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West Virginia  
Hospital Data Submission System

*Data Collection  
Policies and Procedures*

West Virginia Hospital Association

January 2020

*West Virginia  
Hospital Data Submission System  
Data Collection Policies and Procedures*

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The West Virginia Health Care Authority (WVHCA) has been charged by the West Virginia Legislature with ensuring compliance with W.Va. Code §16-29B-1 et seq. and the Financial Disclosure Rule, 65 C.S.R. 13. Collection of data for all hospital inpatient stays and outpatient encounters is a part of this duty. Data collected and analyzed through the West Virginia Hospital Data Submission System (HDSS) are used by state and federal agencies, hospitals, universities, and non-profit organizations for health care regulatory and planning purposes. The WVHCA analyzes these data to assess health care access, quality, and cost, as well as disease prevalence and disparities, in West Virginia. This information is used to inform hospital Certificate of Need decisions, and statewide health policy efforts.

This document outlines the required protocols for submission of hospital inpatient and outpatient data to the WVHCA. Additional documents outlining guidelines and specifications for data reporting and editing can be accessed from the WVHCA website at <https://hca.wv.gov/fdhome/HospInpatientData/Pages/default.aspx>.

## **I. Data Specifications**

- A. Hospital inpatient and outpatient data are required to be extracted from billing systems and submitted by all hospitals to the WVHCA in the formats outlined in the *837I Companion Guide* and *Data Element Specifications* documents, which specify the required data file layout and field content.
- B. Data must be submitted for all hospital inpatient discharges and outpatient encounters, regardless of the expected source of payment. This is to include, but is not limited to, self-pay and charity discharges, and swing bed discharges. Long term and skilled nursing care discharges should NOT be included.
- C. For each inpatient stay and outpatient encounters, the record(s) submitted must represent the final and complete claim. It is recommended that one final record be submitted per discharge, after the claim has been closed.
- D. For all inpatient stays that result in a birth, a separate record/claim must be submitted for mother and baby(s).

## **II. Data Submission and Quality**

- A. Discharge and encounter records are required to be submitted on a monthly basis within 60 days after the end of the submission month.
- B. Data are required to be submitted to the DHHR vendor, the West Virginia Hospital Association, utilizing the Hospital Data Submission System (HDSS), as outlined in the *837I Companion Guide* and *Data Element Specification*.

- C. Upon upload to the HDSS, edit checks are performed on the data to assess the completeness and quality of records. Results of the edit checks are displayed in the HDSS and must be reviewed prior to inclusion of the data in the master database. All fatal errors must be corrected while warning errors are provided for consideration and review. A complete list of the edit checks are outlined in the *Edit Check Definitions* guide.
- D. As stated in Section I.C, subsequent records can be submitted to adjust, supplement, or void claims previously submitted to the master database. Refer to the *HDSS User Guide* for specific information on revising the master database.
- E. Data quality reports (*EditDetail* and *Verification*) are available on the data submission and editing website to provide information regarding the completeness and accuracy of submitted data. These reports are designed to assist in the data submission process and should be reviewed regularly to identify and assess data errors. Refer to the *HDSS User Guide* for specific information on accessing and using the DQRs.

### III. Reconciliation

A complete and accurate dataset is ensured by conducting data reconciliation at the time of data submission.

- A. A Submission Details Report is created for every file uploaded. This report provides the batch ID, original filename, submission date, facility Medicare number, user submitting the file, date range of data within the file, date the file was processed, date the file was deleted and the user that deleted it (if applicable), status of the batch and format of the data file received.  
Additional information on this report includes a list of record counts for each bill type, a total record count loaded, a summary of records that were not loaded and a list of record counts by month-year.
- B. The Verification Report is an Excel document that shows distributions of inpatient and outpatient records by month and patient data elements.  
Data elements include discharges/visits by month, priority of admission, point of origin, patient discharge status, age, sex, race, ethnicity, number of diagnosis codes, number of procedure codes, length of stay, primary payer and payer by Medicare provider number.  
Users compare this report to internal reports to validate and reconcile the data uploads.
- C. The Submit List report provides a listing of all accounts included in the batch. The Submit List report includes Patient Account Number, Medicare Provider Number, Admission Date, Discharge Date, Bill Type and Payer Code.  
Hospitals use this detailed listing to further investigate any questions or issues that were identified when reviewing the Verification Report.

The Submission Details Report and Verification Reports are created and updated each time data is uploaded or manually corrected. Based on the outcome of the reconciliation process, users may choose to delete the batch and resubmit a corrected file or make corrections to the records using the online patient correction process. Additional details may be found in the *HDSS User Guide*.

Summary reports by hospital are available for monitoring volumes and errors. The WV Health Care Authority and/or their discharge data vendor will work with hospitals to resolve any discrepancies identified.

#### **IV. Compliance**

- A. Compliance with these policies and procedures is required by W. Va. Code §16-29B-1 *et seq.* and the Financial Disclosure Rule, 65 C.S.R. 13. Facilities are deemed out of compliance if submissions are 120 days overdue or if data quality or format is not in conformity with the required specifications.
- B. Noncompliant facilities may be announced in the Health Care Authority's weekly newsletter *Health Care Review*.

#### **V. Technical Assistance**

All documentation outlining the required guidelines and specifications for data reporting and editing can be accessed from the WVHCA website at:

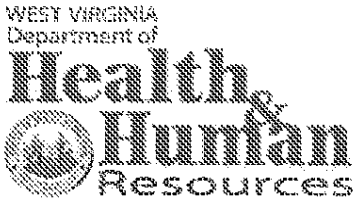
<https://hca.wv.gov/tdhome/HospInpatientData/Pages/default.aspx>

For technical assistance related to the data submission website (HDSS), contact the West Virginia Hospital Association.

Liz Tate  
Director, Data Collection and Training  
Email: [ltate@wvha.org](mailto:ltate@wvha.org)  
Office: (304) 353-9710

For additional information related to data reporting policies, procedures, or requirements, contact:

Michael J. Morris  
Operation Director  
WV Department of Health & Human Resources  
Office of Management Information Services  
One Davis Square  
Charleston, WV 25301  
Email: [Michael.J.Morris@wv.gov](mailto:Michael.J.Morris@wv.gov)  
Office: (304) 356-4129



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**West Virginia  
Hospital Data Submission System**

***Data Element  
Specifications Guide***

West Virginia Hospital Association

January 2020

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## Introduction

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The West Virginia Hospital Data Submission System (HDSS) collects, processes, and analyzes inpatient and outpatient discharge data that are collected by the West Virginia Health Care Authority (WVHCA). This Guide outlines specifications for the data elements that are required to be submitted to the WVHCA/WVDHHR by all non-federal hospitals in the state. The table below defines the information that is contained in the data element tables presented in this Guide.

Refer to the *Data Collection Policies and Procedures* guide for hospital inpatient data reporting requirements. Additional technical documents are available to provide specific details regarding the data file layout and submission procedures. All data reporting and technical documentation can be accessed from the WVHCA website (<http://www.hca.wv.gov/edhome/hospinpatientData>) or from the Hospital Data Submission System (HDSS) (<https://www.hidionline.com/HIDNetV3/>).

