
# THCIC Data Collection

# Healthcare Facility Procedures and

# Technical Specifications

# 5010 Inpatient and Outpatient Appendices

**Version 4.8** **December 1, 2023**

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# Appendix A1 VALID COUNTRY CODES AND STATE CODES

## 1.1 Country Codes

| Code | Short Name |
|---|---|
| AD | Andorra |
| AE | United Arab Emirates |
| AF | Afghanistan |
| AX | Aland Islands / Åland Islands |
| AL | Albania |
| DZ | Algeria |
| AS | American Samoa |
| AD | Andorra |
| AO | Angola |
| AI | Anguilla |
| AQ | Antarctica |
| AG | Antigua and Barbuda |
| AR | Argentina |
| AM | Armenia |
| AW | Aruba |
| AU | Australia |
| AT | Austria |
| AZ | Azerbaijan |
| BS | Bahamas |
| BH | Bahrain |
| BD | Bangladesh |
| BB | Barbados |
| BY | Belarus |
| BE | Belgium |
| BZ | Belize |
| BJ | Benin |
| BM | Bermuda |
| BT | Bhutan |
| BO | Bolivia, Plurinational State of |
| BQ | Bonaire, Sint Eustatius and Saba |
| BA | Bosnia and Herzegovina |
| BW | Botswana |
| BV | Bouvet Island |
| BR | Brazil |
| IO | British Indian Ocean Territory |
| BN | Brunei Darussalam |
| BG | Bulgaria |
| BF | Burkina Faso |
| BI | Burundi |

| Code | Short Name |
|---|---|
| CV | Cabo Verde |
| KH | Cambodia |
| CM | Cameroon |
| CA | Canada |
| KY | Cayman Islands |
| CF | Central African Republic |
| TD | Chad |
| CL | Chile |
| CN | China |
| CX | Christmas Island |
| CC | Cocos (Keeling) Islands |
| CO | Colombia |
| KM | Comoros |
| CG | Congo |
| CD | Congo, the Democratic Republic of the CK |
| CR | Costa Rica |
| CI | Cote d'Ivoire / Côte d'Ivoire |
| HR | Croatia |
| CU | Cuba |
| CW | Curacao / Curaçao |
| CY | Cyprus |
| CZ | Czech Republic |
| DK | Denmark |
| DJ | Djibouti |
| DM | Dominica |
| DO | Dominican Republic |
| EC | Ecuador |
| EG | Egypt |
| SV | El Salvador |
| GQ | Equatorial Guinea |
| ER | Eritrea |
| EE | Estonia |
| ET | Ethiopia |
| FK | Falkland Islands (Malvinas) |
| FO | Faroe Islands |
| FJ | Fiji |
| FI | Finland |
| FR | France |

| Code | Short Name |
|---|---|
| GF | French Guiana |
| PF | French Polynesia |
| TF | French Southern Territories |
| GA | Gabon |
| GM | Gambia |
| GE | Georgia |
| DE | Germany |
| GH | Ghana |
| GI | Gibraltar |
| GR | Greece |
| GL | Greenland |
| GD | Grenada |
| GP | Guadeloupe |
| GU | Guam |
| FM | Micronesia, Federated States of |
| MD | Moldova, Republic of |
| MC | Monaco |
| MN | Mongolia |
| ME | Montenegro |
| MS | Montserrat |
| MA | Morocco |
| MZ | Mozambique |
| MM | Myanmar |
| NA | Namibia |
| NR | Nauru |
| NP | Nepal |
| NL | Netherlands |
| NC | New Caledonia |
| NZ | New Zealand |
| NI | Nicaragua |
| NE | Niger |
| NG | Nigeria |
| NU | Niue |
| NF | Norfolk Island |
| MP | Northern Mariana Islands |
| NO | Norway |
| OM | Oman |
| PK | Pakistan |
| PW | Palau |
| PS | Palestine, State of |
| PA | Panama |
| PG | Papua New Guinea |
| PY | Paraguay |
| PE | Peru |

| Code | Short Name |
|---|---|
| PH | Philippines |
| PN | Pitcairn |
| PL | Poland |
| PT | Portugal |
| PR | Puerto Rico |
| QA | Qatar |
| RE | Reunion! Réunion |
| RO | Romania |
| RU | Russian Federation |
| RW | Rwanda |
| BL | Saint Barthelemy / Saint Barthélemy |
| SH | Saint Helena, Ascension and Tristan da Cunha |
| KN | Saint Kitts and Nevis |
| LC | Saint Lucia |
| MF | Saint Martin (French part) |
| PM | Saint Pierre and Miquelon |
| VC | Saint Vincent and the Grenadines |
| WS | Samoa |
| SM | San Marino |
| ST | Sao Tome and Principe |
| SA | Saudi Arabia |
| SN | Senegal |
| RS | Serbia |
| SC | Seychelles |
| GT | Guatemala |
| GG | Guernsey |
| GN | Guinea |
| GW | Guinea-Bissau |
| GY | Guyana |
| HT | Haiti |
| HM | Heard Island and McDonald Islands |
| VA | Holy See (Vatican City State) |
| HN | Honduras |
| HK | Hong Kong |
| HU | Hungary |
| IS | Iceland |
| IN | India |
| ID | Indonesia |
| IR | Iran, Islamic Republic of |
| IQ | Iraq |
| IE | Ireland |
| IM | Isle of Man |

| Code | Short Name |
|---|---|
| IL | Israel |
| IT | Italy |
| JM | Jamaica |
| JP | Japan |
| JE | Jersey |
| JO | Jordan |
| KZ | Kazakhstan |
| KE | Kenya |
| KI | Kiribati |
| KP | Korea, Democratic People's Republic of |
| KR | Korea, Republic of |
| KW | Kuwait |
| KG | Kyrgyzstan |
| LA | Lao People's Democratic Republic |
| LV | Latvia |
| LB | Lebanon |
| LS | Lesotho |
| LR | Liberia |
| LY | Libya |
| LI | Liechtenstein |
| LT | Lithuania |
| LU | Luxembourg |
| MO | Macao |
| MK | Macedonia, the former Yugoslav Republic of |
| MG | Madagascar |
| MW | Malawi |
| MY | Malaysia |
| MV | Maldives |
| ML | Mali |
| MT | Malta |
| MH | Marshall Islands |
| MQ | Martinique |
| MR | Mauritania |
| MU | Mauritius |
| YT | Mayotte |
| MX | Mexico |
| SL | Sierra Leone |
| SG | Singapore |
| SX | Sint Maarten (Dutch part) |
| SK | Slovakia |
| SI | Slovenia |
| SB | Solomon Islands |
| SO | Somalia |
| ZA | South Africa |
| GS | South Georgia and the South Sandwich Islands |
| SS | South Sudan |
| ES | Spain |
| LK | Sri Lanka |
| SD | Sudan |
| SR | Suriname |
| SJ | Svalbard and Jan Mayen |
| SZ | Swaziland |
| SE | Sweden |
| CH | Switzerland |
| SY | Syrian Arab Republic |
| TW | Taiwan, Province of China |
| TJ | Tajikistan |
| TZ | Tanzania, United Republic of |
| TH | Thailand |
| TL | Timor-Leste |
| TG | Togo |
| TK | Tokelau |
| TO | Tonga |
| TT | Trinidad and Tobago |
| TN | Tunisia |
| TR | Turkey |
| TM | Turkmenistan |
| TC | Turks and Caicos Islands |
| TV | Tuvalu |
| UG | Uganda |
| UA | Ukraine |
| AE | United Arab Emirates |
| GB | United Kingdom |
| US | United States |
| UM | United States Minor Outlying Islands |
| UY | Uruguay |
| UZ | Uzbekistan |
| VU | Vanuatu |
| VE | Venezuela, Bolivarian Republic of |
| VN | Viet Nam |
| VG | Virgin Islands, British |
| VI | Virgin Islands, U.S. |
| WF | Wallis and Futuna |
| EH | Western Sahara |

| Code | Short Name |
|---|---|
| YE | Yemen |
| ZM | Zambia |
| ZW | Zimbabwe |

## 1.2 Two–Letter State and Possession Abbreviations Including Military States

(from USPS.com)

| Abbreviation | State/Possession |
|---|---|
| AL | ALABAMA |
| AK | ALASKA |
| AS | AMERICAN SAMOA |
| AZ | ARIZONA |
| AR | ARKANSAS |
| CA | CALIFORNIA |
| CO | COLORADO |
| CT | CONNECTICUT |
| DE | DELAWARE |
| DC | DISTRICT OF COLUMBIA |
| FM | FEDERATED STATES OF MICRONESIA |
| FL | FLORIDA |
| GA | GEORGIA |
| GU | GUAM |
| HI | HAWAII |
| ID | IDAHO |
| IL | ILLINOIS |
| IN | INDIANA |
| IA | IOWA |
| KS | KANSAS |
| KY | KENTUCKY |
| LA | LOUISIANA |
| ME | MAINE |
| MH | MARSHALL ISLANDS |
| MD | MARYLAND |
| MA | MASSACHUSETTS |
| MI | MICHIGAN |
| MN | MINNESOTA |
| MS | MISSISSIPPI |
| MO | MISSOURI |
| MT | MONTANA |
| NE | NEBRASKA |
| NV | NEVADA |
| NH | NEW HAMPSHIRE |
| NJ | NEW JERSEY |
| NM | NEW MEXICO |
| NY | NEW YORK |
| NC | NORTH CAROLINA |
| ND | NORTH DAKOTA |
| MP | NORTHERN MARIANA ISLANDS |

| Abbreviation | State/Possession |
|---|---|
| OH | OHIO |
| OK | OKLAHOMA |
| OR | OREGON |
| PW | PALAU |
| PA | PENNSYLVANIA |
| PR | PUERTO RICO |
| RI | RHODE ISLAND |
| SC | SOUTH CAROLINA |
| SD | SOUTH DAKOTA |
| TN | TENNESSEE |
| TX | TEXAS |
| UT | UTAH |
| VT | VERMONT |
| VI | VIRGIN ISLANDS |
| VA | VIRGINIA |
| WA | WASHINGTON |
| WV | WEST VIRGINIA |
| WI | WISCONSIN |
| WY | WYOMING |
| **Abbreviation** | **Military "State"** |
| AA | Armed Forces Americas (except Canada) |
| AE | Armed Forces Europe, the Middle East, and Canada |
| AP | Armed Forces Pacific |

## 1.3 Canadian Provinces and Territories

(from USPS.com)

| Abbreviation | Canadian Province/Territory |
|---|---|
| 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 |

# Appendix A2 DEFAULT OR MISSING DATA VALUES

## 2.1 Unknown Patient Address

**If the address of the patient is unknown, use the following:**

| ANSI Loop.Data Segment | Default Code or Information |
|---|---|
| 2010AA or 2310E.N301 (Patient Address Line-1) | Healthcare facility's street address |
| 2010AA or 2310E.N302 (Patient Address Line-2) | "Unknown" |
| 2010AA or 2310E.N401 (Patient City) | Healthcare facility's city |
| 2010AA or 2310E.N402 (Patient State) | TX |
| 2010AA or 2310E.N403 (Patient ZIP) | Healthcare facility's ZIP code |

**If the address of the patient is unknown, and in a Foreign Country (other than Canada), use the following:**

| ANSI Loop.Data Segment | Default Code or Information |
|---|---|
| 2010BA or 2010CA.N402 (Patient State) | FC or XX |
| 2010BA or 2010CA.N403 (Patient ZIP) | "00000" or "XXXXX" |
| 2010BA or 2010CA.N404 (Patient Country) | See appendices for Country Codes |

## 2.2 Unknown Social Security Number

**If an SSN could not be obtained:**

| ANSI Loop.Data Segment | Default Code or Information |
|---|---|
| 2010BA REF02 or 2300.K301 (Patient Social Security Number) | Spaces, or 999999999 (if system requires an entry) |

## 2.3 Unknown Date of Birth

**If a patient's date of birth is not known:**

| ANSI Loop.Data Segment | Default Code or Information |
|---|---|
| 2010CA.DMG02 (Patient Birth Date) | 19010101 = 01/01/1901 |

## 2.4 Unknown ZIP Code

| ANSI Loop.Data Segment | Default Code or Information |
|---|---|
| 2010BA or 2010CA.N403 (Patient ZIP) | XXXXX OR 00000 |

## 2.5 Temporary Licenses

**If a practitioner does not have a state license, use the following:**

| ANSI Loop.Data Segment | Default Code or Information |
|---|---|
| **INPATIENT CLAIMS DATA**<br>2310A or 2310B. NM109 (NPI) or REF02 (State License) Physicians, respectively) (Attending or Operating | TXTEMP OTHnnn<br>RESnnn or TEMPnn<br>Where "n" = a number (0-9) assigned by the healthcare facility |
| **OUTPATIENT CLAIMS DATA**<br>**INST**. – 2310B or 2310C. NM109 (NPI) or REF02 (State License) Operating Physicians or Other Operating Physicians | TXTEMP OTHnnn<br>RESnnn or TEMPnn<br>Where "n" = a number (0-9) assigned by the healthcare facility |
| **OUTPATIENT CLAIMS DATA**<br>**PROF**. - 2310B or 2420A NM109 (NPI) or REF02 (State License) (Rendering Physicians 1 or 2 respectively | TXTEMP OTHnnn<br>RESnnn or TEMPnn<br>Where "n" = a number (0-9) assigned by the healthcare facility |

