Division of Health Statistics
Tennessee Department of Health

Hospital Discharge Data System

User Manual

2011

Hospital Discharge Data System
User Manual

STATE OF TENNESSEE
Department of Health
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, **6th** Floor
425 Fifth Avenue North
Nashville, TN 37243
615-741-1954

Department of Health. Authorization No. 343381
05/13 Web site only

Table of Contents

Section I

1. Introduction…… ……..5
2. Reporting Procedures…..……...6
3. Changes to the Manual 2007 through 2011……...7

Section II

1. Data System Summary.....10
2. Timing and Frequency of Data Submission.....13
3. Format for Data Submission.....14
4. General Reporting Requirements.....15
   4.1 UB-04 Billing Contact.....15
   4.2 Reportable Records.....15
   4.3 Reporting of Multi-Page or Continuation Bills……16
   4.4 Reporting of Wrong Procedure, Wrong Patient, Wrong Site……...16
   4.5 Special Reporting Requirements.....17
   4.6 Data Editing and Quality Control.....18
   4.7 Default Values.....18
   4.8 ICD-10 Coding…….18
5. Record Format Information…….…19
6. HDDS Contacts……...20

Section III

1. Required Data Elements and Codebook Definitions.....22
2. Data Dictionary.....26
3. UB-04 Data Record Format.....130

Section IV

1. Enabling Legislation – TCA 68-1-108.....139
2. Rules and Regulations.....140
3. Transmittal Information Form.....147
4. Reporting Method Form.....148
5. UB-04 Reporting Form.....149
6. US Standard State Abbreviations.....150
7. English Country name and Code Elements ISO 3166 – 1..……151
8. Source of Admission Codes – 2007 ……157
9. Payer Classification Codes (Primary, Secondary and Tertiary) – 2007……..…159

SECTION I

Introduction

Background

In 1975, the American Hospital Association brought the National Uniform Billing Committee (NUBC) together to develop a single *billing form* and standard data set that could be used nationwide by institutional providers and payers for handling health care claims. In 1982, the NUBC voted to accept the UB-82 and its associated data manual for implementation as a national uniform bill. Virtually all states adopted the use of the UB-82 data set.

When the NUBC established the UB-82 data set design and specifications, it also imposed an eight-year moratorium on changes to the structure of the data set design. Upon the expiration of the moratorium, the NUBC embarked on a process to evaluate how well the UB-82 data set performed and consequently, the UB-92 was created, incorporating the best of the UB-82 along with other changes that further improved on the previous data set design.

Tennessee Code Annotated (T.C.A.), Section 68-1-108, prior to July 1994 required insurance companies to submit UB-92 claims data to the Department of Health. However, in July 1994, the law was revised and T.C.A., Section 68-1-108 now requires each licensed hospital to report all claims data found on the UB-92 form or a successor form on every inpatient and outpatient discharge to the commissioner of health.

In 2007, a nationwide change from the UB-92 form for hospital claims billing to the UB-04 form occurred. The reporting of claims billing data from Tennessee hospitals to the Department of Health also changed at that time.

Hospital Discharge Data System

The purpose of the Hospital Discharge Data System (HDDS) is to collect and summarize hospital claims data so charges for similar types of services can be analyzed and compared in order to help promote a more price competitive environment in the medical marketplace. This data can also be used as a tool to gauge the delivery of health care services to patients and has broad policy implications for shaping the future of our health delivery system.

All hospitals licensed by the Tennessee Department of Health (TDH) are required by Tennessee law to report patient-level discharge information to the Department. Discharges from rehabilitation hospitals, from rehabilitation and psychiatric units within acute care hospitals, and from free-standing ambulatory surgical treatment centers that are part of a hospital, should all be reported if they are from a TDH licensed hospital and meet the requirements for "Reportable Records" as defined in Section II.4.2. Discharges for charity or free care are included in the reporting requirement and they are handled similarly.

The current system is based on the UB-04 form. This system has been revised in accordance with UB-04 definitions, layouts and standards. In addition an effort has also been made to define commonly used health claim data items into the UB-04 coding structure for those health care facilities whose data systems contain information which is not organized according to UB-04 definitions and standards.

Reporting Procedures

Hospitals may comply with the reporting requirements in T.C.A., Section 68-1-108 in one of two ways:

1) Hospitals can participate in the Tennessee Hospital Association's Health Information Network (THA-HIN) and use its vendor to provide data reporting services. The vendor edits the data and provides a mechanism to hospitals for correcting data each quarter. The vendor also provides detailed reports to the hospitals based on the data and submits edited and corrected data to the Department's Hospital Discharge Data System staff each quarter. *Hospitals submitting data directly to the Tennessee Hospital Association are known as HIN hospitals.*

2) Hospitals or their designated data vendor create data files in the UB-04 format with standard codes and submit them to the Tennessee Department of Health's Hospital Discharge Data System staff. Allowable data submission media are described in Section II of this manual. *Hospitals submitting data directly to the Tennessee Department of Health are known as Non-HIN hospitals*.

For HIN hospitals data submission 1) the THA-HIN and its vendor will be responsible for all data quality processes and procedures used to finalize data for their client hospitals each quarter provided the data submitted by the vendor to the Department does not exceed the allowed error margins. HIN hospitals should follow reporting instructions provided by the vendor or by the THA.

For Non-HIN hospitals data submission 2) above, the Department will coordinate quality control procedures and communicate with the hospitals in order to improve data quality. Respondents with non UB-04 standard computerized data systems or any other non-standard circumstances should check with the HDDS staff in advance of data reporting

Changes to the Manual from 2007 through 2011

Numerous and significant changes have been made to the UB-04 manual from 2007 through 2011. Some fields have been have been changed or codes have been added or deleted for existing fields. To reflect these changes please review the new reporting instructions needed for claims data reporting.

Type of Bill field has changed from a three digit code field to a four digit code field. The first digit is currently reported as a leading zero on ***most*** bill types. See Section III.2. Data Dictionary for further instructions on this field.

The Source of Admission field is now called the ***Point of Origin/Visit*** field. The point of origin is where the patient came from before presenting to this hospital. The following codes are no longer valid for this field:

Code 7 – Emergency Room
Code B – Transfer from another Home Health Agency
Code C – Readmission to Same Home Health Agency

The reporting of **Wrong Procedure, Wrong Patient, Wrong Site** for inpatient claims can be handled according to current CMS reporting instructions. This is the preferred procedure. Facilities that would find the preferred procedure to be very difficult may use an alternate reporting procedure. This is based on the previous CMS instructions. The reporting of outpatient claims is the same for both procedures of inpatient reporting. See Section II 4.4 Reporting of Wrong Procedure, Wrong Patient, Wrong Site.

The ***HCPCS/Rates/HIPPS Rates Codes*** field is now a six position field. The sixth position should be left blank with the current five-digit HCPCS code. This will allow for possible future expansion to six digits. The two-digit modifiers should then begin in the seventh, ninth, eleventh, and thirteenth positions.

Payer Code "T" (TennCare NOS) and "O"(Other, Unknown). Both are valid payer codes but no more than 10% of the inpatient or outpatient discharges should be flagged using either of these codes. Since an actual payer must be known in order to bill, use of these codes should be very rare.

Payer Code "N" (Division of Health Services voc. Rehab). Usage of this code has expanded and should be used if the payer for prisoners is not covered by an existing payer code.

Patient Status Code "21" (Discharged/Transferred to Court/Law Enforcement). This new patient discharge status code has been added at the national level for any prisoner from whom a facility provides heath care.

The former Medicare Provider Number field is now used to report the ***Joint Annual Report ID (JAR)***. This is a required field for all records submitted by a HIN hospital. The facility National Provider ID (NPI) is a required field for every discharge record.

Changes to the Manual from 2007 through 2011 (continued)

Admitted From ED Flag. This is a new field (field number 262). If any Condition Code has a value of "P7" then report "Y" in this field. Otherwise report "N".

SECTION II

Data System Summary

Data Set Name: Hospital Discharge Data System (HDDS)

Location/Owner of Data Set: Tennessee Department of Health, Division of Health Statistics

System Administrator: George Wade (615) 532-7883

Purpose for Which Data Collected: This system collects and summarizes data so that charges for similar types of services may be analyzed and compared in order to help promote a more price competitive environment in the medical market place. This data also provides useful information for assessing the health status of Tennesseans.

Restrictions on Data Use: Confidential data is restricted and is accessible only for approved research projects. This data may not be sold, transferred, or used for any purpose or purposes other than those stated in the approved request.

Process for Accessing Data: Requests for data are handled by Statistical Services. Contact Statistical Services at (615) 741-4939 or HealthStatistics.Health@tn.gov.

Description:
Method of Data Collection: UB-04 forms
Percent Return: 95% - 99%
Frequency of Updating: Annually
Years of Data: UB-92: 1995 – 2007; UB-04: 2007 – Present

Types of Data Output Available: Fixed format text files on CDs

Cost for Data Output: Yes

Standard Reports Generated: Hospital Charge Reports

UB – 04 Data Elements:
Patient Control Number
Medical/Health Record Number
Type of Bill
Federal Tax Number Sub ID
Federal Tax Number
Statement Covers Period From – Through
Patient Address – City
Patient Address – State
Patient Address – Zip Code
Patient Address – Country Code
Birth Date of Patient
Sex of Patient

UB – 04 Data Elements: (continued)

Admission Date
Admission Hour
Type of Admission/Visit
Point of Origin
Patient Discharge Status
Do Not Resuscitate Flag
Accident State
Accident Code
Accident Date
Revenue Codes
HCPCS/Rates/HIPPS Rates Codes
Service Date(s)
Creation Date
Units of Service
Total Charges by Revenue Code Category
Non-Covered Charges
Classification of Payer(s)
Health Plan Identification Number
Patient's Relationship to Insured(s)
National Provider Identification (NPI)
Patient Relationship to Insured
Insured's Unique ID Number
Insurance Group Number(s)
Name of Insured's Employer
Diagnosis and Procedure Version Qualifier
Principal Diagnosis Code with POA
Other Diagnosis Codes with POA
Admitting Diagnosis Code
Patient Reason for Visit Code
Prospective Payment System (PPS)
External Cause of Injury Code (E-Code)
Principal Procedure Code
Principal Procedure Date
Other Procedure Codes and Dates
Attending Provider ID Numbers
Operating Provider ID Numbers
Other Provider1 ID Numbers
Other Provider2 ID Numbers
Joint Annual Report of Hospitals ID (JAR)
Social Security Number of Patient
Race/Ethnicity of Patient
Type of Emergency Department Visit
Outcome of Emergency Department Visit

UB – 04 Data Elements: (continued)

Patient Address – Street
Patient Initials
Primary Insured Initials
Secondary Insured Initials
Tertiary Insured Initials
Patient Name – First and Last
Primary Insured Name – First and Last
Secondary Insured Name – First and Last
Tertiary Insured Name – First and Last

Timing and Frequency of Data Submission

All data must be received by the Department or the THA-HIN vendor within 60 days following the close of the period during which the hospital discharge occurred according to the following quarterly schedule:

Quarter	Time Span	Submission Deadline
Q1	January 1 – March 31	May 30
Q2	April 1 – June 30	August 29
Q3	July 1 – September 30	November 29
Q4	October 1 – December 31	March 1

After editing and correcting as necessary, the THA-HIN vendor will submit data on a regular schedule to the Department. The vendor must receive the hospital's data by the above submission due date in order to meet the agreed upon dates required by the Department for final quarterly data.

Data reported directly to the Department should be sent to:

Hospital Discharge Data System
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 5th Avenue North
Nashville, Tennessee 37243

Format for Data Submission

Data Submission Media

Currently, data submitted directly to the Department should use one of the following media types:

- PC Compatible CD-ROM
- ASCII - File E-Mail Attachment
- Secure Website

All data should be provided in display format with no packed fields.

All CD-ROMs must have an external label including the hospital name, address, number of records, and the reporting time frame for the data (i.e., 4th quarter, 2010).

Data sent via e-mail attachment *should* be accompanied with a Transmittal Information Form (see details below) that contains this information.

Hospitals submitting data through the THA-HIN vendor should follow instructions provided by the vendor or by THA.

Data Submission Forms

Reporting Method Form: This form is sent out as a reminder of the data submission due date to hospitals reporting directly to HDDS. It tells *how* the data will be reported to HDDS *or if the facility will submit their data through THA* for that quarter. This form is required for hospitals reporting directly to HDDS. A copy of the form is in Section IV.4. This form can be faxed, e-mailed or sent by regular mail on/before the date indicated on the form. This form has been revised and will be used starting with 2011 data.

Transmittal Information Form: This form is required for hospitals reporting directly to the HDDS and must be included with each data submission. A copy of the form is in Section IV.3. This form can be faxed, e-mailed or sent by regular mail *along* with the data. This form has been revised and will be used starting with 2011 data.

General Reporting Requirements

UB-04 Billing Contact

Additional information on the use of the UB-04 billing form is contained in the National Uniform Billing Committee's Official UB-04 Data Specifications Manual. This can be obtained by contacting:

American Hospital Association
National Uniform Billing Committee – UB-04
P.O. Box 92247
Chicago, IL 60675-2247

For questions call 312-422-3390.

There is a charge for this publication. The Official UB-04 Data Specification Manual is not necessary, however, for data reporting. Tennessee's UB-04 format follows the national standard.

Reportable Records

Reporting of the following records is required:

- All inpatient records.
- All emergency room records. These are defined as having a revenue code in the range of 0450 through 0459 in any revenue code field.
- All outpatient observation records. These are defined as having a revenue code of 0760, 0762, or 0769 in any revenue code field. (These are also known as twenty-three hour observation records.)
- All ambulatory surgery records. These are defined as having a procedure code in the range 00.01 through 86.99. These records should be reported for the specified procedure codes whether found in the Principal Procedure Code field or in any of the Other Procedure Code fields.
- Selected Diagnostic Service records. These records require several new outpatient bill types (012X, 014X and 07XX) in addition to any discharges that would have met the previous definition for required reporting. However, the submission of discharges with these newly added bill types only apply to the reporting of five new selected diagnostic services that require certificate of need (CON) approval.

  Bill type 012X indicates "Hospital Inpatient – Medicare Part B"; bill type 014X indicates "Hospital – other (for hospital referenced diagnostic services)"; and bill type 07XX

Reportable Records (continued)

indicates services provided by hospital clinics. If records with these bill types or any other previously required record includes the following diagnostic services (as defined by revenue codes), this discharge is required.

1. Lithotrispy: Bill type = inpatient or outpatient and revenue code = 079X in any revenue code field.
2. PET Scans: Bill type = inpatient or outpatient and revenue code = 0404 in any revenue code field.
3. MRIs and MRAs: Bill type = inpatient or outpatient and revenue code = 061X in any revenue code field.
4. Megavoltage radiation therapy: Bill type = inpatient or outpatient and revenue code = 0333 in any revenue code field.
5. CT Scans: Bill type = inpatient or outpatient and revenue code = 035X in any revenue code field.

Reporting of Multi-Page or Continuation Bills

- The record layout for reporting hospital discharge claims to the Department of Health only allows twenty-three (23) lines for the reporting of revenue codes with their associated fields. Each line allows for the reporting of one revenue code and all its associated fields. Each distinct revenue code/HCPCS code combination necessitates the generation of a line. Also, each new revenue code without a HCPCS code necessitates the generation of a new line, with the HCPCS field left blank. Frequently, a claim may have more than twenty-three lines. These longer claims are called multi-page or continuation bills. The reporting of a multi-page bill will require the use of two or more records.
- Each record of a multi-page bill will contain duplicate information on all fields of the bill except for the revenue codes and their associated fields (fields 24—39) and except for total of total charges (field 140). The revenue codes and associated fields will vary as needed to provide complete reporting for the bill. (The Data Dictionary pages for the revenue codes and associated fields provide more detail on their reporting.) The total of total charges will only be reported on the last record of the bill. It will be left blank on all previous records

Reporting of Wrong Procedure, Wrong Patient, Wrong Site

- The reporting of Wrong Procedure, Wrong Patient, and Wrong Site for inpatient claims can be handled according to current CMS reporting instructions. This is the preferred procedure. Facilities that would find the preferred procedure to be very difficult may use an alternate reporting procedure. This is based on the previous CMS instructions. The reporting of outpatient claims is the same for both procedures of inpatient reporting.

Reporting of Wrong Procedure, Wrong Patient, Wrong Site (continued)

- **Preferred Procedure for Reporting Inpatient Claims:** Both the right claim and the wrong claim should be reported. The right claim should be reported normally.

- The wrong claim should be reported as a Type of Bill 110, i.e. put "0110" in positions 76-79. The E-codes for wrong procedure, wrong patient, or wrong site should be reported in the "Other Diagnosis Codes" fields as they are reported to CMS. The appropriate E-codes are:

  E8765 – Performance of wrong operation (procedure) on correct patient
  E8766 – Performance of operation (procedure) on patient not scheduled for surgery
  E8767 – Performance of correct operation (procedure) on wrong side/body part

- **Alternate Procedure for Reporting Inpatient Claims:** Both the right claim and the wrong claim should be reported. The right claim should be reported normally.

- The wrong claim should be reported with the applicable CMS surgical error code put in positions 2273-2274 of the record. The CMS surgical error codes are "MX" for a wrong surgery on the patient, "MY" for surgery on the wrong body part, and "MZ" for surgery on the wrong patient.

- **Procedure for Reporting Outpatient Claims:** Only one claim should be reported. To indicate the surgical error the NCD modifier specified by CMS should be reported as a modifier to the appropriate CPT code. These modifiers are "PA" for surgery on the wrong body part, "PB" for surgery on the wrong patient, and "PC" for a wrong surgery on the patient.

Special Reporting Requirements

- Newborn admissions should generate a separate record from that of the mother, even for normal well newborns. The appropriate codes are admission type "4" point of origin "5" or "6" and the appropriate primary diagnosis code.

- All data submitted should be final, admission-through-discharge data for a particular reporting period. Interim bills should be held until they can be combined and submitted as a final bill.

- Procedures performed within 72 hours of admission should be included as part of the discharge record. Those performed earlier should be submitted as a separate record.

- Charity/free discharges are required to be reported. Like other discharges, the physician/professional ID number(s) reported on these records should be the ID number for those who attended the patient while in the hospital. Identification numbers are required for the attending physician/professional and others involved in the management of the patient's medical care.

Special Reporting Requirements (continued)

- Discharges from Skilled Nursing Facilities (SNF) units are not reportable. SNF claims will not be included in the final database because SNF units are licensed as nursing home beds not as hospital beds. Swing bed utilization is reportable if the bed is used for acute care service.

- Satellite hospitals licensed under a parent facility must file separate UB-04 claims data from the parent hospital. The UB-04 data for a parent and its satellite can be submitted together as long as the records from each facility are in separate files and identified separately.

- Discharges from Rehabilitation and Psychiatric units of acute care hospitals and from Rehabilitation Hospitals are required to be reported.

- If the hospital licensed its outpatient surgery unit as a freestanding ambulatory surgery treatment center, reporting these discharges is required. The type of bill for outpatient surgery claims will usually be "831" ("8"=Special Facility; "3"=Ambulatory Surgery Treatment Center; "1"=Admit through Discharge claim).

Data Editing and Quality Control

The Hospital Discharge Data System staff will review and edit data submitted directly to the Department. If errors or inconsistencies are identified when UB-04 data are edited, the Hospital Discharge Data System staff will report the errors to the appropriate hospital in writing. The hospital will be asked to investigate these errors and to supply correct information **within 15 working days** of the date that the error is reported to the hospital.

For hospitals that have signed agreements with THA and have their data edited and corrected prior to being submitted to the Hospital Discharge Data System each quarter, no additional edits will be performed unless the data exceeds the error threshold set by the Tennessee Department of Health**.**

Default Values

Default values have been defined for some of the required fields. The use of default values will prevent errors from being flagged when a required data item is unavailable or unknown. Default values for a field, if present, are given in the Data Dictionary in Section III.2.

ICD-10 Coding

In October 2013 CMS is moving to ICD-10 for diagnoses and procedures. Some Payers may not require use of ICD-10, but all UB reporting will be expected to use ICD-10 diagnosis and procedure codes beginning with October 2013 discharge.

Reporting of outpatient principal procedures are required to be in ICD procedure codes. This also includes ALL outpatient procedures using CPT/HCPCS.

Record Format Information

Alpha-Numeric fields (A):
Left justify and blank fill to the right.

Numeric fields (N):
Right justify, unpacked, and zero filled to the left.

Numeric Format for Charge and Non-Covered Charge Fields
All charge fields (Fields 117-164) should be reported as numeric fields, right justified, unpacked, and zero filled to the left with an implied two decimals. In the case of a credit, replace the leading zero with a minus (-) sign. For example, a charge of $1230.00 would be reported as 0000123000. Likewise, a credit of $1230.00 would be reported as -000123000. This same format should be used when reporting accommodation rates in the HCPSC/Rates/HIPPS Rate Codes (Fields 47-69).

Non-covered charges are a new requirement for UB-04 reporting. They should be reported on all relevant claims. According to the UB-04 billing guidelines the Total Charges fields (FL 47) include both covered and non-covered charges and the portion of the total charges that are not covered are identified in the non-covered charges fields (FL 48).

This format replaces the COBOL signed format (PIC S9 (8) V99) that was used for reporting charges on the UB-92 layout.