### Data Element Specification Table Layout

#### Data Element Name

Description	A description or definition of the data element.
837i Guide	WVHDSS File Specifications 837i Companion Guide corresponding page number
UB-04 Element	Reference to the UB-04 Form Locator.
HDSS Field	Name of the data element as it appears in the West Virginia Hospital Data Submission System.
Format & Valid Codes	A description of the required format and accepted codes.
Edit Check Errors & Warnings	A list of the errors and/or warnings that may appear in the Hospital Data Submission System as a result of the edits checks performed on the data element. Fatal errors on inpatient records must be corrected before data may be considered complete. Outpatient records are considered complete and do not require corrections if overall fatal error rate is less than 5%.
Notes	Any special data submission or processing notes related to the data element.

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## Alphabetical Index of Data Elements

This table presents an alphabetical list of the data elements, their abbreviated field name in the Hospital Data Submission System (HDSS), and the page number of the corresponding data element specifications table in this Guide.

Data Element Name / Field Description	HDSS Field Name	Page Number
Admission Date	Admit Date	4
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Present on Admission Code(s)	POA	15
Principal Diagnosis Code	Diagnosis Code (1 <sup>st</sup> listed)	16
Principal Procedure Code	Procedure Code (1 <sup>st</sup> listed)	16
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Social Security Number	SSN	18
Statement Coverage Dates	Statement from Date, Statement thru (Discharge) Date	18
Total Claim Charges	Total Charges	18

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### Admission Date & Time

Description	Date & Time of admission to hospital
837i Guide	Page 3
UB-04 Element	FL 12 & 13
HDSS Field	Admit Date
Format & Valid Codes	Date formatted as specified in the <i>WVHDSS File Specifications 837i Companion Guide</i>
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 1101 = Admit date is missing (no error on Outpatients)</li> <li>• 1102 = Admit date is invalid</li> <li>• 1103 = Admit date is greater than discharge date</li> </ul>
Notes	Admission date is formatted as CCYYMMDDHHMM.

### Admission Type Code/Priority of Visit

Description	Code indicating the priority (type) of admission
837i Guide	Page 3
UB-04 Element	FL 14
HDSS Field	Admit Type
Format & Valid Codes	Submit valid codes per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 2801 = Priority of visit is missing</li> <li>• 2802 = Priority of visit is invalid</li> <li>• 2805 = Priority of visit newborn, birthdate prior to Admit date</li> </ul>
Notes	<ol style="list-style-type: none"> <li>1. For births occurring in the hospital, the admission type should be coded as '4.' This code requires the use of the newborn codes for source of admission.</li> <li>2. In accordance with <i>WVHCA Data Collection Policies and Procedures</i>, separate discharge records should be submitted for newborns and mothers.</li> </ol>

### Admit from Emergency Room Condition Code

Description	Code indicating patient admitted directly from facility's Emergency Room/Dept. (Inpatient only)
837i Guide	Page 3
UB-04 Element	FL 18-28
HDSS Field	Condition Code
Format & Valid Codes	Submit a "P7" per NUBC Official UB-04 Data Specifications if the patient was admitted as an inpatient directly from the emergency room/department.
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 7102 = Condition code is invalid (Inpatient Only)</li> <li>• 7103 = Condition code P7 reported, no 45x revenue code reported (Inpatient Only)</li> </ul>
Notes	

## Alphabetical Index of Data Elements

### Admitting Diagnosis Code

Description	Code indicating the diagnosis at the time of admission (Inpatient only)
837i Guide	Page 3
UB-04 Element	FL 69
HDSS Field	Admit Diagnosis
Format & Valid Codes	ICD-10-CM Codes
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"><li>• 4501 = Admit DX is missing (Inpatient only)</li><li>• 4502 = Admit DX is invalid (Inpatient only)</li></ul>
Notes	

### Auto Accident State Code

Description	State abbreviation code where the auto accident occurred
837i Guide	Page 3
UB-04 Element	FL 29
HDSS Field	Acc. State
Format & Valid Codes	Two-digit state abbreviation
Edit Check <i>Fatal Errors</i>	
Notes	Required when the services reported on the claim are related to an auto accident.

### Bill Type Code

Description	Code indicating the specific type of bill
837i Guide	Page 3
UB-04 Element	FL 04
HDSS Field	Bill Type
Format & Valid Codes	Submit valid codes per NUBC Official UB-04 Data Specifications. <b>All Hospital Inpatient and Outpatient visits</b> should be reported EXCEPT skilled nursing and long-term care discharges.
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"><li>• 4101 = Bill type is missing</li><li>• 4102 = Bill type is invalid</li></ul>
Notes	The 837 format requires the bill type code to be submitted in two fields. It is displayed as one field in the HDSS.

## Alphabetical Index of Data Elements

### External Cause of Injury Code

Description	Code pertaining to external cause of injuries, poisoning, or adverse effect
837i Guide	Page 4
UB-04 Element	FL 72a-c
HDSS Field	Diagnosis Codes – ECM Code
Format & Valid Codes	ICD-10-CM Codes
Edit Check <i>Fatal Errors</i>	
Notes	<ul style="list-style-type: none"> <li>Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment.</li> </ul>

### External Cause of Injury POA Code

Description	Code indicating present on admission status of external cause of injuries, poisoning, or adverse effect
837i Element	Page 5
UB-04 Element	FL 72a-c
HDSS Field	EPOA
Format & Valid Codes	<p><i>*Refer to the 837i documentation for details regarding the format of the POA field.</i></p> <p><i>*Refer to ICD-10-CM Official Guidelines for additional code descriptions and instructions.</i></p> <p>Y = Yes (Present at the time of inpatient admission)</p> <p>N = No (Not present at the time of inpatient admission)</p> <p>U = No information in the record (Documentation is insufficient to determine if condition was present on admission or not)</p> <p>W = Clinically Undetermined (Provider is unable to clinically determine whether condition was present on admission or not)</p> <p>Blank/null = Unreported/not used (Exempt from POA reporting)</p>
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>5002 = ECM POA is invalid (Inpatient only)</li> </ul>
Notes	Per ICD-10-CM and CMS guidelines, some hospitals and diagnosis codes are exempt from POA reporting. Medicare Provider numbers with the first 3 digits of 511, 512, 513, 514, 515, 51S, 51T, 51U, or 51Z are exempt. Although it is not required, exempt hospitals are strongly encouraged to submit POA information to the WVHCA.

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### HCPCS/CPT Code

Description	Code used to represent medical procedures and services provided
837I Guide	Page 4
UB-04 Element	FL 44
HDSS Field	Revenue Codes - HCPCS
Format & Valid Codes	HCPCS
Edit Check <i>Fatal Errors</i>	
Notes	<ol style="list-style-type: none"> <li>1. Healthcare Common Procedure Coding System (HCPCS) is a set of health care procedure codes based on CPT (Current Procedural Terminology).</li> <li>2. Required in outpatient records only</li> </ol>

### Medical Record Number

Description	Number assigned to the patient's medical/health record by the provider
837I Guide	Page 4
UB-04 Element	FL 03b
HDSS Field	Medical Record Number
Format & Valid Codes	No standard format required
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 301 = Medical record number is missing</li> </ul>
Notes	The patient control number identifies a single episode of care; the medical record number identifies a patient across multiple episodes of care.