## 2.6 Alcohol, Drug Use or HIV Conditions

**Patients covered by 42 USC 290dd-2 or 42 CFR Part 2.1**

If a patient has an alcohol or drug use or HIV condition, the following mask must be applied to protect the identity of the patient:

| Data Element | Loop | Data Element | Action and Default Value |
|---|---|---|---|
| Patient Control Number | 2300 | CLM01 | Retain. Unique to institution and episode of care. Will be used by healthcare facility to review and certify data. This data element is not included in the public use data file. |
| Patient Last Name | 2010BA or 2010CA | NM103 | Remove. Replace with "Doe" |
| Patient First Name | 2010BA or 2010CA | NM104 | Remove. Replace with "Jane" if female, or "John" if male, can include a sequential number, e.g., John1, John2, John3. |
| Patient Middle Initial | 2010BA or 2010CA | NM105 | Remove. Leave blank. |
| Patient Date of Birth | 2010BA or 2010CA | DMG02 | Retain. DOB will not be provided in the public use data file and it will be transformed to age (in years). |
| Patient Address | 2010BA or 2010CA | N301 | Remove. Replace with healthcare facility street address. |
| Patient City | 2010BA or 2010CA | N401 | Retain. |

| Data Element | Loop | Data Element | Action and Default Value |
|---|---|---|---|
| Patient State | 2010BA or 2010CA | N402 | Retain. |
| Patient Zip Code | 2010BA or 2010CA | N403 | Retain. |
| Patient Country Code | 2010CA | N404 | Retain. |
| Medical Record Number | 2300 | REF02 | Remove. Replace with 99999. |
| Patient SSN | 2010BA or 2300 | REF02, K301 | Remove. Replace with default value of 999999999. |

Records submitted for substance abuse patients containing personal identifiers should include the specified default values in the identifier fields. The healthcare facility patient control number is normally considered to be a personal identifier. However, in order to provide a means to correct records that do not pass THCIC audits, we are requesting that the patient control number be submitted with each record in the healthcare facility's data.

# Appendix A3 RACE AND ETHNICITY QUESTIONNAIRE DOCUMENTS

The Department of State Health Services has created two documents (in English and Spanish) that healthcare facility staff can use to obtain the ethnicity and race information required to be collected on healthcare facility inpatients and outpatients by Texas State law Chapter 108, Texas Health & Safety Code and administrative rules found at Title 25 Texas Administrative Code, Chapter 421, Rule 421.9 (C) 1 and 2 or Title 25 Texas Administrative Code, Chapter 421, Rule 421.67 (C) 1 and 2. The rules specify that the patient should self-report and that if the patient cannot (for example, comatose, severely injured, or died shortly after admission) or refuses, the healthcare facility staff shall use their best judgment to identify the patient's ethnic and racial background.

An instruction sheet follows this page that the healthcare facility may provide to its personnel to use as a guide for administering collection of this information, after which are English and Spanish versions of the questions to be presented to the patient (pages 14 and 15). Use of these documents is optional, though the collection and submission of the data is required; the healthcare facility can modify the documents' formatting but not the content. Also, you may translate the document into other languages, as appropriate.

If you have questions regarding this document and the requirements, please contact

**THCIC at (512) 776-7261 or Email THCICHelp@dshs.texas.gov.**

# Instructions For State Ethnicity and Race Questionnaire

## For collecting and reporting patient Ethnicity and Race to the THCIC System

**RECOMMENDED PROCEDURE**

I. Present Questionnaire to the patient, parents or the legal guardian of the patient and say, "The State of Texas requires healthcare facilities to provide this information to the state".

If a patient, parent, or legal guardian of the patient asks "Why?", then tell them that is required by state law. You can then choose to either read aloud or refer them to the top of the page under "Background Information".

II. If the patient is unable to read, a person elected by the patient or healthcare facility personnel should read the questions to the patient and record the responses.

III. If the patient refuses or cannot respond to the question (for example, comatose, severely injured, deceased), healthcare facility personnel should select the most appropriate choice in their own opinion (with available information) in the Ethnicity and Race categories.

A. If the **Ethnicity** choice cannot be determined by appearance or last name, mark the patient as "non-Hispanic".

B. If the **Race** choice cannot be determined by appearance or last name, mark the patient as "Other".

**Note:** Hispanic patients should be marked "White" for their race unless there is evidence they are of a different race (Black, Asian or Pacific Islander, or American Indian/Eskimo/Aleut). For example, many persons from the Caribbean Islands such as the Dominican Republic are of a "Hispanic" ethnicity and "Black" race.

# State Required Ethnicity and Race Questions

## BACKGROUND INFORMATION

Texas law requires the Department of State Health Services to collect information on the race and ethnic backgrounds of hospital, ambulatory surgery center, and freestanding emergency medical care facility patients. The rules state "In order to obtain this data, the facility staff retrieves the patient's response from a written form or asks the patient, or the person speaking for the patient to classify the patient. If the patient, or person speaking for the patient, declines to answer, the facility staff is to use its best judgment to make the correct classification based on available data."

**The data obtained through this process will be used to assist researchers in determining whether all citizens of Texas have access to cost-effective, good quality health care.**

If patients fail to identify their own race and ethnic backgrounds, healthcare facility staff will use its best judgment in making the identification.

## QUESTIONS

**Question #1: Ethnic Background**
Mark the box that the patient believes most accurately identifies his/her **ethnic** background.

**Is the patient . . .?**

- ❑ **(1) Hispanic/Latino**
- ❑ **(2) Not Hispanic/Latino**

**Question #2: Race**
Mark the box that the patient believes most accurately identifies his/her **race**.

**Is the patient . . .?**

- ❑ **(1) American Indian/Eskimo/Aleut**
- ❑ **(2) Asian or Pacific Islander**
- ❑ **(3) Black**
- ❑ **(4) White**
- ❑ **(5) Other** Includes: all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category.

# Preguntas Sobre El Origen Étnico y La Raza Exigidas Por El Estado

## EL CONTEXTO

La ley de Texas exige al Departamento Estatal de Servicios de Salud de Texas que reúna información sobre la raza y el origen étnico de los pacientes de hospitales, centros de cirugia ambulatorial, o de centros independientes de atención médica de emergencia. El reglamento establece que "Para obtener dichos datos, el personal del centro recupera la respuesta del paciente de un formulario escrito o le pregunta al paciente o le pide a la persona que habla por el paciente que clasifique al paciente. Si el paciente o la persona que habla por el paciente se rehúsa a contestar, el personal del centro ha de, a su mejor juicio, hacer la clasificación correcta basada en los datos disponibles".

Los datos obtenidos mediante este proceso se usarán para ayudar a que los investigadores determinen si todos los ciudadanos de Texas tienen acceso a atención médica de buena calidad a costo efectivo.

Si los pacientes no identifican su propia raza y origen étnico, el personal del centro de salud hará la identificación, a su mejor juicio.

## PREGUNTAS

**Pregunta #1: Origen étnico**
Marque la casilla que el paciente cree que más fielmente identifica su **origen étnico**.

**¿Qué es el paciente?**

- ❑ **(1) Hispano/latino**
- ❑ **(2) No es hispano/latino**

**Pregunta #2: Raza**
Marque la casilla que el paciente cree que más fielmente identifica su **raza**.

**¿Qué es el paciente?**

- ❑ **(1) Indio americano, esquimal o aleutiano**
- ❑ **(2) Asiático o isleño del Pacífico**
- ❑ **(3) Negro**
- ❑ **(4) Blanco**
- ❑ **(5) Otro.** Se incluyen todas las otras respuestas no listadas arriba. Los pacientes que se consideran a sí mismos multirraciales o mixtos deben elegir esta categoría.

# Appendix A4 REVENUE CODE GROUPINGS FOR PUDF

Codes are a subset of the list from the Centers for Medicare and Medicaid's "EXPANDED MODIFIED MEDICARE PROVIDER ANALYSIS AND REVIEW (MEDPAR) RECORD -- FROM CMS DATA DICTIONARY"

| | Category | Type | Revenue Codes |
|---|---|---|---|
| 1 | Accommodation | Private Room Days & Charges | 011x, 014x |
| 2 | Accommodation | Semi-private Room Days & Charges | 010x, 012x, 013x, 016x, 017x, 018x, 019x |
| 3 | Accommodation | Ward Days & Charges | 015x |
| 4 | Accommodation | Intensive Care Days & Charges | 020x |
| 5 | Accommodation | Coronary Care Days & Charges | 021x |
| 1 | Ancillary | Other Charges | 0002-0099, 022x, 023x, 024x, 052x, 053x, 055x, 056x, 057x, 058x, 059x, 060x, 064x, 065x, 066x, 067x, 068x, 069x, 070x, 076x, 077x, 078x, 090x, 091x, 092x, 093x, 094x, 095x, 099x, 210x, 310x |
| 2 | Ancillary | Pharmacy Charges | 025x, 026x, 063x |
| 3 | Ancillary | Medical/Surgical Supply Charges | 027x, 062x |
| 4 | Ancillary | Durable Medical Equipment Charges | 0290, 0291, 0292, 0294-0299 |
| 5 | Ancillary | Used Durable Medical Equipment Charges | 0293 |
| 6 | Ancillary | Physical Therapy Charges | 042x |
| 7 | Ancillary | Occupational Therapy Charges | 043x |
| 8 | Ancillary | Speech Pathology Charges | 044x, 047x |
| 9 | Ancillary | Inhalation Therapy Charges | 041x, 046x |
| 10 | Ancillary | Blood Charges | 038x |
| 11 | Ancillary | Blood Administration Charges | 039x |
| 12 | Ancillary | Operating Room Charges | 036x, 071x, 072x |
| 13 | Ancillary | Lithotripsy Charges | 079x |
| 14 | Ancillary | Cardiology Charges | 048x, 073x |
| 15 | Ancillary | Anesthesia Charges | 037x |
| 16 | Ancillary | Laboratory Charges | 030x, 031x, 074x, 075x, |
| 17 | Ancillary | Radiology Charges | 028x, 032x, 033x, 034x, 035x, 040x |
| 18 | Ancillary | MRI Charges | 061x |
| 19 | Ancillary | Outpatient Services Charges | 049x, 050x |
| 20 | Ancillary | Emergency Room Charges | 045x |
| 21 | Ancillary | Ambulance Charges | 054x |
| 22 | Ancillary | Professional Fees Charges | 096x, 097x, 098x |
| 23 | Ancillary | Organ Acquisition Charges | 081x, 089x |
| 24 | Ancillary | ESRD Revenue Setting Charges | 080x, 082x, 083x, 084x, 085x, 086x, 087x, 088x |

| | Category | Type | Revenue Codes |
|---|---|---|---|
| 25 | Ancillary | Clinic Visit Charges | 051x |

# Appendix A5 INPATIENT & OUTPATIENT AUDIT ID'S

## 5.1 Table A Pre-Processing Audits (Format Check)

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ001 - Missing/Invalid ISA Interchange Control Header Segment. | RJ001 - The first three characters in all 837 files are 'ISA'. This file does not start with 'ISA'. Our system has stopped processing this file. |
| RJ002 - ISA06 (Interchange Sender ID) contains invalid Submitter _ID='SUB999'. | RJ002 - Submitter Id's are six characters long, begin with 'SUB', and are followed by three numbers (e.g. SUB999). Do not put 'TH' in front of your Submitter Id. THSUB999 is a login, SUB999 is a Submitter Id. |
| RJ003 - ISA08 (Interchange Receiver ID) must = YTH837 or YTHCIC. | RJ003 - The 8th element of the ISA segment (ISA08) holds the receiver id. This must be either 'YTH837' or 'YTHCIC'. It identifies the intended recipient of this transmission. |
| RJ004 - ISA13 (Interchange Control Number) must be > zero. | RJ004 - The 13th element of the ISA segment (ISA13) must contain a non-zero control number. This 'Interchange Control Number' is assigned by the sender and it must match the same number in the IEA02 data element at the end of the data interchange. |
| RJ005 - ISA15 (Usage Indicator) must be a 'P' or 'T'. Your file has '?'. | RJ005 - The test/Production (T/P) indicator must be in the 103rd position in the ISA segment (first line in the file). The ISA segment must be 106 characters long. This error can occur when the ISA segment is edited directly. |
| RJ006 - Data Element Separator is blank or not distinct value. Your file has '?'. | RJ006 - The 'data element separator' is read from the 4th position of the ISA segment (first line in the file). It separates all pieces of data in every segment for the rest of the file. It must be distinct and non-blank. |
| RJ007 - Component Element Separator blank or not distinct value. Your file has '?'. | RJ007 - The 'component element separator' is read from the 105th position of the ISA segment (first line in the file). It is used to parse out fields containing related data. It must be distinct and non-blank. |
| RJ008 – Segment Terminator is blank, missing, or not a distinct value. | RJ008 - The 'segment terminator' is read from the 106th position of the ISA segment (first line in the file). It indicates the end of a data segment. It must be distinct and non-blank. This error can occur when the ISA segment is edited directly. The ISA segment MUST BE 106 characters long. |