Revenue code and charge values:
After the entry for the last Revenue Code, any remaining Revenue Code and Charge fields must be blank or zero filled. No zero filled, or space filled Revenue Code or Charge fields should precede the last Revenue Code and Charge (except for items having a Charge of $0.00).

See Section III 2 Data Dictionary for the instructions on Reporting of Revenue Code Line Item Fields for more detail.

HDDS Contacts

Technical questions regarding the Tennessee Hospital Discharge Data System should be directed to:

George Wade
Manager, Patient Record Data Systems
Division of Health Statistics
(615) 532-7883
George.Wade@tn.gov

OR

Glenn Baker
Manager, Hospital Discharge Data System
Division of Health Statistics
(615) 532-7861
Glenn.Baker@tn.gov

SECTION III

Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type **N:** Numeric **A-N:** Alpha-Numeric	UB-04 Form Locator*	Page No.
1	Filler	A-N	- -	N/A
2	Patient Control Number	A-N	Form Locator 3A	26
3	Medical/Health Record Number	A-N	Form Locator 3B	27
4	Type of Bill	N	Form Locator 4	28
5	Federal Tax Sub ID Number	A-N	Form Locator 5	30
6	Federal Tax	A-N	Form Locator 5	31
7 – 8	Statement Covers Period – From and Through	N	Form Locator 6	32
9	Patient's Address – City	A-N	Form Locator 9B	33
10	Patient's Address – State	A-N	Form Locator 9C	34
11	Patient's Address – Zip Code	A-N	Form Locator 9D	35
12	Patient's Address – Country Code	A-N	Form Locator 9E	36
13	Patient's Date of Birth	N	Form Locator 10	37
14	Patient's Sex	A-N	Form Locator 11	38
15	Admission Date	N	Form Locator 12	39
16	Admission Hour	A-N	Form Locator 13	40
17	Type of Admission/Visit	A-N	Form Locator 14	41
18	Point of Origin/Visit	A-N	Form Locator 15	42
19	Patient Discharge Status	A-N	Form Locator 17	45
20	Do Not Resuscitate Flag	A-N	- -	46
21	Accident State	A-N	Form Locator 29	47
22	Accident Code	A-N	- -	48
23	Accident Date	N	- -	49
24 – 46	Revenue Codes	N	Form Locator 42	50
47 – 69	HCPCS/Rates/HIPPS Rates Codes	A-N	Form Locator 44	52
70 – 92	Service Date(s)	N	Form Locator 45	54
93	Creation Date	N	Form Locator 45	55
94 – 116	Unit(s) of Service	N	Form Locator 46	56
117 – 139	Total Charges (by Revenue Code Category)	N	Form Locator 47	57
140	Total of Total Charges	N	- -	59
141 – 163	Non-Covered Charges (by Revenue Code Category)	N	Form Locator 48	60
164	Total of Non-Covered Charges	N	- -	62

Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type **N**: Numeric **A-N**: Alpha-Numeric	UB-04 Form Locator*	Page No.
165	Payer Classification Code - Primary	A-N	50A	63
166	Payer Classification Code - Secondary	A-N	50B	65
167	Payer Classification Code - Tertiary	A-N	50C	67
168	Health Plan ID – Primary (formerly Provider Number)	A-N	Form Locator 51A	69
169	Health Plan ID – Secondary (formerly Provider Number)	A-N	Form Locator 51B	70
170	Health Plan ID – Tertiary (formerly Provider Number)	A-N	Form Locator 51C	71
171	National Provider ID (NPI)	A-N	Form Locator 56	72
172	Patient's Relationship to Insured-Primary	A-N	Form Locator 59A	73
173	Patient's Relationship to Insured – Secondary	A-N	Form Locator 59B	74
174	Patient's Relationship to Insured – Tertiary	A-N	Form Locator 59C	75
175	Insured's Unique ID Number – Primary	A-N	Form Locator 60A	76
176	Insured's Unique ID Number – Secondary	A-N	Form Locator 60B	77
177	Insured's Unique ID Number – Tertiary	A-N	Form Locator 60C	78
178	Insurance Group Number – Primary	A-N	Form Locator 62A	79
179	Insurance Group Number – Secondary	A-N	Form Locator 62B	80
180	Insurance Group Number – Tertiary	A-N	Form Locator 62C	81
181	Name of Primary Insured's Employer	A-N	Form Locator 65A	82
182	DX and PX Version Qualifier	A-N	Form Locator 66	83
183	Principal Diagnosis Code	A-N	Form Locator 67	84
184	Present On Admission Code (POA) for Principal Diagnosis	A-N	Form Locator 67	85

Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type **N:** Numeric **A-N:** Alpha-Numeric	UB-04 Form Locator*	Page No.
185 – 218	Other Diagnosis Codes and POA 1 – 17	A-N	Form Locator 67A - Q	87
219	Admitting Diagnosis Code	A-N	Form Locator 69	91
220 - 222	Patient's Reason for Visit Code	A-N	Form Locator 70A–C	92
223	Prospective Payment System Code (PPS)	A-N	Form Locator 71	93
224	External Cause Of Injury Code (E Code)1	A-N	Form Locator 72A	95
225	E-Code1 POA	A-N	Form Locator 72A	96
226	External Cause Of Injury Code (E Code)2	A-N	Form Locator 72B	95
227	E-Code2 POA	A-N	Form Locator 72B	96
228	External Cause Of Injury Code (E Code)3	A-N	Form Locator 72C	95
229	E-Code3 POA	A-N	Form Locator 72C	96
230 – 231	Principal Procedure Code and Date	A-N	Form Locator 74	98
232 – 233	Other Procedure Code and Date1	A-N	Form Locator 74A	100
234 – 235	Other Procedure Code and Date2	A-N	Form Locator 74B	100
236 - 237	Other Procedure Code and Date3	A-N	Form Locator 74C	100
238 – 239	Other Procedure Code and Date4	A-N	Form Locator 74D	100
240 – 241	Other Procedure Code and Date5	A-N	Form Locator 74E	100
242 – 244	Attending Physician ID Number	A-N	Form Locator 76	102
245 – 247	Operating Physician ID	A-N	Form Locator 77	103
248 – 250	Other Provider ID1 Number	A-N	Form Locator 78	104
251 – 253	Other Provider ID2 Number	A-N	Form Locator 79	105
254	Joint Annual Report ID	A-N	- -	106
255	Patient's Social Security Number	A-N	- -	107
256	Patient's Race/Ethnicity	N	- -	108
257	Type of Emergency Department Visit	A-N	- -	109

Required Data Element and Codebook Definitions

Field No.	Field Description	Field Type **N:** Numeric **A-N:** Alpha-Numeric	UB-04 Form Locator*	Page No.
258	Outcome of Emergency Department Visit	N	- -	110
259 – 261	Fields for Vendor and State use only	A-N	- -	N/A
262	Admitted From ED Flag	A-N	- -	111
263	Wrong Procedure/Patient/Site Code	A-N	- -	112
264	Patient Initials First and Last Name	A-N	- -	113
265	Primary Insured Initials – First and Last Name	A-N	- -	115
266	Secondary Insured Initials – First and Last Name	A-N	- -	117
267	Tertiary Insured Initials – First and Last Name	A-N	- -	119
268	Patient Address – Street	A-N	Form Locator 9A	121
269	Patient Name – First	A-N	Form Locator 8A	122
270	Patient Name – Last	A-N	Form Locator 8B	123
271-272	Primary Insured's Name – First and Last	A-N	Form Locator 58A	124
273-274	Secondary Insured's Name – First and Last	A-N	Form Locator 58B	126
275-276	Tertiary Insured's Name – First and Last	A-N	Form Locator 58C	128

* A number that specifies the location of the data field on the paper UB-04 form.

A-N = Alpha Numeric
N = Numeric

Field Detail:

Data Dictionary

Field No.	Field Description
2	Patient Control Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	26 – 50	Left Justified	Yes	3A

Description:
Patient Control Number (or Account Number) is the number assigned to this patient *for this date of service.* This number will not be used again by this hospital. It is unique for this visit and for this date of service.

Used to uniquely identify a particular data record for systems development, management, and control purposes and to facilitate retrieval of claims or patient records by the hospital for communication regarding errors found on individual records. Also used to merge interim claims.

Comments:
This data item is required. Providing this data does not breach individual patient confidentiality since the system has no number-name matching information. This field is not released to the public.

Data Dictionary

Field No.	Field Description
3	Medical/Health Record Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	51 – 75	Left Justified	Yes	3B

Description:
Medical record number is a number the hospital assigns to each patient. This number is unique to the patient and is always used whenever the same patient has services at the hospital.

The medical/health record is typically used to do an audit of the history of treatment. This number should not be confused with the Patient Control Number (Form Locator 3A) which is used to track the financial history of the patient.

This data is used to assist hospital personnel in locating a specific medical record. Selected types of discharges are studied in detail by the health department staff (i.e., traumatic brain injury cases and birth defects cases).

Comments:
Do not substitute Patient Control Number. Both fields must be provided.
This field is not released to the public.

Data Dictionary

Field No.	Field Description
4	Type of Bill

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha Numeric	4	76 – 79	Right Justified	Yes	4

Description:
A four-digit code indicating the specific type of facility, bill classification, and the frequency of billing. The first of the four digits is reported as a leading zero.

This code is used to verify and distinguish between inpatient and outpatient hospital claims, to identify and merge interim claims, and to verify discharge date.

Valid Values:
The first digit is currently reported as a leading zero on ALL bill types.

Second Digit: Type of Facility	Third Digit: Inpatient or Outpatient	Fourth Digit: Frequency of Bill
1 = Hospital 4 = Christian Science Hospital 8 = Special Facility	1 = Inpatient 3 = Outpatient or Ambulatory Surgery Center 4 = Outpatient – Other 5 = Critical Access Hospital	0 = Nonpayment 1 = Admission through Discharge Claim 5 = Late Charge(s) – Only Claim 7 = Replacement of Prior Claim 8 = Void/Cancel of Prior Claim

Example: 0111 = Hospital, Inpatient, Admission through Discharge Claim

Comments:
The discharge date is not included on the UB-04 form. The Type of Bill and the Statement Covers Period data elements are used to determine the discharge date.

All data submitted should be final, admission-through-discharge data for a particular reporting period. Interim bills should be held until they can be combined and submitted by the hospital as a final bill. The final bill should reflect all charges and services provided during the entire stay.

Three special outpatient bill types (012X, 014X and 07XX) are only required to be submitted IF selected diagnostic services were provided. If one of these services (defined by revenue code) is not present on the bill, records with these bill types are not reportable. See Selected Diagnostic Service records under Reportable Records in Section II.4.2 Reportable Records for complete instructions.

Field No.	Field Description
4	Type of Bill (continued from previous page)

In addition to its general use, Type of Bill 0110 has a specific use in the preferred procedure for the reporting of Wrong Procedure, Wrong Patient, Wrong site inpatient claims. The right claim should be reported normally.

- **The wrong claim should be reported as a Type of Bill 110, i.e. put "0110" in positions 76-79. The E-codes for wrong procedure, wrong patient, or wrong site should be reported in the "Other Diagnosis Codes" fields as they are reported to CMS. The appropriate E-codes are:**

  E8765 – Performance of wrong operation (procedure) on correct patient
  E8766 – Performance of operation (procedure) on patient not scheduled for surgery
  E8767 – Performance of correct operation (procedure) on wrong side/body part

See Section II.4.4 Reporting of Wrong Procedure, Wrong Patient, Wrong Site for complete instructions.

Data Dictionary

Field No.	Field Description
5	Federal Tax Sub ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	80 – 83	Left Justified	Yes	5

Description:
The Federal Tax Sub ID Number assigned to the hospital that uniquely identifies affiliated subsidiaries.

This number is used to identify subsidiaries of hospitals submitting claims so that the data may be aggregated by and comparison made among hospitals and among their subsidiaries.

Comments:
This field is defined by the provider. Blank is a valid response for a hospital having no Federal Tax Sub ID Number.

Data Dictionary

Field No.	Field Description
6	Federal Tax Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	10	84 – 93	Left Justified	Yes	5

Description:
The number assigned to the provider by the federal government for tax reporting purposes. The number is also known as the tax identification number (TIN) or employer identification number (EIN).

The format for the data is: AA-AAAAAAA.

A unique number used to identify individual hospitals submitting claims so that the data may be aggregated by and comparison made among hospitals.

Data Dictionary

Field No.	Field Description
7 – 8	Statement Covers Period – From and Through

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	16	94 – 109	Right Justified	Yes	6

Description:
This date field covers the beginning and ending service dates of the entire period reflected by this bill.

If this is an interim bill (denoted by a "2" or "3" in the fourth digit of Type of Bill), the ending date would not be considered the discharge date. An individual may receive several interim bills before they are discharged. Interim bills should be held until they can be combined and submitted as a final bill. See Section II.4.5 Special Reporting Requirements for complete instructions.

The format for both Beginning Service Date (94 - 101) and Ending Service Date (102 - 109) is MMDDYYYY. Use leading zeroes when appropriate.

This data element is used in conjunction with Type of Bill (Field Number 4, Form Locator Number 4) to validate admission date and determine discharge date. This information is used to verify reporting period of data and for calculating length of stay of patient hospitalization.

Comments:
This data element can be used to assure that the claim is for the appropriate time period. The claims records should be admission through discharge; however, if this is an interim bill the Statement Covers Period will not be the beginning and ending date of this hospitalization. Discharge date is not indicated explicitly on the UB-04 forms, therefore the fields Type of Bill and Statement Covers Period are used to determine length of stay and discharge date.

Note:
For services received on a single date, both the dates will be the same. These two dates are also known as "from" and "through" dates. This date is distinctly different from Form Locator 12. The "From Date" SHOULD NOT be confused with Admission Date though they may be the same date.

Data Dictionary

Field No.	Field Description
9	Patient's Address – City

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	110 – 139	Left Justified	Yes	9B

Description:
The patient's city address as defined by the payer organization. This data is used to properly classify the patient's city of residence and to allow for analysis by place of residence.

Valid Values:
The following table gives the proper coding of homeless persons and residents of foreign countries for all patient address items:

Address	Patient is Homeless	Patient is a Foreign Resident
State	Leave Blank	Leave Blank
City	**Leave Blank**	**Leave Blank**
Zip Code	H (in first position)	F (in first position)

Data Dictionary

Field No.	Field Description
10	Patient's Address – State

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	140 – 141	Left Justified	Yes	9C

Description:
The patient's state address as defined by the payer organization. This data is used to properly classify the patient's state of residence and to allow for analysis by place of residence.

Valid Values:
The following table gives the proper coding of homeless persons and residents of foreign countries for all patient address items:

Address	Patient is Homeless	Patient is a Foreign Resident
State	**Leave Blank**	**Leave Blank**
City	Leave Blank	Leave Blank
Zip Code	H (in first position)	F (in first position)

Comments:
Use the standard Post Office State Abbreviations for state addresses. These abbreviations are listed in Section IV.6.

Data Dictionary

Field No.	Field Description
11	Patient's Address - Zip Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	9	142 – 150	Left Justified	Yes	9D

Description:
The patient's zip code address as defined by the payer organization. This data is used to properly classify the patient's county of residence and to allow for analysis by place of residence.

Valid Values:
If unknown, fill the first five digits with 9. The remaining four digits can be left blank or filled with 9.

The following table gives the proper coding of homeless persons and residents of foreign countries for all patient address items:

Address	Patient is Homeless	Patient is a Foreign Resident
State	Leave Blank	Leave Blank
City	Leave Blank	Leave Blank
Zip Code	**H (in first position)**	**F (in first position)**

Comments:
Do not include hyphen; it is implied.

Data Dictionary

Field No.	Field Description
12	Patient's Address – Country Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	151 – 154	Left Justified	Yes	9E

Description:
The patient's country code address as defined by the payer organization. This data is used to properly classify the patient's country of residence and to allow for analysis by place of residence.

Valid Values:

- If unknown or United States resident, leave blank.
- Use code UM for American Territories.
- Use code CA for Canadian provinces and territories.
- Use the Alpha – 2 Country Codes from Part I of ISO 3166. See Section IV.7 for a current list of codes.

Data Dictionary

Field No.	Field Description
13	Patient's Date of Birth

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	155 – 162	Right Justified	Yes	10

Description:
Record the patient's date of birth using the format MMDDYYYY.

Use leading zeroes when appropriate.

If some elements of the date of birth are known and some unknown, report the known elements and fill the unknown elements with 9's.

If patient DOB is unknown but Age is known, estimate year of birth (subtract age from current year) and report month and date as unknown, 9999[estimated] YYYY.

If patient DOB is unknown and Age is unknown, report DOB as unknown, 99999999.

This data element is used to determine the age of the patient.

Data Dictionary

Field No.	Field Description
14	Patient's Sex

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	163 – 163	Left Justified	Yes	11

Description:
Enter the sex of the patient according to the following codes:

F = Female
M = Male
U = Unknown

This data element is used in the Diagnostic Related Group (DRG) classification process and in data analysis.

Data Dictionary

Field No.	Field Description
15	Admission Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	164 – 171	Right Justified	Yes	12

Description:
The date the patient was admitted to the hospital for inpatient care, outpatient service, or start of care.

This data should be in the format MMDDYYYY. Use leading zeroes when appropriate.

This data element will be used to help determine the patient's length of stay and to verify the appropriateness of the reporting period for this record.

Note:
This is a discrete data element and SHOULD NOT be confused with the Statement Covers Period "from date" on Form Locator 06.

Data Dictionary

Field No.	Field Description
16	Admission Hour

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	172 – 173	Left Justified	Yes	13

Description:
The code referring to the hour during which the patient was admitted for inpatient care.

Give the hour the patient was admitted using a twenty-four hour clock. Use '99' to indicate unknown admit time.

This field does not apply to outpatients since they are not admitted for inpatient care. This field should be left blank on outpatient records.

Valid time format: 00-23, 99, or blank

Code	Time – AM	Code	Time – PM
00	**12:00 Midnight – 12:59**	**12**	**12:00 Noon – 12:59**
01	**01:00 – 01:59**	**13**	**01:00 – 01:59**
02	**02:00 – 02:59**	**14**	**02:00 – 02:59**
03	**03:00 – 03:59**	**15**	**03:00 – 03:59**
04	**04:00 – 04:49**	**16**	**04:00 – 04:49**
05	**05:00 – 05:59**	**17**	**05:00 – 05:59**
06	**06:00 – 06:59**	**18**	**06:00 – 06:59**
07	**07:00 – 07:59**	**19**	**07:00 – 07:59**
08	**08:00 – 08:59**	**20**	**08:00 – 08:59**
09	**09:00 – 09:59**	**21**	**09:00 – 09:59**
10	**10:00 – 10:59**	**22**	**10:00 – 10:59**
11	**11:00 – 11:59**	**23**	**11:00 – 11:59**
		99	**UNKNOWN**
		Blank	**Record is not an inpatient admission**

Data Dictionary

Field No.	Field Description
17	Type of Admission/Visit

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	174 – 175	Left Justified	Yes	14

Description:
A code indicating the priority of the admission or visit.

This information will be used in data and patient referral analyses.

Valid Values:

Code	Type	Description
1	Emergency	The patient requires immediate intervention as a result of a severe, life threatening or potentially disabling condition.
2	Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder.
3	Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4	Newborn	This code is for a baby born within the facility and it necessitates the use of special Source Of Admission Codes, Form Locator 15.
5	Trauma Center	This code is for a visit to a trauma center/hospital as designated by the state or local government authority or as verified by the American College of Surgeons and involving a trauma activation.
6 – 8	Reserved	National assignment.
9	Unknown	Information not available.

Comments:
There are special instructions for Mother/Baby claims, see Form Locator 15 (Point of Origin). Point of Origin (previously known as Source of Admission) and Type of Admission should be used together when reviewing records. Form Locator 14 (Type of Admission) can be used independently of Form Locator 15 (Point of Origin) but not vice versa.

Data Dictionary

Field No.	Field Description
18	Point of Origin/Visit (previously called Source of Admission)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	176 – 177	Left Justified	Yes	15

Description:
A code indicating the point of origin of this admission to be used in data analysis and patient referral analysis. This code focuses on the patient's place or point of origin rather than the source of a physician order or referral. The point of origin is where the patient came from before presenting to this hospital.

Valid Values:
If Type of Admission (Form Locator 14) equals: "1" (Emergency), "2" (Urgent), "3" (Elective), "5" (Trauma Center) or "9" (Unknown), use the following codes:

Code	Source	Description
1	Non-healthcare Facility Point of Origin	**IP**-The patient was admitted to this facility**.** **OP**-The patient presents to this facility for outpatient services. This code includes patients coming from home or work and patients receiving care at home (home health services).
2	Clinic or Physician's Office	**IP**-The patient was admitted to this facility **OP**-The patient presented to this facility for outpatient services If patient went to physician and physician sent patient to ED, point of origin code 2 would be used.
3		(THIS CODE IS NO LONGER USED**.**)
4	Transfer from a Hospital (different acute care facility)	**IP**-The patient was admitted to this facility as a hospital transfer from an acute care facility where he/she was an inpatient or outpatient. **OP**-The patient was transferred to this facility as an outpatient from an acute care facility. This excludes transfers from hospital inpatients in the same facility.
5	Transfer from a Skilled Nursing Facility	**IP**-The patient was admitted to this facility as a transfer from a SNF or ICF (intermediate care facility) where he/she was a resident. **OP**-The patient was referred to this facility for outpatient or referenced diagnostic services from the SNF or ICF (intermediate care facility) where he/she was a resident.
6	Transfer from Another Health Care Facility	**IP**-The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. **OP**-The patient presented to this facility for services from another healthcare facility not defined elsewhere in this list where he/she was an inpatient or outpatient.

