting Medicare Part D Claims.)
"TV" = Title V
"VA" = Veterans Affairs Plan

"WC" = Workers' Compensation Health Claim
"ZZ" = Type of Insurance is not known.

**Edit Applications:**

Must equal "09" , "11", "12", "13", "14", "15", "16", "17", "AM", "BL", "CH", "CI", "DS", "FI", "HM", "LM", "MA", "MB", "MC", "OF", "TV", "VA", "WC", or "ZZ".

The table below indicate the additional data items that are required, depending on the value in the Claim Filing Indicator Code for Other Subscriber:

The Payer ID, Insured's Policy Number and Billing NPI are required when the Claim Filing Indicator Code for Other Subscriber (and Source of Payment Typology) are reported with a Medicaid or Medicare payer type.

| **Claim Filing Indicator Code for Other Subscriber** | **Payer ID** | **Insured's Policy Number** | **Billing NPI (Previously Provider ID)** |
|---|---|---|---|
| 09, 11, 13, 14, 15, 17, AM, CH, DS, FI, LM, OF, TV, VA, WC, ZZ | --------- | ---------- | -------- |
| 12, CI, HM, | Required | Required IP only | -------- |
| 16, BL, MA, MB, MC | Required | Required IP only | Required |

**Data Element in Output Data Set:** Yes

Note: This element could be replaced by the Source of Payment Typology.

## Other Subscriber Name Entity Code Qualifier

**Data Element Name:** Other Subscriber Name Entity Code Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330A | NM101 | 98 | IL | Entity Identifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying an organizational entity or a physical location.

**Codes and Values:**

"IL" = Insured or Subscriber

**Edit Applications:**

Must equal "IL".

**Data Element in Output Data Set:** No

## Other Subscriber Name Entity Type Qualifier

**Data Element Name:** Other Subscriber Name Entity Type Qualifier

**Format-Length:** ID – 1

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330A | NM102 | 1065 | 1 | Entity Type Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"1" = Person

**Edit Applications:**

Must equal "1".

**Data Element in Output Data Set:** No

## Other Subscriber Last Name

**Data Element Name:** Other Subscriber Last Name

**Format-Length:** AN - 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330A | NM103 | 1035 | | Other Subscriber Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 58 | N/A | |

---

**Definition:**

Individual last name.

**Codes and Values:**

Equals other subscriber last name.

**Edit Applications:**

1. Must not equal zero or blanks.

2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Other Subscriber Identification Code Qualifier

**Data Element Name:** Other Subscriber Identification Code Qualifier

**Format-Length:** ID – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330A | NM108 | 66 | See Below | Identification Code Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"II" = Standard Unique Health Identifier for each individual in the United States

"MI" = Member Identification Number

**Edit Applications:**

Must equal "II" or "MI".

**Data Element in Output Data Set:** No

## Insured's Policy Number for Other Subscriber

**Data Element Name:** Insured's Policy Number for Other Subscriber

**Format-Length:** AN - 19

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330A | NM109 | 67 | | Other Subscriber Identifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 60 | N/A | |

---

**Definition:**

The unique identification number assigned by the payer to identify the patient.

**Codes and Values:**

| Payer | Type of Number |
|---|---|
| Blue Cross | Enter the information depending on specific Blue Cross Plan needs and contract requirement. |
| CHAMPUS | Enter information depending on CHAMPUS regulations. |
| Medicaid | Enter Medicaid Client Identification Number (CIN) of the insured or case head Medicaid number shown on the Medicaid Identification Card. |
| Medicare | Enter the patient's Medicare HIC number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form or as reported by the Social Security Office. |

For all other payer types, commercial insurers, etc., enter the insured's unique number assigned by the payer.

**Edit Applications:**

Inpatient only:

1. Required if the first reported Claim Filing Indicator Code is "12", "BL", "CI", "HM", Medicare ("MA", "MB", or "16"), or Medicaid ("MC").

2. Required if Source of Payment Typology I is Medicare (1xxxx) or Medicaid (2xxxx).

**Data Element in Output Data Set:** Yes

## Other Subscriber Secondary Identification Qualifier

**Data Element Name:** Other Subscriber Secondary Identification Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330A | REF01 | 128 | SY | Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the Reference Identification.

**Codes and Values:**

"SY" = Social Security Number

**Edit Applications:**

Must equal "SY".

**Data Element in Output Data Set:** No

## Policy Number for Other Subscriber

**Data Element Name:** Policy Number for Other Subscriber

**Format-Length:** A/N – 19

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330A | REF02 | 127 | | Other Subscriber Secondary Identification Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 60 | N/A | |

---

**Definition:**

The number used to identify a secondary Policy Number for the Other Subscriber.