### Medicare Provider Number (CMS Certification Number/PTAN)

Description	Medicare provider identification number indicating the type of service (Inpatient only)
837I Guide	Page 4
UB-04 Element	N/A
HDSS Field	Medicare No.
Format & Valid Codes	Six-digit Medicare certification number issued by CMS specific to type of hospital service/unit including: Acute Critical Access Long Term Acute Care Rehabilitation Psychiatric Swing
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 6001 = Medicare number is missing (Inpatient only)</li> <li>• 6002 = Medicare number is invalid (Inpatient only)</li> <li>• 6003 = Medicare number doesn't match bill type (Inpatient only)</li> </ul>
Notes	This number is assigned by the Centers for Medicare & Medicaid Services (CMS) Division of Survey & Certifications.

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### NPI Attending Physician

Description	Unique national provider identification number assigned to the attending provider
837I Guide	Page 4
UB-04 Element	FL 76
HDSS Field	Attending
Format & Valid Codes	10-character National Provider Identifier
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"><li>• 2601 = Attending physician missing</li></ul>
Notes	The attending provider is the individual who had overall responsibility for the patient's medical care and treatment reported in the claim.

### NPI Billing Provider

Description	Unique national provider identification number assigned to the provider submitting the bill
837I Guide	Page 4
UB-04 Element	FL 56
HDSS Field	NPI
Format & Valid Codes	10-character National Provider Identifier
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"><li>• 6301 = Facility NPI is missing</li><li>• 6302 = Facility NPI is invalid</li><li>• 6303 = Facility NPI is not on file</li></ul>
Notes	

### NPI Operating Physician

Description	Unique national provider identification number assigned to the operating physician
837I Guide	Page 4
UB-04 Element	FL 77
HDSS Field	Operating
Format & Valid Codes	10-character National Provider Identifier
Edit Check <i>Fatal Errors</i>	
Notes	The operating physician is the individual with the primary responsibility for performing the surgical procedure(s).

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### NPI Other Physician(s) (Includes Rendering Provider)

Description	Unique national provider identification number assigned to other physicians involved in care
837i Guide	Page 4, 5
UB-04 Element	FL 78, FL 79
HDSS Field	NPI_OTH1, NPI_OTH2, NPI_RENDER
Format & Valid Codes	10-character National Provider Identifier
Edit Check <i>Fatal Errors</i>	
Notes	NPIs for two additional physicians can be submitted.

### Other Diagnosis Code(s)

Description	Codes corresponding to additional/secondary conditions related to the admission
837i Guide	Page 4
UB-04 Element	FL 67A-C
HDSS Field	Diagnosis Codes – Diagnosis Code (not listed first)
Format & Valid Codes	ICD-10-CM Diagnosis Codes
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 1504 = Other DX is invalid</li> <li>• 1522 = Other DX is duplicated of principal DX</li> <li>• 1523 = Duplicate secondary diagnosis reported</li> </ul>
Notes	<ol style="list-style-type: none"> <li>1. Report additional conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.</li> <li>2. Up to 24 secondary diagnosis codes can be submitted.</li> </ol>

### Other Procedure Code(s)

Description	Codes identifying additional significant procedures performed during the service period
837i Guide	Page 6
UB-04 Element	FL 74a-e
HDSS Field	Procedure Codes – Procedure Code (not listed first)
Format & Valid Codes	ICD-10-CM Procedure Codes
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 1603 = Other PX is invalid</li> <li>• 1607 = Other PX date, but no other PX</li> </ul>
Notes	Report all (up to 12) additional procedures that were most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

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### Other Procedure Dates

Description	Dates corresponding to other procedure codes
837i Guide	Page 7
UB-04 Element	FL 74 a-e
HDSS Field	Procedure Codes – Procedure Date (not listed first)
Format & Valid Codes	Dates formatted as specified in the <i>WVHDSS File Specifications 837i Companion Guide</i>
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 1702 = Other PX date is missing</li> <li>• 1708 = Other PX date is not between stnt from date and discharge date (Inpatient only)</li> </ul>
Notes	

### Patient Address Line

Description	Patient address line, street address or PO Box
837i Guide	Page 5
UB-04 Element	FL 09
HDSS Field	Address
Format & Valid Codes	Submit street address per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	
Notes	

### Patient Birth Date

Description	Date of birth of the patient
837i Guide	Page 5
UB-04 Element	FL 10
HDSS Field	Birth Date
Format & Valid Codes	Date formatted as YYYYMMDD
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 701 = Birthdate is invalid</li> <li>• 702 = Birthdate is missing</li> <li>• 703 = Birthdate is greater than Admit date</li> <li>• 2805 = Priority of visit newborn, birthdate prior to Admit date</li> </ul>
Notes	

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### Patient City Name

Description	Patient address line, city name
837i Guide	Page 5
UB-04 Element	FL 09
HDSS Field	City
Format & Valid Codes	Submit city name per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	
Notes	This field will not be visible or editable on the HDSS, and it will not appear on any reports.

### Patient Control Number

Description	Unique identification number assigned to each discharge
837i Guide	Page 5
UB-04 Element	FL 03a
HDSS Field	Patient Control Number
Format & Valid Codes	No standard format required. However, the patient control number is used as the record key and if it is missing the record will be skipped and not counted.
Edit Check <i>Fatal Errors</i>	
Notes	The patient control number must be unique to each discharge

### Patient First Name

Description	First name of the patient
837i Guide	Page 5
UB-04 Element	FL 08
HDSS Field	First Name
Format & Valid Codes	Submit per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	
Notes	

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### Patient Last Name

Description	Last name of the patient
837I Guide	Page 5
UB-04 Element	FL 08
HDSS Field	Last Name
Format & Valid Codes	Submit per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	
Notes	

### Patient Gender Code

Description	Sex of the patient as recorded at admission
837I Guide	Page 5
UB-04 Element	FL 11
HDSS Field	Sex
Format & Valid Codes	M = Male F = Female U = Unknown
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"><li>• 501 = Sex is invalid</li><li>• 502 = Sex is missing</li></ul>
Notes	

### Patient Name Suffix

Description	Patient name suffix
837I Guide	Page 5
UB-04 Element	FL 08
HDSS Field	Suffix
Format & Valid Codes	Submit per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	
Notes	

## Alphabetical Index of Data Elements

### Patient Race & Ethnicity Code

Description	Race and ethnicity as reported by the patient
837I Guide	Page 5
UB-04 Element	N/A
HDSS Field	Race
Format & Valid Codes	Submit WVHCA valid codes as outlined below. 1 = White and Non-Hispanic 2 = White and Hispanic/Latino 3 = White and Unknown Ethnicity 4 = Black and Non-Hispanic 5 = Black and Hispanic/Latino 6 = Black and Unknown Ethnicity 7 = Asian 8 = Native Hawaiian or Other Pacific Islander 9 = American Indian or Alaska Native M = Multiple Races and Non-Hispanic R = Multiple Races and Hispanic/Latino S = Multiple Races and Unknown Ethnicity T = Unknown Race and Hispanic/Latino Y = Other U = Unknown
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 601 = Race is invalid</li> <li>• 602 = Race is missing</li> </ul>
Notes	New race and ethnicity codes were required with the implementation of the WVHCA 837I 4010 file format. They are continued with the 837I 5010 file format.