Field No.	Field Description
18	Point of Origin/Visit (previously called Source of Admission) continued

Code	Source	Description
7	Emergency Room	**(code not valid after July 1, 2010)**
8	Court/Law Enforcement	**IP**-The patient was admitted for inpatient services upon the direction of a court of law, or upon the request of a law enforcement agency representative. **OP**-The patient was referred to this facility for outpatient or referenced diagnostic services upon the direction of a court of law, or upon the request of a law enforcement agency representative. **This code now includes transfers from incarceration facilities.**
9	Unknown	Information not available.
A		(THIS CODE IS NO LONGER USED) See Appendix
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit in Same Hospital (resulting in separate claim)	**IP**-The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer. **OP**-The patient received OP services in this facility as a transfer from within this hospital resulting in a separate claim to the payer. (For purposes of this code, "Distinct Unit" is a unique unit or level of care requiring the issuance of a separate claim to the payer. Examples include observation services, psychiatric units, rehabilitation units, swing beds in an acute hospital.)
E	Transfer from Ambulatory Surgery Center	**IP**-The patient was admitted to this facility as a transfer from an ambulatory surgery center. **OP**-The patient was referred to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.
F	Transfer from Hospice and is Under a Hospice Plan of care or Enrolled in a Hospice Program	**IP**-The patient was admitted to this facility as a transfer from a hospice. **OP**-The patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.

Field No.	Field Description
18	Point of Origin/Visit (previously called Source of Admission) continued

If Type of Admission (Form Locator 14) equals "4", (Newborn), use the following codes:

Code	Source	Description
5	Born Inside This Hospital	Baby was born inside this hospital.
6	Born Outside of This Hospital	Baby was born outside this hospital. This code includes babies born in transit to the hospital.

Note: For previous Source of Admission Codes see Section IV.8. The change from Source of Admission codes to Point of Origin codes was October 1, 2007. The use of Point of Origin code 7 – Emergency Room ended on July 1, 2010.

Data Dictionary

Field No.	Field Description
19	Patient Discharge Status

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	178 – 179	Left Justified	Yes	17

Description:
A code indicating patient's status through the date the billing statement covers.

Valid Values:

Code	Patient Status
01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short term general hospital for inpatient care.
03	Discharged/transferred to a skilled nursing facility (SNF).
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to a Designated Cancer Center or Children's Hospital (effective Q208)
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
09	Admitted as an inpatient to this hospital (only for Medicare outpatient claims).
20	Deceased.
21	Discharged/transferred to Court/Law Enforcement. Also transfers to jail, prison or other detention facilities.
30	Still a patient or expected to return for outpatient services.
40	Expired at home (Valid only for Medicare and TRICARE claims for hospice care).
41	Expired in a medical facility (Valid only for Medicare and TRICARE claims for hospice care).
42	Expired - place unknown (Valid only for Medicare and TRICARE claims for hospice care).
43	Discharged/transferred to a Federal Health Care Facility.
50	Discharged to Hospice - home.
51	Discharged to Hospice - medical facility.
61	Discharged/transferred to a hospital-based swing bed within this institution.
62	Discharged/transferred to another rehabilitation facility including rehabilitation distinct parts units of a hospital.
63	Discharged/transferred to a Medicare-certified long-term care hospital (LTCH).
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH).
70	Discharged/transferred to Another Type of Healthcare Institution Not Defined Elsewhere in this Code List.

For interim bills, patient status should be "30". But these bills are not currently collected (see Section II.4.5 Special Reporting Requirements).

Data Dictionary

Field No.	Field Description
20	Do Not Resuscitate Flag

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	180 -180	Left Justified	Yes	N/A

Description:
This field applies to both inpatient and outpatient discharges. The majority of time, DNR will be "NO" on outpatient records but there can be a hospice or nursing home patient sent to the ER who will have a DNR order written.

Currently the national guidelines indicate that "a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital and it is clearly documented in the patient's record".

A new DNR order must be provided with each admission/OP visit. Prior DNR orders have no standing with subsequent admissions/visits.

A DNR can be removed by the patient or by the patient's family (if the patient has been deemed incompetent). If removed, report DNR as No.

Valid Values
Y = Yes
N = No

This is a one digit field. If any Condition Code (FL 18 – 28) has a value of **"P1"**, then report "Y" in this field; otherwise report "N".

Data Dictionary

Field No.	Field Description
21	Accident State

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	181 – 182	Left Justified	Yes	29

Description:
The state where the accident occurred. This data is used to properly classify the state in which the accident occurred.

Comments:
Only report Accident State if occurrence code = 01-05. (See documentation on Field number 22, Accident Code, for more details.)

Use the standard Post Office Abbreviations for U. S. states, American Territories and Canadian provinces. These abbreviations are listed in Section IV.6.

If accident occurred outside the U.S. or Canada, use code 'XX'.

If Accident State is unknown, use code 'ZZ'.

Data Dictionary

Field No.	Field Description
22	Accident Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	183 – 184	Left Justified	Yes	N/A

Description:
This is a two digit field. The appropriate codes for this field are 01 through 05 only.

If any Occurrence Code (FL 31 – 34) has a value of 01 through 05, then report the code here and its associated date in Field 23. Report the Accident State in Field 21.

If **more than one Occurrence Code is 01 through 05**, then report the code that is associated with the most recent date.

If more than one Occurrence Code is 01 through 05 **with the same date**, then report the code with the lowest numeric value.

Report one Occurrence Code and ***date only***.

Valid Values

Valid Codes	Description	Definition
01	Accident/Medical Coverage	Indicates accident-related injury for which there is medical payment coverage.
02	No Fault Insurance/Including Auto Accident/Other	State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Accident resulting from a third party's action that may involve a civil court action in an attempt to require payment by third party, other than no-fault liability.
04	Accident/Employment Related	Accident that relates to patient's employment.
05	Accident/No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage.
99	Accident occurred but code 01-03 is not known.	Use this code when you know an accident occurred but you cannot determine which code 01-03 is appropriate. In these rare cases, the Accident State and Accident Dates should be known

Data Dictionary

Field No.	Field Description
23	Accident Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	185 -192	Right Justified	Yes	N/A

Description:
The valid format for this field is MMDDYYYY.

This date will correspond with the code reported in the Accident Code field. It is the date that corresponds to the Occurrence Code reported to the Accident Code field (field number 22).

If the Occurrence Code (FL 31 – 34) is 01 through 05, then report the date in the Accident Date field.

If **more than one Occurrence Code is 01 through 05**, then report the ***most recent date***.

If more than one Occurrence Code is 01 through 05 with the same date, then report the ***date with the associated code that has the lowest numeric value.***

Report one Occurrence Code and ***date only***.

- If month and year are known, but day is unknown, report month and year and report day as unknown (i.e. '07992010').
- If only the year is known, report the year and report month and day as unknown (i.e., '99992010').
- If year of the accident is unknown, report Accident Date as '99999999'.

Data Dictionary

Field No.	Field Description
24 – 46	Revenue Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha -Numeric	4	See below	Left Justified	Yes	42

Description:
This code identifies a specific accommodation, ancillary service, or billing calculation. The individual revenue code indicates that a part of the total charge claimed is categorized under a specific revenue source. The valid range for revenue codes is currently 0024-3110.

Each record layout allows for up to 23 revenue code lines. Additional (continuation) records may be necessary if there are more than 23 line item charges.

The revenue code is a four digit field. The first three digits indicate the service and the fourth digit indicates the sub-category within the service.

This data is used to obtain a more valid comparison of hospital charges by diagnosis.

Field Number	Field Name	UB-04 Form Locator Number 42	HDDS File Positions
24	Revenue Codes	Revenue Code 1, Line 1	193 – 196
25		Revenue Code 2, Line 2	197 – 200
26		Revenue Code 3, Line 3	201 – 204
27		Revenue Code 4, Line 4	205 – 208
28		Revenue Code 5, Line 5	209 – 212
29		Revenue Code 6, Line 6	213 – 216
30		Revenue Code 7, Line 7	217 – 220
31		Revenue Code 8, Line 8	221 – 224
32		Revenue Code 9, Line 9	225 – 228
33		Revenue Code 10, Line 10	229 – 232
34		Revenue Code 11, Line 11	233 – 236
35		Revenue Code 12, Line 12	237 – 240
36		Revenue Code 13, Line 13	241 – 244
37		Revenue Code 14, Line 14	245 – 248
38		Revenue Code 15, Line 15	249 – 252
39		Revenue Code 16, Line 16	253 – 256
40		Revenue Code 17, Line 17	257 – 260
41		Revenue Code 18, Line 18	261 – 264
42		Revenue Code 19, Line 19	265 - 268

Data Dictionary

Field No.	Field Description
24 – 46	Revenue Codes (continued from previous page)

Field Number	Field Name	UB-04 Form Locator Number 42	HDDS File Positions
43	Revenue Codes	Revenue Code 20, Line 20	269 – 272
44		Revenue Code 21, Line 21	273 – 276
45		Revenue Code 22, Line 22	277 – 280
46		Revenue Code 23, Line 23	281 – 284

Comments:
Note that for any bill that includes more than 23 revenue codes or separate charges (claims of two or more pages), a separate electronic record should be submitted for each page. The Total Charges will be on the last record of multi-record bills. See Section II.4.3 Reporting of Multi-Page or Continuation Bills.

Example:

Revenue Code	Service Date	Service Units	Total Charges
0252 (Pharmacy/Non-Generic Drugs)		1	13.00
0261 (IV Therapy/Infusion Pump)		1	10.00
(Total Charges)			23.00

Reporting of Revenue Code Line Item Fields:
The revenue code line item fields should be reported for all records. In some cases more than one HCPCS code may be associated with a single revenue code. In such cases each revenue code/HCPCS code combination should be reported on a separate line and the associated charges should be reported for that line item. Thus multiple lines may be needed to report the detail for a single revenue code. If a revenue code has no HCPCS code associated with it, only one line need be reported with the HCPCS field left blank. However, the charge associated with that revenue code should still be reported. On all revenue code lines, the appropriate number of units should continue to be reported.

This will in some cases necessitate the use of a continuation, or multi-page record. The total charge for the continuation bill is put in Field 140 (positions 1190-1199) on the final record of the bill. Field 140 should be left blank on earlier records of the continuation bill. See Section II.4.3 Reporting of Multi-Page or Continuation Bills for detailed instructions.

Data Dictionary

Field No.	Field Description
47 – 69	HCPCS/Rates/HIPPS Rates Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	14	Next Page	Next Page	Yes	44

Description:
The record layout allows for 23 HCPCS/Rates/HIPPS Rates Codes. This field should be used to report the following:

1. HCPCS/CPT codes for outpatient records (and some inpatient records), or
2. Daily accommodation charge* for inpatient records when a room and board revenue code (RC 0100-0219) is reported, or
3. HIPPS rate codes.

Each HCPCS code should be left justified in its appropriate fourteen space field. The sixth position should be left blank with the current five-digit HCPCS code. This will allow for a possible future expansion of this field to six digits. The two digit modifiers should then begin in the seventh, ninth, eleventh, and thirteenth positions as needed.

If outpatient records include revenue code 0760, 0762, or 0769 (observation revenue codes), the information that is reported in the HCPCS/Rate/HIPPS field (Form Locator 44) for this revenue code should be HCPCS information. Do not report the observation room rate for the outpatient observation visit in FL 44. Room rate should be reported in FL 44 only when the record is an inpatient stay and when revenue codes = 010X - 021X.

In addition to their general use, NCD modifiers to CPT codes are used in the reporting of Wrong Procedure, Wrong Patient, Wrong Site outpatient claims. Only one claim should be reported. To indicate the surgical error the NCD modifier specified by CMS should be reported as a modifier to the appropriate CPT code. These modifiers are "PA" for surgery on the wrong body part, "PB" for surgery on the wrong patient, and "PC" for a wrong surgery on the patient. See Section II.4.4 Reporting of Wrong Procedure, Wrong Patient, Wrong Site for complete instructions.

***Reporting Charge Fields:**
All charge fields should be reported as numeric fields, right justified, unpacked, and zero filled to the left with an implied two decimals. In the case of a credit, replace the leading zero with a minus (-) sign. *For example*, a charge of $1230.00 would be reported as 0000123000. Likewise, a credit of $1230.00 would be reported as -000123000.

Data Dictionary

Field No.	Field Description
47 – 69	HCPCS/Rates/HIPPS Rates Codes (continued)

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	14	Next Page	See Below	Yes	44

All charge fields should be reported as numeric fields, right justified, unpacked, and zero filled to the left with an implied two decimals. In the case of a credit, replace the leading zero with a minus (-) sign. *For example*, a charge of $1230.00 would be reported as 0000123000. Likewise, a credit of $1230.00 would be reported as -000123000.

Field Number	Field Name	UB-04 Form Locator Number 42	HDDS File Positions
47	HCPCS/Rates/ HIPPS Rates Codes	HCPCS/Rates/HIPPS Rates Code 1, Line 1	285 – 298
48		HCPCS/Rates/HIPPS Rates Code 2, Line 2	299 – 312
49		HCPCS/Rates/HIPPS Rates Code 3, Line 3	313 – 326
50		HCPCS/Rates/HIPPS Rates Code 4, Line 4	327 – 340
51		HCPCS/Rates/HIPPS Rates Code 5, Line 5	341 – 354
52		HCPCS/Rates/HIPPS Rates Code 6, Line 6	355 – 368
53		HCPCS/Rates/HIPPS Rates Code 7, Line 7	369 – 382
54		HCPCS/Rates/HIPPS Rates Code 8, Line 8	383 – 396
55		HCPCS/Rates/HIPPS Rates Code 9, Line 9	397 – 410
56		HCPCS/Rates/HIPPS Rates Code 10, Line 10	411 – 424
57		HCPCS/Rates/HIPPS Rates Code 11, Line 11	425 – 438
58		HCPCS/Rates/HIPPS Rates Code 12, Line 12	439 – 452
59		HCPCS/Rates/HIPPS Rates Code 13, Line 13	453 – 466
60		HCPCS/Rates/HIPPS Rates Code 14, Line 14	467 – 480
61		HCPCS/Rates/HIPPS Rates Code 15, Line 15	481 – 494
62		HCPCS/Rates/HIPPS Rates Code 16, Line 16	495 – 508
63		HCPCS/Rates/HIPPS Rates Code 17, Line 17	509 – 522
64		HCPCS/Rates/HIPPS Rates Code 18, Line 18	523 – 536
65		HCPCS/Rates/HIPPS Rates Code 19, Line 19	537 – 550
66		HCPCS/Rates/HIPPS Rates Code 20, Line 20	551 – 564
67		HCPCS/Rates/HIPPS Rates Code 21, Line 21	565 – 578
68		HCPCS/Rates/HIPPS Rates Code 22, Line 22	579 – 592
69		HCPCS/Rates/HIPPS Rates Code 23, Line 23	593 – 606

Data Dictionary

Field No.	Field Description
70 – 92	Service Date(s)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	See Below	Right Justified	Yes	45

Description:
The date the indicated service was provided. The field will be blank if the date the service was provided falls within the range of the dates reported in the Statement Covers Period (Form Locator 6).

The date should be in the following format: MMDDYYYY.

The record layout form allows 23 lines for Service Date(s).

Field Number	Field Name	UB-04 Form Locator Number 45	HDDS File Positions
70	Service Date(s)	Service Date 1, Line 1	607 – 614
71		Service Date 2, Line 2	615 – 622
72		Service Date 3, Line 3	623 – 630
73		Service Date 4, Line 4	631 – 638
74		Service Date 5, Line 5	639 – 646
75		Service Date 6, Line 6	647 – 654
76		Service Date 7, Line 7	655 – 662
77		Service Date 8, Line 8	663 – 670
78		Service Date 9, Line 9	671 – 678
79		Service Date 10, Line 10	679 – 686
80		Service Date 11, Line 11	687 – 694
81		Service Date 12, Line 12	695 – 702
82		Service Date 13, Line 13	703 – 710
83		Service Date 14, Line 14	711 – 718
84		Service Date 15, Line 15	719 – 726
85		Service Date 16, Line 16	727 – 734
86		Service Date 17, Line 17	735 – 742
87		Service Date 18, Line 18	743 – 750
88		Service Date 19, Line 19	751 – 758
89		Service Date 20, Line 20	759 – 766
90		Service Date 21, Line 21	767 – 774
91		Service Date 22, Line 22	775 – 782
92		Service Date 23, Line 23	783 – 790

Data Dictionary

Field No.	Field Description
93	Creation Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	791 – 798	Right Justified	Yes	45

Description:
Enter the date the bill was created or prepared for submission.

The date format for this field is MMDDYYYY.

Data Dictionary

Field No.	Field Description
94 – 116	Unit(s) of Service

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	7	See Below	Right Justified	Yes	46

Description:
A quantitative measure of services rendered to or for the patient by revenue category. Can include items such as number of accommodation days, miles, pints of blood, or renal dialysis, etc.

The record layout form allows 23 fields for Unit(s) of Service.

This data is used to properly classify, analyze and make comparisons for a particular revenue code.

Field Number	Field Name	UB-04 Form Locator Number 46	HDDS File Positions
94	Unit(s) of Service	Unit(s) of Service 1, Line 1	799 – 805
95		Unit(s) of Service 2, Line 2	806 – 812
96		Unit(s) of Service 3, Line 3	813 – 819
97		Unit(s) of Service 4, Line 4	820 – 826
98		Unit(s) of Service 5, Line 5	827 – 833
99		Unit(s) of Service 6, Line 6	834 – 840
100		Unit(s) of Service 7, Line 7	841 – 847
101		Unit(s) of Service 8, Line 8	848 – 854
102		Unit(s) of Service 9, Line 9	855 – 861
103		Unit(s) of Service 10, Line 10	862 – 868
104		Unit(s) of Service 11, Line 11	869 – 875
105		Unit(s) of Service 12, Line 12	876 – 882
106		Unit(s) of Service 13, Line 13	883 – 889
107		Unit(s) of Service 14, Line 14	890 – 896
108		Unit(s) of Service 15, Line 15	897 – 903
109		Unit(s) of Service 16, Line 16	904 – 910
110		Unit(s) of Service 17, Line 17	911 – 917
111		Unit(s) of Service 18, Line 18	918 – 924
112		Unit(s) of Service 19, Line 19	925 – 931
113		Unit(s) of Service 20, Line 20	932 – 938
114		Unit(s) of Service 21, Line 21	939 – 945
115		Unit(s) of Service 22, Line 22	946 – 952
116		Unit(s) of Service 23, Line 23	953 – 959

Data Dictionary

Field No.	Field Description
117 – 139	Total Charges (by Revenue Code)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	Next Page	Right Justified	Yes	47

Description:
Total Charges pertaining to the related Revenue Code for the current billing period as reflected by the statement covers period. Total Charges include both covered and non-covered charges. Each record layout allows for up to 23 fields for revenue codes or charges.

This data is used to properly analyze and to obtain a more valid comparison of hospital charges by revenue code.

Reporting Charge Fields:
All charge fields should be reported as numeric fields, right justified, unpacked, and zero filled to the left with an implied two decimals. In the case of a credit, replace the leading zero with a minus (-) sign. *For example*, a charge of $1230.00 would be reported as 0000123000. Likewise, a credit of $1230.00 would be reported as -000123000.

This same format should be used when reporting all charge type information in the following fields:

- accommodation rates reported in field numbers 47-69;
- revenue line charges reported in field numbers 117-139;
- total of revenue line charges reported in field number 140;
- revenue line non-covered charges reported in field numbers 141-163; and
- total of revenue line non-covered charges in field number 164.

Data Dictionary

Field No.	Field Description
117 – 139	Total Charges (by Revenue Code) (continued from previous page)

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
117	Total Charges (by Revenue Code)	Charges 1, Line 1	960 – 969
118		Charges 2, Line 2	970 – 979
119		Charges 3, Line 3	980 – 989
120		Charges 4, Line 4	990 – 999
121		Charges 5, Line 5	1000 – 1009
122		Charges 6, Line 6	1010 – 1019
123		Charges 7, Line 7	1020 – 1029
124		Charges 8, Line 8	1030 – 1039
125		Charges 9, Line 9	1040 – 1049
126		Charges 10, Line 10	1050 – 1059
127		Charges 11, Line 11	1060 – 1069
128		Charges 12, Line 12	1070 – 1079
129		Charges 13, Line 13	1080 – 1089
130		Charges 14, Line 14	1090 – 1099
131		Charges 15, Line 15	1100 – 1109
132		Charges 16, Line 16	1110 – 1119
133		Charges 17, Line 17	1120 – 1129
134		Charges 18, Line 18	1130 – 1139
135		Charges 19, Line 19	1140 – 1149
136		Charges 20, Line 20	1150 – 1159
137		Charges 21, Line 21	1160 – 1169
138		Charges 22, Line 22	1170 – 1179
139		Charges 23, Line 23	1180 – 1189

Comments:
For any bill of two or more pages (a multi-record or continuation bill), a separate record should be submitted for each page if submission is via magnetic medium. The total charge for a multi-record bill will be on the last record of the bill in field 140 only (Total of Total Charges, see next page). This field in previous records of the bill should be left blank.