**Codes and Values:**

Equals "Other Insured Additional Identifier".

**Edit Applications:**

1. Must not equal zero or blanks.
2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Other Payer Name Entity Code Qualifier

**Data Element Name:** Other Payer Name Entity Code Qualifier

**Format-Length:** ID – 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330B | NM101 | 98 | PR | Entity Identifier Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code identifying an organizational entity or a physical location.

**Codes and Values:**

"PR" = Insured or Subscriber

**Edit Applications:**

Must equal "PR".

**Data Element in Output Data Set:** No

## Other Payer Name Entity Type Qualifier

**Data Element Name:** Other Payer Name Entity Type Qualifier

**Format-Length:** ID – 1

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330B | NM102 | 1065 | 2 | Entity Type Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

A code qualifying the type of entity.

**Codes and Values:**

"2" = Non-Person

**Edit Applications:**

Must equal "2".

**Data Element in Output Data Set:** No

## Other Payer Last Name

**Data Element Name:** Other Payer Last Name

**Format-Length:** AN - 60

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330B | NM103 | 1035 | | Other Payer Last Name |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 50 | N/A | |

---

**Definition:**

Individual last name of other subscriber.

**Codes and Values:**

Equals Other Payer Last Name or organization name.

**Edit Applications:**

1. Must not equal zero or blanks.
2. Must be numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid entries.

**Data Element in Output Data Set:** Yes

## Other Payer Name Identification Code Qualifier

**Data Element Name:** Other Payer Name Identification Code Qualifier

**Format-Length:** ID – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330B | NM108 | 66 | PI | Identification Code Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does Not Apply – needed only for Electronic Submission |

---

**Definition:**

Code qualifying the type of entity.

**Codes and Values:**

"PI" = Payer Identification

**Edit Applications:**

Must equal "PI".

**Data Element in Output Data Set:** No

## Other Payer Identification Number

**Data Element Name:** Other Payer Identification Number

**Format-Length:** AN - 19

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330B | NM109 | 67 | | Other Payer Identifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 51 | N/A | |

---

**Definition:**

The unique identification number assigned by the payer to identify the patient.

**Codes and Values:**

| Payer | Type of Number |
|---|---|
| Blue Cross | Plan Number |
| Commercial Insurers | National Association of Insurance Commissioners (NAIC) Number<br><br>Commercial insurance companies and Health Maintenance Organizations (HMOs) are regulated by the Louisiana Department of Insurance (DOI) and issued NAIC numbers. Additional information on these numbers and any other HMO-specific codes may be found on the DOI website at http://www.ldi.state.la.us. |
| Medicaid | 13-Digit Recipient Identification Number Assigned by the Louisiana Department of Health and Hospitals<br><br>Additional information on this number may be found on the Louisiana Medicaid website at http://www.lamedicaid.com. |
| Medicare | Blue Cross Number or Commercial Insurer NAIC Number Depending on Intermediary |

**Edit Applications:**

Inpatient Only:

1. Required if the first reported Claim Filing Indicator Code is “12”, “BL”, “CI”, “HM”, Medicare (“MA”, “MB”, or “16”), or Medicaid (“MC”).

2. Required if Source of Payment Typology I is Medicare (1xxxx) or Medicaid (2xxxx).

**Data Element in Output Data Set:** Yes

## Other Payer Secondary Identification Qualifier

**Data Element Name:** Other Payer Secondary Identification Qualifier

**Format-Length:** ID - 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | OP |
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330B | REF01 | 128 | See Below | Reference Identification Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code qualifying the Reference Identification.

**Codes and Values:**

"2U" = Payer Identification Number

"NF" = National Association of Insurance Commissioners (NAIC) Code

**Edit Applications:**

Must equal "2U" or "NF".

**Data Element in Output Data Set:** No

## Other Payer Secondary Identification Number

**Data Element Name:** Other Payer Secondary Identification Number

**Format-Length:** A/N – 19

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| S | S | S |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2330B | REF02 | 127 | | Other Payer Secondary Identification Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 51 | N/A | |

---

**Definition:**

The number identifying the payer organization associated with this sequence for which the provider might expect some payment of the bill.

**Codes and Values:**

Equals "Other Insured Additional Identifier".

**Edit Applications:**

1. If Claim Filing Indicator Code is "12", "16", "CI", "BL", "HM", "MA", "MB", "MC", then Other Payer Secondary Identification should be reported.