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ009 - Data Element Separator, Component Element Separator, and Segment Terminator are not distinct values. | RJ009 - The 'data element separator', the 'component element separator', and the 'segment terminator' tell our software how to locate and break apart all the remaining information in the rest of the file. They must be distinct values. |
| RJ010 - Missing Functional Group Header (GS Segment). | RJ010 - The GS (group start) segment is missing. This segment follows an ISA segment in a valid 837 submission file. It signifies the start of a group of claims. |
| RJ011 - GS06 (Group Control Number) must be > zero. | RJ011 - GS06 (group control number) is a number at the start and end of every group of claim data. This number must not be zero. |
| RJ012 - GS08 (Ver/Rel/Ind Code=?????) not valid | RJ012 - The 8th element of the GS segment (GS08) is supposed to be an 837 format version number. Your file has an invalid value in this data field |
| RJ013 - Missing Transaction Set Header (ST Segment). | RJ013 - The ST (start of transaction) segment is missing. This segment follows the GS segment and signifies the beginning of a transaction set. |
| RJ014 - ST01 (Transaction Set Identifier Code) is not '837'. | RJ014 - The 1st element of the ST segment (ST01) must be '837'. |
| RJ015 - ST02 (Transaction Set Control Number) is blank. | RJ015 - The 2nd element in the ST segment (ST02) must contain a control number. It cannot be blank, and it must match the control number later in the file in segment SE02. |
| RJ016 - Missing BHT segment (Beginning of Hierarchical Transaction). | RJ016 - The BHT segment is the 4th segment in an 837 file. It signifies the beginning of a hierarchical transaction set. |
| RJ017 - BHT03 (Reference Identification) is blank. | RJ017 - The 3rd element of the BHT segment (BHT03) is designed to contain Reference Identification information assigned by your system. This gives you a way to record transaction sets. This element cannot be blank. |
| RJ018 - BHT04 Transaction Set Creation Date not valid. Your file has '??/??/????'. Format should be YYYYMMDD. | RJ018 - The 4th element of the BHT segment (BHT04) must contain a valid date. This data element is defined as the transaction set creation date. |
| RJ019 - Missing/invalid Billing/Pay-To Hierarchical Level Segment (HL03 = '20'). | RJ019 - The hierarchical structure (HL segments) of every 837 file is validated. Our system looks for correct relationships between 'parent' and 'child' HL segments. Your file has a subscriber HL segment that does not point to a billing parent HL segment. |

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ020 - Billing/Pay-To Hierarchical ID Number (HL01) not greater than Previous Hierarchical ID Number. | RJ020 - The hierarchical structure (HL segments) of every 837 file is validated. The id number of every HL billing segment must be greater than the preceding HL segment id number. |
| RJ021 - Billing/Pay-To Hierarchical Child Code (HL04) not = 1. | RJ021 - The hierarchical structure (HL segments) of every 837 file is validated. For HL billing segments the 4th element (HL04) must = 1. |
| RJ022 - Missing Subscriber Hierarchical Level Segment. | RJ022 - The hierarchical structure (HL segments) of every 837 file is validated. Our system looks for correct relationships between 'parent' and 'child' HL segments. In this case, a child HL record does not point to its parent HL record. |
| RJ023 - Subscriber Hierarchical ID Number (HL01) not greater than Previous Hierarchical ID Number. | RJ023 - The hierarchical structure (HL segments) of every 837 file is validated. The id number of every HL subscriber segment must be greater than the preceding HL segment id number. |
| RJ024 - Subscriber Hierarchical Parent ID Number (HL02) not less than Subscriber Hierarchical ID Number (HL01). | RJ024 - The hierarchical structure (HL segments) of every 837 file is validated. The parent id points to a previous HL segment. This parent id therefore must always be less than the current HL segment id. |
| RJ025 - Missing Patient Hierarchical Level Segment. | RJ025 - The subscriber HL segment will indicate if a patient HL segment comes next. This error is triggered when no following patient HL segment is found. |
| RJ026 - Patient Hierarchical ID Number(HL01) not greater than Previous Hierarchical ID | RJ026 - The hierarchical structure (HL segments) of every 837 file is validated. The id number of every HL patient segment must be greater than the preceding HL segment id number. |
| RJ027 - Patient Hierarchical Parent ID Number (HL02) not less than Patient Hierarchical ID Number (HL01). | RJ027 - The hierarchical structure (HL segments) of every 837 file is validated. The parent id points to a previous HL segment. This parent id therefore must always be less than the current HL segment id. |
| RJ028 - Missing Transaction Set Trailer (SE Segment). | RJ028 - The SE (end of transaction) segment is missing. All transaction sets must begin with an ST segment and end with an SE segment. |

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ029 - Value (SE01=???) not equal num of segments counted in Transaction Set (actual cnt ST thru SE=???). | RJ029 - 837 submission files keep a count of how many segments (data lines) are within each transaction set. Transaction sets start with an ST segment and end with an SE segment. The SE segment contains the count of all segments in the group. This count does not match the actual count in your file. This error commonly occurs after manually editing an 837 file because the segment count is no longer accurate after lines have been added or deleted. |
| RJ030 - SE02 (Transaction Set Control Number) not equal to segment ST02 (Transaction Set Control Number). | RJ030 - The 2nd element of the SE segment (SE02, transaction set end) contains a control number that must match the same number in the 2nd element of the preceding ST segment (ST02, transaction set start). |
| RJ031 - Missing Functional Group Trailer (GE Segment). | RJ031 - The GE (group end) segment is missing. GS and GE segments are used to signify the start and end of functional groups in 837 files. |
| RJ032 - Value (GE01=???) not equal number of transaction sets included in Functional Group (actual count=???). | RJ032 - 837 submission files keep a count of how many transaction sets (ST segments) are within each functional group. This count is reported in the 1st element of the GE segment (GE01). This count does not match the actual count of ST segments in your file. |
| RJ033 - GS06 (Group Control Number=?) value not equal segment GE02 (Group Control Number=?) Value. | RJ033 - Claims are grouped inside 'starting' and 'ending' segments. A group control number is assigned to each group of claims. This control number is inserted in the GS (group start) and GE (group end) segments. In your submission file these control numbers do not match each other. |
| RJ034 - Missing Interchange Control Trailer (IEA Segment). | RJ034 - The IEA segment is the last data segment found in an interchange of 837 claim data. It is missing in your file. Check to ensure your transmission was not truncated or terminated incorrectly. |
| RJ035 - Value (IEA01=?) not equal number of Functional Groups included in Interchange (actual count=?). | RJ035 - The IEA segment (interchange control trailer) signifies the end of an interchange of data. The 1st element (IEA01) contains a count of the number of functional groups (GS segments) within the interchange. This count is incorrect in your file. |

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ036 - IEA02 (Interchange Ctrl Number=?) value not equal ISA13 (Interchange Control Number=?) value. | RJ036 - 837 files contain a control number for validation of interchange transmissions. This control number appears at the start (ISA segment) and end (IEA segment) of each interchange transmission. In your submission file these control numbers do not match each other. |
| RJ037 - Primary Subscriber is self-pay, but no claim present. | RJ037 - We did not find a CLM (claim) segment after an SBR (subscriber) segment that indicated the claim was self-pay. |
| RJ038 - Subscriber Claim is present, but Subscriber is NOT the Primary Subscriber | RJ038 - Your file contains a claim where the first insurance payer is not flagged as the primary subscriber to insurance. This audit is designed to ensure that THCIC receives primary (not secondary or tertiary) claims. The PCN (patient control number) is located in the CLM segment that can be found in the current HL block referenced above. |
| RJ039 - Invalid Relationship code in Subscriber Segment. | RJ039 - The 2nd element of the SBR (subscriber) segment is invalid. This element holds the 'Patient Relationship to Insured' value. If the patient is the subscriber, then SBR02 must = '18'. Otherwise it must be blank. |
| RJ040 - Subscriber is not the Patient, but the Subscriber Hierarchical Child Code (HL04) NOT = 1. | RJ040 - The 'Patient Relationship to Insured' value from segment SBR02 is blank, meaning that the subscriber is not the patient.<br>In this case, a separate patient HL (hierarchical level) section is anticipated. This patient HL section has not been found. If the patient is the insured, then the SBR02 must = '18'. If the patient is not the insured, then you must insert the missing patient claim HL section. |
| RJ041 - Element REF*1J (THCIC_ID=999999) lookup validation on this Provider Id failed. | RJ041 - The THCIC provider id is located in segment REF*1J. This error is triggered when a REF*1J has an invalid provider id, or has no provider id, or when there are no REF*1J segments found in an ST-SE block. The provider id is a six-digit number assigned by THCIC. |
| RJ042 - Element NM109, provider NPI num validation failed.<br>Your #: ??????????<br>Our #: ?????????? | RJ042 - The 9th element of the NM1 segment (NM109) contains the NPI number. The NPI number in your submission file does not match our internal records. |

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ043 - Element N3 (street addr) validation on provider failed.<br>Your addr:???<br>Our addr: ???<br>(1st 15 characters only) | RJ043 - The street address is found in the N3 segment. The first fifteen characters of the provider street address in your file do not match the first 15 characters (see above) in our internal records. |
| RJ044 - More than one Payer Name Segment for Primary Subscriber. | RJ044 - There is more than one NM1 (payer name) segment associated with a primary subscriber (SBR) segment. |
| RJ045 - More than one Payer Name Segment for Secondary Subscriber. | RJ045 - There is more than one NM1 (payer name) segment associated with a secondary subscriber (SBR) segment. |
| RJ046 - Submitter ID mismatch in ISA06and NM109 Segments. | RJ046 - The submitter id is repeated in three places in your file:<br>1. ISA06 (6th element of the ISA segment)<br>2. GS02 (2nd element of the GS segment)<br>3. NM109 (9th element of the NM1*41 segment) The submitter id is either missing from the NM1, or it is not the 9th field. |
| RJ047 - Number of LX Service Line Segments exceed the maximum 999 threshold. | RJ047 - Institutional claims cannot include more than 999 service lines (charges) in a claim, and professional claims cannot include more than 50 service lines. The PCN (patient control number) is located in the CLM segment. To find the PCN, locate the segment causing the error and search backward to find the CLM segment. |
| RJ049 - First character in segment must be alphanumeric. | RJ049 - All data segments start with a 2-3 letter acronym indicating what type of data follows, and end with the 'segment terminator' located and read from position 106 of the ISA line (first line). All data segments must start with an alpha character. |
| RJ050 - The first five characters of all GS08 elements must match the first five characters in the ISA12 element. | RJ050 - The 8th element of the GS segment (GS08) and 12th element of the ISA segment (ISA12) hold the interchange version number. The first five characters of these two locations must match. |

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ051 - The 837 file format Version 4010 is not allowed after June 30, 2012. This file is rejected | RJ051 - 4010 is an older version of the 837 electronic formats. It is no longer allowed. You must contact your software vendor to discuss how to get your system to create 837 files in the 5010 format version. |
| RJ052 - Element REF*EI, provider EIN num. validation failed.<br>Your #: ?????????<br>Our #: ????????? | RJ052 - The 2nd element of the REF*EI segment contains the EIN number. The provider EIN number in your submission file does not match our internal records. |
| RJ053 - Too many claims for test submission. You must limit test submissions to 1000 claims or less. | RJ053 - THCIC/System13 requires test submissions to be no greater than 1000 claims. This limit does not apply to production data. |
| RJ054 - Provider 999999 is listed as 'Inactive' by THCIC. | RJ054 - THCIC's records for this facility show it is listed as inactive. Contact THCIC directly to discuss this issue: (512) -776-7261 |
| RJ055 - Logged in Submitter Id=SUB999 does not match the ISA06 Submitter Id=SUB??? | RJ055 - The 6th element of the ISA segment (ISA06) is the submitter id. The submitter id for your login account does not match the submitter id indicated by your upload file in location ISA06. |
| RJ056 - Bad character found in segment, position number nnn. | RJ056 - Non-ASCII characters are not allowed in 837 transmission files. This may be a binary file, or a bad character may be in your claim data. You can find the PCN (patient control number) by looking in your submission file for the 'CLM' segment preceding the bad character. |
| RJ057 – Un-Zip failed. Zip file corrupted or password protected. | RJ057 - System13 only accepts compressed files in '.zip' or '.gz' format, without a password. |
| RJ058 - Line item error. A line item number (charge) was skipped. | RJ058 - The service lines (charges) must begin with line number 1 and must be sequential throughout the claim. Charge line numbers are stored in the 1st field of the LX segment (LX01). |

| Audit MSG. ID. - Message | Audit Description |
|---|---|
| RJ059 - [SV2/SV1] service line incompatible with version number for [inst./prof] claims (your claims (your ver. #=??????????). | RJ059 - Institutional version claims transmit service lines using 'SV2' segments. Professional version claims transmit services lines using 'SV1' segments. The service lines in your file are not formatted in accordance with the 'Inst/Prof' version number indicated in the GS segment. The version number is in the 8th field of the GS segment (GS08). |
| RJ060 - Facility not ASC, Institutional 5010 version format required | The facility is not an ASC. The institutional format (005010X223A2) is required.<br>If Provider table: Facility Type <> "ASC" and <> "Dental ASC" then GS08 must = 005010X223A2 |
| RJ061 - SBR (subscriber) segment missing in HL (hierarchical level). | RJ061 - The Subscriber SBR segment is required in order to properly identify the patient. The SBR segment (along with its associated fields) normally appears immediately after an HL (hierarchical level) segment. |
| RJ062 - Wrong ICD qualifier detected within DX, PX, or E-codes. | RJ062 - Wrong ICD qualifier detected within DX, PX, or E-codes. The claim contains ICD [9/10] version qualifiers.<br><br>Claims with statement thru date of 10/1/2015 and later MUST REPORT all Diagnosis (DX), Procedure (PX), and E-codes using the ICD-10 version of codes AND QUALIFIERS.<br><br>· ICD-10 DX qualifiers: ABK, ABJ, ABF, APR<br>· ICD-10 PX qualifiers: BBR, BBQ<br>· ICD-10 Ecode qualifier: ABN |
| RJ063 - The required K3 data segment is missing. | RJ063 - Effective January 1st, 2020, the K3 data segment is required on every claim and used to report patient race and ethnicity. It is conditionally used to report social security number for claims where the patient is not the subscriber. Your submission file generation software needs to be modified to reflect this change in requirements. |
| RJ064 - The K301 data element is an invalid length. | RJ064 - Effective January 1st, 2020, the K3 data segment should conditionally contain race, ethnicity, and social security number. If the patient is the subscriber, the K301 data element must be 2 characters long to contain race and ethnicity. In that scenario, social security number is required on the REF*SY data segment. Otherwise, if the patient is not the subscriber, the K301 data element must be 11 characters long to contain race, ethnicity, and social security number. Your submission file generation software needs to be modified to reflect this change in requirements. |