(Note for data analysts: The UB-92 sets compiled by the Department for data analysis have had all charge fields converted to a standard numeric format using a minus sign in the first digit for negative values. The charge field format for the older data sets is the same as the current reporting format.)

See Section II.4.3 Reporting of Multi-Page or Continuation Bills.

Data Dictionary

Field No.	Field Description
140	Total of Total Charges

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	1190-1199	Right Justified	Yes	N/A

Description:
Give the total for all the Total Charges by Revenue Code Fields for the bill. This total should include both covered and non-covered charges.

Reporting Charge Fields:
All charge fields should be reported as numeric fields, right justified, unpacked, and zero filled to the left with an implied two decimals. In the case of a credit, replace the leading zero with a minus (-) sign. *For example*, a charge of $1230.00 would be reported as 0000123000. Likewise, a credit of $1230.00 would be reported as -000123000.

This same format should be used when reporting all charge type information in the following fields:

- accommodation rates reported in field numbers 47-69;
- revenue line charges reported in field numbers 117-139;
- total of revenue line charges reported in field number 140;
- revenue line non-covered charges reported in field numbers 141-163; and
- total of revenue line non-covered charges in field number 164.

Comment:
For a multi-record or continuation bill, this total should be on the last record **only** with this field on the previous records left blank.

See Section II.4.3 Reporting of Multi-Page or Continuation Bills.

Data Dictionary

Field No.	Field Description
141 – 163	Non-Covered Charges (by Revenue Code)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	Next Page	Right Justified	Yes	48

Description:
The UB-04 form allows 23 lines for Charges.

This data is used to properly analyze and to obtain a more valid comparison of non-covered hospital charges by revenue code.

Reporting Charge Fields:
All charge fields should be reported as numeric fields, right justified, unpacked, and zero filled to the left with an implied two decimals. In the case of a credit, replace the leading zero with a minus (-) sign. *For example*, a charge of $1230.00 would be reported as 0000123000. Likewise, a credit of $1230.00 would be reported as -000123000.

This same format should be used when reporting all charge type information in the following fields:

- accommodation rates reported in field numbers 47-69;
- revenue line charges reported in field numbers 117-139;
- total of revenue line charges reported in field number 140;
- revenue line non-covered charges reported in field numbers 141-163; and
- total of revenue line non-covered charges in field number 164.

Data Dictionary

Field No.	Field Description
141 – 163	Non-Covered Charges (by Revenue Code) (continued from previous page)

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
141	Non-Covered Charges (by Revenue Code Category)	Non-Covered Charges 1, Line 1	1200 – 1209
142		Non-Covered Charges 2, Line 2	1210 – 1219
143		Non-Covered Charges 3, Line 3	1220 – 1229
144		Non-Covered Charges 4, Line 4	1230 – 1239
145		Non-Covered Charges 5, Line 5	1240 – 1249
146		Non-Covered Charges 6, Line 6	1250 – 1259
147		Non-Covered Charges 7, Line 7	1260 – 1269
148		Non-Covered Charges 8, Line 8	1270 – 1279
149		Non-Covered Charges 9, Line 9	1280 – 1289
150		Non-Covered Charges 10, Line 10	1290 – 1299
151		Non-Covered Charges 11, Line 11	1300 – 1309
152		Non-Covered Charges 12, Line 12	1310 – 1319
153		Non-Covered Charges 13, Line 13	1320 – 1329
154		Non-Covered Charges 14, Line 14	1330 – 1339
155		Non-Covered Charges 15, Line 15	1340 – 1349
156		Non-Covered Charges 16, Line 16	1350 – 1359
157		Non-Covered Charges 17, Line 17	1360 – 1369
158		Non-Covered Charges 18, Line 18	1370 – 1379
159		Non-Covered Charges 19, Line 19	1380 – 1389
160		Non-Covered Charges 20, Line 20	1390 – 1399
161		Non-Covered Charges 21, Line 21	1400 – 1409
162		Non-Covered Charges 22, Line 22	1410 – 1419
163		Non-Covered Charges 23, Line 23	1420 – 1429

Field No.	Field Description
164	Total of Non-Covered Charges

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	10	1430-1439	Right Justified	Yes	N/A

Description:
Give the total for all the Non-Covered charges for the bill.

Reporting Charge Fields:
All charge fields should be reported as numeric fields, right justified, unpacked, and zero filled to the left with an implied two decimals. In the case of a credit, replace the leading zero with a minus (-) sign. *For example*, a charge of $1230.00 would be reported as 0000123000. Likewise, a credit of $1230.00 would be reported as -000123000.

This same format should be used when reporting all charge type information in the following fields:

- accommodation rates reported in field numbers 47-69;
- revenue line charges reported in field numbers 117-139;
- total of revenue line charges reported in field number 140;
- revenue line non-covered charges reported in field numbers 141-163; and
- total of revenue line non-covered charges in field number 164.

Data Dictionary

Field No.	Field Description
165	Payer Classification Code – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1440-1443	Left Justified	Yes	50A

Description:
The name or type of payer organization from which the hospital first expects some payment for the bill.

The UB-04 form has three **lines for Form Locator 50**. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary. This data is used to identify and analyze data for a particular payer organization and to analyze hospital case mix data.

In 2009, limits were put on the use of vague payer codes "T" and "O". Payer code "T" indicates the patient is on 'TennCare but the MCO is not specified'. Payer code "O" indicates that the payer is 'Other than one of the payer codes below or Unknown'. No more than 10% of the TennCare discharges can indicate payer code "T" and no more than 10% of all discharges can indicate payer code "O". These limits apply separately to the inpatient and the outpatient discharges each quarter.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield-not managed care
C	Federal, Champus (Military)
D	Medicaid-(not TennCare) Do NOT use this code for TennCare. See TennCare MCO payer codes below.
I	Commercial Insurance-(not managed care) Also use this code for liability cases where non-health insurance may be payer.
M	Medicare-(not managed care)
N	Division of Health Services (Voc. Rehab.) and government payers not otherwise coded. (Use this code also if the payer is a government agency and the payment is not covered by a specific payer code, e.g. if services are provided to prisoners that are paid for by the state or if care is provided to mental health patients that is covered by the Department of Mental Health.)
O	Other, Unknown (in 2009 no more than 10% IP records and no more than 10% OP records can be reported with this code)
P	Self Pay
S	Self Insured, Self Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)

Data Dictionary

Field No.	Field Description
165	Payer Classification Code – Primary (continued)

Code	Payer Classification
	TennCare Managed Care Organization MCO Codes
8	AmeriChoice (previously John Deere/Heritage)
10	AmeriGroup community Care (new MCO effective April 1, 2007)
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State's TennCare product administered by Blue Cross)
T	TennCare-Plan Unspecified. In 2009 no more than 10% IP and no more than 10% OP records can be reported with this vague TennCare code in the primary payer field. However, this code may be used in the secondary or tertiary payer fields if patients have TennCare_Medicare supplement as secondary or tertiary payer (i.e., QMB patients).
H	**Blue Cross Managed Care – HMO/PPO/Other Managed Care** Payer designated may be listed as, but is not limited to, names such as: • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	**Commercial (Managed Care – HMO/PPO/Other Managed Care)** Payer may be listed as, but is not limited to, names such as: • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	**Medicare (HMO/PSO)** Payer may be listed as, but is not limited to, names such as: • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross (Blue Cross managed Medicare) • Heritage/John Deere • Cigna • Medicare Advantage

Data Dictionary

Field No.	Field Description
166	Payer Classification Code – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1444-1447	Left Justified	Yes	50B

Description:
The name or type of payer organization from which the hospital might second expect some payment for the bill. **Many bills will lack a secondary payer; this field will then be blank.**

The UB-04 form has three **lines for Form Locator 50**. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

This data is used to identify and analyze data for a particular payer and to analyze hospital case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield-not managed care
C	Federal, Champus (Military)
D	Medicaid-(not TennCare) Do NOT use this code for TennCare. See TennCare MCO payer codes below.
I	Commercial Insurance-(not managed care) Also use this code for liability cases where non-health insurance may be payer.
M	Medicare-(not managed care)
N	Division of Health Services (Voc. Rehab.) and government payers not otherwise coded. (Use this code also if the payer is a government agency and the payment is not covered by a specific payer code, e.g. if services are provided to prisoners that are paid for by the state or if care is provided to mental health patients that is covered by the Department of Mental Health.)
O	Other, Unknown (in 2009 no more than 10% IP records and no more than 10% OP records can be reported with this code)
P	Self Pay
S	Self Insured, Self Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)

Field No.	Field Description
166	Payer Classification Code – Secondary (continued)

Code	Payer Classification
	TennCare Managed Care Organization MCO Codes
8	AmeriChoice (previously John Deere/Heritage)
10	AmeriGroup community Care (new MCO effective April 1, 2007)
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State's TennCare product administered by Blue Cross)
T	TennCare-Plan Unspecified. In 2009 no more than 10% IP and no more than 10% OP records can be reported with this vague TennCare code in the primary payer field. However, this code may be used in the secondary or tertiary payer fields if patients have TennCare_Medicare supplement as secondary or tertiary payer (i.e., QMB patients).
H	**Blue Cross Managed Care – HMO/PPO/Other Managed Care** Payer designated may be listed as, but is not limited to, names such as: • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	**Commercial (Managed Care – HMO/PPO/Other Managed Care)** Payer may be listed as, but is not limited to, names such as: • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	**Medicare (HMO/PSO)** Payer may be listed as, but is not limited to, names such as: • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross (Blue Cross managed Medicare) • Heritage/John Deere • Cigna • Medicare Advantage

Comments: Many bills will not have a Secondary Payer.

Field No.	Field Description
167	Payer Classification Code – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1448-1451	Left Justified	Yes	50C

Description:
The name or type of payer organization from which the hospital might third expect some payment for the bill. **Many bills will lack a third payer; this field will then be blank.**

The UB-04 form has three lines **for Form Locator 50**. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

This data is used to identify and analyze data for a particular payer organization at the request of the payer organization and to analyze hospital case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield-not managed care
C	Federal, Champus (Military)
D	Medicaid-(not TennCare) Do NOT use this code for TennCare. See TennCare MCO payer codes below.
I	Commercial Insurance-(not managed care) Also use this code for liability cases where non-health insurance may be payer.
M	Medicare-(not managed care)
N	Division of Health Services (Voc. Rehab.) and government payers not otherwise coded. (Use this code also if the payer is a government agency and the payment is not covered by a specific payer code, e.g. if services are provided to prisoners that are paid for by the state or if care is provided to mental health patients that is covered by the Department of Mental Health.)
O	Other, Unknown (in 2009 no more than 10% IP records and no more than 10% OP records can be reported with this code)
P	Self Pay
S	Self Insured, Self Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)

Field No.	Field Description
167	Payer Classification Code – Tertiary (continued)

Code	Payer Classification
	TennCare Managed Care Organization MCO Codes
8	AmeriChoice (previously John Deere/Heritage)
10	AmeriGroup community Care (new MCO effective April 1, 2007)
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State's TennCare product administered by Blue Cross)
T	TennCare-Plan Unspecified. In 2009 no more than 10% IP and no more than 10% OP records can be reported with this vague TennCare code in the primary payer field. However, this code may be used in the secondary or tertiary payer fields if patients have TennCare_Medicare supplement as secondary or tertiary payer (i.e., QMB patients).
H	**Blue Cross Managed Care – HMO/PPO/Other Managed Care** Payer designated may be listed as, but is not limited to, names such as: • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	**Commercial (Managed Care – HMO/PPO/Other Managed Care)** Payer may be listed as, but is not limited to, names such as: • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	**Medicare (HMO/PSO)** Payer may be listed as, but is not limited to, names such as: • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross (Blue Cross managed Medicare) • Heritage/John Deere • Cigna • Medicare Advantage

Comments: Many bills will not have a Tertiary Payer.

Field No.	Field Description
168	Health Plan Identification Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1452-1466	Left Justified	Yes	51A

Description:
This field contains the number used by the primary health plan to identify itself. Report the HIPAA national plan identifier when it is mandated for use. Until that point, report the legacy or proprietary number as defined in trading partner agreements.

This data is used to properly classify the source of the primary payer indicated in Form Locator 50A.

If primary payer code is reported as 'O' (Other, Unknown), 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
169	Health Plan Identification Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1467-1481	Left Justified	Yes	51B

Description:
This field contains the number used by the secondary health plan to identify itself. Report the HIPAA national plan identifier when it is mandated for use. Until that point, report the legacy or proprietary number as defined in trading partner agreements.

This data is used to properly classify the source of the secondary payer indicated in Form Locator 50B.

Comments:
Many bills will lack a Secondary Payer Name and will have no Secondary Health Plan ID number.

If secondary payer code is reported as 'O' (Other, Unknown), 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
170	Health Plan Identification Number – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1482-1496	Left Justified	Yes	51C

Description:
This field contains the number used by the tertiary health plan to identify itself. Report the HIPAA national plan identifier when it is mandated for use. Until that point, report the legacy or proprietary number as defined in trading partner agreements.

This data is used to properly classify the source of the tertiary payer indicated in Form Locator 50C.

Comments:
Many bills will lack a Tertiary Payer Name and will have no Tertiary Health Plan ID number.

If tertiary payer code is reported as ‘O’ (Other, Unknown), ‘P’ (Self-pay) or ‘Z’ (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
171	National Provider ID (NPI)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	15	1497-1511	Left Justified	Yes	56

Description:
Provide the correct NPI number for the hospital that is associated with the type of services provided to the patient. It is extremely important that the correct NPI be reported in each record submitted by the hospital. (See further explanation below.*)

- If the patient received acute care services, report the hospital's acute care NPI.
- If the hospital has distinct units for psychiatric and/or rehabilitation services and the patient received these types of services, report the hospitals' psychiatric NPI or the rehab NPI in this field.

* **In late 2008, the Department of Health changed the requirement for reporting POA information. At this time, the Department decided to use the same requirements for POA reporting as used by CMS. Therefore, the Department requires that POA information be reported only on discharges from acute care hospitals. Furthermore, if an acute care hospital has a psychiatric or rehabilitation distinct part unit, discharges from these distinct part units are also excluded from the POA reporting requirement *as long as the records from these distinct part units show the appropriate NPI associated with that distinct part unit.***

This change means that critical access hospitals, cancer hospitals, long term care hospitals, pediatric hospitals, psychiatric hospitals, and rehabilitation hospitals no longer have to report POA on the diagnoses in the discharges. Also, discharges from psychiatric or rehabilitation distinct part units within acute care hospitals may also be exempt from POA reporting.

Data Dictionary

Field No.	Field Description
172	Patient's Relationship to Insured – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1512-1513	Left Justified	Yes	59A

Description:
The code number indicates the relationship of the patient to the insured individual named in Form Locator 58A.

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver donor
53	Life partner
G8	Other relationship

Comments:
The code "21" should be used when this relationship is not known to the hospital. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use code "21" in this field, or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Data Dictionary

Field No.	Field Description
173	Patient's Relationship to Insured – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1514-1515	Left Justified	Yes	59B

Description:
The code number indicates the relationship of the patient to the insured individual named in Form Locator 58B. **If there is no second payer, this field should be left blank.**

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver donor
53	Life partner
G8	Other relationship

Comments:
The code "21" should be used when this relationship is not known to the hospital. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use code "21" in this field, or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Data Dictionary

Field No.	Field Description
174	Patient's Relationship to Insured – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1516-1517	Left Justified	Yes	59C

Description:
The code number indicates the relationship of the patient to the insured individual named in Form Locator 58C. **If there is no third payer this field should be left blank.**

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver donor
53	Life partner
G8	Other relationship

Comments:
The code "21" should be used when this relationship is not known to the hospital. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use code "21" in this field, or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Data Dictionary

Field No.	Field Description
175	Insured's Unique ID Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	1518-1537	Left Justified	Yes	60A

Description:
A unique identification number assigned to the insured by the payer organization indicated in Form Locators 58A (Insured's Name Primary).

Comments:
This field should be filled with 9 if unknown. Note: Payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use all 9s in this field or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Note:
This number may be that of a person other than the patient if the patient's insurance coverage is through another person's individual or group insurance.

Data Dictionary

Field No.	Field Description
176	Insured's Unique ID Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	1538-1557	Left Justified	Yes	60B

Description:
A unique identification number assigned to the insured by the payer organization indicated in Form Locator 58B (Insured's Name Secondary).

Comments:
Must be provided if there is a second payer: When there is no second payer this field should be left blank. This field should be filled with 9 if unknown. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use all 9s in this field or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Note:
This number may be that of a person other than the patient if the patient's insurance coverage is through another person's individual or group insurance.

Data Dictionary

Field No.	Field Description
177	Insured's Unique ID Number - Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	1558-1577	Left Justified	Yes	60C

Description:
A unique identification number assigned to the insured by the payer organization indicated in Form Locator 58C (Insured's Name Tertiary).

Comments:
Must be provided if there is a third payer: When there is no third payer this field should be left blank. This field should be filled with 9 if unknown. Note that payer codes "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use all 9s in this field or this field may be left blank. For all other payer codes, blank in this field is considered an error.

Note:
This number may be that of a person other than the patient if the patient insurance coverage is through another person's individual or group insurance.

Data Dictionary

Field No.	Field Description
178	Insurance Group Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	17	1578-1594	Left Justified	Yes	62A

Description:
The identification number or code assigned by the carrier or administrator to identify the group under which the individual is covered. (Note the number assigned references the Name of the Insured in Form Locator 58A.)

This data is used to be able to identify and analyze data for a particular employee group at the request of the employer.

Comments:
This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error.

Data Dictionary

Field No.	Field Description
179	Insurance Group Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	17	1595-1611	Left Justified	Yes	62B

Description:
The identification number or code assigned by the carrier or administrator to identify the second group under which the individual is covered. (Note the number assigned references the Name of the Insured in Form Locator 58B.)

This data is used to be able to identify and analyze data for a particular employee group at the request of the employer.

Comments:
Must be provided if there is a second payer. When there is no second payer this field should be left blank. This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error.

Data Dictionary

Field No.	Field Description
180	Insurance Group Number - Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	17	1612-1628	Left Justified	Yes	62C

Description:
The identification number or code assigned by the carrier or administrator to identify the third group under which the individual is covered. (Note the number assigned references the Name of the Insured in Form Locator 58C.)

This data is used to be able to identify and analyze data for a particular employee group at the request of the employer.

Comments:
This must be provided if there is a third payer. When there is no third payer this field should be left blank. This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error.

Data Dictionary

Field No.	Field Description
181	Name of Primary Insured's Employer

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1629-1653	Left Justified	Yes	65A

Description:
The name of the employer who provides health care coverage for the insured person identified in Form Locator 58A. The insured person may or may not be the patient.

Comments:
This field should be filled with 9 if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9s may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error.

Data Dictionary

Field No.	Field Description
182	Diagnosis and Procedure Version Qualifier (DX and PX)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	1654-1655	Left Justified	Yes	66

Description:
The qualifier that denotes the version of International Classification (ICD) of Diseases reported.

Give the Diagnosis and Procedure version qualifier for the codes used in this bill.

Note: Qualifier codes reflect the edition portion of the ICD:
9 – Ninth Revision
0 – Tenth Revision

Data Dictionary

Field No.	Field Description
183	Principal Diagnosis Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	1656-1662	Left Justified	Yes	67

Description:
The ICD-9-CM code describing the principal diagnosis (i.e., the condition chiefly responsible for the admission of the patient for care). The principal diagnosis should reflect the information contained in the patient's medical record for the current stay. The principal diagnosis may be a V code. The V code can appear in the following situations:

a) When a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.

b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

This data is used to identify the primary medical diagnosis or conditions for which the patient required hospital care. This data is also used to group hospital charges and may be grouped for comparisons and analyses according to similar diagnosis.

Comments:
Must be present. All valid ICD-9-CM codes are appropriate. Include leading zeroes when necessary for the code to appear exactly as represented by the appropriate ICD-9-CM code. ***Example: If diagnosis code is 036.81 then report the code as 03681; not 3681.*** If a V code is used, the "V" should be in the first position and left justified.

Do not include decimal point; it is implied.

Note: See Section II.4.8 for more information on ICD-10 coding.

Data Dictionary

Field No.	Field Description
184	Present On Admission Code (POA) for Principal Diagnosis

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	1663-1663	Left Justified	Yes	67

Description:
This code will be reported after the Principal Diagnosis (FL 67) code in position 1663. Follow the comprehensive guidelines on POA as published in the ICD-9-CM Official Guidelines for Coding and Reporting.

The five reporting options for all diagnosis reporting are as follows:

Code	Definition
Y	Yes
N	No
U	No Information in the Record
W	Clinically Undetermined
BLANK, 1	Exempt from POA Reporting*

*** Edit allows blank or '1' to be reported in POA if diagnosis is on list of exempt diagnosis codes. Effective July 1, 2011.**

In late 2008, the Department of Health changed the requirement for reporting POA information. At this time, the Department decided to use the same requirements for POA reporting as used by CMS. Therefore, the Department requires POA information be reported only on discharges from acute care hospitals. Furthermore, if an acute care hospital has a psychiatric or rehabilitation distinct part unit, discharges from these distinct part units are also excluded from the POA reporting requirement *as long as the records from these distinct part units show the appropriate NPI associated with that distinct part unit.*

This change means that critical access hospitals, cancer hospitals, long term care hospitals, pediatric hospitals, psychiatric hospitals, and rehabilitation hospitals no longer have to report POA on the diagnoses in the discharges. Also, discharges from psychiatric or rehabilitation distinct part units within acute care hospitals may also be exempt from POA reporting.