2. If Source of Payment Typology (SoP) is 21xxx (Medicaid Managed Care), then Other Payer Secondary Identification Number should equal a value from Appendix ?.

**Data Element in Output Data Set:** Yes

## Service Line Number

**Data Element Name:** Service Line Number

**Format-Length:** N – 6

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | LX01 | 554 | | Assigned Number |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A number assigned for differentiation or to reference a line number within a transaction set. LX01 is used to indicate bundling in the Line Item Adjudication Loop. The LX functions as a line counter.

The Service Line LX segment must begin with one and is incremented by one for each additional service line of a claim.

**Codes and Values:**

Equals a numeric value from 1 to 999.

**Edit Applications:**

Must enter a numeric value from 1 to 999 (entered sequentially).

**Data Element in Output Data Set:** No

## Revenue Code

**Data Element Name:** Revenue Code

**Format-Length:** AN – 4

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV201 | 234 | | Service Line Revenue Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 42 | A/N | |

---

**Definition:**

Codes that identify specific accommodations, ancillary service, or unique billing calculations or arrangements.

This data element is called the "Service Line Revenue Code" in the X12 guidelines. It is commonly referred to as the "Revenue Code". Each service should be assigned a revenue code:

1. For inpatient services involving multiple services for the same item, providers should aggregate the services under the assigned revenue code and then report the total number of units that represent those services

2. If multiple services are provided on the same day for like services, that is, those with the same HCPCS, the provider should aggregate the like services for each day and report the date along with the number of units provided, as well as the revenue code. The exception is for the Evaluation and Management (E/M) HCPCS code. For E/M HCPCS, report each of these separately but also use Condition Code "G0" to indicate a Distinct Medical visit.

3. Services provided on different days should be listed separately along with the date of service, units and revenue code.

For a submitted record to be identified in the Louisiana system as an Emergency Department or Ambulatory Surgery visit, the appropriate Revenue Codes must be reported as indicated below.

**Codes and Values:**

1. Must be a valid code in accordance with the Revenue Codes in UB Specifications Manual.

2. Emergency Department services must have the following codes:

| Revenue Code | Description |
|---|---|
| 0450 | Emergency Room |
| 0451 | Emergency Medical Treatment and Active Labor Act (EMTALA) Emergency Medical Screening Service |
| 0452 | ER Beyond EMTALA Screening |
| 0456 | Urgent Care |
| 0459 | Other Emergency Room Care |

3. Ambulatory Surgery services must have one of the following codes:

| Revenue Code | Category | Sub Category |
|---|---|---|
| 0360 | Operating Room Services | General Classification |
| 0361 | Operating Room Services | Minor Surgery |
| 0362 | Operating Room Services | Organ Transplant, Other than Kidney |
| 0367 | Operating Room Services | Kidney Transplant |
| 0369 | Operating Room Services | Operating Room Services |
| 0480 | Cardiology | General Classification |
| 0481 | Cardiology | Cardiac Catheter Lab |
| 0482 | Cardiology | Stress Test |
| 0483 | Cardiology | Echocardiology |
| 0489 | Cardiology | Other Cardiology |
| 0490 | Ambulatory Surgery | General Classification |
| 0499 | Ambulatory Surgery | Other Ambulatory Surgery Care |
| 0750 | Gastrointestinal Services | General Classification |
| 0760* | Specialty Services | General Classification |
| 0762 | Specialty Services | Observation Hours |
| 0790 | Extra-Corporeal Shock Wave | General Classification |

*Any of the following CPT/HCPCS codes must also be reported with Revenue Code 0760:

99217-99220 (hospital observation services)
99234-99236 (observation or inpatient care services (including admission and discharge services))
G0378 (hospital observation service)
G0379 (direct admission of patient for hospital observation care).

**Edit Applications:**

1. If the Revenue Code is entered, then the appropriate Service Line Rate, Service Units, Service Line Charge Amount, and Service Line Non-Covered Charge Amount must also be reported.

2. If a Revenue Code is entered, the associated Total Charges and Total Non-Covered Charges must also be reported.

3. If Revenue Codes 0001 through 0099 are reported, the associated charges must **not** be included in the totals calculated for the Total Charges or Total Non-Covered Charges.

4. On Inpatient submissions, It is necessary to report at least one Revenue Code between the values of 010x and 100x with each inpatient claim.