### Patient State

Description	Patient address line, state abbreviation
837I Guide	Page 5
UB-04 Element	FL 09
HDSS Field	State
Format & Valid Codes	Submit state per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	
Notes	

## Alphabetical Index of Data Elements

### Patient (Discharge) Status Code

Description	Code indicating the status of the patient at the end of the service period covered on this bill
837I Guide	Page 6
UB-04 Element	FL 17
HDSS Field	Discharge Status
Format & Valid Codes	Submit valid codes per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 1001 = Patient disposition is invalid</li> <li>• 1002 = Patient disposition is missing</li> <li>• 1003 = Patient disposition is invalid for inpatient (Inpatient only)</li> </ul>
Notes	

### Patient Zip Code

Description	Zip code where the patient resides
837I Guide	Page 6
UB-04 Element	FL 09 subset
HDSS Field	Zip
Format & Valid Codes	Five-digit postal zip code
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 2001 = Zip code is missing</li> <li>• 2002 = Zip code is invalid</li> </ul>
Notes	

### Payer Code(s)

Description	Codes indicating the primary, secondary, and tertiary payers billed for the service
837I Guide	Page 6
UB-04 Element	FL 50
HDSS Field	Payers - Code
Format & Valid Codes	Submit WVHCA payer codes as defined in the <i>WVHCA Payer Coding Specifications</i>
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 401 = Primary payer is invalid</li> <li>• 402 = Primary payer is missing</li> <li>• 403 = Payer is invalid</li> </ul>
Notes	Secondary and tertiary payer codes are required to be submitted when other payers are known to potentially be involved in paying the claim.

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### Point of Origin (Admission Source Code)

Description	Code indicating the point of patient origin for the admission
837i Guide	Page 6
UB-04 Element	FL 15
HDSS Field	Admit Source
Format & Valid Codes	Submit valid codes per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 2201 = Point of origin is missing</li> <li>• 2202 = Point of origin is invalid</li> <li>• 2203 = Point of origin is invalid for newborn</li> </ul>
Notes	In accordance with WVHCA <i>Data Collection Policies and Procedures</i> , separate discharge records should be submitted for newborns and mothers. If Admit Type = 4 then Admit Source must be 5 or 6.

### Present on Admission (POA) Code(s)

Description	Present on admission code corresponding to a diagnosis code (Inpatient only)
837i Guide	Page 6
UB-04 Element	FL 67, FL67 A-Q
HDSS Field	Diagnosis Codes - POA
Format & Valid Codes	<p><i>*Refer to the 837i documentation for details regarding the format of the POA field.</i></p> <p><i>*Refer to ICD-10-CM Official Guidelines for additional code descriptions and instructions.</i></p> <p>Y = Yes (Present at the time of inpatient admission)</p> <p>N = No (Not present at the time of inpatient admission)</p> <p>U = No information in the record (Documentation is insufficient to determine if condition was present on admission or not)</p> <p>W = Clinically Undetermined (Provider is unable to clinically determine whether condition was present on admission or not)</p> <p>Blank/null = Unreported/not used (Exempt from POA reporting)</p>
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 1301 = Principal DX POA is missing (Inpatient only)</li> <li>• 1302 = Principal DX POA is invalid (Inpatient only)</li> <li>• 1304 = Other DX POA is missing (Inpatient only)</li> <li>• 1305 = Other DX POA is invalid (Inpatient only)</li> <li>• 1309 = Principal DX POA is invalid, DX code exempt (Inpatient only)</li> <li>• 1310 = Other DX POA is invalid, DX code exempt (Inpatient only)</li> </ul>
Notes	Per ICD-10-CM and CMS guidelines, some hospitals and diagnosis codes are exempt from POA reporting. Medicare Provider numbers with the first 3 digits of 511, 512, 513, 514, 515, 51S, 51T, 51U, or 51Z are exempt. Although it is not required, exempt hospitals are strongly encouraged to submit POA information.

## Alphabetical Index of Data Elements

### Principal Diagnosis Code

Description	Code indicating the condition determined to be chiefly responsible for the admission
837i Guide	Page 4
UB-04 Element	FL 67
HDSS Field	Diagnosis Codes – Diagnosis Code (listed first)
Format & Valid Codes	ICD-10-CM Diagnosis Codes
Edit Check Fatal Errors	<ul style="list-style-type: none"> <li>• 1501 = Principal DX missing</li> <li>• 1502 = Principal Dx invalid</li> <li>• 1505 = ECM code is invalid as principal DX</li> </ul>
Notes	

### Principal Procedure Code

Description	Code identifying the inpatient principal procedure performed during the service period
837i Guide	Page 6
UB-04 Element	FL 74
HDSS Field	Procedure Codes – Procedure Code (listed first)
Format & Valid Codes	ICD-10-CM Procedure Codes
Edit Check Fatal Errors	<ul style="list-style-type: none"> <li>• 1602 = Principal PX is invalid</li> <li>• 1606 = Principal PX date, but no principal PX</li> </ul>
Notes	<ul style="list-style-type: none"> <li>• Required when a procedure was performed.</li> </ul>

### Principal Procedure Date

Description	Date corresponding to the principal procedure code
837i Guide	Page 7
UB-04 Element	FL 74
HDSS Field	Procedure Codes – Procedure Date (listed first)
Format & Valid Codes	Dates formatted as specified in the <i>WVHDSS File Specifications 837i Companion Guide</i>
Edit Check Fatal Errors	<ul style="list-style-type: none"> <li>• 1701 = Principal PX date is missing</li> <li>• 1707 = Principal PX date is not between stmt from date and discharge date (Inpatient only)</li> </ul>
Notes	

## Alphabetical Index of Data Elements

### Revenue Codes

Description	Codes identifying specific accommodation and ancillary services provided
837i Guide	Page 7
UB-04 Element	FL 42
HDSS Field	Revenue Codes - Code
Format & Valid Codes	Submit valid codes per NUBC Official UB-04 Data Specifications
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 3701 = Revenue code is missing</li> <li>• 3702 = Revenue code is invalid</li> <li>• 3711 = More than 999 revenue line items</li> </ul>
Notes	A maximum of 999 revenue codes and corresponding units/charges may be submitted.

### Revenue Units

Description	Service quantity pertaining to the corresponding revenue code
837i Guide	Page 7
UB-04 Element	FL 46
HDSS Field	Revenue Codes – Units
Format & Valid Codes	Number of units
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 3801 = Revenue units missing</li> <li>• 3802 = Revenue units non-numeric</li> <li>• 3803 = Revenue units are negative</li> </ul>
Notes	A maximum of 999 revenue codes and corresponding units/charges may be submitted.

### Revenue Charges

Description	Total charges pertaining to the corresponding revenue code
837i Guide	Page 7
UB-04 Element	FL 47
HDSS Field	Revenue Code - Charge
Format & Valid Codes	Dollar amount – 15-character max (including decimal point). If the decimal point is not submitted, it will be interpreted that the charge is a whole dollar amount. For example, '30025' = \$30,025.00 '300.25' = \$300.25
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 3901 = Revenue charge is missing</li> <li>• 3903 = Revenue charge is &lt;0 or &gt;Total Charges</li> </ul>
Notes	A maximum of 999 revenue codes and corresponding units/charges may be submitted.