Field No.	Field Description
184	Present On Admission Code (POA) for Principal Diagnosis (continued)

Note: Coding professionals should follow the comprehensive guidelines on POA as published in the ICD-9-CM Official Guidelines or Coding and Reporting.

See http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf. Refer to Appendix 1 for the Present on Admission Reporting Guidelines.

Note: See Section II.4.8 for more information on ICD-10 coding.

Data Dictionary

Field No.	Field Description
See Next Page	Other Diagnosis Codes (A – Q)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	Next Page	Left Justified	Yes	67A - Q

Description:
The ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently and which have an effect on the treatment received or the length of stay.

This data is used to be able to further refine the principal diagnosis, so that hospital charges may be grouped for comparisons and analyzed according to similar diagnosis.

Comments:
Include leading zeroes when necessary for the code to appear exactly as represented by the appropriate ICD-9-CM code. ***Example: If diagnosis code is 036.81 then report the code as 03681; not 3681.*** When coded, the letters "V" or "E" should be in the first position of the field and left justified. The reporting of the decimal between the third and fourth digits is unnecessary because it is implied.

The record layout does not allow for a V code field or more than three E code fields so the other diagnosis fields will have to be used when these conditions exist. The other diagnosis code fields will permit the use of ICD-9-CM V and E codes where appropriate. Note that the V code may also be in the principal diagnosis field. Note also that Form Locator 72 is the E code field, however, in some cases more than three E codes is appropriate.

E codes are provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. See Field No. 224 (External Cause of Injury Code) for a more complete description of E Code usage.

In addition to their general use, E codes are used in the preferred procedure for the reporting of Wrong Procedure, Wrong Patient, Wrong Site inpatient claims. The wrong claim should be reported as a Type of Bill 110, i.e. put "0110" in positions 76-79. The E-codes for the wrong procedure, wrong patient, or wrong site should be reported in the Other Diagnosis Codes fields as they are reported to CMS. The appropriate E-codes are:

E8765 – Performance of wrong operation (procedure) on correct patient
E8766 – Performance of operation (procedure) on patient not scheduled for surgery
E8767 – Performance of correct operation (procedure) on wrong side/body part

See Section II.4.4 Reporting of Wrong Procedure, Wrong Patient, Wrong Site for complete instructions.

Data Dictionary

Field No.	Field Description
See Next Page	Other Diagnosis Codes (A – Q) (continued from previous page)

The V code can appear in the following situations:

a) When a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.

b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
185	Other Diagnosis Codes	Other Diagnosis 1, FL-67A	1664 – 1670
187		Other Diagnosis 2, FL-67B	1672 – 1678
189		Other Diagnosis 3, FL-67C	1680 – 1686
191		Other Diagnosis 4, FL-67D	1688 – 1694
193		Other Diagnosis 5, FL-67E	1696 – 1702
195		Other Diagnosis 6, FL-67F	1704 – 1710
197		Other Diagnosis 7, FL-67G	1712 – 1718
199		Other Diagnosis 8, FL-67H	1720 – 1726
201		Other Diagnosis 9, FL-67I	1728 – 1734
203		Other Diagnosis 10, FL-67J	1736 – 1742
205		Other Diagnosis 11, FL-67K	1744 – 1750
207		Other Diagnosis 12, FL-67L	1752 – 1758
209		Other Diagnosis 13, FL-67M	1760 – 1766
211		Other Diagnosis 14, FL-67N	1768 – 1774
213		Other Diagnosis 15, FL-67O	1776 – 1782
215		Other Diagnosis 16, FL-67P	1784 – 1790
217		Other Diagnosis 17, FL-67Q	1792 - 1798

See Section II.4.8 for more information on ICD-10 coding.

Note for Data Analysts: A recoding of released data sets may put E Codes reported in the Other Diagnosis Code fields into the E Code field.

Data Dictionary

Field No.	Field Description
See Next Page	POA Codes (for Other Diagnosis A – Q)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	See Below	Left Justified	Yes	67A – Q

Description:
This code will be reported after the Other Diagnosis (FL 67A – Q) code in positions indicated below.

In late 2008, the Department of Health changed the requirement for reporting POA information. At this time, the Department decided to use the same requirements for POA reporting as used by CMS. Therefore, the Department requires that POA information is reported only on discharges from acute care hospitals. Furthermore, if an acute care hospital has a psychiatric or rehabilitation distinct part unit, discharges from these distinct part units are also excluded from the POA reporting requirement *as long as the records from these distinct part units show the appropriate NPI associated with that distinct part unit.*

This change means that critical access hospitals, cancer hospitals, long term care hospitals, pediatric hospitals, psychiatric hospitals, and rehabilitation hospitals no longer have to report POA on the diagnoses in the discharges. Also, discharges from psychiatric or rehabilitation distinct part units within acute care hospitals may also be exempt from POA reporting

Follow the comprehensive guidelines on POA as published in the ICD-9-CM Official Guidelines for Coding and Reporting.

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
186	Other POA Codes	Other POA Codes 1 (FL 67A)	1671 – 1671
188		Other POA Codes 2 (FL 67B)	1679 – 1679
190		Other POA Codes 3 (FL 67C)	1687 – 1687
192		Other POA Codes 4 (FL 67D)	1695 – 1695
194		Other POA Codes 5 (FL 67E)	1703 – 1703
196		Other POA Codes 6 (FL 67F)	1711 – 1711
198		Other POA Codes 7 (FL 67G)	1719 – 1719
200		Other POA Codes 8 (FL 67H)	1727 – 1727
202		Other POA Codes 9 (FL 67I)	1735 – 1735
204		Other POA Codes 10 (FL 67J)	1743 – 1743
206		Other POA Codes 11 (FL 67K)	1751 – 1751
208		Other POA Codes 12 (FL 67L)	1759 – 1759

Data Dictionary

Field No.	Field Description
See previous page	POA Codes (for Other Diagnosis A – Q) (continued from previous page)

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
210	Other POA Codes	Other POA Codes 13 (FL 67M)	1767 – 1767
212		Other POA Codes 14 (FL 67N)	1775 – 1775
214		Other POA Codes 15 (FL 67O)	1783 – 1783
216		Other POA Codes 16 (FL 67P)	1791 – 1791
218		Other POA Codes 17 (FL 67Q)	1799 – 1799

The five reporting options for all diagnosis reporting are as follows:

Code	Definition
Y	Yes
N	No
U	No Information in the Record
W	Clinically Undetermined
BLANK, 1	Exempt from POA Reporting*

*** Edit allows blank or '1' to be reported in POA if diagnosis is on list of exempt diagnosis codes. Effective July 1, 2011.**

Note: Coding professionals should follow the comprehensive guidelines on POA as published in the ICD-9-CM Official Guidelines or Coding and Reporting.

See http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf. Refer to Appendix 1 for the Present on Admission Reporting Guidelines.

Note: See Section II.4.8 for more information on ICD-10 coding.

Data Dictionary

Field No.	Field Description
219	Admitting Diagnosis Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	1800-1806	Left Justified	Yes	69

Description:
Used for inpatient hospital claims. This is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

E-codes are not valid in this field.

This diagnosis code ***will not*** have a Present on Admission (POA) Code.

Data Dictionary

Field No.	Field Description
220 - 222	Patient's Reason for Visit Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	1807-1827	Left Justified	Yes	70A – C

Description:
Used for all "unscheduled outpatients visits"* for outpatient bills. The ICD-CM diagnosis codes describing the patient's reason for visit at the time of outpatient registration. Do not report the decimal (it is implied).

Three (3) fields are allowed to report up to 3 reasons for the outpatient visit using ICD-CM diagnosis codes.

These fields are for Outpatient bills only.

These diagnosis codes ***will not*** have Present on Admission (POA) codes.

Field Number	Field Name	UB-04 Form Locator Number 70A – C	HDDS File Positions
220	1st Patient's Reason for Visit Code	70A	1807 – 1813
221	2nd Patient's Reason for Visit Code	70B	1814 – 1820
222	3rd Patient's Reason for Visit Code	70C	1821 – 1827

* "Unscheduled outpatient visits" include claims with Type of Bill 013X or 085X and Type of Admission 1, 2, or 5 and Revenue Codes 045X (emergency room), 0516 (urgent care clinic), 0526 (freestanding urgent care clinic), or 0762 (observation).

Data Dictionary

Field No.	Field Description
223	Prospective Payment System Code (PPS)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1828-1831	Left Justified	Yes	71

Description:
Give the code indicating the Prospective Payment System (if any) used for this bill.

Data Dictionary

Field No.	Field Description
See next page	External Cause of Injury Code (E Code)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	Next page	Left Justified	Yes	72A - C

Description:
E codes are provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, or other adverse effects.

A code used to describe an external cause creating the need for medical attention. Valid range is E800 – E999. See ICD-9-CM, Volume 1 for classification of the codes and further clarification of the fifth and sixth digits.

The E code is used to compare and analyze causes of injury.

Comments:
E codes are required when an ICD-9 code of 800.xx – 995.8x is listed as the principal diagnosis.

If there is an E-code reported in these positions, it may relate to an "Other diagnosis" code rather than to the principal diagnosis. While the edit requires an E-code in these positions IF the principal diagnosis = 800.xx – 995.8x, there may be an E-code in these positions when the principal diagnosis does NOT equal this range because the E-code relates to one of the Other Diagnosis codes (see cases (2) and (3) below).

If more than one E code is applicable, use the following priorities for recording E codes in this field:

(1) Principal diagnosis of an injury or poisoning.

(2) Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis.

(3) Other diagnosis with an external code.

If there are more than three E Codes, record any additional E codes in the Other Diagnosis Fields (FL 68 through FL 75).

Other Information:
E codes should not be confused with the 800 – 999 range of ICD-9-CM diagnosis codes. They have very different meanings. The E code describes the external cause of the injury; the ICD-9-CM diagnosis code describes the resulting trauma. For example, to compare E code 837.1 to ICD-9-CM diagnosis code 837.1:

Field No.	Field Description
See below	External Cause of Injury Code (E Code) (continued from previous page)

E837 means "Explosion, Fire or Burning in water craft" and the fourth digit "1" means "Occupant of small boat, powered".

ICD-9-CM code 837 means "Dislocation of Ankle" and the fourth digit "1" means "Open Dislocation".

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
224	External Cause of Injury Code1	72A	1832 – 1838
226	External Cause of Injury Code2	72B	1840 – 1846
228	External Cause of Injury Code3	72C	1848 – 1854

See Section II.4.8 for more information on ICD-10 coding.

Note for Data Analysts: A recoding of released data sets may put E Codes reported in the Other Diagnosis Code fields into the E Code field.

Data Dictionary

Field No.	Field Description
See below	External Cause of Injury POA Codes (1 – 3)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	See below	Left Justified	Yes	72A – C

Description:
This code will be reported after the External Cause of Injury code (FL 72A – C) in the file positions given below.

Comments:
Only add POA code if applicable.

Field Number	Field Name	Description	HDDS File Position
225	E-Code1POA	After External Cause of Injury Code FL 72A	1839 – 1839
227	E-Code2 POA	After External Cause of Injury Code FL 72B	1847 – 1847
229	E-Code3 POA	After External Cause of Injury Code FL 72C	1855 – 1855

The five reporting options for all diagnosis reporting are as follows:

Code	Definition
Y	Yes
N	No
U	No Information in the Record
W	Clinically Undetermined
BLANK, 1	Exempt from POA Reporting*

* Edit will allow blank or '1' in this field for E-codes that are on exempt list of codes. **Effective July 1, 2011.**

In late 2008, the Department of Health changed the requirement for reporting POA information. At this time, the Department decided to use the same requirements for POA reporting as used by CMS. Therefore, the Department requires that POA information be reported only on discharges from acute care hospitals. Furthermore, if an acute care hospital has a psychiatric or rehabilitation distinct part unit, discharges from these distinct part units are also excluded from the POA reporting requirement *as long as the records from these distinct part units show the appropriate NPI associated with that distinct part unit.*

Field No.	Field Description
See below	External Cause of Injury POA Codes (1 – 3) continued from previous page

This change means that critical access hospitals, cancer hospitals, long term care hospitals, pediatric hospitals, psychiatric hospitals, and rehabilitation hospitals no longer have to report POA on the diagnoses in the discharges. Also, discharges from psychiatric or rehabilitation distinct part units within acute care hospitals may also be exempt from POA reporting.

Note: Coding professionals should follow the comprehensive guidelines on POA as published in the ICD-9-CM Official Guidelines for Coding and Reporting.

See http://www.cdc.gov/nchs/data/icd9/icdguide10.pdf. Refer to Appendix 1 for the Present on Admission Reporting Guidelines.

See Section II.4.8 for more information on ICD-10 coding.

Data Dictionary

Field No.	Field Description
230	Principal Procedure Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	1856-1862	Left Justified	Yes	74

Description:
The ICD-9-CM Procedure Code that identifies the principal procedure performed during the period covered by this bill.

The code for the procedure that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or the procedure most related to the principal diagnosis.

This data is used to further refine patient diagnosis. The code can also be used to analyze medical practice patterns.

Comments:
ICD-9-CM coding is required for the procedure code.

This code should be reported for both inpatients and outpatients.

See Section II.4.8 for more information on ICD-10 coding.

Data Dictionary

Field No.	Field Description
231	Principal Procedure Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	1863-1870	Right Justified	Yes	74

Description:
Date on which the principal procedure described on this bill was performed.

The date should be in MMDDYYYY format.

This date should be reported for both inpatients and outpatients.

Data Dictionary

Field No.	Field Description
See below	Other Procedure Codes A – E

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	7	See Below	Left Justified	Yes	74A – E

Description:
The ICD-9-CM Procedure Codes identifying all significant procedures other than the principal procedure performed during the period covered by this bill.

These codes are used to further refine patient diagnosis. They can also be used to analyze medical practice patterns.

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
232	Other Procedure Codes	Other Procedure Code, FL 74A	1871 – 1877
234		Other Procedure Code, FL 74B	1886 – 1892
236		Other Procedure Code, FL 74C	1901 – 1907
238		Other Procedure Code, FL 74D	1916 – 1922
240		Other Procedure Code, FL 74E	1931 – 1937

Comments:
The other procedure codes and the appropriate date(s) should be entered in descending order of importance.

These are reported for inpatient bills only.

Note Section II.4.8 for more information on ICD-10 coding.

Data Dictionary

Field No.	Field Description
See below	Other Procedure Dates

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	8	See Below	Right Justified	Yes	74A - E

Description:
The dates on which the Other Procedures Codes identified in Form Locator 74A –E were performed.

These dates together with their associated procedure codes can be used to analyze medical practice patterns. Use date format as follows: MMDDYYYY

Field Number	Field Name	UB-04 Form Locator Number	HDDS File Positions
233	Other Procedure Codes	Other Procedure Date, FL 74A	1878 – 1885
235		Other Procedure Date, FL 74B	1893 – 1900
237		Other Procedure Date, FL 74C	1908 – 1915
239		Other Procedure Date, FL 74D	1923 – 1930
241		Other Procedure Date, FL 74E	1938 – 1945

Comments:
The other procedure dates should be entered in the same order as the associated procedures.

These are reported for inpatient bills only.

Data Dictionary

Field No.	Field Description
242 – 244	Attending Physician ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1946-1970	Left Justified	Yes	See below

Description:
The identification numbers of the health care provider who has primary responsibility for the patient's medical care and treatment, and/or would be expected to certify the medical necessity of the services rendered.

This provider ID is broken into two components: 1) Provider's Tennessee state license number and 2) NPI or UPIN.

1) Provider's Tennessee state license number:
The first component, provider's Tennessee state license number has 2 parts and it uses 12 positions. The first part is a two-character profession code that specifies what type of provider is caring for the patient. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician's assistant, **NP**=nurse practitioner, **MW**= midwife, **PS**=licensed psychologist, **DC**=doctor of chiropractic medicine, and **UK**=unknown.

The second part of the first component is the Tennessee state license number of the provider. The license number should be placed into the ten positions following the profession code. Leading zeroes should be used to fill the 10-digits allowed for the license number. *Example:* MD license number 2635 should be reported as MD0000002635.

If the provider's Tennessee license number is unknown, report the profession code as "UK" and report the license number as ten 9s ('9999999999'). Even if you know the provider was a medical doctor or osteopath, if the license number is unknown, report the profession code as "UK". Having the profession code without the license number is not useful information. (Note '9999999999' can only be used with "UK**"** and "UK" can only be used with all 9s.)

2) Provider's NPI or UPIN:
The second component is the NPI or UPIN number for the provider. This should be left-justified into the thirteen positions following the state license number. Use 'OTH000' for unknown NPI/UPIN.

Hospitals should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing hospital costs and utilization data by the attending physician.

Field Number	Field Description	UB-04 Form Locator	Field Length	HDDS File Position
242	Attending - Profession Code	N/A	2	1946 – 1947
243	Attending - TN License Number	76	10	1948 – 1957
244	Attending – NPI/UPIN	76	13	1958 – 1970

Data Dictionary

Field No.	Field Description
245 – 247	Operating Physician ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1971-1995	Left Justified	Yes	See below

Description:
The identification numbers of the health care provider who has primary responsibility for the patient's surgical procedures.

This provider ID is broken into two components: 1) Provider's Tennessee state license number and 2) NPI or UPIN.

1) Provider's Tennessee state license number:
The first component, provider's Tennessee state license number has 2 parts and it uses 12 positions. The first part is a two-character profession code that specifies what type of provider is caring for the patient. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician's assistant, **NP**=nurse practitioner, **MW**= midwife, **PS**=licensed psychologist, **DC**=doctor of chiropractic medicine, and **UK**=unknown.

The second part of the first component is the Tennessee state license number of the provider. The license number should be placed into the ten positions following the profession code. Leading zeroes should be used to fill the 10-digits allowed for the license number. *Example:* MD license number 2635 should be reported as MD0000002635.

If the provider's Tennessee license number is unknown, report the profession code as "UK" and report the license number as ten 9s ('9999999999'). Even if you know the provider was a medical doctor or osteopath, if the license number is unknown, report the profession code as "UK". Having the profession code without the license number is not useful information. (Note '9999999999' can only be used with "UK**"** and "UK" can only be used with all 9s.)

2) Provider's NPI or UPIN:
The second component is the NPI or UPIN number for the provider. This should be left-justified into the thirteen positions following the state license number. Use 'OTH000' for unknown NPI/UPIN.

Hospitals should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing hospital costs and utilization data by the operating physician.

Field Number	Field Description	UB-04 Form Locator	Field Length	HDDS File Position
245	Operating - Profession Code	N/A	2	1971 - 1972
246	Operating - TN License Number	77	10	1973 - 1982
247	Operating – NPI/UPIN	77	13	1983 - 1995

Data Dictionary

Field No.	Field Description
248 – 250	Other Provider ID1 Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	1996-2020	Left Justified	Yes	78

Description:
The identification numbers of a healthcare provider (other than the attending provider or operating provider) involved with this case. This field can be left blank.

This provider ID is broken into two components: 1) Provider's Tennessee state license number and 2) NPI or UPIN.

1) Provider's Tennessee state license number:
The first component, provider's Tennessee state license number has 2 parts and it uses 12 positions. The first part is a two-character profession code that specifies what type of provider is caring for the patient. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician's assistant, **NP**=nurse practitioner, **MW**= midwife, **PS**=licensed psychologist, **DC**=doctor of chiropractic medicine, and **UK**=unknown.

The second part of the first component is the Tennessee state license number of the provider. The license number should be placed into the ten positions following the profession code. Leading zeroes should be used to fill the 10-digits allowed for the license number. *Example:* MD license number 2635 should be reported as MD0000002635.

If the provider's Tennessee license number is unknown, report the profession code as "UK" and report the license number as ten 9s ('9999999999'). Even if you know the provider was a medical doctor or osteopath, if the license number is unknown, report the profession code as "UK". Having the profession code without the license number is not useful information. (Note '9999999999' can only be used with "UK**"** and "UK" can only be used with all 9s.)

2) Provider's NPI or UPIN:
The second component is the NPI or UPIN number for the provider. This should be left-justified into the thirteen positions following the state license number. Use 'OTH000' for unknown NPI/UPIN.

Hospitals should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing hospital costs and utilization data by the other physician.

Field Number	Field Description	Field Length	HDDS File Position
248	Other ID1 - Profession Code	2	1996 - 1997
249	Other ID1 - TN License Number	10	1998 – 2007
250	Other ID1 – NPI/UPIN	13	2008 - 2020

Data Dictionary

Field No.	Field Description
251 – 253	Other Provider ID2 Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	25	2021-2045	Left Justified	Yes	79

Description:
The identification numbers of a healthcare provider (other than the attending provider, operating provider or the first other provider) involved with the case. This field can be left blank.

This provider ID is broken into two components: 1) Provider's Tennessee state license number and 2) NPI or UPIN.