## 5.2 Table B Claim Level Audits

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **600** | **I** | Missing Principal Procedure Date | If the Principal Procedure exists, the Principal Procedure Date must exist and contain a valid date of the format ccyymmdd. | Error |
| **601** | **I** | Principal Procedure not reported when Other Procedure(s) reported | The Principal Procedure is not reported, is blank or contains zeroes and Other Procedure(s) are reported. | Error |
| **602** | **I** | Invalid Principal Procedure | The Principal Procedure field does not contain a valid ICD, CPT or HCPCS code. The Principal Procedure code must be valid for the time period covering the discharge date. | Error |
| **603** | **I, Out/I, Out/P** | Duplicate Diagnosis Codes | The same ICD diagnosis code is reported more than once on the same claim. | Error |
| **604** | **I, Out/I, Out/P** | Patient Gender not consistent with Other Diagnosis | The Gender of the patient does not agree with a gender specific Other Diagnosis. | Error |
| **605** | **I, Out/I, Out/P** | Invalid Other Diagnosis | If reported, the Other Diagnosis Code field must contain a valid ICD code. | Error |
| **606** | **I, Out/I, Out/P** | Invalid E-Code | If an E-Code field is reported, it must contain a valid value. | Error |
| **607** | **I, Out/I, Out/P** | Invalid Principal Diagnosis | Principal Diagnosis is a required field and must contain a valid ICD code. | Error |
| **608** | **I, Out/I, Out/P** | Missing Principal Diagnosis | Principal Diagnosis is a required field. | Error |
| **609** | **I** | Invalid Principal Procedure Date | If the Principal Procedure exists, the Principal Procedure Date must contain a valid date of the format ccyymmdd. | Error |
| **610** | **I, Out/I, Out/P** | Duplicate E-Codes | The same ICD E-code value is reported more than once in the same record. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **612** | **I** | Principal Procedure Date before 1971 | The Principal Procedure Date field must contain a date after 1970. | Error |
| **613** | **I, Out/I** | Invalid Value Code | The Value Code field does not contain a valid NUBC code value. | Error |
| **614** | **I, Out/I** | Invalid Occurrence Span Code | If reported, the Occurrence Span Code field must contain a valid NUBC code value. | Error |
| **615** | **I** | Invalid Admitting Diagnosis | Admitting Diagnosis is a required field and must contain a valid ICD code. | Error |
| **616** | **I** | Age > 1 day and Principal Diagnosis = newborn before admission | The age, at admission, of an infant not born in the hospital, is greater than 1 day. | Warning |
| **617** | **I** | Other Procedure Date earlier than three days before Admission Date or after Statement Thru Date | The Other Procedure Date must be on or after the third day before Admission Date and on or before the Statement Thru Date. | Error |
| **618** | **I** | Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date. | The Principal Procedure Date must be on or after the third day before the Admission Date and on or before the Statement Thru Date. | Error |
| **619** | **I** | Other Procedure Date before 1971 | The Other Procedure Date field must contain a date after 1970. | Error |
| **620** | **I** | Invalid Other Procedure Date | The Other Procedure Date field must contain a valid date of the format ccyymmdd. | Error |
| **621** | **I** | Procedure Date missing for Other Procedure | An Other Procedure Date is required when a corresponding Other Procedure is present. | Error |
| **622** | **I** | Patient Gender not consistent with Other Procedure | Patient Gender is not consistent with a gender related Other Procedure. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **623** | **I** | Invalid Other Procedure | If reported, an Other Procedure field must contain valid ICD, CPT or HCPCS code. The Other Procedure code also must be valid for the discharge date of the claim. | Error |
| **624** | **I, Out/I** | Invalid Condition Code | The Condition Code field must contain a valid NUBC code value. | Error |
| **625** | **I, Out/I, Out/P** | Patient Gender not consistent with the Principal Diagnosis | The patient Gender does not agree with a gender specific Principal Diagnosis. | Error |
| **626** | **I, Out/I, Out/P** | Missing Patient State | The Patient State field is required. | Error |
| **627** | **I, Out/I, Out/P** | Missing Patient ZIP | The ZIP code of the patient address is a required field. | Error |
| **628** | **I, Out/I, Out/P** | Invalid Patient Country | The Patient Country field of the patient address contains an invalid value. | Error |
| **629** | **I, Out/I, Out/P** | Missing Patient Country | The Patient State indicates a foreign country but the Country field of the patient address is invalid or missing. The Country is required when a patient's address is not in the US or a US territory. | Error |
| **630** | **I, Out/I, Out/P** | Missing Patient Birth Date | Patient Birth Date is a required field and must contain a valid date of format ccyymmdd. | Error |
| **631** | **I, Out/I, Out/P** | Patient age > 115 years or < zero years | The value in the Patient Birth Date field indicates that the patient is older than 115 years or has not yet been born. | Error |
| **632** | **I** | Patient Birth Date > Admission Date and Admission Type not newborn | The patient's Birth Date is after the Admission Date but the Admission Type is not for a newborn (4). The patient Birth Date cannot be later than the Admission Date, unless the Admission Type is newborn. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **633** | **I, Out/I, Out/P** | Missing Patient Gender | Patient Gender is a required field and must contain M, F or U. | Error |
| **634** | **I, Out/I, Out/P** | Missing Patient Race | Patient Race is a required field. | Error |
| **635** | **I, Out/I, Out/P** | Missing Patient Ethnicity | Patient Ethnicity is a required field and must contain 1 or 2. | Error |
| **636** | **I, Out/I, Out/P** | Patient SSN not 9 numeric characters | Patient Social Security Number is a required field and must contain 9 numeric characters. | Error |
| **637** | **I, Out/I, Out/P** | Invalid Patient SSN | The Patient Social Security Number field contains a number that is not the confidentiality default (999999999) and is not a valid number recognized by the Social Security Administration. | Error |
| **638** | **I, Out/I, Out/P** | Missing Patient Medical Record Number | The Medical Record Number field is required and cannot contain spaces or all zeroes. | Error |
| **639** | **I, Out/I, Out/P** | Missing Facility Type Code | Facility Type Code field is required field. The Facility Type Code is the first two characters of the claim's bill type. | Error |
| **640** | **I, Out/I, Out/P** | Missing Claim Frequency Type Code | Claim Frequency Type Code is a required field. The Claim Frequency Type Code is the third character of the claim's bill type. | Error |
| **641** | **I** | Statement From Date after Statement Thru Date | The Statement From Date must be on or before the Statement Thru Date. | Error |
| **641** | **Out/I** | Statement From Date after Statement Thru Date | If Statement Date Range submitted the Statement From Date must be on or before the Statement Thru Date. | Error |
| **642** | **I** | Statement From Date before Patient Birth Date | The Statement From Date must be on or after the Patient Birth Date. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **642** | **Out/I** | Statement From Date before Patient Birth Date | If Statement Date Range submitted the Statement From Date must be on or after the Patient Birth Date. | Error |
| **643** | **I** | Admission Date before 1971 | The patient Admission Date must be after 1970. | Error |
| **644** | **I** | Admission Date after Statement Thru Date | The patient Admission Date must be on or before the Statement Thru Date. | Error |
| **645** | **I** | Missing Admission Type | Admission Type field is required. | Error |
| **646** | **I** | Missing Point of Origin (Admission Source) | Point of Origin (Admission Source) is a required field. | Error |
| **646** | **Out/ED** | Missing Point of Origin (Admission Source) | Point of Origin (Admission Source) is a required field for ED claims. | Error |
| **647** | **I** | Missing Patient Discharge Status | Patient Discharge Status is a required field. | Error |
| **647** | **Out/ED** | Missing Patient Discharge Status | Patient Discharge Status is a required field for ED claims. | Error |
| **648** | **I** | Missing Admitting Diagnosis | Admitting Diagnosis is a required field. | Error |
| **649** | **I, Out/I** | Invalid Occurrence Code | If an Occurrence Code field exists, the field must contain a valid NUBC value. | Error |
| **650** | **I** | Date of Birth not = Admission Date and Admission Type = Newborn | The Patient Birth Date is not equal to the Admission Date yet the Admission Type is newborn. | Warning |
| **651** | **I** | Newborn with birth date not within 3 days (+/-) of the Admission Date and newborn diagnosis present | If the Admission Type indicates a newborn, then the Date of Birth must be within 3 days of the Admission Date and a newborn Diagnosis must be present. | Error |
| **652** | **I** | Admission Type = Newborn and Principal Diagnosis Not = Newborn | The Admission Type code indicates newborn, but the Principal Diagnosis is not for a newborn. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **653** | **I** | Patient Birth Date Not = Admission Date and (Principal Diagnosis = Newborn or Admission Type = Newborn) | The Principal Diagnosis or the Admission Type indicates newborn in this hospital, but the Patient Birth Date and Admission Date are not the same. | Warning |
| **654** | **I** | Missing 019x Revenue Code for Bill Type 17x. Will expire 10/1/05. | If Bill Type 17x is reported, then one Revenue Code field must contain 019x. | Error |
| **655** | **I, Out/I** | Invalid Point of Origin (Admission Source) | The Point of Origin (Admission Source) Code must contain one of the following values: 1, 2, 4, 5, 6, 8, 9, D, E, F. | Error |
| **656** | **I, Out/I** | Invalid Admission Type | The Admission Type field must contain one of the following values: 1, 2, 3, 4, 5, 9. | Error |
| **657** | **I** | Invalid Facility Type Code | The Facility Type Code field contains an invalid value. The Facility Type Code is the first two characters of the claim's bill type. | Error |
| **657** | **Out/I** | Invalid Facility Type Code | The Facility Type Code field contains an invalid Outpatient-I unique allowable value. The Facility Type Code is the first two characters of the claim's bill type. | Error |
| **657** | **Out/P** | Invalid Facility Type Code | The Facility Type Code field contains an invalid Outpatient-P unique allowable value. The Facility Type Code is the first two characters of the claim's bill type. | Error |
| **658** | **I** | Invalid Claim Frequency Type Code | The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **658** | **Out/I** | Invalid Claim Frequency Type Code | The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type. | Error |
| **658** | **Out/P** | Invalid Claim Frequency Type Code | The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type. | Error |
| **659** | **I,Out/I,Out/P** | Invalid Patient Birth Date | Patient Birth Date is a required field and must contain a valid date of format ccyymmdd. | Error |
| **660** | **I, Out/I, Out/P** | Invalid Patient Ethnicity | The Patient Ethnicity field contains an invalid value. Patient Ethnicity is a required field and must contain 1 or 2. | Error |
| **661** | **I, Out/I, Out/P** | Invalid Patient Gender | Patient Gender is a required field and must contain M, F or U. | Error |
| **662** | **I, Out/I, Out/P** | Invalid Patient State | The value in the Patient State field of the patient address is not valid. | Error |
| **663** | **I, Out/I, Out/P** | Invalid Patient ZIP | The ZIP Code of the patient address must be at least 5 numeric characters in length and must contain XXXXX's or 00000's or a valid ZIP Code (USPS ZIP Code table). | Error |
| **664** | **I, Out/I, Out/P** | Invalid Patient Race | Patient Race is a required field and must contain a valid code value. | Error |
| **665** | **I, Out/I, Out/P** | Missing Patient Social Security Number | Patient Social Security Number is a required field and must contain 9 numeric characters. | Error |
| **666** | **I, Out/I** | Invalid Patient Discharge Status | The Patient Discharge Status must contain a valid NUBC code value. | Error |
| **667** | **I, Out/I, Out/P** | Missing Total Claim Charges | Total Claim Charges field is a required field and must contain a numeric value. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **668** | **I, Out/I, Out/P** | Total Claim Charges not = sum of Service Lines Charges | The Total Claim Charges must equal the sum of all Service Line Charges. | Error |
| **669** | **I, Out/I** | Non-numeric Value Code Associated Amount | If the Value Code exists, the Value Code Associated Amount must exist and contain a numeric value. | Error |
| **670** | **I, Out/I** | Revenue Code in first service line detail is missing | At least one revenue code is required. | Error |
| **671** | **I, Out/I** | Invalid Revenue Code | The Revenue Code field must contain a valid revenue code (per Texas UB04 Manual). | Error |
| **672** | **I** | Invalid Revenue Procedure Code | If it exists, the Revenue Procedure Code field must contain a valid CPT or HCPCS code. | Error |
| **672** | **Out/I** | Invalid Revenue Procedure Code | If it exists, the Product/Service Procedure Code field must contain a valid CPT or HCPCS code. | Error |
| **672** | **Out/P** | Invalid Product/Service Procedure Code | If it exists, the Product/Service Procedure Code field must contain a valid CPT or HCPCS code. | Error |
| **673** | **I, Out/I** | Charges not present for Revenue Code | The Charge Amount field is required when a corresponding service line Revenue Code is present. | Error |
| **673** | **Out/P** | Charges not present for Product/Service Procedure Code | The Charge Amount field is required when a corresponding service line Product/Service Procedure Code is present. | Error |
| **674** | **I, Out/I** | Service Line Charge not numeric | The Service Line Charge Amount must be numeric if a corresponding Revenue Code is present. | Error |
| **674** | **Out/P** | Service Line Charge not numeric | The Service Line Charge Amount must be numeric if a corresponding Product/Service Procedure Code is present. | Error |
| **675** | **I, Out/I** | Invalid Unit Code | Unit Code field must contain "DA" or "UN" or "F2". | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **675** | **Out/P** | Invalid Unit Code | Unit Code field must contain "DA" or "UN" or "MJ". | Error |
| **676** | **I, Out/I** | Missing or Invalid Unit Quantity | A Unit Quantity field is required when a corresponding revenue code is present and the field must contain a numeric value. | Error |
| **676** | **Out/P** | Missing or Invalid Unit Quantity | A Unit Quantity field is required when a corresponding procedure code is present and the field must contain a numeric value. | Error |
| **677** | **I, Out/I, Out/P** | Invalid Unit Rate | The Unit Rate field must contain a numeric value. | Error |
| **678** | **I, Out/I** | Non-numeric Non-Covered Charge Amount | When present, a service line Non-Covered Charge Amount field must contain a numeric value. | Error |
| **679** | **I, Out/I** | Charges present but no corresponding Revenue Code | Service Line Charges exists but there is no corresponding Revenue Code. | Error |
| **679** | **Out/P** | Charges present but no corresponding Product/Service Procedure Code | Service Line Charges exists but there is no corresponding Product/Service Procedure Code. | Error |
| **680** | **I** | Questionable Revenue Procedure Modifier 1 | The HCPCS/CPT Revenue Procedure Modifier Code 1 field contains a value not recognized by Medicare. | Warning |
| **680** | **Out/I, Out/P** | Questionable Revenue Procedure Modifier 1 | The HCPCS/CPT Product/Service Procedure Modifier Code 1 field contains a value not recognized by Medicare. | Warning |
| **681** | **I** | Questionable Revenue Procedure Modifier 2 | The HCPCS/CPT Revenue Procedure Modifier Code 2 field contains a value not recognized by Medicare. | Warning |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **681** | **Out/I, Out/P** | Questionable Revenue Procedure Modifier 2 | The HCPCS/CPT Product/Service Procedure Modifier Code 2 field contains a value not recognized by Medicare. | Warning |
| **682** | **I** | Questionable Revenue Procedure Modifier 3 | The HCPCS/CPT Revenue Procedure Modifier Code 3 field contains a value not recognized by Medicare. | Warning |
| **682** | **Out/I, Out/P** | Questionable Revenue Procedure Modifier 3 | The HCPCS/CPTProduct/Service Procedure Modifier Code 3 field contains a value not recognized by Medicare. | Warning |
| **683** | **I** | Questionable Revenue Procedure Modifier 4 | The HCPCS/CPT Revenue Procedure Modifier Code 4 field contains a value not recognized by Medicare. | Warning |
| **683** | **Out/I, Out/P** | Questionable Revenue Procedure Modifier 4 | The HCPCS/CPT Product/Service Procedure Modifier Code 4 field contains a value not recognized by Medicare. | Warning |
| **684** | **I, Out/I, Out/P** | Invalid Total Claim Charges | Total Claim Charges field is a required field and must contain a numeric value not less than zero. | Error |
| **685** | **I, Out/I** | Missing Unit Measurement Code. | A Revenue Code field exists but there is not a corresponding Unit Measurement Code field. | Error |
| **685** | **Out/P** | Missing Unit Measurement Code. | A Procedure Code field exists but there is not a corresponding Unit Measurement Code field. | Error |
| **686** | **I, Out/I, Out/P** | Invalid Product Service ID qualifier | The qualifier for the Product Service ID must contain a valid code. The Product Service ID Qualifier qualifies the Revenue Procedure Code that follows. | Error |
| **687** | **I, Out/I** | Missing Value Code Associated Amount | If the Value Code is reported, the Value Code Associated Amount must exist and be numeric. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **688** | **I** | Invalid Attending Practitioner Qualifier | The Attending Practitioner Qualifier field identifies the type of license contained in the Attending Practitioner Identifier field and the field must contain "XX" or "0B". | Error |
| **688** | **Out/ED** | Invalid Physician 2 (ED Attending) Qualifier for ED claim | The Physician 2 (ED Attending) Qualifier field for ED claims identifies the type of license contained in the Physician 2 Identifier field on ED claims and the field must contain "XX" or "0B". | Error |
| **689** | **I** | Missing Attending Practitioner Identifier | The Attending Practitioner Identifier field is required. The Attending Practitioner Identifier field must contain the practitioner's NPI, state license number, or a recognized temporary license number. | Error |
| **689** | **Out/ED** | Missing Physician 2 (ED Attending) Identifier for ED claim | The Physician 2 (ED Attending) Identifier field for ED claims is required. The Physician 2 Identifier field for ED claims must contain the practitioner's NPI, state license number, or a recognized temporary license number. | Error |