## Alphabetical Index of Data Elements

### Social Security Number

Description	Patient social security number (Inpatient only)
837i Guide	Page 6
UB-04 Element	N/A
HDSS Field	SSN
Format & Valid Codes	Submit social security number with no spaces or dashes.
Edit Check <i>Fatal Errors</i>	
Notes	If unknown, put 999999999

### Statement Coverage Dates

Description	Dates of the service period included on the bill
837i Guide	Page 7
UB-04 Element	FL 06
HDSS Fields	Statement from Date Statement thru (Discharge) Date
Format & Valid Codes	Dates formatted as specified in the <i>WVHDDS File Specifications 837i Companion Guide</i>
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 201 = Discharge date is invalid</li> <li>• 202 = Discharge date is missing</li> <li>• 203 = Discharge date is prior to Admit date (Inpatient only)</li> <li>• 205 = Discharge date is greater than current date</li> <li>• 1101 = Admit date is missing (Inpatient only)</li> <li>• 1102 = Admit date is invalid</li> <li>• 1103 = Admit date is greater than discharge date</li> <li>• 5201 = Statement from date is missing</li> <li>• 5203 = Statement from date is prior to admit date by &gt;3 days (Inpatient only)</li> <li>• 5205 = Statement from date is after statement through date</li> </ul>
Notes	The 837 format requires the statement coverage dates to be submitted as one field. They are displayed as two fields in the HDSS.

### Total Claim Charges

Description	Total charges billed for the services included on the bill
837i Guide	Page 7
UB-04 Element	N/A
HDSS Field	Total Charges
Format & Valid Codes	Dollar amount – 15-character max (including decimal point). If the decimal point is not submitted, it will be interpreted that the charge is a whole dollar amount.
Edit Check <i>Fatal Errors</i>	<ul style="list-style-type: none"> <li>• 2501 = Total charges revenue code missing</li> <li>• 2508 = Total charges more than +5% of line item total (Inpatient only)</li> </ul>
Notes	The charge amount submitted in this field will be presented in the HDSS as the Total Claim Charges (TCHG).



West Virginia  
Hospital Data Submission System

*File Specifications*  
*837I Companion Guide*

West Virginia Hospital Association

May 2020

## Overview

The following information is intended to serve only as a companion document to the Washington Publishing Company's 837I implementation guide. The use of this document is solely for the purpose of clarification.

## ANSI 837I Completion Information

To ensure that your claim files are processed correctly, please include the following information in the appropriate ANSI EDI elements:

ANSI Element	
ISA07	"ZZ" qualifier
ISA08	Production ID: "WVHCA"
ISA15	Enter T when submitting a test claim file. Enter P when submitting a production claim file.
GS03	Production ID: "WVHCA"

## Transaction Set Notes:

Loop 2400 can be repeated up to 999 times to accommodate multiple accommodation and ancillary charges. Each occurrence of Loop 2400 must contain the LX segment which assigns an identification number (counter) for each occurrence. In other words, for each LX segment, increment the LX01 by 1. You can only send one SV2 segment per Loop 2400.

The total claim amount should be sent ONLY in the CLM segment (in the CLM02). DO NOT send the total claim amount in an SV2 segment.

## Transaction Set Details

The 837 described in this document covers two different scenarios.

- 1 The Subscriber IS the Patient
- 2 The Subscriber IS NOT the Patient

The requirements for each of these scenarios differ slightly, yet both are accounted for in the implementation guide.

The tables in the last two sections of this document address both scenarios separately and indicate the MINIMUM REQUIREMENTS for each.

## Key Information Required

WV Health Care Authority / WV Hospital Association require certain pieces of information to successfully process claims. Below is an explanation of these requirements:

<u>Required Field:</u>	<u>Location / Notes:</u>
Admission Date	Send in the DTP03 data element where DTP01 ="435" and DTP02 = "DT". The format of this date/time is CCYYMMDDHHMM. This DTP is in Loop 2300. Not required on outpatient records.
Admission Type Code/Priority of Visit	Send in the CL101 data element in Loop 2300.
Admit from Emergency Room	Send the code P7 in the HI01-02 component data element where HI01-01 = "BG"
Auto Accident State Code	If this claim is related to an auto accident, send the two-character state abbreviation in the auto accident state segment (REF). Send in REF02 where REF01="LU" within Loop 2300.
Batch Date (HCA)	Send this value in the BHT04 data element to supply the date when the data was written to the file.
Batch Number (HCA)	Send this value in the BHT03 data element to supply the batch ID assigned to a deliverable batch
Bill Type (Uniform Bill Type Code)	The first and second positions of the Uniform Bill Type Code should be sent in CLM05-01 within Loop 2300. The third position of the Uniform Bill Type Code should be sent in CLM05-03 within Loop 2300.
Diagnosis Code (Admitting)	Send this code in the HI01-2 component data element where HI01-1 = "ABJ". Not required on outpatient records

**Required Field:****Location / Notes:**

Diagnosis Codes (Other)	Send the first other diagnosis code (if applicable) in the HI01-2 component data element where HI01-1 = "ABF". You can send up to 12 other diagnosis codes in this segment, each one qualified by "ABF" in the first component data element. In addition, you can send a second occurrence of this HI segment if needed to report up to 5 additional other diagnosis codes.
Diagnosis Code (Principal)	Send this code in the HI01-2 component data element where HI01-1 = "ABK" first sub-element of the first element).
External Cause of Injury Code	Send this code in the HI01-2 component data element where HI01-1 = "ABN"
External Cause of Injury POA	Send the EPOA in the HI01-9 component data element of the external cause of injury code HI component data element
Federal Tax Number of the Billing Provider	Send in the REF02 data element where REF01 = "EI" in the NM1 Loop qualified by "85" in Loop2010AA.
HCPCS/CPT Code	Send standard HCPCS/CPT in the SV2 segment, element SV202 of Loop 2400 qualified by "HC".
Medical Record Number	Send this in the REF02 data element where REF01 = "EA". This REF segment is located in Loop 2300 following the CL1 segment.
Medicare Provider Number (aka CCN – CMS Certification Number)	Send in the REF02 data element where REF01 = "G2" using billing provider secondary information in Loop 2010BB
NPI (Attending Provider)	Send the Attending Physician's National Provider Identifier in the NM109 data element where NM101 = "71" and NM108 = "XX" in Loop 2310A.
NPI (Billing Provider)	Send this code in the NM102-09 component data element within Loop 2010AA where NM102-08 = "XX" and NM102-01 = "85".
NPI (Operating Physician)	If applicable, send the Operating Physician's National Provider Identifier in the NM109 data element where NM101 = "72" and NM108 = "XX" in Loop 2310B.
NPI (Other Operating Physician)	If applicable, send the Other Operating Physician's National Provider Identifier in the NM109 data element where NM101 = "ZZ" and NM108 = "XX" in Loop 2310C. The standard generally only allows for one occurrence of the Loop 2310C Other Operating Physician, but both can be successfully processed. If applicable, please send two occurrences of Loop 2310C to report two Other Operating Physicians.

