LOUISIANA HEALTH CARE DATA SPECIFICATIONS MANUAL

Louisiana Department of Health and Hospitals

October 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

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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 <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 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 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 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 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 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
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	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 Subscriber 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*** *~*

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*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

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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 Thru 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 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 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
AB	Alberta
BC	British Columbia
MB	Manitoba
NB	New Brunswick
NL	Newfoundland and Labrador
NT	Northwest Territories
NS	Nova Scotia
NU	Nunavut
ON	Ontario
PE	Prince Edward Island
QC	Quebec
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