| **690** | **I** | Invalid Attending Practitioner Identifier | The Attending Practitioner Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn"). | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **690** | **Out/ED** | Invalid Physician 2 (ED Attending) Identifier for ED claim | The Physician 2 (ED Attending) Identifier field for an ED claim does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn"). | Error |
| **691** | **I** | Missing Attending Practitioner Last Name | The Attending Practitioner Last Name is a required field. | Error |
| **691** | **Out/ED** | Missing Physician 2 (ED Attending) Last Name on ED claim | The Physician 2 (ED Attending) Last Name on ED claims is a required field. | Error |
| **692** | **I** | Invalid Operating Practitioner Qualifier | The Operating Practitioner Qualifier field identifies the type of license contained in the Operating Practitioner Identifier field and the field must contain "XX" or "0B". | Error |
| **692** | **Out/I** | Invalid Physician 1 (Operating) Qualifier | The Physician 1 (Operating) Qualifier field identifies the type of license contained in the Physician 1 Identifier field and the field must contain "XX" or "0B". | Error |
| **693** | **I** | Invalid Operating Practitioner Identifier | The Operating Practitioner Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn"). | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **693** | **Out/I** | Invalid Physician 1 (Operating) Identifier | The Physician 1 (Operating) Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn"). | Error |
| **694** | **I** | Missing Attending Practitioner First Name | Attending Practitioner First Name is a required field. | Error |
| **694** | **Out/ED** | Missing Physician 2 (ED Attending) First Name | Physician 2 (ED Attending) First Name is a required field. | Error |
| **695** | **I** | Invalid Attending Practitioner Name Match | The 1st three characters of the Attending Practitioner's Last Name field and the first character of the Attending Practitioner's First Name field do not match an entry in the THCIC Practitioner Reference File. | Warning |
| **695** | **Out/ED** | Invalid Physician 2 (ED Attending) Name Match | The 1st three characters of the Physician 2 (ED Attending) Last Name field and the first character of the Physician 2 First Name field do not match an entry in the THCIC Practitioner Reference File. | Warning |
| **696** | **I** | Invalid Operating Practitioner Name Match | The 1st three characters of the Operating Practitioner's Last Name field and the first character of the Operating Practitioner's First Name field does not match an entry in the THCIC Practitioner Reference File. | Warning |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **696** | **Out/I** | Invalid Physician 1 (Operating) Name Match | The 1st three characters of the Physician 1 (Operating) Last Name field and the first character of the Physician 1 First Name field does not match an entry in the THCIC Practitioner Reference File. | Warning |
| **697** | **I, Out/I, Out/P** | Missing Claim Filing Indicator Code for Subscriber | Claim Filing Indicator Code for the subscriber is a required field and must contain the primary source of payment. | Error |
| **698** | **I, Out/I, Out/P** | Invalid Claim Filing Indicator Code for Other Subscriber | The Claim Filing Indicator Code field for the Other Subscriber does not contain a valid value. The Claim Filing Indicator Code field in the Other Subscriber segment contains the Secondary Payer Source code. | Error |
| **699** | **I, Out/I, Out/P** | Missing Primary Payer Plan ID | NOTE: This audit is suspended until the NPI rule is implemented for payers.<br>The Primary Payer Plan ID is required. | Warning |
| **700** | **I, Out/I, Out/P** | Invalid Claim Filing Indicator Code for Subscriber | The Claim Filing Indicator Code field for the Subscriber does not contain a valid value. The Claim Filing Indicator Code field in the Subscriber segment contains the Primary Payer Source code. | Error |
| **701** | **I, Out/I, Out/P** | Primary Payer Name is required | The Primary Payer Name is required. | Error |
| **702** | **I, Out/I, Out/P** | Missing Secondary Payer Name | The Secondary Payer Name is required when a Claim Filing Indicator Code containing the secondary payer source code exists for the Other Subscriber (secondary subscriber). | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **703** | **I, Out/I, Out/P** | Missing Secondary Payer Plan ID | NOTE: This audit is suspended until the NPI rule is implemented. The Secondary Payer Plan ID field is required when a secondary source of payment is reported. | Warning |
| **704** | **Out/I** | Missing Physician 2 (Other) Identifier | The Physician 2 (Other) Identifier field is required if the Physician 2 Qualifier is not = spaces. The Physician 2 Identifier field must contain the practitioner's NPI, state license number, or a recognized temporary license number. | Error |
| **705** | **Out/P** | Invalid Related_Cause_Two Code | If Related_Cause_Two code value is reported, it must contain a valid value. | Error |
| **706** | **Out/P** | Invalid Related_Cause_Three Code | If Related_Cause_Three code value is reported, it must contain a valid value. | Error |
| **707** | **I** | Missing Operating Practitioner Identifier | If the operating practitioner qualifier is reported, the Identifier for the Operating Practitioner is required. | Error |
| **707** | **Out/I** | Missing Physician 1 (Operating) Identifier | If the Physician 1 (Operating) qualifier is reported, the Identifier for the Physician 1 is required. | Error |
| **708** | **I** | Missing Operating Practitioner First Name | The Operating Practitioner First Name is required if an operating practitioner is reported. | Error |
| **708** | **Out/I** | Missing Physician 1 (Operating) First Name | The Physician 1 (Operating) First Name is required if an operating practitioner is reported. | Error |
| **709** | **I, Out/I** | Invalid Length for Occurrence Span Associated Date | If the Occurrence Span Code Associated exists, then the Occurrence Span Associated Date field must contain 17 characters. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **710** | **Out/I** | Invalid Physician 2 (Other) Qualifier | The Physician 2 (Other) Qualifier field identifies the type of license contained in the Physician 2 Identifier field and the field must contain "XX" or "0B". | Error |
| **711** | **Out/I** | Invalid Physician 2 (Other) Identifier | The Physician 2 (Other) Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn"). | Error |
| **712** | **Out/I** | Missing Physician 2 (Other) First Name | Physician 2 (Other) First Name is a required field if the associated provider number is present. | Error |
| **713** | **I, Out/I** | Missing Occurrence Code Associated Date | If an Occurrence Code exists, then the Occurrence Date field must exist. | Error |
| **714** | **I** | Patient Gender not consistent with the Principal Procedure | The patient gender does not agree with a gender specific principal procedure. | Error |
| **715** | **I, Out/I** | Invalid Occurrence Span From Date | If an Occurrence Span Code exists, then the Occurrence Span From Date must contain a valid date of format ccyymmdd. The Occurrence Span From Date is the first 8 characters of the Occurrence Span Associated Date field. | Error |
| **716** | **I, Out/I** | Invalid Occurrence Code Associated Date | If the Occurrence Code exists, the Occurrence Code Associated Date field must exist and contain a valid date of format ccyymmdd. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **717** | **I, Out/I** | Invalid Occurrence Span Thru Date | If an Occurrence Span Code exists, then the Occurrence Span Thru Date must be a valid date of format ccyymmdd. The Occurrence Span Thru Date is the last 8 characters of the Occurrence Span Associated Date field. | Error |
| **718** | **I, Out/I** | Missing Occurrence Span Code Associated Date | If an Occurrence Span Code exists, then the Occurrence Span Code Associated Date field must exist. The Occurrence Span Code Associated Date field contains the Occurrence Span From Date and the Occurrence Span Thru Date and is of the format ccyymmdd-ccyymmdd. | Error |
| **719** | **I, Out/I, Out/P** | Invalid Statement From Date | Statement From Date is a required field and must be a valid date. The Statement From Date is the first 8 characters of the Statement Dates field and is of format ccyymmdd. | Error |
| **720** | **I, Out/I, Out/P** | Invalid Statement Thru Date | Statement Thru Date is a required field and must be a valid date. The Statement Thru Date is the last 8 characters of the Statement Dates field and of format ccyymmdd. | Error |
| **721** | **I** | Invalid Admission Date | Admission Date is a required field. The admission date is taken from the Admission Date and Hour field. The first eight characters of the Admission Date and Hour field must be a valid date of the format ccyymmdd. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **722** | **I** | Invalid Admission Hour | Admission Hour is a required field. The admission hour is taken from the 9th and 10th characters of the Admission Date and Hour field. The Admission Hour field must contain one of (00-23). | Error |
| **723** | **I** | Birth Date after Statement Thru Date or Procedure Date | The patient Birth Date is after one of the following dates: Statement Thru Date, Principal Procedure Date, Other Procedure Date. | Error |
| **723** | **Out/I, Out/P** | Birth Date after Statement Date, Statement Thru Date or Service Date | The patient Birth Date is after one of the following dates: Statement Date, Statement Thru Date, or a Service Date. | Error |
| **724** | **I** | Missing Patient Discharge Hour | Patient Discharge Hour is a required field of format hhmm. | Error |
| **725** | **I, Out/I, Out/P** | Missing Patient Address Line 1 | The first line of the patient's address of residence is required. | Error |
| **726** | **I, Out/I, Out/P** | Missing Patient Account Number | The Patient Account Number is required. | Error |
| **727** | **I** | Missing Admission Date and Hour | Admission Date and Hour is a required field. | Error |
| **728** | **I** | Invalid Discharge Hour | Discharge Hour is a required field and must contain a valid hour of 00 - 23. | Error |
| **729** | **I, Out/I, Out/P** | Missing Patient City | The city of the patient's address is required. | Error |
| **730** | **I** | Missing Operating Practitioner Last Name | If the operating practitioner is reported, the Operating Practitioner Last Name field is required. | Error |
| **730** | **Out/I** | Missing Physician 1 (Operating) Last Name | If the Physician 1 (Operating) is reported, the Physician 1 Last Name field is required. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **731** | **Out/I** | Missing Physician 2 (Other) Last Name | The Physician 2 (Other) Last Name is a required field if the associated provider number is present. | Error |
| **732** | **Out/I** | Invalid Physician 2 (Other) Name Match | The 1st three characters of the Physician 2 (Other) Last Name field and the first character of the Physician 2 First Name field do not match an entry in the THCIC Practitioner Reference File. | Warning |
| **733** | **Out/I** | Invalid Reason for Visit Code | Reason for Visit Code must contain a valid ICD code. | Error |
| **734** | **Out/P** | Invalid Related Cause Code | If Related Cause code value is reported, it must contain a valid value. | Error |
| **735** | **Out/I, Out/P** | Invalid Procedure Date | Procedure Date is a required field when a procedure code is present and it must be a valid date. The Procedure Date is the first 8 characters of the Service Date field and is of format ccyymmdd. | Error |
| **736** | **Out/I, Out/P** | Procedure Date is more than 30 days before the Statement Date or after the Statement Thru Date. | The Procedure Date must be within the range of 30 days before the Statement From Date and before the Statement Thru Date inclusive. | Error |
| **742** | **Out/P** | Invalid Rendering1 Provider Qualifier | The Rendering1 Provider Qualifier field identifies the type of license contained in the Rendering1 Provider Identifier field and the field must contain "XX" or "0B". | Error |
| **743** | **Out/P** | Missing Rendering1 Provider Identifier | If the Rendering1 Provider Qualifier is reported, the Rendering1 Provider Identifier field is required. The Rendering1 Provider Identifier field must contain the practitioner's NPI or state license number. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **744** | **Out/P** | Invalid Rendering1 Provider Identifier | The Rendering1 Provider Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn"). | Error |
| **745** | **Out/P** | Missing Rendering1 Provider First Name | Rendering1 Provider First Name is a required field if the associated provider number is present. | Error |
| **746** | **Out/P** | Missing Rendering1 Provider Last Name | Rendering1 Provider Last Name is a required field if the associated provider number is present. | Error |
| **747** | **Out/P** | Invalid Rendering1 Provider Name Match | The 1st three characters of the Rendering1 Provider's Last Name field and the first character of the Rendering Provider's First Name field do not match an entry in the THCIC Practitioner Reference File. | Warning |
| **751** | **Out/P** | Invalid Rendering2 Provider Qualifier | The Rendering2 Provider Qualifier field identifies the type of license contained in the Rendering2 Provider Identifier field and the field must contain "XX" or "0B". | Error |
| **752** | **Out/P** | Missing Rendering2 Provider Identifier | If the Rendering2 Provider Qualifier is reported, the Rendering2 Provider Identifier field is required. The Rendering2 Provider Identifier field must contain the practitioner's NPI or state license number. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **753** | **Out/P** | Invalid Rendering2 Provider Identifier | The Rendering2 Provider Identifier field does not contain a valid NPI, a valid state license number (number does not match THCIC Practitioner Reference File), or is not a recognized temporary number ("TXTnnn","OTHnnn", "RESnnn","TEMnnn"). | Error |
| **754** | **Out/P** | Missing Rendering2 Provider First Name | Rendering2 Provider First Name is a required field if the associated provider number is present. | Error |
| **755** | **Out/P** | Missing Rendering2 Provider Last Name | Rendering2 Provider Last Name is a required field if the associated provider number is present. | Error |
| **756** | **Out/P** | Invalid Rendering2 Provider Name Match | The 1st three characters of the Rendering2 Provider's Last Name field and the first character of the Rendering2 Provider's First Name field do not match an entry in the THCIC Practitioner Reference File. | Warning |
| **757** | **I, Out/I, Out/P** | Missing Patient First Name | Patient First Name is a required field. | Error |
| **758** | **I, Out/I, Out/P** | Missing Patient Last Name | Patient Last Name is a required field. | Error |
| **759** | **Out/I, Out/P** | Invalid Procedure Through Date | Procedure Through Date must be a valid date. The Procedure Through Date is located in characters 10-17of the Service Date field and is of format ccyymmdd. | Error |
| **760** | **Out/I, Out/P** | Procedure Through Date is more than 30 days before the Statement From Date or after Statement Thru Date. | The Procedure Through Date must be within the range of 30 days before the Statement From Date and before Statement Thru Date inclusive. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **761** | **Out/P** | Invalid Service Line Facility Type Code | The Service Line Facility Type Code field contains an invalid value for ANSI 837 Professional Claim. | Error |
| **763** | **I** | Invalid POA value | If the associated diagnosis code is present, then the Present On Admission (POA) indicator must be either N, U, W or Y. A space is allowed only if the reporting provider is exempt from reporting POA or the diagnosis code is POA exempt. | Error |
| **764** | **I** | Invalid POA value | If the associated e-code is present, then the Present On Admission (POA) indicator must be either N, U, W or Y. A space is allowed only if the reporting provider is exempt from reporting POA or the diagnosis code is POA exempt. | Error |
| **765** | **I, Out/I, Out/P** | Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Principal Diagnosis. | Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Principal Diagnosis. | Error |
| **766** | **I, Out/I, Out/P** | Only Ecodes may be reported with the Ecode qualifier or in the Ecode section. | Only Ecodes (External Causes of Morbidity) may be reported with the Ecode qualifier or in the Ecode section. | Error |
| **767** | **I, Out/I, Out/P** | Manifest diagnosis codes may not be used as the Principal Diagnosis Code | Manifest diagnosis codes may not be used as the Principal Diagnosis Code | Error |
| **768** | **I** | Manifest diagnosis codes may not be used as the Admitting Diagnosis Code | Manifest diagnosis codes may not be used as the Admitting Diagnosis Code | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **769** | **Out/I, Out/P** | Manifest diagnosis codes may not be used as the Reason for Visit Code | Manifest diagnosis codes may not be used as the Reason for Visit Code | Error |
| **770** | **I, Out/I, Out/P** | Principal Diagnosis code is the wrong ICD version for the claim's statement through date | Principal Diagnosis code is the wrong ICD version for the claim's statement through date | Error |
| **771** | **I** | Admitting Diagnosis code is the wrong ICD version for the claim's statement through date | Admitting Diagnosis code is the wrong ICD version for the claim's statement through date | Error |
| **772** | **Out/I, Out/P** | Reason for Visit Diagnosis code is the wrong ICD version for the claim's statement through date | Reason for Visit Diagnosis code is the wrong ICD version for the claim's statement through date | Error |
| **773** | **I, Out/I, Out/P** | Other Diagnosis code is the wrong ICD version for the claim's statement through date | Other Diagnosis code is the wrong ICD version for the claim's statement through date | Error |
| **774** | **I, Out/I, Out/P** | Ecode is the wrong ICD version for the claim's statement through date | Ecode is the wrong ICD version for the claim's statement through date | Error |
| **775** | **I** | Principal Procedure code is the wrong ICD version for the claim's statement through date | Principal Procedure code is the wrong ICD version for the claim's statement through date | Error |
| **776** | **I** | Other Procedure code is the wrong ICD version for the claim's statement through date | Other Procedure code is the wrong ICD version for the claim's statement through date | Error |
| **777** | **I** | Patient Gender not consistent with Admitting Diagnosis | The Gender of the patient does not agree with a gender specific Admitting Diagnosis. | Error |
| **778** | **Out/I, Out/P** | Patient Gender not consistent with Reason for Visit Diagnosis | The Gender of the patient does not agree with a gender specific Reason for Visit Diagnosis. | Error |