**Required Field:****Location / Notes:**

NPI (Rendering Provider)	Send the Rendering Provider's National Provider Identifier in the NM109 data element where NM101 = "82" and NM108 = "XX" in Loop 2310D.
Patient Address Line	Send in the N301 data element in the NM1 Loop qualified by "IL" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" in Loop 2010CA if the Subscriber is not the Patient.
Patient Birth Date	Send in the DMG02 data element in Loop 2010BA if the Patient is the Subscriber, else in Loop 2010CA if the Patient is not the Subscriber.
Patient City Name	Send in the N401 data element in the NM1 Loop qualified by "IL" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" in Loop 2010CA if the Subscriber is not the Patient. -
Patient Control Number	Send in the CLM01 data element in Loop 2300.
Patient First Name	Send in the NM104 data element in the NM1 Loop qualified by "IL" and where NM102="1" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" and NM102="1" in Loop 2010CA if the Subscriber is not the Patient
Patient Gender Code	Send in the DMG03 data element in Loop 2010BA if the Patient is the Subscriber, else in Loop 2010CA if the patient is not the Subscriber
Patient Middle Name/Initial	Send in the NM105 data element in the NM1 Loop qualified by "IL" and where NM102="1" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" and NM102="1" in Loop 2010CA if the Subscriber is not the Patient
Patient Last Name	Send in the NM103 data element in the NM1 Loop qualified by "IL" and where NM102="1" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" and NM102="1" in Loop 2010CA if the Subscriber is not the Patient
Patient Name Suffix	Send in the NM107 data element in the NM1 Loop qualified by "IL" and where NM102="1" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" and NM102="1" in Loop 2010CA if the Subscriber is not the Patient
Patient Race & Ethnicity Code	Send a valid race and ethnicity code in the DMG05 data element in Loop 2010BA if the Patient is the Subscriber, else in Loop 2010CA if the Patient is not the Subscriber. Refer to the WVHDSS Data Element Specifications Guide for required codes.

**Required Field:**

**Location / Notes:**

Patient SSN

Send in the REF02 data element where REF01 = "SY" in Loop 2010BA if the Subscriber is the Patient, else send in the REF02 data element where REF01 = "SY" in Loop 2010CA if the Subscriber is not the Patient. Note that this field must not have spaces or dashes.

Patient State Code

Send in the N402 data element in the NM1 Loop qualified by "IL" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" in Loop 2010CA if the Subscriber is not the Patient. -

Patient Status Code  
(Discharge Status)

Send this code in the CL103 data element within Loop 2300.

Patient Zip Code

Send in the N403 data element in the NM1 Loop qualified by "IL" in Loop 2010BA if the Subscriber is the Patient, else in the NM1 Loop qualified by "QC" in Loop 2010CA if the Subscriber is not the Patient.

Payer Code

Up to 3 codes can be submitted to identify the expected source of payment. Refer to the WVHDSS Data Element Specifications Guide for required codes.

- Send the primary payer in the NM109 data element within Loop 2010BB with NM108 = "PI" where NM101 = "PR" and NM102 = "2" in the 2010BB Loop.
- If applicable, send the secondary payer in the NM109 data element within Loop 2330B with NM108 = "PI" where NM101 = "PR" and NM102 = "2" in the 2330B Loop.
- If applicable, send the third payer in the NM109 data element within Loop 2330B with NM108 = "PI" where NM101 = "PR" and NM102 = "2" as described for the secondary payer.

Point of Origin  
(Admission Source Code)

Send in the CL102 data element in Loop 2300. Effective for claims with a start date of 1/1/2011 or later. The value '7' is no longer valid.

Present on Admission  
(POA) Codes

Send the POA for Primary Diagnosis in the HI01-9 component data element qualified by "ABK" in the first component data element. You can send up to 12 other POAs in this segment, each one qualified by "ABF" in the first component data element. In addition, you can send a second occurrence of this HI segment if needed to report up to 5 additional other POAs

Procedure Codes (Other)

Send the first other procedure code (if applicable) in the HI01-2 component data element where HI01-1 = "BBQ". You can send up to 11 additional other procedure codes in this segment.

Procedure Code (Principal)

Send this code in the HI01-2 component data element where HI01-1 = "BBR".

**Required Field:**

**Location / Notes:**

Procedure Date (Principal)

In Loop 2300, send this code in the HI01-4 component data element where HI01-3 = "D8".

Procedure Date (Other)

Send the first other procedure date (if applicable) in the HI01-4 component data element where HI01-3 = "D8". You can send up to 11 additional other procedure dates in this segment.

Revenue Codes, Charges, Unit

Send information about the revenue code in the SV2 segment within Loop 2400 with a National Uniform Billing Committee (NUBC) Revenue Code less than 70 or greater than 219 (in the SV201 data element within Loop 2400).

- Send the revenue charge amount in the SV203 data element.
- Send the revenue quantity in the SV205 data element
- Send the revenue unit of measure ("DA" Days or "UN" Unit) that describes the ancillary quantity in the SV204 data element

Statement Coverage Dates

Send this as a date range in the DTP03 data element where DTP01 = "434" and DTP02 = "RD8". Format will be CCYYMMDD-CCYYMMDD. First date is the coverage start date. Second date is the coverage end date. This DTP is in Loop 2300.

Total Claim Charges

Send the total claim amount in the CLM02 data element in Loop 2300.

**MINIMUM REQUIREMENTS if the Subscriber IS the Patient:**

Loop	Segment	Element	Description
	BHT	BHT01	Hierarchical Structure Code
	BHT	BHT02	Transaction Set Purpose Code
	BHT	BHT03	HCA Batch Number
	BHT	BHT04	HCA Batch Date
	BHT	BHT06	Transaction Type Code
	ST	ST03	"005010X223A2" Transaction Type
1000A			Submitter Name Loop
1000A	NM1	NM101	Entity ID Code "41"
1000A	NM1	NM102	Entity Type Qualifier
1000A	NM1	NM108	Identification Code Qualifier
1000A	NM1	NM109	Identification Code
1000A	PER	PER01	Contact Function Code "IC"
1000A	PER	PER03	Communication Number Qualifier
1000A	PER	PER04	Communication Number
1000B			Receiver Name Loop
1000B	NM1	NM101	Entity Identifier Code "40"
1000B	NM1	NM102	Entity Type Qualifier "2"
1000B	NM1	NM108	Identification Code Qualifier
1000B	NM1	NM109	Identification Code
2000A			Billing/Provider Loop
2000A	HL	HL01	Hierarchical ID Number
2000A	HL	HL03	"20" Hierarchical Level Code
2000A	HL	HL04	Hierarchical Child Code
2010AA	NM1		Billing Provider Information
2010AA	NM1	NM101	"85" Billing Provider
2010AA	NM1	NM102	"2" Non-Person Entity
2010AA	NM1	NM103	Last Name
2010AA	NM1	NM108	"XX" NPI Qualifier
2010AA	NM1	NM109	National Provider Identifier
2010AA	N3	N301	Address Information
2010AA	N4	N401	City Name
2010AA	REF	REF01	"EI" Employer's ID Number
2010AA	REF	REF02	Federal Tax Number
2000B			Subscriber Loop
2000B	HL	HL01	Hierarchical ID Number
2000B	HL	HL02	Hierarchical Parent ID Number
2000B	HL	HL03	"22" Hierarchical Level Code
2000B	HL	HL04	"0" Hierarchical Child Code
2000B	SBR	SBR01	"P" for Primary Payer
2010BA	NM1		Subscriber-Patient Information
2010BA	NM1	NM101	"IL" Insured or Subscriber
2010BA	NM1	NM102	"1" Person
2010BA	N4	N403	Subscriber-Patient Zip Code
2010BA	DMG	DMG01	"D8" Date/Time Qualifier
2010BA	DMG	DMG02	Subscriber-Patient Birth Date
2010BA	DMG	DMG03	Subscriber-Patient Gender Code