5. For outpatient claims, there must be at least one total and non-covered charge for all revenue codes reported except for the 036x, 045x, 048x, 049x, 051x, 052x, 075x, 076x or 079x categories. For these exceptions the total and non-covered charges may be rolled up to the first occurrence of the revenue code category with zero reported for subsequent occurrences on each claim.

**Data Element in Output Data Set:** Yes

## HCPCS Procedure Code Qualifier

**Data Element Name:** HCPCS Procedure Code Qualifier

**Format-Length:** AN – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV202-1 | 235 | HC | Product or Service ID Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

The SV202 data element is a composite medical procedure identifier. The first element of the composite is SV202-1. This element is for the code identifying the type/source of the descriptive number used in the Product/Service ID.

**Codes and Values:**

"HC" = Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

**Edit Applications:**

Must equal "HC".

**Data Element in Output Data Set:** No

## CPT Procedure Code

**Data Element Name:** CPT Procedure Code

**Format-Length:** AN – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV202-2 | 234 | | Procedure Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 44 | N/A | |

---

**Definition:**

The SV202 data element is a composite medical procedure identifier. The second element of the composite is SV202-2, which is used for reporting the actual procedure code. The American Medical Association's Current Procedural Terminology 4th Edition (CPT-4) Code or the Healthcare Common Procedure Coding System (HCPCS) code and modifiers, which applies to the outpatient procedure performed and associated with each line of service.

**Codes and Values:**

Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4) or the Centers for Medicare and Medicaid Services HCPCS code for procedures performed.

**Edit Applications:**

Edits pertaining to CPT4 and HCPCS codes are validated on the basis of the Statement-Through Date.

**Data Element in Output Data Set:** Yes

## Procedure Modifier 1

**Data Element Name:** Procedure Modifier 1

**Format-Length:** AN – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV202-3 | 1339 | | Procedure Modifier 1 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 44 | N/A | |

---

**Definition:**

The SV202 data element is a composite medical procedure identifier. The third element of the composite is SV202-3, which is used for reporting the first modifier. The modifier clarifies or improves the reporting accuracy of the associated procedure code. The American Medical Association's Current Procedural Terminology 4th Edition (CPT-4) Code or the Healthcare Common Procedure Coding System (HCPCS) code and modifiers, which applies to the outpatient procedure performed and associated with each line of service.

**Codes and Values:**

Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4) or the Centers for Medicare and Medicaid Services HCPCS code for procedures performed.

**Edit Applications:**

1. Edits pertaining to CPT4 and HCPCS codes are validated on the basis of the Statement-Through Date.

2. If CPT-4/HCPCS & Modifier 1 is entered, the associated Outpatient Revenue Code, Charges and Non-Covered Charges must also be reported.

**Data Element in Output Data Set:** Yes

## Procedure Modifier 2

**Data Element Name:** Procedure Modifier 2

**Format-Length:** AN – 2

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV202-4 | 1339 | | Procedure Modifier 2 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 44 | N/A | |

---

**Definition:**

The SV202 data element is a composite medical procedure identifier. The fourth element of the composite is SV202-4, which used for reporting the second modifier. The modifier clarifies or improves the reporting accuracy of the associated procedure code. The American Medical Association's Current Procedural Terminology 4th Edition (CPT-4) Code or the Healthcare Common Procedure Coding System (HCPCS) code and modifiers, which applies to the outpatient procedure performed and associated with each line of service.

**Codes and Values:**

Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4) or the Centers for Medicare and Medicaid Services HCPCS code for procedures performed.

**Edit Applications:**

1. Edits pertaining to CPT4 and HCPCS codes are validated on the basis of the Statement-Through Date.

2. If CPT-4/HCPCS & Modifier 2 is entered, the associated Outpatient Revenue Code, Charges and Non-Covered Charges must also be reported.

**Data Element in Output Data Set:** Yes

## Procedure Modifier 3

**Data Element Name:** Procedure Modifier 3

**Format-Length:** AN – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV202-5 | 1339 | | Procedure Modifier 3 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 44 | N/A | |

---

**Definition:**

The SV202 data element is a composite medical procedure identifier. The fifth element of the composite is SV202-5, which is used for reporting the third modifier. The modifier clarifies or improves the reporting accuracy of the associated procedure code. The American Medical Association's Current Procedural Terminology 4th Edition (CPT-4) Code or the Healthcare Common Procedure Coding System (HCPCS) code and modifiers, which applies to the outpatient procedure performed and associated with each line of service.

**Codes and Values:**

Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4) or the Centers for Medicare and Medicaid Services HCPCS code for procedures performed.