| Audit ID | Status | Audit Message | Audit Description | Audit Severity |
|---|---|---|---|---|
| **779** | **I, Out/I, Out/P** | Patient Gender not consistent with Ecode | The Gender of the patient does not agree with a gender specific Ecode. | Error |
| **780** | **I** | Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Admitting Diagnosis. | Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Admitting Diagnosis. | Error |
| **781** | **Out/I, Out/P** | Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Reason for Visit Diagnosis. | Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Reason for Visit Diagnosis. | Error |
| **782** | **I, Out/I, Out/P** | Ecodes must be reported with the Ecode qualifier or in the Ecode section and not as Other Diagnosis. | Ecode (External Causes of Morbidity) diagnosis codes must be reported with the Ecode qualifier or in the Ecode section and not as Other Diagnosis. | Error |
| **783** | **Out/I (not FEMC), Out/P** | The Claim must have either a THCIC required HCPCS code or the Claim must have a THCIC required revenue code. | The non-FEMC claim does not contain at least one required HCPCS code or it does not contain at least one required revenue code. | Error |
| **784** | **Out/I (FEMC)** | The Claim must contain at least one HCPCS code. | The FEMC claim does not contain at least one HCPCS/procedure code. | Error |
| **785** | **Out/I** | Missing Reason for Visit Code. | Reason for Visit Code is a required field. | Error |
| **786** | **I, Out/I, Out/P** | Statement Period Thru > Processing Date | The Statement Period Thru date is after the Claim's processing date. | Error |

# Appendix A6 PAYER SOURCE CODING GUIDE

(*Claim Filing Indicator Code*)
**CATEGORY DESCRIPTIONS**

### 11 Other non-federal programs

Payment is made by a state or local program and most likely funded by tax dollars. This could include claims for which application to a program has been made but eligibility has not been determined. Can include, entities such as: The Texas Rehabilitation Commission, Texas Kidney Foundation, Non - Federal incarceration and Adoption Agencies

### 12 Preferred Provider Organization (PPO)

PPO is a type of managed care insurance. PPO plans combine some elements of the HMO plan with elements of the indemnity plan. Like HMOs, the PPO plans have contracts with a specific list of medical providers. The enrollees may go outside of the network but will incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

### 13 Point of Service (POS)

POS is a type of managed care and the category is new with the THCIC 837. A POS is an HMO/PPO hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans.

### 14 Exclusive Provider Organization (EPO)

EPO is a type of managed care and the category is new with the THCIC 837. An EPO is a more restrictive type of preferred provider organization plan under which beneficiaries must use providers from a specific network of physicians and healthcare facilities to receive coverage. In most cases, there is no coverage for care received from a non-network provider except in an emergency situation.

### 15 Indemnity Insurance

This is a fee-for-service health insurance plan that is not otherwise specified as a PPO, HMO, or EPO, whether group or individual, it includes individual insurance and an employer's self- funded insurance. An indemnity plan reimburses the patient and/or provider as expenses are incurred.