**MINIMUM REQUIREMENTS if the Subscriber IS the Patient:**

Loop	Segment	Element	Description
2010BA	DMG	DMG05	Subscriber-Patient Race and Ethnicity Code
2010BA	N3	N301	Subscriber-Patient Address Line
2010BA	N4	N401	Subscriber-Patient City Name
2010BA	N4	N402	Subscriber-Patient State Code
2010BA	REF	REF01	"SY" Social Security Number Qualifier
2010BA	REF	REF02	Subscriber-Patient SSN
2010BA	NM1	NM107	Subscriber-Patient Name Suffix
2010BA	NM1	NM103	Subscriber-Patient Last Name
2010BA	NM1	NM105	Subscriber-Patient Middle Name/Initial
2010BA	NM1	NM104	Subscriber-Patient First Name
2010BB	NM1		Payer Information
2010BB	NM1	NM101	"PR" Payer
2010BB	NM1	NM102	"2" Non-Person Entity
2010BB	NM1	NM108	"PI" Payer Identification
2010BB	NM1	NM109	Primary Payer Code
2010BB	N3	N301	Address Information
2010BB	N4	N401	City Name
2010BB	REF	REF01	"G2" Medicare Provider Number
2010BB	REF	REF02	Medicare Provider Number
2300	HI	HI01	"D8" Principal Procedure Date Qualifier
2300	HI	HI01	Principal Procedure Date
2300	HI	HIxx	"D8" Other Procedure Date Qualifier
2300	HI	HIxx	Other Procedure Dates
2300	CLM	CLM01	Patient Control Number
2300	CLM	CLM02	Total Claim Charges
2300	CLM	CLM05	Health Care Service Location Information - Facility Code Value - the first & second positions of the Uniform Billing Claim Form Bill Type code
2300	CLM	CLM05	Health Care Service Location Information - Facility Code Qualifier "A"
2300	CLM	CLM05	Health Care Service Location Information - Claim Frequency Type Code - the third position of the Uniform Billing Claim Form Bill Type Code
2300	REF	REF01	"LU" Location Number
2300	REF	REF02	Auto Accident State or Province Code
2300	DTP	DTP01	"434" Statement Coverage Dates Qualifier
2300	DTP	DTP02	"RD8" Date Format Qualifier
2300	DTP	DTP03	Statement Coverage Dates
2300	DTP	DTP01	"435" Admission Date Qualifiers
2300	DTP	DTP02	"DT", "D8" Date Format Qualifiers
2300	DTP	DTP03	Admission Date
2300	CL1	CL101	Admission Type Code
2300	CL1	CL102	Admission Source Code
2300	CL1	CL103	Patient Status Code
2300	REF	REF01	"EA" Medical Record Identification Number
2300	REF	REF02	Medical Record Number

**MINIMUM REQUIREMENTS if the Subscriber IS the Patient:**

Loop	Segment	Element	Description
2300	HI	HI01	"ABK" Principal Diagnosis Qualifier
2300	HI	HI01	Principal Diagnosis Code
2300	HI	HI01	POA for Principal Diagnosis
2300	HI	HI01	"ABJ" Admitting Diagnosis Qualifier
2300	HI	HI01	Admitting Diagnosis Code
2300	HI	HI01	"ABN" E-Code Qualifier
2300	HI	HI01	External Cause of Injury Code (E-Code)
2300	HI	HI01	POA for External Cause of Injury Code
2300	HI	Hlxx	"ABF" Other Diagnosis Qualifier
2300	HI	Hlxx	Other Diagnosis Codes
2300	HI	Hlxx	POA(s) for Other Diagnosis Code(s)
2300	HI	HI01	"BBR" Principal Procedure Qualifier
2300	HI	HI01	Principal Procedure Code
2300	HI	Hlxx	"BBQ" Other Procedure Qualifier
2300	HI	Hlxx	Other Procedure Codes
2300	HI	HI01	"BG" Condition Code Qualifier
2300	HI	HI01	P7 Condition Code
2310A	NM1		Attending Provider
2310A	NM1	NM101	"71" Attending Provider
2310A	NM1	NM102	Entity Type Qualifier
2310A	NM1	NM103	Last Name
2310A	NM1	NM108	"XX" NPI Qualifier
2310A	NM1	NM109	National Provider Identifier
2310B	NM1		Operating Physician
2310B	NM1	NM101	"72" Operating Physician
2310B	NM1	NM102	Entity Type Qualifier
2310B	NM1	NM103	Last Name
2310B	NM1	NM108	"XX" NPI Qualifier
2310B	NM1	NM109	National Provider Identifier
2310C	NM1		Other Physician (Primary & Secondary)
2310C	NM1	NM101	"ZZ" Other Physician
2310C	NM1	NM102	Entity Type Qualifier
2310C	NM1	NM103	Last Name
2310C	NM1	NM108	"XX" NPI Qualifier
2310C	NM1	NM109	National Provider Identifier
2320	SBR	SBR01	"S" for Secondary Payer "T" for Tertiary Payer
2330B	NM1	NM101	"PR" Payer
2330B	NM1	NM102	"2" Non-Person Entity
2330B	NM1	NM108	"PI" Payer Identification
2330B	NM1	NM109	Secondary/Tertiary Payer Codes
2400	LX	LX01	Service Line Number
2400	SV2	SV201	Revenue Code
2400	SV2	SV202	"HC" Standard HCPCS/CPT Code
2400	SV2	SV203	Line Item Charge Amount
2400	SV2	SV204	"DA" Days or "UN" Unit
2400	SV2	SV205	Quantity of days or units

**MINIMUM REQUIREMENTS if the Subscriber IS NOT the Patient:**

Loop	Segment	Element	Description
	BHT	BHT01	Hierarchical Structure Code
	BHT	BHT02	Transaction Set Purpose Code
	BHT	BHT03	HCA Batch Number
	BHT	BHT04	HCA Batch Date
	BHT	BHT06	Transaction Type Code
	ST	ST03	"005010X223A2" Transaction Type
1000A			Submitter Name Loop
1000A	NM1	NM101	Entity ID Code "41"
1000A	NM1	NM102	Entity Type Qualifier
1000A	NM1	NM108	Identification Code Qualifier
1000A	NM1	NM109	Identification Code
1000A	PER	PER01	Contact Function Code "IC"
1000A	PER	PER03	Communication Number Qualifier
1000A	PER	PER04	Communication Number
1000B			Receiver Name Loop
1000B	NM1	NM101	Entity Identifier Code "40"
1000B	NM1	NM102	Entity Type Qualifier "2"
1000B	NM1	NM108	Identificaton Code Qualifier
1000B	NM1	NM109	Identification Code
2000A			Billing/Provider Loop
2000A	HL	HL01	Hierarchical ID Number
2000A	HL	HL03	"20" Hierarchical Level Code
2000A	HL	HL04	Hierarchical Child Code
2010AA	NM1		Billing Provider Information
2010AA	NM1	NM101	"85" Billing Provider
2010AA	NM1	NM102	"2" Non-Person Entity
2010AA	NM1	NM103	Last Name
2010AA	NM1	NM108	"XX" NPI Qualifier
2010AA	NM1	NM109	National Provider Identifier
2010AA	REF	REF01	"EI" Employer's ID Number
2010AA	N3	N301	Address Information
2010AA	N4	N401	City Name
2010AA	REF	REF02	Employer's ID Number
2000B			Subscriber Loop
2000B	HL	HL01	Hierarchical ID Number
2000B	HL	HL02	Hierarchical Parent ID Number
2000B	HL	HL03	"22" Hierarchical Level Code
2000B	HL	HL04	"1" Hierarchical Child Code
2000B	SBR	SBR01	"P" for Primary Payer
2010BB	NM1		Payer Information
2010BB	NM1	NM101	"PR" Payer
2010BB	NM1	NM102	"2" Non-Person Entity
2010BB	NM1	NM103	Organization Name
2010BB	NM1	NM108	"PI" Payer Identification
2010BB	NM1	NM109	Payer Identificaton Number
2010BB	N3	N301	Address Information
2010BB	N4	N401	City Name