**Edit Applications:**

1. Edits pertaining to CPT4 and HCPCS codes are validated on the basis of the Statement-Through Date.

2. If CPT-4/HCPCS & Modifier 3 is entered, the associated Outpatient Revenue Code, Charges and Non-Covered Charges must also be reported.

**Data Element in Output Data Set:** Yes

## Procedure Modifier 4

**Data Element Name:** Procedure Modifier 4

1. **Format-Length:** AN – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV202-6 | 1339 | | Procedure Modifier 4 |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 44 | N/A | |

---

**Definition:**

The SV202 data element is a composite medical procedure identifier. The sixth element of the composite is SV202-6, used for reporting the fourth modifier. The modifier clarifies or improves the reporting accuracy of the associated procedure code. The American Medical Association's Current Procedural Terminology 4th Edition (CPT-4) Code or the Healthcare Common Procedure Coding System (HCPCS) code and modifiers, which applies to the outpatient procedure performed and associated with each line of service.

**Codes and Values:**

Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4) or the Centers for Medicare and Medicaid Services HCPCS code for procedures performed.

**Edit Applications:**

1. Edits pertaining to CPT4 and HCPCS codes are validated on the basis of the Statement-Through Date.

2. If CPT-4/HCPCS & Modifier 4 is entered, the associated Outpatient Revenue Code, Charges and Non-Covered Charges must also be reported.

**Data Element in Output Data Set:** Yes

## Line Item Charge Amount

**Data Element Name:** Line Item Charge Amount

**Format-Length:** R – 18

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV203 | 782 | | Line Item Charge Amount |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 47 | N/A | |

---

**Definition:**

The Line Item Charge amount is for services incurred by the patient during the billing period that will be charged to the primary payer. The amount is inclusive of the provider's base charge and any applicable tax amounts reported within this line's amount segments. The Line Item charge amounts are related to the Service Line Revenue Code.

**Codes and Values:**

Equals the Line Item Charge Amount entered in dollars and cents.

Example: $125.24 would be entered as: 125.24

**Edit Applications:**

1. Must equal Line Item Charge Amount.

2. The Line Item Charge Amount must be equal to or greater than the corresponding Service Line Non-Covered Charges.

3. If Line Item Charge Amount is reported, the associated Revenue Code, Service Line Non-Covered Charge, and Service Unit Count must also be reported.

<u>ED and AS</u>:

It is necessary to report at least **one** Revenue Code with each AS or ED claim. There must be at least one Line Item Charge Amount and Non-Covered Charge Amount for all Revenue Codes reported except for the 036x, 045x, 048x, 049x, 075x, or 079x categories. For these exceptions, the Line Item Charge Amount and Line Item Non-Covered Charge Amount may be rolled up to the first occurrence of the revenue code category with zero reported for subsequent occurrences on each outpatient claim.

**Data Element in Output Data Set:** Yes

## Measurement Code

**Data Element Name:** Measurement Code

**Format-Length:** ID – 2

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV204 | 355 | See Below | Unit or Basis for Measurement Code |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 46 | N/A | |

---

**Definition:**

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

**Codes and Values:**

"DA" = Days (When service line charges are reported)

"UN" = Unit

**Edit Applications:**

Must equal "DA" or "UN" when service line charges are reported.

**Data Element in Output Data Set:** Yes

## Service Unit Count

**Data Element Name:** Service Unit Count

**Format-Length:** N – 4

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV205 | 380 | | Service Unit Count |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 46 | N/A | |

---

**Definition:**

A quantitative measure of services rendered that occurred by revenue category to or for the patient. The number of service units that occurred during the bill period for the patient. This will include items such as number of accommodation days, miles, pints of blood, and renal dialysis treatments.

**Codes and Values:**

1. Equals Days or Units.

2. Must be greater than zero.

**Edit Applications:**

1. When reporting days, the number must be less than or equal to the number of days in the billing period as documented in Admission Date/Start of Care and Statement Through Date. The total number of days reported must not exceed the calculated length of stay.

2. When reporting days, the appropriate revenue code, Service Rate (4050R only), Total Charges, and Total Non-Covered Charges must also be reported to reflect room and board accommodations.

3. When reporting units, the value of unit can be reported as “1” or more based on the provider’s practice, health plan requirements or regulation.

4. When HCPCS codes are reported, the unit is defined by the HCPCS definition. Where the unit is not defined by the HCPCS codes, units can be reported as “1” or more based on the provider’s practice, health plan requirements or regulation.