Indemnity plans usually do not require beneficiaries to choose from a provider Network for covered care.

### 16 Health Maintenance Organization – Medicare Risk

Medicare risk is a contractual relationship between CMS and HMO managed care plans where the plan provides specific health care benefits to beneficiaries in exchange for a prepaid fixed monthly amount from CMS. These benefits replace traditional Medicare benefits. Programs included in the Medicare managed care risk programs fall under the Medicare + Choice contract. These are called Coordinated Care Plans.

### 17 Dental Maintenance Organization

This is an organization of dental providers which provides services to its members.

### AM Automobile Medical

This category is new with the THCIC 837. Automobile medical or no-fault insurance coverage (Including a self-insured plan) that pays for all or part of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile.

### BL Blue Cross (THCIC recommends that this category not be used.)

This category refers to a specific insurance company. Blue Cross provides many different plan options (PPO, HMO).

### CH CHAMPUS

CHAMPUS Civilian Health and Medical Program of the Uniformed Services, (also known as TRICARE) is a health benefits program offered through the Military Health Services System of the Department of Defense of inactive military, their spouses, beneficiaries, dependents of active-duty, retired and deceased military. CHAMPUS provides authorized in-patient and out-patient care from civilian sources, on a cost-sharing basis

### CICommercial Insurance (THCIC recommends that this category not be used)

This category is misinterpreted as being any insurance that can be purchased on the open market (commercially). However, there are other categories that provide more specific categorization.

### DS Disability

Disability insurance pays benefits in the event that the policy holder becomes incapable of working. This does not include worker's compensation insurance or other tax-funded programs.

Types of disability insurance include:

- Short-term disability: a disability not lasting longer than six months.
- Partial disability: Any condition, resulting from illness or injury, that keeps an insured from performing one or more occupation related activities.

- Total disability: A disability that prevents an insured from performing duties essential to his/her regular job.
- Permanent disability: An inability to work at any job.

### FI Federal Employees Program

Healthcare programs developed specifically for Federal Government employees.

### HM Health Maintenance Organization (HMO)

An HMO is an organized system that arranges or provides a set of health care services to members in return for a prepaid or periodic charge paid by or on the behalf of the enrollees.

Membership in an HMO requires plan members to obtain their health services from doctors and healthcare facilities affiliated with the HMO. Members usually select a primary care physician who manages all of the health care and serves as a gatekeeper for specialty care.

### LM Liability Medical

Insurance which pays only for medical services on behalf of an insured for loss arising out of the insured's responsibility to others imposed by law or assumed by contract.

### MA Medicare Part A

Federal insurance program for people aged 65 and older, people with disabilities, or people with End- Stage Renal Disease (ESRD). Medicare Part A covers in-hospital services.

### MB Medicare Part B

Federal insurance program for people aged 65 and older, people with disabilities, -or people with End- Stage Renal Disease (ESRD). Medicare Part B covers physician and other outpatient services.

### MC Medicaid

Medicaid is a jointly funded, federal – state, health insurance program for low-income and needy people. Medicaid is run by the state and covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments. The state provides Medicaid eligibility to people eligible for Supplemental Security Income (SSI) benefits. This includes the CHIP/SCHIP programs.

### OF Other Federal Program

Federal tax-funded programs, other than Medicare, Medicaid, CHAMPUS and Veteran's Administration, that pay for health services, such programs include Indian Health Service, Federal incarceration, US Marshall's Office, and Crime Victims.

### TV Title V

The Children with Special Health Care Needs (CSHCN) Services Program, funded through the Title V Block grant, provides services to children with extraordinary medical needs, disabilities, and chronic health conditions. The CSHCN Services Program's health care benefits include payments for medical care, family support services, and related services not covered by Medicaid, CHIP, private insurance, or other third-party payers VA Veterans Administration Plan. The Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to its customers. Services are provided primarily in VHA facilities.

### VA Veterans Administration Plan

The Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to its customers. Services are provided primarily in VHA facilities.

### WC Workers Compensation Health Plan

Workers Compensation insurance covers the cost of medical care and rehabilitation for workers injured on the job. It also compensates them for lost wages and provides death benefits for their dependents if the workers are killed in work-related accidents, including terrorist attacks.

### ZZ Charity or Unknown

This category is new with the THCIC 837. This category is used to report services for which payment or reimbursement will not be provided by be paid by a local, county, or state program or by private insurance. It is also used to report claims for which the payer source is unknown at the time that the claim is reported to THCIC.

If no payment is expected, enter "CHARITY" in the Payer Organization Name and in the Payer Identification fields.

If the payer is unknown at the time the claim is reported to THCIC, enter "UNKNOWN" in the Payer Organization Name and in the Payer Identification fields.

If an application has been made to Medicaid or another state or local program, "Program name Application" may be used in the Payer Organization Name field.

**Payor source descending order of frequency**

| If... | Then Use Code |
|---|---|
| Medicaid (including HMO, PPO, EPO, POS) or CHIP/SCHIP | MC |
| Medicare Health Maintenance Organization (HMO) | 16 |
| Medicare Health Maintenance Organization (HMO) | MB |
| Medicare Part A or Medicare (including PPO, EPO, POS, Indemnity) | MA |

| If... | Then Use Code |
|---|---|
| Preferred Provider Organization (PPO) | 12 |
| Health Maintenance Organization (HMO) | HM |
| Local or State Program (including county or hospital district indigent program) | 11 |
| Self-Pay or Unknown or Healthcare facility charity | ZZ |
| CHAMPUS | CH |
| Veterans Administration Plan | VA |
| Exclusive Provider Organization (EPO) | 14 |
| Point of Service (POS) | 13 |
| Automobile Medical or No-Fault Insurance | AM |
| Liability Medical | LM |
| Disability | DS |
| Other Federal Programs not listed above (including Indian Health Service, Federal incarceration, Crime victims, US Marshall's office) | OF |
| Workers Compensation Health Plan | WC |
| Title V<br>Children with Special Health Care Needs (CSHCN) Services Program | TV |
| If none of the above, will be Indemnity | 15 |

# Appendix A7 KEY DATA ELEMENTS FOR MATCHING INPATIENT CLAIMS

THCIC uses the following data elements to create a key for matching XX7 replacement, XX3 Intermediate Interim, XX4 Final Interim and XX8 Void/Cancel claims:

- THCIC Number
- PCN/PAN - Patient Control Number or Patient Account Number
- MRN – Medical Record Number
- Admit Date
- Admit Hour
- Type of Bill (Facility Type Code plus Claim Frequency Code)
- Statement Covers Period From Date

The use of these data elements maximizes the integrity of claim matching. However, it decreases the number of data elements that can be changed using the XX7 claim. To change any of the above data elements, the XX8 Void claim must be used and then an original claim type can be submitted.

# Appendix A8 KEY DATA ELEMENTS FOR MATCHING OUTPATIENT CLAIMS

THCIC uses the following data elements to create a key for matching XX7 replacement and XX8 Void/Cancel claims for THCIC 837 Institutional Claims:

- THCIC Number
- PCN/PAN - Patient Control Number or Patient Account Number
- MRN – Medical Record Number
- Statement Covers Period From and Thru Date

The use of these data elements maximizes the integrity of claim matching. However, it decreases the number of data elements that can be changed using the XX7 claim. To change any of the above data elements, the XX8 Void claim must be used and then an original claim type can be submitted.

THCIC uses the following data elements to create a key for matching XX7 replacement and XX8 Void/Cancel claims for THCIC 837 Professional Claims:

- THCIC Number
- PCN/PAN - Patient Control Number or Patient Account Number
- MRN – Medical Record Number
- Date – Service Date

The use of these data elements maximizes the integrity of claim matching. However, it decreases the number of data elements that can be changed using the XX7 claim. To change any of the above data elements, the XX8 Void claim must be used and then an original claim type can be submitted.

# Appendix A9 CHANGES MADE SINCE THE PREVIOUS VERSION(S)

Changes to the THCIC Data Collection Healthcare Facility Procedures and Technical Specifications 5010 Inpatient and Outpatient Appendices

## Changes from Version 4.7 to 4.8 on 12/1/2023

### Appendix A7

1. Replaced "System 13, Inc." with "THCIC".
2. Removed footnote reference to UB92.

### Appendix A8

1. Removed "Key Data Elements to be added." from the beginning of the section.
2. Replaced "System 13, Inc." with "THCIC".
3. Removed footnote reference to UB92.

## Changes from Version 4.6 to 4.7 on 9/14/2023

### Appendix A5 – 5.2 Table B Claim Level Audits

1. Added Audit ID 786.

## Changes from Version 4.5 to 4.6 on 6/2/2022

### Appendix A3 - first page

1. Updated contact information from "Bruce Burns, manager, or Andy Alegria, business analyst" to "THCIC".
2. Updated instructions title from "INSTRUCTIONS FOR STATE ETHNICITY AND RACE QUESTIONNAIRE For Hospitals and Ambulatory Surgery Centers use only for collecting and reporting patient Ethnicity and Race" to "Instructions for State Ethnicity and Race Questionnaire For collecting and reporting patient Ethnicity and Race to the THCIC System".

### Appendix A3 - Recommended Procedure

1. I - replaced "a healthcare facility" with "healthcare facilities" and replaced "and either read" to "You can choose to either read aloud".
2. II - replaced "cannot read" with "is unable to read".
3. III - added "in their own opinion" after "appropriate choice".
4. III A. - changed formatting of "ethnicity".
5. III B. - changed formatting of "Race".
6. Note - replaced "Hispanics" with "Hispanic patients".

### Appendix A3 – English form

1. Changed formatting of title.

2. Added "freestanding emergency medical care facility" to list of patients for which the state collects race and ethnicity.
3. Removed "(Hospital or Ambulatory Surgery Center)" from between facility and staff.
4. Replaced "whether or not all citizens of Texas are receiving access to adequate health care" with "whether all citizens of Texas have access to cost-effective, good quality health care."

### Appendix A3 – Spanish form

1. Changed formatting of title.
2. Replaced "en los centros de salud" with "de hospitales, centros de cirugia ambulatorial, o de centros independientes de atención médica de emergencia".
3. Removed "u hospital" from after "el personal del centro".
4. Replaced "reciben acceso a una asistencia sanitaria adecuada" with "tienen acceso a atención médica de buena calidad a costo efectivo".
5. Added "es" bewteen "No" and "hispano/latino".

## Changes from Version 4.4 to 4.5 on 3/30/2022

### Appendix – A5, Table 5.2

1. Audit code 733 description changed from "Reason for Visit Code is a required field, if visit is unscheduled, and must contain a valid ICD code." to "Reason for Visit Code must contain a valid ICD code."
2. Added audit code 785.

## Changes from Version 4.3 to 4.4 on 1/25/2021

### Appendix – A5, Table 5.1

1. Audit MSD. ID. RJ053 description updated, "The THCIC Data Warehouse" replaced with "THCIC/System13".
2. Audit MSD. ID. RJ057 description updated, "The THCIC Data Warehouse" replaced with "System13".

## Changes from Version 4.2 to 4.3 on 1/8/2021

### Appendix – A5, Table 5.2

1. Audit code 733 " Out/P Invalid Reason for visit Code" is removed.
2. Audit code 762 "The Claim must have either a THCIC required HCPCS code, or the Claim must have a THCIC required revenue code and contain at least one procedure code" is removed.
3. Audit code 783 "The Claim must have either a THCIC required HCPCS code or the Claim must have a THCIC required revenue code" is added.
4. Audit code 784 "The Claim must contain at least one HCPCS code" is added.

## Changes from Version 4.1 to 4.2

### Appendix – A1

Consolidated the Military "State" abbreviations and updated section titles.

### Appendix – A3

Updated THCIC staff contact information.

## Changes are from Version 4.0 to 4.1

### Appendix – A5

1. RJ062 - Wrong ICD qualifier detected within DX, PX, or E-codes. The claim contains ICD [9/10] version qualifiers.
   Claims with statement thru date of 10/1/2015 and later MUST REPORT all Diagnosis (DX), Procedure (PX), and E-codes using the ICD-10 version of codes AND QUALIFIERS. For claims prior to 10/1/2015 use ICD-9 version.
   ICD-9 DX qualifiers: BK, BJ, BF, PR
   ICD-9 PX qualifiers: BR, BQ
   ICD-9 Ecode qualifier: BN
   ICD-10 DX qualifiers: ABK, ABJ, ABF, APR
   ICD-10 PX qualifiers: BBR, BBQ
   ICD-10 Ecode qualifier: ABN
2. RJ063 - Effective January 1st, 2020, the K3 data segment is required on every claim and used to report patient race and ethnicity. It is conditionally used to report social security number for claims where the patient is not the subscriber. Your submission file generation software needs to be modified to reflect this change in requirements.
3. RJ064 - Effective January 1st, 2020, the K3 data segment should conditionally contain race, ethnicity, and social security number. If the patient is the subscriber, the K301 data element must be 2 characters long to contain race and ethnicity. In that scenario, social security number is required on the REF*SY data segment. Otherwise, if the patient is not the subscriber, the K301 data element must be 11 characters long to contain race, ethnicity, and social security number. Your submission file generation software needs to be modified to reflect this change in requirements.