**MINIMUM REQUIREMENTS if the Subscriber IS NOT the Patient:**

Loop	Segment	Element	Description
2010BB	REF	REF01	"G2" Medicare Provider Number
2010BB	REF	REF02	Medicare Provider Number
2000C			Patient Hierarchical Loop
2000C	HL	HL01	Hierarchical Parent ID Number
2000C	HL	HL02	Hierarchical Parent ID Number
2000C	HL	HL03	"23" Hierarchical Level Code
2000C	HL	HL04	"0" Hierarchical Child Code
2000C	PAT	PAT01	Individual Relation Code "1"
2010CA	NM1		Patient Information
2010CA	NM1	NM101	"QC" Patient Qualifier
2010CA	NM1	NM102	"1" Person Entity Type Qualifier
2010CA	N4	N403	Patient Zip Code
2010CA	DMG	DMG01	"D8" Date/Time Qualifier
2010CA	DMG	DMG02	Patient Birth Date
2010CA	DMG	DMG03	Patient Gender Code
2010CA	DMG	DMG05	Patient Race and Ethnicity Code
2010CA	N3	N301	Patient Address Line
2010CA	N4	N401	Patient City Name
2010CA	N4	N402	Patient State Code
2010CA	REF	REF01	"SY" Social Security Number Qualifier
2010CA	REF	REF02	Patient SSN
2010CA	NM1	NM107	Patient Name Suffix
2010CA	NM1	NM103	Patient Last Name
2010CA	NM1	NM105	Patient Middle Name/Initial
2010CA	NM1	NM104	Patient First Name
2300	HI	HI01	"D8" Principal Procedure Date Qualifier
2300	HI	HI01	Principal Procedure Date
2300	HI	HIxx	"D8" Other Procedure Date Qualifier
2300	HI	HIxx	Other Procedure Dates
2300	CLM	CLM01	Patient Control Number
2300	CLM	CLM02	Total Claim Charge Amount
2300	CLM	CLM05	Health Care Service Location Information - Facility Code Value - the first & second positions of the Uniform Billing Claim Form Bill Type code
2300	CLM	CLM05	Health Care Service Location Information - Facility Code Qualifier "A"
2300	CLM	CLM05	Health Care Service Location Information - Claim Frequency Type Code - the third position of the Uniform Billing Claim Form Bill Type Code
2300	REF	REF01	"LU" Location Number
2300	REF	REF02	Auto Accident State or Province Code
2300	DTP	DTP01	"434" Statement Coverage Dates Qualifier
2300	DTP	DTP02	"RD8" Date Format Qualifier
2300	DTP	DTP03	Statement Coverage Dates
2300	DTP	DTP01	"435" Admission Date Qualifiers
2300	DTP	DTP02	"DT", "D8" Date Format Qualifiers
2300	DTP	DTP03	Admission Date

**MINIMUM REQUIREMENTS if the Subscriber IS NOT the Patient:**

Loop	Segment	Element	Description
2300	CL1	CL101	Admission Type Code
2300	CL1	CL102	Admission Source Code
2300	CL1	CL103	Patient Status Code
2300	REF	REF01	"EA" Medical Record Identification Number Qualifier
2300	REF	REF02	Medical Record Number
2300	HI	HI01	"ABK" Principal Diagnosis Qualifier
2300	HI	HI01	Principal Diagnosis Code
2300	HI	HI01	POA for Principal Diagnosis
2300	HI	HI02	"ABJ" Admitting Diagnosis Qualifier
2300	HI	HI02	Admitting Diagnosis Code
2300	HI	HI01	"ABN" E-Code Qualifier
2300	HI	HI01	External Cause of Injury Code (E-Code)
2300	HI	HI01	POA for External Cause of Injury Code
2300	HI	Hlxx	"ABF" Other Diagnosis Qualifier
2300	HI	Hlxx	Other Diagnosis Codes
2300	HI	Hlxx	POA(s) for Other Diagnosis Code(s)
2300	HI	HI01	"BBR" Principal Procedure Qualifier
2300	HI	HI01	Principal Procedure Code
2300	HI	Hlxx	"BBQ" Other Procedure Qualifier
2300	HI	Hlxx	Other Procedure Codes
2300	HI	HI01	"BG" Condition Code Qualifier
2300	HI	HI01	P7 Condition Code
2310A	NM1		Attending Provider
2310A	NM1	NM101	"71" Attending Provider
2310A	NM1	NM102	Entity Type Qualifier
2310A	NM1	NM103	Last Name
2310A	NM1	NM108	"XX" NPI Qualifier
2310A	NM1	NM109	National Provider Identifier
2310B	NM1		Operating Physician
2310B	NM1	NM101	"72" Operating Physician
2310B	NM1	NM102	Entity Type Qualifier
2310B	NM1	NM103	Last Name
2310B	NM1	NM108	"XX" NPI Qualifier
2310B	NM1	NM109	National Provider Identifier
2310C	NM1		Other Physician (Primary & Secondary)
2310C	NM1	NM101	"ZZ" Other Physician
2310C	NM1	NM102	Entity Type Qualifier
2310C	NM1	NM103	Last Name
2310C	NM1	NM108	"XX" NPI Qualifier
2310C	NM1	NM109	National Provider Identifier
2320	SBR	5BR01	"S" for Secondary Payer "T" for Tertiary Payer
2330B	NM1	NM101	"PR" Payer
2330B	NM1	NM102	"2" Non-Person Entity
2330B	NM1	NM108	"PI" Payer Identification
2330B	NM1	NM109	Secondary/Tertiary Payer Codes
2400	LX	LX01	Service Line Number
2400	SV2	SV201	Revenue Code

**MINIMUM REQUIREMENTS if the Subscriber IS NOT the Patient:**

<b>Loop</b>	<b>Segment</b>	<b>Element</b>	<b>Description</b>
2400	SV2	SV202	"HC" Standard HCPCS/CPT Code
2400	SV2	SV203	Line Item Charge Amount
2400	SV2	SV204	"DA" Days or "UN" Unit
2400	SV2	SV205	Quantity of days or units