5. A zero or negative value is not allowed.

**Data Element in Output Data Set:** Yes

## Accommodations Rate

**Data Element Name:** Accommodations Rate

**Format-Length:** N – 9

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | N | N |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV206 | 1371 | | Unit Rate |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 44 | N/A | |

---

**Definition:**

The rate charged per day for a specific accommodation.

**Codes and Values:**

Equals Accommodation Rate when Service Line charges are reported. The amount must be entered in dollars and cents.

Example: $125.24 would be entered as: 125.24

**Edit Applications:**

1. Must equal rate (when service line charges are reported).

2. This data element is required when the associated revenue code is 100-219.

3. If Accommodations Rate is reported, then Revenue Code, Service Units (Days), Total Charges, and Total Non-Covered Charges must also be reported for the associated accommodation.

4. Louisiana allows a maximum of 50 Accommodations Rates to be reported.

5. If charges per day for either accommodation (IP) or ancillary (ED, AS) services are less than $100.00 or greater than $20,000.00, the record will be rejected.

**Data Element in Output Data Set:** Yes

## Non-Covered Charges Amount

**Data Element Name:** Non-Covered Charges Amount

**Format-Length:** N – 10

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | SV207 | 782 | | Non-Covered Charge Amount |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 48 | N/A | |

---

**Definition:**

Non-covered charge amount reflects the non-covered charges for the primary payer as it pertains to the associated revenue code.

**Codes and Values:**

Equals Non-Covered Charge Amount entered in dollars and cents.

Example: $125.24 would be entered as: 125.24

**Edit Applications:**

1. Must equal Non-Covered Charge Amount.

2. If Non-Covered Charges are entered, the associated Revenue Code and Line Item Charge Amount must also be reported.

3. Non-Covered Charge Amount must be less than or equal to the corresponding Line Item Charge Amount.

4. If Non-Covered Charge Amount is entered, then Revenue Code, Service Unit Count, Line Item Charge Amount, and HCPCS Accommodations Rate must also be reported.

5. It is necessary to report at least **one** Revenue Code with each ED or AS claim. There must be at least one Line Item Charge Amount and Non-Covered Charge Amount for all Revenue outpatient codes reported except for the 036x, 045x, 048x, 049x, 051x, 052x, 075x, 076x or 079x categories. For these exceptions, the Line Item Charge Amount and non-covered charge amount may be rolled up to the first occurrence of the revenue code category with zero reported for subsequent occurrences on each outpatient claim.

**Data Element in Output Data Set:** Yes

## Service Date Qualifier

**Data Element Name:** Service Date Qualifier

**Format-Length:** ID - 3

| Data Edit Specifications | | |
|---|---|---|
| IP | ED | AS |
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | DTP01 | 374 | 472 | Date Time Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code specifying type of date or time, or both date and time.

**Codes and Values:**

"472" = Service

**Edit Applications:**

Must equal "472" .

**Data Element in Output Data Set:** No

## Service Date Format Qualifier

**Data Element Name:** Service Date Format Qualifier

**Format-Length:** ID - 3

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | DTP02 | 1250 | D8 | Date Time Period Format Qualifier |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | | | Does not apply – needed only for Electronic submission |

---

**Definition:**

A code indicating the data format, time format, or date and time format.

**Codes and Values:**

"D8" = Date Expressed in format CCYYMMDD

**Edit Applications:**

Must equal "D8".

**Data Element in Output Data Set:** No

## Service Date

**Data Element Name:** Service Date

**Format-Length:** N – 8 Statement From
N – 8 Statement Through

Data Edit Specifications

| IP | ED | AS |
|---|---|---|
| R | R | R |

**Revision Date:** April 2012

**National Standard Mapping**

| Electronic – 837I | X12 Loop | Ref Des. | Data Element | Code | X12 Data Element Name |
|---|---|---|---|---|---|
| Version 5010R | 2400 | DTP03 | 1251 | | Service Date |

| Paper Form | Locator | Code Qualifier | Description |
|---|---|---|---|
| UB-04 | FL 45 | N/A | |

**Definition:**

The date the ED or AS service was provided. When more than one service was provided on different dates, report each date of service.

**Codes and Values:**

Equals date of service.

**Edit Applications:**

Must be a valid date in accordance with the Date Edit Validation Table in Appendix A.

**Data Element in Output Data Set:** Yes

# APPENDICES

# Appendix A
# Date Edit Validation Table

| VALID MONTH CODE | VALID DAY CODE | VALID YEAR CODE |
|---|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 | Valid Numeric |
| 04, 06, 09, 11 | Greater than 00 and less than 31 | Valid Numeric |
| 02 | Greater than 00 and less than 29 (less than 30 on leap year) | Valid Numeric |

Month, day and year must equal one of the values specified in the appropriate column.