1) Provider's Tennessee state license number:
The first component, provider's Tennessee state license number has 2 parts and it uses 12 positions. The first part is a two-character profession code that specifies what type of provider is caring for the patient. The valid values are: **MD**=medical doctor, **DO**=doctor of osteopathy, **DS**=dentist, **DP**=doctor of podiatry, **PA**=physician's assistant, **NP**=nurse practitioner, **MW**= midwife, **PS**=licensed psychologist, **DC**=doctor of chiropractic medicine, and **UK**=unknown.

The second part of the first component is the Tennessee state license number of the provider. The license number should be placed into the ten positions following the profession code. Leading zeroes should be used to fill the 10-digits allowed for the license number. *Example:* MD license number 2635 should be reported as MD0000002635.

If the provider's Tennessee license number is unknown, report the profession code as "UK" and report the license number as ten 9s ('9999999999'). Even if you know the provider was a medical doctor or osteopath, if the license number is unknown, report the profession code as "UK". Having the profession code without the license number is not useful information. (Note '9999999999' can only be used with "UK**"** and "UK" can only be used with all 9s.)

2) Provider's NPI or UPIN:
The second component is the NPI or UPIN number for the provider. This should be left-justified into the thirteen positions following the state license number. Use 'OTH000' for unknown NPI/UPIN.

Hospitals should NOT submit internal facility-assigned ID numbers for the professionals practicing in the facility. These numbers are not useful outside the individual facility.

This data will provide the capability of analyzing hospital costs and utilization data by the other physician.

Field Number	Field Description	Field Length	HDDS File Position
251	Other ID2 - Profession Code	2	2021 - 2022
252	Other ID2 - TN License Number	10	2023 – 2032
253	Other ID2 – NPI/UPIN	13	2033 – 2045

Data Dictionary

Field No.	Field Description
254	Joint Annual Report ID Number (JARID)

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	**12**	2046-2057	Left Justified	No*	57

Description:
Report the 5-digit number assigned by the TN Department of Health that is used in the collection of data for the Joint Annual Report of Hospitals. This number should be provided in each record reported by the hospital. Each hospital -- even parent and their satellite hospitals – has a unique **Joint Annual Report ID number** assigned by the TN Department of Health. **Left justify the 5 digit code in the 12 positions allowed.**

This data is used to properly identify the facility in which the services are performed, especially in satellite facilities.

Comments:
*Optional, but requested for those hospitals where the same Federal Tax ID is used in satellite facilities.

This field is required for hospitals reporting through the THA-HIN.

Data Dictionary

Field No.	Field Description
255	Patient's Social Security Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	10	2058-2067	Left Justified	Yes	N/A

Description:
This field is not specifically included on the UB-04 form. However, since the patient's social security number may or may not be included as part of another field (Insured's Unique ID Number Form Locator-60A - C), this field should be used only to collect and report the actual SSN of the patient. Left justify, leaving a blank space in the 10th position of this field.

A unique, identifying number for each patient. For patients who lack a social security number or for whom it is unknown, this field should be reported all 9s.

This data will allow for linking of multiple records for the same patient. This field can be used to unduplicate counts for different types of medical conditions when a patient is hospitalized more than once. Hospital discharge records are reviewed by the department to identify any cases of traumatic brain injuries and/or birth defects. This information is provided to hospital staff or to departmental staff for more detailed medical record abstraction. If SSN is provided on each discharge record, it could prevent the hospital from being requested to abstract a medical record more than once (if a patient is seen more than once for the same condition).

Comments:
This field is confidential and not available for public release.

Data Dictionary

Field No.	Field Description
256	Patient's Race/Ethnicity

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	2	2068-2069	Right Justified	Yes	N/A

Description:
This field is not included on the UB-04 form. This field is required to be reported in addition to the data elements contained on the UB-04.

This field should include information on the patient's race/ethnicity. This information may have to be brought in from other parts of the patient's record.

This data will be used for hospital discharge data analysis by race/ethnicity.

Enter patient's race and ethnicity (2 parts). Put code for race in position 2068. Put code for ethnicity in position 2069.

Valid Codes:

Valid Code	Description (Race)	HDDS File Position
1	White or Caucasian	2068
2	Black or African American	
3	Native American or Alaskan Native	
4	Asian or Pacific Islander	
5	Other Race (other than 1 – 4)	
9	Unknown Race	

Valid Code	Description (Ethnicity)	HDDS File Position
1	Hispanic Origin	2069
2	Not Hispanic Origin	
9	Hispanic Origin Unknown	

Comments:
The Patient's Race/Ethnicity field is for statistical and epidemiological purposes only. Staff assessment of its value is sufficient.

Data Dictionary

Field No.	Field Description
257	Type of Emergency Department Visit

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha -Numeric	1	2070-2070	Right Justified	Yes	N/A

Description:
This code is used for all Emergency Room visits. For every discharge record, if there is a revenue code 0450-0459, this field is required to be reported. Likewise, if there is no revenue code 0450-0459, this field must be left blank.

This is a one digit field.

Valid Values:

Valid Codes	Description ED Visit
1	Not Considered an emergency (non-emergent)
2	Urgent
3	Emergency
9	Hospital does not screen ED visits
Blank	This record did not contain revenue code 0450-0459.

Data Dictionary

Field No.	Field Description
258	Outcome of Emergency Department Visit

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Numeric	1	2071-2071	Right Justified	Yes	N/A

Description:
This code is used for all Emergency Room visits. For every discharge record, if there is a revenue code 0450-0459, this field is required to be reported. Likewise, if there is no revenue code 0450-0459, this field must be left blank.

This is a one digit field

Valid Values:

Valid Codes	Description ED Outcome Visit
1	Visit reclassified as emergency and patient treated in ED
2	Patient redirected and not treated in ED
3	Patient chooses to pay and is treated in ED
4	Emergency visit, patient treated in ED
9	Not Applicable because hospital does not screen ED visits
Blank	This record did not contain revenue code 0450-0459.

Data Dictionary

Field No.	Field Description
262	Admitted From ED Flag

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	1	2272-2272	Left Justified	Yes	NA

Description:
If any Condition Code (FL 18-23) has a value of "P7" **or there is a revenue code 0450-0459 on the record,** then report "Y" at position 2272 of the record. Otherwise report "N" in this position.

This position "2272" (as well as positions 2273-2274) is in a portion of the record layout listed as "State Generated Flags". These three positions have not been used by the State and are now available for use by the hospitals.

Note:
Position 2272 is edited for a 'Y' or 'N' **only** on **Inpatient** records. Blank is an invalid code for Inpatient records in position 2272.

Effective 7/1/2010.

Data Dictionary

Field No.	Field Description
263	Wrong Procedure/Patient/Site Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2273-2274	Left Justified	Yes	NA

Description:
This is the alternate procedure for reporting Wrong Procedure, Wrong Patient, Wrong Site inpatient records. See Section II.4.4 for complete details.

Valid Values:

For inpatient claims both right claim and wrong claim should be reported. The right claim should be reported normally or left blank.

The wrong claim should be reported with the applicable CMS surgical error code put in positions 2273-2274 of the record.

Inpatient Claims

CMS Error Code	Description
MX	Wrong surgery on patient
MY	Surgery on wrong body part
MZ	Surgery on wrong patient

Note:
This is for inpatient claims only. DO NOT use this position for outpatient claims. For outpatient claims, if there is a wrong site/wrong patient/wrong procedure event, report the appropriate modifiers with the appropriate CPT/HCPCS code to indicate this.

Data Dictionary

Field No.	Field Description
264a	Patient Initials - First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2275-2276	Left Justified	Yes	NA

Description:
Enter the first two letters of the patient's first name as given in FL 8A. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = JO
T Anthony Jones = T

For Vendor use only.

Data Dictionary

Field No.	Field Description
264b	Patient Initials - Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2277-2280	Left Justified	Yes	NA

Description:
Enter the first two letters and the last two letters of the patient's last name as given in FL 8B. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = SMTH
Robert Ray = RAY
Carla Thompson-Jones = THES

For Vendor use only.

Data Dictionary

Field No.	Field Description
265a	Primary Insured Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2281-2282	Left Justified	Yes	NA

Description:
Enter the first two letters of the primary insured's first name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = JO
T Anthony Jones = T

For Vendor use only.

Data Dictionary

Field No.	Field Description
265b	Primary Insured Initials –Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2283-2286	Left Justified	Yes	NA

Description:
Enter the first two letters and the last two letters of the primary insured's last name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = SMTH
Robert Ray = RAY
Carla Thompson-Jones = THES

For Vendor use only.

Data Dictionary

Field No.	Field Description
266a	Secondary Insured Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2287-2288	Left Justified	Yes	NA

Description:
Enter the first two letters of the secondary insured's first name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = JO
T Anthony Jones = T

For Vendor use only.

Data Dictionary

Field No.	Field Description
266b	Secondary Insured Initials –Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2289-2292	Left Justified	Yes	NA

Description:
Enter the first two letters and the last two letters of the secondary insured's last name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = SMTH
Robert Ray = RAY
Carla Thompson-Jones = THES

For Vendor use only.

Data Dictionary

Field No.	Field Description
267a	Tertiary Insured Initials – First Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	2293-2294	Left Justified	Yes	NA

Description:
Enter the first two letters of the tertiary insured's first name as given in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = JO
T Anthony Jones = T

For Vendor use only.

Data Dictionary

Field No.	Field Description
267b	Tertiary Insured Initials –Last Name

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	2295-2298	Left Justified	Yes	NA

Description:
Enter the first two letters and the last two letters of the tertiary insured's last name as given in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. This information is confidential and will be deleted after processing.

Comments:
This field should be left blank by hospitals.

Example:

John Smith = SMTH
Robert Ray = RAY
Carla Thompson-Jones = THES

For Vendor use only.

Data Dictionary

Field No.	Field Description
268	Patient Address – Street

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha Numeric	40	2299-2338	Left Justified	Yes	9A

Description:
Enter the street address of the patient as found in FL 9A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing.

This information will only be reported to the Department for infants and selected accident victims.

Data Dictionary

Field No.	Field Description
269	Patient Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2339-2358	Left Justified	Yes	8A

Description:
Enter the patient's first name as given in FL 8A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

Data Dictionary

Field No.	Field Description
270	Patient Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2359-2388	Left Justified	Yes	8B

Description:
Enter the patient's last name as given in FL 8B. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

Data Dictionary

Field No.	Field Description
271	Primary Insured's Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2389-2408	Left Justified	Yes	58A

Description:
Enter the primary Insured's first name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

If primary payer code is reported as 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
272	Primary Insured's Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2409-2438	Left Justified	Yes	58A

Description:
Enter the primary Insured's last name as given in FL 58A. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

If primary payer code is reported as 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
273	Secondary Insured's Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2439-2458	Left Justified	Yes	58B

Description:
Enter the secondary Insured's first name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

If there is no secondary payer, this field may be left blank. If secondary payer code is reported as 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
274	Secondary Insured's Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2459-2488	Left Justified	Yes	58B

Description:
Enter the secondary Insured's last name as given in FL 58B. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

If there is no secondary payer, this field may be left blank. If secondary payer code is reported as 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
275	Tertiary Insured's Name – First

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	20	2489-2508	Left Justified	Yes	58C

Description:

Enter the tertiary Insured's first name in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

If there is no tertiary payer, this field may be left blank. If tertiary payer code is reported as 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

Data Dictionary

Field No.	Field Description
276	Tertiary Insured's Name – Last

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	30	2509-2538	Left Justified	Yes	58C

Description

Enter the tertiary Insured's last name as given in FL 58C. This information will be used by the Tennessee Department of Health for matching with other sources of data. It is confidential and will be deleted after processing. This information will only be reported to the Department for infants and selected accident victims.

If there is no tertiary payer, this field may be left blank. If tertiary payer code is reported as 'P' (Self-pay) or 'Z' (Indigent/Free), this field may be left blank.

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
1	Filler	-	A-N	25	1	25
2	Patient Control Number	3A		25	26	50
3	Medical/Health Record Number	3B	A-N	25	51	75
4	Type of bill	4	A-N	4	76	79
5	Federal Tax Sub ID Number	5	A-N	4	80	83
6	Federal Tax Number	5	A-N	10	84	93
7	Statement Covers Period - From MMDDYYYY	6	N	8	94	101
8	Statement Covers Period – Through MMDDYYYY	6	N	8	102	109
9	Patient's Address – City	9B	A-N	30	110	139
10	Patient's Address – State	9C	A-N	2	140	141
11	Patient's Address – Zip Code	9D	A-N	9	142	150
12	Patient's Address – Country Code	9E	A-N	4	151	154
13	Patient's Date of Birth – MMDDYYYY	10	N	8	155	162
14	Patient's Sex	11	A-N	1	163	163
15	Admission Date – MMDDYYYY	12	N	8	164	171
16	Admission Hour	13	A-N	2	172	173
17	Type of Admission/Visit	14	A-N	2	174	175
18	Point of Origin/Visit	15	A-N	2	176	177
19	Patient Discharge Status	17	A-N	2	178	179
20	Do Not Resuscitate Flag	-	A-N	1	180	180
21	Accident State	29	A-N	2	181	182
22	Accident Code	-	A-N	2	183	184
23	Accident Date – MMDDYYYY	-	N	8	185	192
24	Revenue Code (1)	42	A-N	4	193	196
25	Revenue Code (2)	42	A-N	4	197	200
26	Revenue Code (3)	42	A-N	4	201	204
27	Revenue Code (4)	42	A-N	4	205	208
28	Revenue Code (5)	42	A-N	4	209	212
29	Revenue Code (6)	42	A-N	4	213	216
30	Revenue Code (7)	42	A-N	4	217	220
31	Revenue Code (8)	42	A-N	4	221	224
32	Revenue Code (9)	42	A-N	4	225	228
33	Revenue Code (10)	42	A-N	4	229	232
34	Revenue Code (11)	42	A-N	4	233	236
35	Revenue Code (12)	42	A-N	4	237	240
36	Revenue Code (13)	42	A-N	4	241	244
37	Revenue Code (14)	42	A-N	4	245	248

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
38	Revenue Code (15)	42	A-N	4	249	252
39	Revenue Code (16)	42	A-N	4	253	256
40	Revenue Code (17)	42	A-N	4	257	260
41	Revenue Code (18)	42	A-N	4	261	264
42	Revenue Code (19)	42	A-N	4	265	268
43	Revenue Code (20)	42	A-N	4	269	272
44	Revenue Code (21)	42	A-N	4	273	276
45	Revenue Code (22)	42	A-N	4	277	280
46	Revenue Code (23)	42	A-N	4	281	284
47	HCPCS/Rates/HIPPS Rate Codes (1)	44	A-N	14	285	298
48	HCPCS/Rates/HIPPS Rate Codes (2)	44	A-N	14	299	312
49	HCPCS/Rates/HIPPS Rate Codes (3)	44	A-N	14	313	326
50	HCPCS/Rates/HIPPS Rate Codes (4)	44	A-N	14	327	340
51	HCPCS/Rates/HIPPS Rate Codes (5)	44	A-N	14	341	354
52	HCPCS/Rates/HIPPS Rate Codes (6)	44	A-N	14	355	368
53	HCPCS/Rates/HIPPS Rate Codes (7)	44	A-N	14	369	382
54	HCPCS/Rates/HIPPS Rate Codes (8)	44	A-N	14	383	396
55	HCPCS/Rates/HIPPS Rate Codes (9)	44	A-N	14	397	410
56	HCPCS/Rates/HIPPS Rate Codes (10)	44	A-N	14	411	424
57	HCPCS/Rates/HIPPS Rate Codes (11)	44	A-N	14	425	438
58	HCPCS/Rates/HIPPS Rate Codes (12)	44	A-N	14	439	452
59	HCPCS/Rates/HIPPS Rate Codes (13)	44	A-N	14	453	466
60	HCPCS/Rates/HIPPS Rate Codes (14)	44	A-N	14	467	480
61	HCPCS/Rates/HIPPS Rate Codes (15)	44	A-N	14	481	494
62	HCPCS/Rates/HIPPS Rate Codes (16)	44	A-N	14	495	508
63	HCPCS/Rates/HIPPS Rate Codes (17)	44	A-N	14	509	522
64	HCPCS/Rates/HIPPS Rate Codes (18)	44	A-N	14	523	536
65	HCPCS/Rates/HIPPS Rate Codes (19)	44	A-N	14	537	550
66	HCPCS/Rates/HIPPS Rate Codes (20)	44	A-N	14	551	564
67	HCPCS/Rates/HIPPS Rate Codes (21)	44	A-N	14	565	578
68	HCPCS/Rates/HIPPS Rate Codes (22)	44	A-N	14	579	592
69	HCPCS/Rates/HIPPS Rate Codes (23)	44	A-N	14	593	606
70	Service Dates (1) – MMDDYYYY	45	N	8	607	614
71	Service Dates (2) – MMDDYYYY	45	N	8	615	622
72	Service Dates (3) – MMDDYYYY	45	N	8	623	630
73	Service Dates (4) – MMDDYYYY	45	N	8	631	638
74	Service Dates (5) – MMDDYYYY	45	N	8	639	646

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
75	Service Date (6) – MMDDYYYY	45	N	8	647	654
76	Service Date (7) – MMDDYYYY	45	N	8	655	662
77	Service Date (8) – MMDDYYYY	45	N	8	663	670
78	Service Date (9) – MMDDYYYY	45	N	8	671	678
79	Service Date (10) – MMDDYYYY	45	N	8	679	686
80	Service Date (11) – MMDDYYYY	45	N	8	687	694
81	Service Date (12) – MMDDYYYY	45	N	8	695	702
82	Service Date (13) – MMDDYYYY	45	N	8	703	710
83	Service Date (14) – MMDDYYYY	45	N	8	711	718
84	Service Date (15) – MMDDYYYY	45	N	8	719	726
85	Service Date (16) – MMDDYYYY	45	N	8	727	734
86	Service Date (17) – MMDDYYYY	45	N	8	735	742
87	Service Date (18) – MMDDYYYY	45	N	8	743	750
88	Service Date (19) – MMDDYYYY	45	N	8	751	758
89	Service Date (20) – MMDDYYYY	45	N	8	759	766
90	Service Date (21) – MMDDYYYY	45	N	8	767	774
91	Service Date (22) – MMDDYYYY	45	N	8	775	782
92	Service Date (23) – MMDDYYYY	45	N	8	783	790
93	Creation Date – MMDDYYYY	45	N	8	791	798
94	Unit(s) of Service (1)	46	N	7	799	805
95	Unit(s) of Service (2)	46	N	7	806	812
96	Unit(s) of Service (3)	46	N	7	813	819
97	Unit(s) of Service (4)	46	N	7	820	826
98	Unit(s) of Service (5)	46	N	7	827	833
99	Unit(s) of Service (6)	46	N	7	834	840
100	Unit(s) of Service (7)	46	N	7	841	847
101	Unit(s) of Service (8)	46	N	7	848	854
102	Unit(s) of Service (9)	46	N	7	855	861
103	Unit(s) of Service (10)	46	N	7	862	868
104	Unit(s) of Service (11)	46	N	7	869	875
105	Unit(s) of Service (12)	46	N	7	876	882
106	Unit(s) of Service (13)	46	N	7	883	889
107	Unit(s) of Service (14)	46	N	7	890	896
108	Unit(s) of Service (15)	46	N	7	897	903
109	Unit(s) of Service (16)	46	N	7	904	910
110	Unit(s) of Service (17)	46	N	7	911	917
111	Unit(s) of Service (18)	46	N	7	918	924

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
112	Unit(s) of Service (19)	46	N	7	925	931
113	Unit(s) of Service (20)	46	N	7	932	938
114	Unit(s) of Service (21)	46	N	7	939	945
115	Unit(s) of Service (22)	46	N	7	946	952
116	Unit(s) of Service (23)	46	N	7	953	959
117	Total Charges (by Revenue Code) (1)	47	N	10	960	969
118	Total Charges (by Revenue Code) (2)	47	N	10	970	979
119	Total Charges (by Revenue Code) (3)	47	N	10	980	989
120	Total Charges (by Revenue Code) (4)	47	N	10	990	999
121	Total Charges (by Revenue Code) (5)	47	N	10	1000	1009
122	Total Charges (by Revenue Code) (6)	47	N	10	1010	1019
123	Total Charges (by Revenue Code) (7)	47	N	10	1020	1029
124	Total Charges (by Revenue Code) (8)	47	N	10	1030	1039
125	Total Charges (by Revenue Code) (9)	47	N	10	1040	1049
126	Total Charges (by Revenue Code) (10)	47	N	10	1050	1059
127	Total Charges (by Revenue Code) (11)	47	N	10	1060	1069
128	Total Charges (by Revenue Code) (12)	47	N	10	1070	1079
129	Total Charges (by Revenue Code) (13)	47	N	10	1080	1089
130	Total Charges (by Revenue Code) (14)	47	N	10	1090	1099
131	Total Charges (by Revenue Code) (15)	47	N	10	1100	1109
132	Total Charges (by Revenue Code) (16)	47	N	10	1110	1119
133	Total Charges (by Revenue Code) (17)	47	N	10	1120	1129
134	Total Charges (by Revenue Code) (18)	47	N	10	1130	1139
135	Total Charges (by Revenue Code) (19)	47	N	10	1140	1149
136	Total Charges (by Revenue Code) (20)	47	N	10	1150	1159
137	Total Charges (by Revenue Code) (21)	47	N	10	1160	1169
138	Total Charges (by Revenue Code) (22)	47	N	10	1170	1179
139	Total Charges (by Revenue Code) (23)	47	N	10	1180	1189
140	Total of Total Charges	-	N	10	1190	1199
141	Non-Covered Charges (by Revenue Code) (1)	48	N	10	1200	1209
142	Non-Covered Charges (by Revenue Code) (2)	48	N	10	1210	1219
143	Non-Covered Charges (by Revenue Code) (3)	48	N	10	1220	1229
144	Non-Covered Charges (by Revenue Code) (4)	48	N	10	1230	1239
145	Non-Covered Charges (by Revenue Code) (5)	48	N	10	1240	1249
146	Non-Covered Charges (by Revenue Code) (6)	48	N	10	1250	1259
147	Non-Covered Charges (by Revenue Code) (7)	48	N	10	1260	1269
148	Non-Covered Charges (by Revenue Code) (8)	48	N	10	1270	1279