## Changes are from Version 3.2 to 4.0

1. 672-I, 672-Out/I, and 672-Out/P: Changed the Audit Description to have HCPCS and CPT as only valid code types.
2. 672-I, 672-Out/I, and 672-Out/P: Changed the Audit Description to have HCPCS and CPT as only valid code types.

3. 676: Was for all three types, made a separate type for Out/P. Changed Audit Description On Out/P to "procedure code" instead of "revenue code". Changed both to have "A Unit" instead of "An Unit" in the description.
4. 680, 681, 682, and 683, two entries for each number: Changed Audit Description to make modifiers only for HCPCS/CPT.
5. 685: Was for all three types, made a separate type for Out/P. Changed Audit Description on Out/P to "A Procedure Code" instead of "A Revenue Code".
6. 692, 693, 696, 707, 708, and 730: On status, remove Out/ED from Out/I,Out/ED. Out/I covered both in these instances.
7. 742, 743, 744, 745, 746, 747: Change "Rendering" to Rendering1" in both the Audit Message and the Audit Description.
8. 763 and 764: Change the Audit Description to remove "1" as a value. Added that a space is allowed if "the diagnosis code is POA exempt."
9. 726 and 762: Changed the Audit Model from "Patient" to "Claim" and the Field to Flag from "control number" to "patient_control_number".
10. 766: Changed the Edit Order from 881 to 879.
11. Changed to following from previous version
    Patient Address is in a Foreign Country (other than Canada):
    If the address of the patient is **a foreign country**, use the following:
    ANSI Loop.Data Segment
    2010BA or 2010CA.N402 (Patient State) FC or XX
    2010BA or 2010CA.N403 (Patient ZIP) "00000" or "XXXXX"
    2010BA or 2010CA.N404 (Patient Country) See appendices for Country C Codes.

## Changes from Version 3.1 to 3.2

Under section: STATE REQUIRED ETHNICITY AND RACE QUESTIONS, pages #12 and 13 of this document: **Paragraph: Question #1: Ethnic Background,** we have removed the five digit (xxxxx) ethnic background (example: < (1) Hispanic/Latino ~~(21352)~~ and **Paragraph: Question #2: Race** < (1) American Indian/Eskimo/Aleut ~~(10025)~~ and so on

Minor modifications (Additions) to Table A, Pre-Processing Audits (Format Check) From Version 3.1 to Version 3.2 (Dec. 7, 2015).

### Appendix – A5,

1) **RJ029** – It used to have a value of (SE01=0000?) and SE=0000?).
   And now the Error Message is: **RJ029 -** Value (SE01=???) not equal num of segments counted in Transaction Set (actual cnt ST thru SE=???).
2) **RJ32** - RJ032 - RJ032 - Value (GE01=000?) not equal number of transaction sets included in Functional Group (actual count=000?).
   And now the Error Message is: **RJ032** - Value (GE01=???) not equal number of transaction sets included in Functional Group (actual count=???).
3) **RJ033** - GS06 (Group Control Number=??????) value not equal segment GE02 (Group Control Number=??????}) Value.

And now the Error Message is: **RJ033 -** RJ033 - GS06 (Group Control Number=?) value not equal segment GE02 (Group Control Number=?) value.

4) **RJ035** - Value (IEA01=000?) not equal number of Functional Groups included in Interchange (actual count=000?).

   And now the Error Message is: **RJ035** - Value (IEA01=?) not equal number of Functional Groups included in Interchange (actual count=?).

5) **RJ042** – RJ042 - Element NM109, provider NPI num validation failed. Your #: ?????????? Our #: ??????????

   And now the Error Message is: **RJ042** Element NM109, provider NPI num validation failed.

   Your #: ??????????

   Our #: ??????????

6) **RJ043** - Element N3 (street addr) validation on provider failed. Your addr 123 Some street. Our addr 456 Another St (1st 15 characters only)

   And now the Error Message is: **RJ043** - Element N3 (street addr) validation on provider failed.

   Your addr: ???

   Our addr: ???

   (1st 15 characters only)

7) **RJ052 -** Element REF*EI, provider EIN num validation failed. Your #: ????????? Our #:?????????

   And now the Error Message is: **RJ052** - Element REF*EI, provider EIN num validation failed.

   Your #: ?????????

   Our #: ?????????

8) **RJ060** - Facility not ASC, Institutional 5010 version format required

   And now the Error Message is: RJ060 - Facility not ASC, Institutional 5010 version format required (ver# 005010X223A2), your ver#??????????

   And the Audit Description now read as: RJ060 - All non-ASC facilities MUST submit claims in Institutional format. Our system validates institutional format by examining the version number in the 8th element of the GS segment (GS08).

9) New Addition - **RJ061 – RJ061** - SBR (subscriber) segment missing in HL (hierarchical level). The Subscriber SBR segment is required in order to properly identify the patient. The SBR segment (along with its associated fields) normally appears immediately after an HL (hierarchical level) segment.

10) Audit 733 Out/P Invalid Reason for visit Code is removed

**11)** New Audit Id's have been added: **765 - 782**

## Changes from Version 2 to Version 3.1

### a. Appendix – A1 Country Codes - ISO 3166

i. Remove the old display table codes of Country Codes and replace it with new display table. ISO 3166 is the International Standard for country codes and codes for their subdivisions. https://www.iso.org/obp/ui/#search. The codes in ISO 3166 are available on the Online Browsing Platform. (OBP) is always up to date.

ii. **USPS State Codes, Military and Canadian Provinces,**
You can find the official USPS (USA) and Canadian abbreviation in the following web sites:
**For United States postal abbreviation codes:**
Official United State Military Postal Services State Abbreviations Codes for **Provinces and Territories in Canada:** Abbreviations for Provinces and Territories in Canada

Note: Official USPS, Military "State" abbreviations codes colored each section with different color: Red for Military "State", and Green for Canada

**b. Appendix – A3** Race and Ethnicity Questionnaire Documents Note below the title of "Instructions for State Ethnicity and Race Questionnaire" is added to specify the documents are for: Hospitals and Ambulatory Surgery Centers **USE Only.**

### c. Appendix – A5,

a. Title of Appendix changed to INPATIENT & OUTPATIENT AUDIT ID'S from INPATIENT AND OUTPATIENT AUDIT ID'S AND AUDIT MESSAGES

b. Table- A - Pre-Processing Audits Format and Claim Construction Checks**.**
   i. Table A is reformatted Audit Message ID and Message are Merged
   ii. Inpatient and Outpatient Audit ID's and Audit Messages have been revised to:
      a. Updated and clarified the audit list messages, providing a Text explanation for each "RJ000" messages.
      b. Modify existing table with clear definitions and add new Audit Messages from RJ048 –RJ059
      c. Added RJ060 for Emergency Department data submission in Institutional format.

c. Table- B **-**Claim Level Audits and Error Messages:
THCIC Inpatient Outpatient Audit Comparison to Table - Containing Audits and Error Messages: (Moved the old Table B Claim Level Audits from website http://www.dshs.state.tx.us/thcic/hospitals/HospitalReportingRequirements.shtm in Microsoft Excel file and incorporated into a table under Appendix – A-5, Table - B -Claim Level Audits

1. Table B Claim Level Audits Updated the following Audits:
   a. Audit code 646 for Inpatient claims is modified adding the new code name "Point of Origin" (Admission Source).
2. Audit code 646 Outpatient Institutional is added as "Missing Point of Origin (Admission Source) Code for Outpatient ED".
3. Audit code 647 added Missing Patient Status Code for Outpatient ED (Outpatient Institutional claims only).
4. Audit code 655 Invalid Point of Origin (Admission Source) code for inpatient claims the Audit Message and Audit Description are updated from " Invalid Admission Source" and " The Admission Source Code is a required field and must contain a valid value of 1 - 9, A." to "Invalid Point of Origin (Admission Source)" and "The Point of Origin (Admission Source) Code is required and must contain one of the following values: 1, 2, 4, 5, 6, 8, 9, D, E, F.", respectively.
5. Audit code 655 Invalid Point of Origin (Admission Source) code for outpatient institutional claims is added
6. Audit code 656 Invalid Admission Type code for outpatient ED claims is added
7. Audit code 657 Invalid Facility Type code for Outpatient Institutional claims, the Audit Description is updated to " The Facility Type Code field contains an invalid Outpatient-I unique allowable value. The Facility Type Code is the first two characters of the claim's bill type" from "Outpatient-I unique allowable values".
8. Audit code 657 Invalid Facility Type code for Outpatient Professional claims, the Audit Description is updated to " The Facility Type Code field contains an invalid Outpatient-I unique allowable value. The Facility Type Code is the first two characters of the claim's bill type" from "Outpatient-P unique allowable values".
9. Audit code 658 Invalid Claim Frequency Type code for Outpatient Institutional claims, the Audit Description is updated to "The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type." from "Outpatient-I unique allowable values".
10. Audit code 658 Invalid Claim Frequency Type code for Outpatient Professional claims, the Audit Description is updated to "The Claim Frequency Type Code contains an invalid value. The Claim Frequency Type Code is the third character of the claim's bill type." from" from "Outpatient-P unique allowable values".
11. Audit code 666 Invalid Patient Discharge Status code for outpatient ED claims is added
12. Audit code 675 Invalid Unit code the description field has the "F2" code removed from the listing for Inpatient and Outpatient Institutional claims.
13. Audit Code 710 Description the phrase "Primary Practitioner" is replaced by "Other Provider".
14. Audit Code 742 Description the phrase "Primary Practitioner" is replaced by "Rendering Provider".

15. Audit code 759 Invalid Procedure through Date for Outpatient Institutional and Outpatient Professional claims was removed since it is duplicated.
16. Audit code 733 - Out/P - Invalid Reason for visit code is deleted from the table.

Data Reporting Requirements in section: Data Correction -We had a section: Audit List, that contain audits and messages used by THCIC for auditing inpatient and outpatient data we made it available in this documentation

1 Appendix B1 and B2 are renumbered to Appendix A7 and A8 respectively
2 New Appendix A7 KEY DATA ELEMENTS FOR MATCHING INPATIENT CLAIMS Footnote - language regarding UB92 electronic file structure deleted.
3 New Appendix A8 KEY DATA ELEMENTS FOR MATCHING OUTPATIENT CLAIMS Footnote - language regarding UB92 electronic file structure deleted.
4 Appendix - A9 PAST VERSION CHANGES THAT HAVE BEEN MADE TO THIS DOCUMENT is added new. It is the listing of all past changes to the different 5010_Inpatient_and_Outpatient-Appendices manual versions is added to the end of the document.

## Changes from Version 1 to Version 2

1. **Appendix – A1** Valid Country Codes the following updates are made
   a. Webpage Hyperlink updated to http://www.iso.org/iso/country_codes/iso_3166_code_lists.htm\ from http://www.iso.org/iso/en/prods-services/iso3166ma/02iso-3166-code-lists/list-en1.html
   b. AX- ÅLAND ISLANDS is added
   c. BO - BOLIVIA, PLURINATIONAL STATE OF is changed from "BOLIVIA"
   d. CW – CURAÇAO is added
   e. GG- GUERNSEY is added
   f. IM- ISLE OF MAN is added
   g. JE- JERSEY is added
   h. LY- LIBYA is changed from "LIBYAN ARAB JAMAHIRIYA"
   i. ME – MONTENEGRO is added
   j. AN - NETHERLANDS ANTILLES is deleted
   k. BL - SAINT BARTHÉLEMY is added
   l. SH - SAINT HELENA, ASCENSION AND TRISTAN DA CUNHA is changed from "SAINT HELENA"
   m. MF - SAINT MARTIN (FRENCH PART) is added
   n. RS – SERBIA is changed from "CS - SERBIA AND MONTENEGRO"
   o. SX - SINT MAARTEN (DUTCH PART) is added
   p. SS - SOUTH SUDAN is added
   q. VE - VENEZUELA, BOLIVARIAN REPUBLIC OF is changed from "VENEZUELA"

2. **Appendix – A2** Default or Missing Data Values
   a. Unknown Social Security Number
      i. Removed reference to UB92 Record.Field
      ii. Updated segment references for Loop 2010CA to K301 from REF02
   b. Unknown ZIP Code - Removed reference to UB92 Record.Field

c. Temporary Licenses
   i. Removed reference to UB92 Record.Field
   ii. INPATIENT CLAIMS DATA
      1. Title added
      2. Segment references are updated NM109 for NPI and REF02 for State License numbers
   iii. OUTPATIENT CLAIMS DATA tables added
      1. INSTITUTIONAL Guide Loops and Segments added
      2. PROFESSIONAL Guide Loops and Segments added.

a. Alcohol, Drug Use and HIV Conditions – Table – Patient SSN – Loop 2300 with K301 replaces Loop 2010CA with REF02.

**3. Appendix – A5** Inpatient and Outpatient Audit ID's and Audit Messages – Table B Claim Level Audits – Audit 677 is deleted.

**4. Appendix – A6** Payer Source Coding Guide – Table –

a. Self/Private Pay, Code "09" is deleted
b. Self-Pay moved to "ZZ" code
c. Liability Code "LI" is deleted.