Month, day and year must have corresponding values within each row.

Century must equal 18, 19 or 20.

The following chronology of dates is used for checking the validity of each date:

- Facility Open Date
- Admission/Start of Care Date
- Discharge Date
- Facility Close Date (if applicable);
- Louisiana Processing Date

# Appendix B
# Hour Reference Table

| 4 Digits Reported on X12 Claim | 2 Digits Reported on X12 Claim | Edited/ Collected by Louisiana | Range |
|---|---|---|---|
| 0000 - 0059 | 00 | 00 | 12:00 - 12:59 Midnight |
| 0100 - 0159 | 01 | 01 | 01:00 - 01:59 |
| 0200 - 0259 | 02 | 02 | 02:00 - 02:59 |
| 0300 - 0359 | 03 | 03 | 03:00 - 03:59 |
| 0400 - 0459 | 04 | 04 | 04:00 - 04:59 |
| 0500 - 0559 | 05 | 05 | 05:00 - 05:59 |
| 0600 - 0659 | 06 | 06 | 06:00 - 06:59 |
| 0700 - 0759 | 07 | 07 | 07:00 - 07:59 |
| 0800 - 0859 | 08 | 08 | 08:00 - 08:59 |
| 0900 - 0959 | 09 | 09 | 09:00 - 09:59 |
| 1000 - 1059 | 10 | 10 | 10:00 - 10:59 |
| 1100 - 1159 | 11 | 11 | 11:00 - 11:59 |
| 1200 - 1259 | 12 | 12 | 12:00 - 12:59 Noon |
| 1300 - 1359 | 13 | 13 | 01:00 - 01:59 |
| 1400 - 1459 | 14 | 14 | 02:00 - 02:59 |
| 1500 - 1559 | 15 | 15 | 03:00 - 03:59 |
| 1600 - 1659 | 16 | 16 | 04:00 - 04:59 |
| 1700 - 1759 | 17 | 17 | 05:00 - 05:59 |
| 1800 - 1859 | 18 | 18 | 06:00 - 06:59 |
| 1900 - 1959 | 19 | 19 | 07:00 - 07:59 |
| 2000 - 2059 | 20 | 20 | 08:00 - 08:59 |
| 2100 - 2159 | 21 | 21 | 09:00 - 09:59 |
| 2200 - 2259 | 22 | 22 | 10:00 - 10:59 |
| 2300 - 2359 | 23 | 23 | 11:00 - 11:59 |
| 9900 - 9999 | 99 | 99 | Unknown |

# Appendix C
# Address Abbreviations

The following abbreviations for all address fields are recommended to insure consistency of reporting and reliability for use.

| | | | |
|---|---|---|---|
| Alley | AL | Junction | JCT |
| And | & | Knoll(s) | KNOL |
| Apartment(s) | APTS | Lane | LA |
| Approach | APP | Manor | MNR |
| Avenue | AV | Meadow(s) | MDWS |
| Boulevard | BLVD | Motel | MTL |
| Bridge | BR | North | N |
| Center | CTR | Nursing Home | NURH |
| Circle | CIR | Park | PK |
| College | CLGE | Parkway | PKWY |
| Commons | COMS | Place | PL |
| Condominium(s) | COND | Plaza | PLZ |
| Corners | CRNS | Plateau | PLAT |
| Court(s) | CT | Point | PT |
| Creek | CRK | Ridge | RI |
| Crescent | CRES | Road | RD |
| Crossing | CRSG | Settlement | SETL |
| Development Center | DEVL | South | S |
| Drive | DR | Square | SQ |
| East | E | Street | ST |
| Estates | ESTS | Terrace | TER |
| Extension | EX | Townhouse | TNHS |
| Garden | GRDN | Trail | TRL |
| Grove | GR | Turnpike | TPK |
| Height(s) | HGTS | Tower(s) | TWRS |
| Highway | HWY | University | UNIV |
| Home(s) | HM | Valley | VAL |
| House | HSE | Village | VLGE |
| Hospital | HOSP | West | W |
| Island | IS | | |

NOTE: Any mention of Mobile Home or Trailer will be TRLR

For a complete listing of "Street Suffixes" go to the Official United States Postal Service (USPS) Abbreviations Web site: https://www.usps.com/send/official-abbreviations.htm