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
149	Non-Covered Charges (by Revenue Code) (9)	48	N	10	1280	1289
150	Non-Covered Charges (by Revenue Code) (10)	48	N	10	1290	1299
151	Non-Covered Charges (by Revenue Code) (11)	48	N	10	1300	1309
152	Non-Covered Charges (by Revenue Code) (12)	48	N	10	1310	1319
153	Non-Covered Charges (by Revenue Code) (13)	48	N	10	1320	1329
154	Non-Covered Charges (by Revenue Code) (14)	48	N	10	1330	1339
155	Non-Covered Charges (by Revenue Code) (15)	48	N	10	1340	1349
156	Non-Covered Charges (by Revenue Code) (16)	48	N	10	1350	1359
157	Non-Covered Charges (by Revenue Code) (17)	48	N	10	1360	1369
158	Non-Covered Charges (by Revenue Code) (18)	48	N	10	1370	1379
159	Non-Covered Charges (by Revenue Code) (19)	48	N	10	1380	1389
160	Non-Covered Charges (by Revenue Code) (20)	48	N	10	1390	1399
161	Non-Covered Charges (by Revenue Code) (21)	48	N	10	1400	1409
162	Non-Covered Charges (by Revenue Code) (22)	48	N	10	1410	1419
163	Non-Covered Charges (by Revenue Code) (23)	48	N	10	1420	1429
164	Total of Non-Covered Charges	-	N	10	1430	1439
165	Payer Classification Code – Primary	50A	A-N	4	1440	1443
166	Payer Classification Code – Secondary	50B	A-N	4	1444	1447
167	Payer Classification Code – Tertiary	50C	A-N	4	1448	1451
168	Health Plan ID – Primary	51A	A-N	15	1452	1466
169	Health Plan ID – Secondary	51B	A-N	15	1467	1481
170	Health Plan ID – Tertiary	51C	A-N	15	1482	1496
171	National Provider ID (NPI)	56	A-N	15	1497	1511
172	Patient's Relationship to Insured – Primary	59A	A-N	2	1512	1513
173	Patient's Relationship to Insured – Secondary	59B	A-N	2	1514	1515
174	Patient's Relationship to Insured – Tertiary	59C	A-N	2	1516	1517
175	Insured's Unique ID Number – Primary	60A	A-N	20	1518	1537
176	Insured's Unique ID Number – Secondary	60B	A-N	20	1538	1557
177	Insured's Unique ID Number – Tertiary	60C	A-N	20	1558	1577
178	Insurance Group Number – Primary	62A	A-N	17	1578	1594
179	Insurance Group Number – Secondary	62B	A-N	17	1595	1611
180	Insurance Group Number – Tertiary	62C	A-N	17	1612	1628
181	Name of Primary Insured's Employer	65A	A-N	25	1629	1653
182	DX and PX Version Qualifier	66	A-N	2	1654	1655
183	Principal Diagnosis Code	67	A-N	7	1656	1662
184	Present On Admission Code (POA) for Principle Diagnosis	67	A-N	1	1663	1663
185	Other Diagnosis1	67A	A-N	7	1664	1670

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
186	Other Diagnosis1 POA	67A	A-N	1	1671	1671
187	Other Diagnosis2	67B	A-N	7	1672	1678
188	Other Diagnosis2 POA	67B	A-N	1	1679	1679
189	Other Diagnosis3	67C	A-N	7	1680	1686
190	Other Diagnosis3 POA	67C	A-N	1	1687	1687
191	Other Diagnosis4	67D	A-N	7	1688	1694
192	Other Diagnosis4 POA	67D	A-N	1	1695	1695
193	Other Diagnosis5	67E	A-N	7	1696	1702
194	Other Diagnosis5 POA	67E	A-N	1	1703	1703
195	Other Diagnosis6	67F	A-N	7	1704	1710
196	Other Diagnosis6 POA	67F	A-N	1	1711	1711
197	Other Diagnosis7	67G	A-N	7	1712	1718
198	Other Diagnosis7 POA	67G	A-N	1	1719	1719
199	Other Diagnosis8	67H	A-N	7	1720	1726
200	Other Diagnosis8 POA	67H	A-N	1	1727	1727
201	Other Diagnosis9	67I	A-N	7	1728	1734
202	Other Diagnosis9 POA	67I	A-N	1	1735	1735
203	Other Diagnosis10	67J	A-N	7	1736	1742
204	Other Diagnosis10 POA	67J	A-N	1	1743	1743
205	Other Diagnosis11	67K	A-N	7	1744	1750
206	Other Diagnosis11 POA	67K	A-N	1	1751	1751
207	Other Diagnosis12	67L	A-N	7	1752	1758
208	Other Diagnosis12 POA	67L	A-N	1	1759	1759
209	Other Diagnosis13	67M	A-N	7	1760	1766
210	Other Diagnosis13 POA	67M	A-N	1	1767	1767
211	Other Diagnosis14	67N	A-N	7	1768	1774
212	Other Diagnosis14 POA	67N	A-N	1	1775	1775
213	Other Diagnosis15	67O	A-N	7	1776	1782
214	Other Diagnosis15 POA	67O	A-N	1	1783	1783
215	Other Diagnosis16	67P	A-N	7	1784	1790
216	Other Diagnosis16 POA	67P	A-N	1	1791	1791
217	Other Diagnosis17	67Q	A-N	7	1792	1798
218	Other Diagnosis17 POA	67Q	A-N	1	1799	1799
219	Admitting Diagnosis Code	69	A-N	7	1800	1806
220	Patient’s Reason for Visit Code	70A	A-N	7	1807	1813
221	Patient’s Reason for Visit Code	70B	A-N	7	1814	1820
222	Patient’s Reason for Visit Code	70C	A-N	7	1821	1827

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
223	Prospective Payment System Code (PPS)	71	A-N	4	1828	1831
224	External Cause of Injury Code1	72A	A-N	7	1832	1838
225	E-Code1 Present On Admission	-	A-N	1	1839	1839
226	External Cause of Injury Code2	72B	A-N	7	1840	1846
227	E-Code2 Present On Admission	-	A-N	1	1847	1847
228	External Cause of Injury Code3	72C	A-N	7	1848	1854
229	E-Code3 Present On Admission	-	A-N	1	1855	1855
230	Principal Procedure Code	74	A-N	7	1856	1862
231	Principal Procedure Date	74	N	8	1863	1870
232	Other Procedure Code	74A	A-N	7	1871	1877
233	Other Procedure Date MMDDYYYY	74A	N	8	1878	1885
234	Other Procedure Code	74B	A-N	7	1886	1892
235	Other Procedure Date MMDDYYYY	74B	N	8	1893	1900
236	Other Procedure Code	74C	A-N	7	1901	1907
237	Other Procedure Date MMDDYYYY	74C	N	8	1908	1915
238	Other Procedure Code	74D	A-N	7	1916	1922
239	Other Procedure Date MMDDYYYY	74D	N	8	1923	1930
240	Other Procedure Code	74E	A-N	7	1931	1937
241	Other Procedure Date MMDDYYYY	74E	N	8	1938	1945
242	Attending Physician – Profession Code	-	A-N	2	1946	1947
243	Attending Physician – TN License Number	76	A-N	10	1948	1957
244	Attending Physician – UPIN/NPI	76	A-N	13	1958	1970
245	Operating Physician – Profession Code	-	A-N	2	1971	1972
246	Operating Physician – TN License Number	77	A-N	10	1973	1982
247	Operating Physician – UPIN/NPI	77	A-N	13	1983	1995
248	Other Provider ID1 – Profession Code	78	A-N	2	1996	1997
249	Other Provider ID1 – TN License Number	78	A-N	10	1998	2007
250	Other Provider ID1 – UPIN/NPI	78	A-N	13	2008	2020
251	Other Provider ID2 – Profession Code	79	A-N	2	2021	2022
252	Other Provider ID2 – TN License Number	79	A-N	10	2023	2032
253	Other Provider ID2 – UPIN/NPI	79	A-N	13	2033	2045
254	Joint Annual Report ID (JARID)	57	A-N	12	2046	2057
255	Patient's Social Security Number	-	A-N	10	2058	2067
256	Patient's Race/Ethnicity	-	A-N	2	2068	2069
257	Type of Emergency Department Visit	-	A-N	1	2070	2070
258	Outcome of Emergency Department Visit	-	N	1	2071	2071
259	Encryption Key	-	A-N	40	2072	2111
260	Vendor Generated Flags	-	A-N	24	2112	2135
261	State Generated Flags	-	A-N	136	2136	2271
262	Admitted From ED Flag	-	A-N	1	2272	2272

UB-04 Data Record Format

Field No.	Field Description	Form Locator	P C* Format	Field Length	Position From	Position Thru
263	Wrong Procedure/Patient/Site Code	-	A-N	2	2273	2274
264a	Patient Initials First Name	-	A-N	2	2275	2276
264b	Patient's Initials Last Name	-	A-N	4	2277	2280
265a	Primary Insured Initials – First Name	-	A-N	2	2281	2282
265b	Primary Insured Initials – Last Name	-	A-N	4	2283	2286
266a	Secondary Insured Initials – First Name	-	A-N	2	2287	2288
266b	Secondary Insured Initials – Last Name	-	A-N	4	2289	2292
267a	Tertiary Insured Initials – First Name	-	A-N	2	2293	2294
267b	Tertiary Insured Initials – Last Name	-	A-N	4	2295	2298
268	Patient's Address – Street	9A	A-N	40	2299	2338
269	Patient's Name – First	8A	A-N	20	2339	2358
270	Patient's Name – Last	8B	A-N	30	2359	2388
271	Primary Insured's Name – First	58A	A-N	20	2389	2408
272	Primary Insured's Name – Last	58B	A-N	30	2409	2438
273	Secondary Insured's Name – First	58B	A-N	20	2439	2458
274	Secondary Insured's Name – Last	58B	A-N	30	2459	2488
275	Tertiary Insured's Name – First	58C	A-N	20	2489	2508
276	Tertiary Insured's Name – Last	58C	A-N	30	2509	2538

***PC Format**
A-N = Alpha Numeric
N = Numeric

SECTION IV

ENABLING LEGISLATION: T.C.A.-68-1-108

68-1-108. Reports of claims data - Penalty for failure to report - Waiver.

(a) Each licensed hospital shall report all claims data found on the UB-04 form or a successor form on every inpatient and outpatient discharge to the commissioner of health. A hospital shall report the claims data to the commissioner at least quarterly. After receiving the claims data, the commissioner shall promptly make such data available for review and copying by the Tennessee hospital association (THA). No information shall be made available to the public by either the commissioner or the THA that reasonably could be expected to reveal the identity of any patient. The claims data reported to the commissioner under this section are confidential and not available to the public until the commissioner processes and verifies such data. The commissioner shall prescribe conditions under which the processed and verified data are available to the public.

(b) A licensed hospital shall pay to the commissioner a civil penalty of five cents (5›) for each day the claims data discharge report is delinquent. A claims data report is delinquent if the commissioner does not receive it before sixty (60) days after the end of the quarter. If the commissioner receives the report in incomplete form, the commissioner shall notify the hospital and provide fifteen (15) additional days to correct the error. The notice shall provide the hospital an additional fifteen (15) days to complete the form and return it to the commissioner prior to the imposition of any civil penalty. The maximum civil penalty for a delinquent report is ten dollars ($10.00) for each discharge record. The commissioner shall issue an assessment of the civil penalty to the hospital. The hospital has a right to an informal conference with the commissioner if the hospital requests such conference within thirty (30) days of receipt of the assessment. After the informal conference or, if no conference is requested, after the time for requesting the informal conference has expired, the commissioner may proceed to collect the penalty by setting the penalty off against funds owed to the hospital or by instituting litigation.

(c) In its request for an informal conference, the hospital may request the commissioner to waive the penalty. The commissioner may waive the penalty in cases of an act of God or other acts beyond the control of the hospital. Waiver of the penalty is in the sole discretion of the commissioner. None of these proceedings is subject to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(d) A hospital licensed pursuant to chapter 11, part 2 of this title shall as a condition of licensure continue to complete and submit annually the report of hospital statistics required by the provisions of § 68-11-310 and regulations promulgated pursuant to that section.

(e) No person or entity, including the THA, may be held liable in any civil action with respect to any report or disclosure of information made under this section unless such person or entity has knowledge of any falsity of the information reported or disclosed.

[Acts 1985, ch. 480, §§ 1-4; 1994, ch. 889, § 1.]

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
HEALTH STATISTICS

CHAPTER 1200-7-3
HOSPITAL DISCHARGE DATA SYSTEM

TABLE OF CONTENTS

1200-7-3-.01	Definitions	1200-7-3-.05	Processing and Verification
1200-7-3-.02	Required Data Elements	1200-7-3-.06	Data Availability
1200-7-3-.03	Submission Time Line	1200-7-3-.07	Confidential Information
1200-7-3-.04	Penalty Assessment	1200-7-3-.08	Repealed

1200-7-3-.01 DEFINITIONS.

(1) "Aggregate Data" is defined as a set of multiple data records that are tabulated, combined, or otherwise summarized for the purpose of describing characteristics of a group of patient discharges.

(2) "Department" is defined as the Department of Health.

(3) "Discharge" shall be defined as the formal release of a patient from a hospital in either an inpatient or outpatient situation.

(4) "Error" is defined as data that are incomplete or inconsistent with the specifications in T.C.A. 68-1-108, these rules, and the Hospital Discharge Data System Procedure Manual.

(5) "Final Joint Annual Report" is defined as the most recent Joint Annual Report filed by a hospital where the data contained therein has been edited, queried and updated by the Department.

(6) "Hospital" shall be defined as in T.C.A. 68-11-201(21)

(7) "Inpatient" shall be defined as a person receiving reception and care in a hospital for a continuous period of twenty-four (24) hours or more for the purpose of giving advice, diagnosis, nursing service, or treatment bearing on the physical health of the person, and a person receiving maternity care involving labor and delivery for any period of time.

(8) "Outpatient" shall be defined as a person receiving reception and care in a hospital for a continuous period less than twenty-four (24) hours for the purpose of giving advice, diagnosis, nursing service, or treatment bearing on the physical health of the person, excluding persons receiving maternity care involving labor and delivery. Reportable outpatient records are defined in the hospital discharge data system manual. Reportable records are defined in terms of the type of service provided and the type of bill on Form UB-92.

(9) "Patient Identifiers" shall be defined to include the following data elements: Patient Control Number, Medical/Health Record Number, Certificate Number/ID Number/SSN, and Patient's Social Security Number.

(10) "Processed Data" is defined as data that have been reviewed by the Department for the purpose of detecting errors, inconsistencies, and/or incomplete elements in the data set.

(11) "Public" shall be defined as anyone other than the THA and agencies of the government of the State of Tennessee.

(12) "Record Level Data" is defined as a set of data that is specific to a single patient discharge.

(Rule 1200-7-3-.01, continued)

(13) "THA" shall be defined as the administrative offices and staff of the Tennessee Hospital Association.

(14) "UB-92" is defined to be CMS Form 1450, the Uniform Hospital Billing Form, or a successor form as established by the National Committee and the State Uniform Billing Implementation Committee.

(15) "Verified Data" is defined as data that have been processed by the Department; the health facilities have had the opportunity to suggest corrections, additions, and/or deletions; and all appropriate revisions have been made to the data by the Department.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-1-108 and 68-11-201.* ***Administrative History:*** *Original rule filed July 30, 1987; effective September 13, 1987. Amendment filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed June 14, 2006; effective August 28, 2006.*

1200-7-3-.02 REQUIRED DATA ELEMENTS.

(1) The Department will prepare the Hospital Discharge Data System (HDDS) Procedure Manual that will list the variables to be reported, their descriptions and reporting format, and other information associated with data submission. The Department shall make future changes in the Procedure Manual when the Commissioner deems changes to be necessary. Reporting entities will be notified by the Department of all revisions. These revisions become effective one hundred and eighty (180) days following the date of notification. At that time, failure to meet the amended requirements are subject to the penalties as prescribed by T.C.A. §68-1-108.

(2) The minimum data set for each reported discharge will include the following data elements:

(a) Patient Control Number

(b) Type of Bill

(c) Federal Tax Number

(d) Statement Covers Period

(e) Patient's Address: City, State and Zip Code

(f) Patient's Date of Birth

(g) Patient's Sex

(h) Admission Date

(i) Admission Type

(j) Source of Admission

(k) Patient's Status

(l) Medical/Health Record Number

(m) Revenue Codes

(n) Date(s) of Service

(o) Unit(s) of Service

(Rule 1200-7-3-.02, continued)

(p) Charges Associated with Revenue Codes

(q) Payer Identification

(r) Provider Number

(s) Patient's Relationship to Insured

(t) Certificate Number/ID Number/SSN

(u) Insurance Group Number

(v) Employment Status Code

(w) Insured's Employer Name

(x) Insured's Employer Location: Zip Code

(y) Principal Diagnosis Codes

(z) Other Diagnosis Codes

(aa) E Code

(bb) Principal Procedure Code and Date

(cc) Other Procedure Codes and Dates

(dd) Attending Physician ID Number

(ee) Other Physician ID Numbers

(ff) Patient's Social Security Number

(gg) Patient's Race/Ethnicity

(3) All inpatient discharges are required to be reported.

(4) All outpatient and emergency room discharges are required to be reported.

(5) All data elements reported by the hospital should be the actual values used by the hospital. None should be encrypted or otherwise altered.

(6) All hospitals which are required to report data by T.C.A. §68-1-108 shall designate one staff member to be responsible for reporting the claims data. The Department shall be notified by the hospital, on a form supplied by the Department, with the name, title, work address, and work telephone number of the designated staff member.

(7) All hospitals which are required to report data by T.C.A. §68-1-108 shall notify Health Statistics and Information on a form supplied by HSI of the name, title, work address, and work telephone number of the designated staff member.

(Rule 1200-7-3-.02, continued)

Authority: T.C.A. §§4-5-202, 4-5-204, and 68-1-108. ***Administrative History:*** *Original rule filed July 30, 1987; effective September 13, 1987. Amendment filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.*

1200-7-3-.03 SUBMISSION TIME LINE.

(1) All required data must be received by the Department each quarter according to the following schedule:

Quarter	Time Span	Submission Due Date
Q1	January 1 – March 31	May 30
Q2	April 1 – June 30	August 29
Q3	July 1 – September 30	November 29
Q4	October 1 – December 31	March 1

(2) All data submissions must be in the form of computer media (e.g., magnetic tape, diskettes).

Authority: T.C.A. §§4-5-202, 4-5-204, and 68-1-108. ***Administrative History:*** *Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed June 14, 2006; effective August 28, 2006.*

1200-7-3-.04 PENALTY ASSESSMENT.

(1) The Department of Health will assess a civil penalty of five cents ($.05) per record per day for delinquent discharge reports.

(2) The maximum civil penalty for a delinquent report is ten dollars ($10) for each discharge record.

(3) For hospitals not submitting any discharge reports by the submission deadline, the number of inpatient hospital discharge reports delinquent for a particular facility per quarter will be estimated by dividing the number of total inpatient discharges/or admissions reported in Schedule G of the most current, final Joint Annual Report of Hospitals (JAR-H) on file with the Department for that facility by four (4).

The number of delinquent outpatient claims reports for a quarter will likewise be estimated using data from the facility's most recent, final Joint Annual Report. This estimate will be obtained by dividing by four (4) the sum of outpatient data from Schedule D for percutaneous lithotripsy procedures, adult and pediatric cardiac catheterizations, adult and pediatric percutaneous transluminal coronary angioplasties, outpatient surgery procedures from dedicated O. R.'s and from procedure rooms, eye, bone, bone marrow, connective, cardiovascular, stem cell, and other transplants, and from Schedule I, total emergency room visits. The sum of the inpatient estimate and the outpatient estimate will be used to calculate the penalty assessed. Any positive or negative adjustments to the final estimate, up to a maximum of ten (10) percent will be made once the actual claims reports are received by the Department.

(4) Hospitals not submitting any discharge reports by the submission deadline will begin accruing penalties starting the day immediately following the submission deadline and ending the day when the actual discharge reports are received by the Department or the maximum penalty is reached (maximum=$10/discharge record).

(5) For all 2006 discharges, the allowable error rate will be no more than 3%. For all discharges in 2007 and subsequent years, the allowable error rate will be no more than 2%. Records that fall within the acceptable rate will not be subject to any penalties. Hospitals that exceed the acceptable error rate will be penalized based on total errors.