# Appendix D
# State Edit Validation Table

**STATES ABBREVIATION TABLE**

| ABR | STATE | ABR | STATE |
|---|---|---|---|
| AL | Alabama | NY | New York |
| AK | Alaska | NC | North Carolina |
| AZ | Arizona | ND | North Dakota |
| AR | Arkansas | OH | Ohio |
| CA | California | OK | Oklahoma |
| CO | Colorado | OR | Oregon |
| CT | Connecticut | PA | Pennsylvania |
| DE | Delaware | RI | Rhode Island |
| DC | District of Columbia | SC | South Carolina |
| FL | Florida | SD | South Dakota |
| GA | Georgia | TN | Tennessee |
| HI | Hawaii | TX | Texas |
| ID | Idaho | UT | Utah |
| IL | Illinois | VT | Vermont |
| IN | Indiana | VA | Virginia |
| IA | Iowa | WA | Washington |
| KS | Kansas | WV | West Virginia |
| KY | Kentucky | WI | Wisconsin |
| LA | Louisiana | WY | Wyoming |
| ME | Maine | AE | Armed Forces in Africa |
| MD | Maryland | AA | Armed Forces in Americas |
| MA | Massachusetts | AE | Armed forces in Canada |
| MI | Michigan | AE | Armed forces in Europe |
| MN | Minnesota | AP | Armed forces in Pacific |
| MS | Mississippi | AS | American Samoa |
| MO | Missouri | FM | Federated States of Micronesia |
| MT | Montana | GU | Guam |
| NE | Nebraska | MH | Marshall Islands |
| NV | Nevada | MP | Northern Mariana Islands |
| NH | New Hampshire | PR | Puerto Rico |
| NJ | New Jersey | PW | Palau |
| NM | New Mexico | VI | Virgin Islands |

For a complete listing of "State Abbreviations" go to the Official United States Postal Service (USPS) Abbreviations Web site: https://www.usps.com/send/official-abbreviations.htm

**CANADIAN PROVINCES ABBREVIATION TABLE**

| ABR | PROVINCE | ABR | PROVINCE |
|---|---|---|---|
| AB | Alberta | NS | Nova Scotia |
| BC | British Columbia | NU | Nunavut |
| MB | Manitoba | ON | Ontario |
| NB | New Brunswick | PE | Prince Edward Island |
| NL | Newfoundland and Labrador | QC | Quebec |
| NT | Northwest Territories | SK | Saskatchewan |
| | | YT | Yukon Territory |

**OTHER**

| | |
|---|---|
| XX | If other than United States or Canada |
| 99 | Unknown |

# Appendix E
# Louisiana Parish Edit Validation Table

| CODE | PARISH | CODE | PARISH |
|---|---|---|---|
| 01 | Acadia | 33 | Madison |
| 02 | Allen | 34 | Morehouse |
| 03 | Ascension | 35 | Natchitoches |
| 04 | Assumption | 36 | Orleans |
| 05 | Avoyelles | 37 | Ouachita |
| 06 | Beauregard | 38 | Plaquemines |
| 07 | Bienville | 39 | Pointe Coupee |
| 08 | Bossier | 40 | Rapides |
| 09 | Caddo | 41 | Red River |
| 10 | Calcasieu | 42 | Richland |
| 11 | Caldwell | 43 | Sabine |
| 12 | Cameron | 44 | Saint Bernard |
| 13 | Catahoula | 45 | Saint Charles |
| 14 | Claiborne | 46 | Saint Helena |
| 15 | Concordia | 47 | Saint James |
| 16 | De Soto | 48 | Saint John the Baptist |
| 17 | East Baton Rouge | 49 | Saint Landry |
| 18 | East Carroll | 50 | Saint Martin |
| 19 | East Feliciana | 51 | Saint Mary |
| 20 | Evangeline | 52 | Saint Tammany |
| 21 | Franklin | 53 | Tangipahoa |
| 22 | Grant | 54 | Tensas |
| 23 | Iberia | 55 | Terrebonne |
| 24 | Iberville | 56 | Union |
| 25 | Jackson | 57 | Vermilion |
| 26 | Jefferson | 58 | Vernon |
| 27 | Jefferson Davis | 59 | Washington |
| 28 | Lafayette | 60 | Webster |
| 29 | Lafourche | 61 | West Baton Rouge |
| 30 | La Salle | 62 | West Carroll |
| 31 | Lincoln | 63 | West Feliciana |
| 32 | Livingston | 64 | Winn |

| OTHER | |
|---|---|
| 88 | Patient lives outside Louisiana |
| 99 | Homeless |