(Rule 1200-7-3-.04, continued)

(6) Hospitals which do not submit corrected discharge records within the additional fifteen (15) days allocated for error correction will accrue delinquent penalties starting the sixteenth day after error notification and ending the day when the actual corrected discharge reports are received by the Department or the maximum penalty is reached (maximum=$10/discharge record). The Commissioner has the authority to delay any penalty for not correcting any particular data element if the failure to correct is due to force majeure or other events of extraordinary circumstances clearly beyond the control of the hospital.

(7) Upon receipt of the penalty assessment, the hospital has the right to an informal conference with the Commissioner. A written request for an informal conference must be received by the Commissioner within thirty (30) days of the assessment.

(8) A notice of an approximate daily assessment of the civil penalty will be sent to the delinquent hospital(s). The assessment will estimate the approximate penalty per day based on the estimated number of discharge reports. The assessment will state that penalties will accrue until the delinquent discharge reports are received or the maximum penalty is reached. Delinquent penalties will be collected starting thirty (30) days from the date of notice and continuing every thirty days until the maximum penalty is reached or the discharge reports are received.

(9) Penalties continue to accumulate for hospitals requesting an informal conference with the Commissioner.

(10) The Commissioner can grant a waiver from penalties to a hospital in cases of force majeure or other events of extraordinary circumstances clearly beyond the control of the hospital. The hospital must make a written request for the waiver and the informal conference within the first thirty (30) days following notification of the assessment. The proceedings before the Commissioner involving penalty waivers are not subject to the Uniform Administrative Procedures Act.

(11) After the conference with the Commissioner or the time frame for requesting a conference has expired, the Commissioner can collect the penalties unless the hospital appeals the Commissioner's decision. Penalties may be off set by funds owed to the hospital by the Department of Health and/or the Department of Finance and Administration. However, if the hospital wishes to appeal the decision of the Commissioner, a request in writing for a hearing before an Administrative Law Judge must be sent to the Commissioner within ten (10) business days of the Commissioner's written determination. Issues involving collection of penalties directly from hospitals resolved by an Administrative Law Judge will be in accordance with the Uniform Administrative Procedures Act.

(12) At the date of collection, penalties for the hospitals that have not submitted any discharge data will be collected based on the estimated number of discharges per day delinquent from the submission deadline to the collection date. Penalties for hospitals that have submitted data will be collected based on the actual number of discharge records that are incomplete or inaccurate for the particular quarter and the actual days delinquent.

Authority: *T.C.A. §§4-5-202, 4-5-204, and 68-1-108.* ***Administrative History:*** *Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.*

1200-7-3-.05 PROCESSING AND VERIFICATION.

(1) If errors, inconsistencies, or incomplete elements are identified by the Department the errors will be reported to the hospital in writing. Upon receiving written notification of errors, the hospital facility shall investigate the problem and shall supply correct information within fifteen (15) days from notification.

(Rule 1200-7-3-.05, continued)

(2) Discharge data reported in an incorrect format or with elements inconsistent with T.C.A. 68-1-108 will be considered in error and returned to the reporting entity.

(3) Discharge data considered in error is subject to the penalties as prescribed in T.C.A. 68-1-108, unless the errors are corrected within fifteen (15) days after the hospital receives notification of existing errors.

(4) After the quarterly data have been computerized, edited, updated, and determined to be the final corrected set by the Department, each hospital shall be given a ten (10) day opportunity to review the quarterly data set relating to their hospital, if they so desire. Upon the expiration of that ten day period, absent receipt of corrections and/or revisions from the hospitals, the quarterly data is considered verified. If corrections and/or revisions are received, the quarterly data is considered verified once the corrections and/or revisions have been made by the Department.

(5) The same procedure as stated in paragraph (4) above shall be used for verification of the final data set at the close of the data year.

Authority: *T.C.A. §§4-5-202, 4-5-204, and 68-1-108.* ***Administrative History:*** *Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.*

1200-7-3-.06 DATA AVAILABILITY.

(1) Within thirty (30) days after all hospitals' claims data has been accumulated into the Department's master database, and has been processed and verified, the Department will send THA a copy of the entire database.

(2) The Commissioner has the authority to delay release of any particular data element(s) if it is determined that the quality or completeness of the information is not acceptable.

(3) The Department may create reports for public release using any available processed and verified aggregate data. It may also provide custom reports, as requested by the public, using any available processed and verified aggregate data. Facility specific aggregate data reports will not be released to the public until the final data set for the calendar year has been processed and verified.

(4) A contractual agent of the Department or of the THA may receive reports of any record necessary, together with any needed patient identifiers, to carry out their contractual duties. This includes any organization contracted with to provide editing, quality control, database management services, or research for the Department or the THA. Any such contractual agent must agree in writing to establish and maintain appropriate controls to protect the confidentiality of the data and must agree to return or destroy any data or records at the termination of the contract.

(5) Record level data files will be made available for public release and purchase under the following conditions. The fee for a quarter of inpatient data will be $300. The fee for a quarter of outpatient data will be $300. The fee for a subset of a quarter of data, inpatient or outpatient, will be $300. The Department maintains a proprietary interest in all record level data files it sells or distributes and such files are made available solely for use by the purchaser and may not be given or sold to another entity. No record level data files will be made available for public release and purchase until eighteen months following the close of the data year.

Authority: *T.C.A. §§4-5-202, 4-5-204, and 68-1-108.* ***Administrative History:*** *Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed June 14, 2006; effective August 28, 2006.*

1200-7-3-.07 CONFIDENTIAL INFORMATION.

(1) All information reported to the Commissioner under this part is confidential until processed and verified by the Commissioner.

(2) In no event may patient identifiers be released to the public at any time.

(3) Information regarding the name of an employer will not be released to the public. Information about any employer may be released to the employer identified in the data record. Hospitals may receive information regarding the name of employer for their claims only.

(4) The data may be released pursuant to 45 C.F.R. § 164.514 (b) or (e). However if either data files and/or reports are otherwise released to the public, to protect patient confidentiality, they must meet the following criteria:

(a) Patient Address City must be deleted.

(b) The month and day of all dates must be deleted.

(c) All zip code areas having a population under 20,000 must have no more than the first three digits shown. Zip code areas having a population of 20,000 or more must have no more than the first five digits shown.

(d) For patients over 89 years of age the Year of Birth must be deleted and the actual patient age may not be shown.

(e) Information that reasonably could be expected to reveal the identity of a patient including those items contained in 45 C.F.R. §164(b)(2)(i) shall be deleted.

(5) Any agency of the State of Tennessee receiving confidential hospital claims data or reports containing such confidential information, shall agree in writing to follow all confidentiality restrictions of the Department concerning use of this data.

(6) The Commissioner may use or authorize use of this data, including the patient identifiers, for purposes that are necessary to provide for or protect the health of the population and as permitted by law.

Authority: *T.C.A. §§4-5-202, 4-5-204, and 68-1-108.* ***Administrative History:*** *Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.*

1200-7-3-.08 REPEALED.

Authority: *T.C.A. §§4-5-202, 4-5-204, and 68-1-108.* ***Administrative History:*** *Original rule filed May 7, 1997; effective July 21, 1997. Repeal filed June 14, 2006; effective August 28, 2006.*

TENNESSEE DEPARTMENT OF HEALTH
HOSPITAL DISCHARGE DATA SYSTEM
TRANSMITTAL INFORMATION

Date:		**Facility ID#:**	

HOSPITAL IDENTIFICATION

Hospital Name:		
Hospital Address:		
Hospital Contact Person:		
Phone No.:	( )	**Fax No:** ( )
Vendor Name:		
Vendor Address:		
Vendor Contact Person:		
Phone No.:	( )	**Fax No:** ( )

DATA DESCRIPTION/TYPE: Please fill in or check all that applies.

☐ Original ☐ Replacement ☐ Test

☐ Quarter ☐ Year

☐ Inpatient ☐ Outpatient ☐ Amb-Surgery

Record Length	Total Record Count	File/Data Set Name
2538		

MEDIA SPECIFICATIONS: Please check all that applies.

☐ E-Mail
☐ Secure E-Mail

☐ CD-ROM
☐ Secure CD-ROM

☐ Secure Website

This form must accompany submitted data and or media

E-Mail this completed form to Nerissa.Harvey@tn.gov
You may also fax this completed form to HDDS @ (615)253-1688
OR mail the completed form to HDDS at the address below:
Hospital Discharge Data System
Division of Health Statistics
6th Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37243
Phone: (615) 741-1954

PH-3924 (Rev. 01/11) S836-1

TENNESSEE DEPARTMENT OF HEALTH

HOSPITAL DISCHARGE DATA SYSTEM
REPORTING METHOD

All hospitals must complete and return this form signed and dated, each and every quarter

Facility Name: _____

Address: _____

Person Completing Form: _____ **Title:** _____

Signature: _____ **Date:** _____

Telephone Number: ( ) _____ **Fax Number:** ( ) _____

For _____ quarter _____ year, this facility will submit UB-04 data by the following method(s):

I. Data submitted directly to Tennessee Department of Health

INPATIENT DISCHARGES

Date Submitted: ☐

Select Method of Reporting:
☐ **E-Mail** ☐ **CD-ROM** ☐ **Website**

SELECTED OUTPATIENT/EMERGENCY ROOM DISCHARGES

Date Submitted: ☐

Select Method of Reporting:
☐ **E-Mail** ☐ **CD-ROM** ☐ **Website**

II. Data submitted directly to Tennessee Hospital Association (THA-HIDI)

INPATIENT DISCHARGES

Date Submitted: ☐

SELECTED OUTPATIENT/EMERGENCY ROOM DISCHARGES

Date Submitted: ☐

E-Mail this completed form to Nerissa.Harvey@tn.gov by the 15th

You may also fax this completed form to HDDS @ (615) 253-1688
OR mail the completed form to HDDS at the address below:

Division of Health Statistics
Hospital Discharge Data System
6th Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37243
Phone: (615) 741-1954

PH-3925 (Rev. 01/11) S836-1

UB-04 FORM


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57
OTHER
PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC

U.S. STANDARD STATE ABBREVIATIONS

ALABAMA	AL	NEW JERSEY	NJ
ALASKA	AK	NEW MEXICO	NM
ARIZONA	AZ	NEW YORK	NY
ARKANSAS	AR	NORTH CAROLINA	NC
CALIFORNIA	CA	NORTH DAKOTA	ND
COLORADO	CO	OHIO	OH
CONNECTICUT	CT	OKLAHOMA	OK
DELAWARE	DE	OREGON	OR
DISTRICT OF COLUMBIA	DC	PENNSYLVANIA	PA
FLORIDA	FL	RHODE ISLAND	RI
GEORGIA	GA	SOUTH CAROLINA	SC
HAWAII	HI	SOUTH DAKOTA	SD
IDAHO	ID	TENNESSEE	TN
ILLINOIS	IL	TEXAS	TX
INDIANA	IN	UTAH	UT
IOWA	IA	VERMONT	VT
KANSAS	KS	VIRGINIA	VA
KENTUCKY	KY	WASHINGTON	WA
LOUISIANA	LA	WEST VIRGINIA	WV
MAINE	ME	WISCONSIN	WI
MARYLAND	MD	WYOMING	WY
MASSACHUSETTS	MA		
MICHIGAN	MI	AMERICAN TERRITORIES	
MINNESOTA	MN		
MISSISSIPPI	MS	AMERICAN SAMOA	AS
MISSOURI	MO	CANAL ZONE	CZ
MONTANA	MT	GUAM	GU
NEBRASKA	NE	PUERTO RICO	PR
NEVADA	NV	TRUST TERRITORIES	TT
NEW HAMPSHIRE	NH	VIRGIN ISLANDS	VI

CANADIAN PROVINCES

ALBERTA	AB	NOVA SCOTIA	NS
BRITISH COLUMBIA	BC	ONTARIO	ON
LABRADOR	LB	PR. EDWARD ISLAND	PE
MANITOBA	MB	QUEBEC	QB
NEW BRUNSWICK	NB	SASKATCHEWAN	SK
NEWFOUNDLAND	NF	YUKON	YK
NORTHWEST TERRITORY	NT		

IF OTHER THAN THE UNITED STATES, TERRITORIES OR CANADA, USE CODE – XX.
IF STATE IS UNKNOWN, USE CODE – ZZ.

ENGLISH COUNTRY NAMES AND CODE ELEMENTS
ISO 3166-1

AFGHANISTAN	AF
ÅLAND ISLANDS	AX
ALBANIA	AL
ALGERIA	DZ
AMERICAN SAMOA	AS
ANDORRA	AD
ANGOLA	AO
ANGUILLA	AI
ANTARCTICA	AQ
ANTIGUA AND BARBUDA	AG
ARGENTINA	AR
ARMENIA	AM
ARUBA	AW
AUSTRALIA	AU
AUSTRIA	AT
AZERBAIJAN	AZ
BAHAMAS	BS
BAHRAIN	BH
BANGLADESH	BD
BARBADOS	BB
BELARUS	BY
BELGIUM	BE
BELIZE	BZ
BENIN	BJ
BERMUDA	BM
BHUTAN	BT
BOLIVIA	BO
BOSNIA AND HERZEGOVINA	BA
BOTSWANA	BW
BOUVET ISLAND	BV
BRAZIL	BR
BRITISH INDIAN OCEAN TERRITORY	IO
BRUNEI DARUSSALAM	BN
BULGARIA	BG
BURKINA FASO	BF
BURUNDI	BI
CAMBODIA	KH
CAMEROON	CM
CANADA	CA
CAPE VERDE	CV
CAYMAN ISLANDS	KY
CENTRAL AFRICAN REPUBLIC	CF
CHAD	TD

English Country Names and Code Elements (continued)

CHILE	CL
CHINA	CN
CHRISTMAS ISLAND	CX
COCOS (KEELING) ISLANDS	CC
COLOMBIA	CO
COMOROS	KM
CONGO	CG
CONGO, THE DEMOCRATIC REPUBLIC OF THE	CD
COOK ISLANDS	CK
COSTA RICA	CR
CÔTE D'IVOIRE	CI
CROATIA	HR
CUBA	CU
CYPRUS	CY
CZECH REPUBLIC	CZ
DENMARK	DK
DJIBOUTI	DJ
DOMINICA	DM
DOMINICAN REPUBLIC	DO
ECUADOR	EC
EGYPT	EG
EL SALVADOR	SV
EQUATORIAL GUINEA	GQ
ERITREA	ER
ESTONIA	EE
ETHIOPIA	ET
FALKLAND ISLANDS (MALVINAS)	FK
FAROE ISLANDS	FO
FIJI	FJ
FINLAND	FI
FRANCE	FR
FRENCH GUIANA	GF
FRENCH POLYNESIA	PF
FRENCH SOUTHERN TERRITORIES	TF
GABON	GA
GAMBIA	GM
GEORGIA	GE
GERMANY	DE
GHANA	GH
GIBRALTAR	GI
GREECE	GR
GREENLAND	GL
GRENADA	GD
GUADELOUPE	GP

English Country Names and Code Elements (continued)

GUAM	GU
GUATEMALA	GT
GUERNSEY	GG
GUINEA	GN
GUINEA-BISSAU	GW
GUYANA	GY
HAITI	HT
HEARD ISLAND AND MCDONALD ISLANDS	HM
HOLY SEE (VATICAN CITY STATE)	VA
HONDURAS	HN
HONG KONG	HK
HUNGARY	HU
ICELAND	IS
INDIA	IN
INDONESIA	ID
IRAN, ISLAMIC REPUBLIC OF	IR
IRAQ	IQ
IRELAND	IE
ISLE OF MAN	IM
ISRAEL	IL
ITALY	IT
JAMAICA	JM
JAPAN	JP
JERSEY	JE
JORDAN	JO
KAZAKHSTAN	KZ
KENYA	KE
KIRIBATI	KI
KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF	KP
KOREA, REPUBLIC OF	KR
KUWAIT	KW
KYRGYZSTAN	KG
LAO PEOPLE'S DEMOCRATIC REPUBLIC	LA
LATVIA	LV
LEBANON	LB
LESOTHO	LS
LIBERIA	LR
LIBYAN ARAB JAMAHIRIYA	LY
LIECHTENSTEIN	LI
LITHUANIA	LT
LUXEMBOURG	LU
MACAO	MO
MACEDONIA, THE FORMER YUGOSLAV REPUBLIC OF	MK

English Country Names and Code Elements (continued)

MADAGASCAR	MG
MALAWI	MW
MALAYSIA	MY
MALDIVES	MV
MALI	ML
MALTA	MT
MARSHALL ISLANDS	MH
MARTINIQUE	MQ
MAURITANIA	MR
MAURITIUS	MU
MAYOTTE	YT
MEXICO	MX
MICRONESIA, FEDERATED STATES OF	FM
MOLDOVA, REPUBLIC OF	MD
MONACO	MC
MONGOLIA	MN
MONTENEGRO	ME
MONTSERRAT	MS
MOROCCO	MA
MOZAMBIQUE	MZ
MYANMAR	MM
NAMIBIA	NA
NAURU	NR
NEPAL	NP
NETHERLANDS	NL
NETHERLANDS ANTILLES	AN
NEW CALEDONIA	NC
NEW ZEALAND	NZ
NICARAGUA	NI
NIGER	NE
NIGERIA	NG
NIUE	NU
NORFOLK ISLAND	NF
NORTHERN MARIANA ISLANDS	MP
NORWAY	NO
OMAN	OM
PAKISTAN	PK
PALAU	PW
PALESTINIAN TERRITORY, OCCUPIED	PS
PANAMA	PA
PAPUA NEW GUINEA	PG
PARAGUAY	PY
PERU	PE

English Country Names and Code Elements (continued)

PHILIPPINES	PH
PITCAIRN	PN
POLAND	PL
PORTUGAL	PT
PUERTO RICO	PR
QATAR	QA
RÉUNION	RE
ROMANIA	RO
RUSSIAN FEDERATION	RU
RWANDA	RW
SAINT HELENA	SH
SAINT KITTS AND NEVIS	KN
SAINT LUCIA	LC
SAINT PIERRE AND MIQUELON	PM
SAINT VINCENT AND THE GRENADINES	VC
SAMOA	WS
SAN MARINO	SM
SAO TOME AND PRINCIPE	ST
SAUDI ARABIA	SA
SENEGAL	SN
SERBIA	RS
SEYCHELLES	SC
SIERRA LEONE	SL
SINGAPORE	SG
SLOVAKIA	SK
SLOVENIA	SI
SOLOMON ISLANDS	SB
SOMALIA	SO
SOUTH AFRICA	ZA
SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS	GS
SPAIN	ES
SRI LANKA	LK
SUDAN	SD
SURINAME	SR
SVALBARD AND JAN MAYEN	SJ
SWAZILAND	SZ
SWEDEN	SE
SWITZERLAND	CH
SYRIAN ARAB REPUBLIC	SY
TAIWAN, PROVINCE OF CHINA	TW
TAJIKISTAN	TJ
TANZANIA, UNITED REPUBLIC OF	TZ
THAILAND	TH

English Country Names and Code Elements (continued)

TIMOR-LESTE	TL
TOGO	TG
TOKELAU	TK
TONGA	TO
TRINIDAD AND TOBAGO	TT
TUNISIA	TN
TURKEY	TR
TURKMENISTAN	TM
TURKS AND CAICOS ISLANDS	TC
TUVALU	TV
UGANDA	UG
UKRAINE	UA
UNITED ARAB EMIRATES	AE
UNITED KINGDOM	GB
UNITED STATES	US
UNITED STATES MINOR OUTLYING ISLANDS	UM
URUGUAY	UY
UZBEKISTAN	UZ
VANUATU	VU
Vatican City State see HOLY SEE	
VENEZUELA	VE
VIET NAM	VN
VIRGIN ISLANDS, BRITISH	VG
VIRGIN ISLANDS, U.S.	VI
WALLIS AND FUTUNA	WF
WESTERN SAHARA	EH
YEMEN	YE
Zaire see CONGO, THE DEMOCRATIC REPUBLIC OF THE	
ZAMBIA	ZM
ZIMBABWE	ZW

This list states the **country names** (official short names **in English**) in alphabetical order as given in ISO 3166-1 **and** the corresponding **ISO 3166-1-alpha-2 code elements**.
This list is updated whenever a change to the official code list in ISO 3166-1 is effected by the ISO 3166/MA. It lists 244 official short names and code elements.

FROM 2007 MANUAL

Field No.	Field Description
18	Source of Admission

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	2	176 – 177	Left Justified	Yes	15

Description:
A code indicating the source of this admission to be used in data analysis and patient referral analysis.

Valid Values:
If Type of Admission (Form Locator 14) equals: "1" (Emergency), "2" (Urgent), "3" (Elective), "5" (Trauma Center) or "9" (Unknown), use the following codes:

Code	Source	Description
1	Physician Referral	Patient was admitted for inpatient services or referred for outpatient services upon the recommendation of his/her personal physician, or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Patient was admitted to this facility for inpatient services or referred to this facility for outpatient services upon the recommendation of this facility's clinic physician, or by the facility's other outpatient department physician in the case of outpatient services.
3	HMO Referral	Patient was admitted for inpatient services or referred for outpatient or referenced diagnostic services upon the recommendation of a Managed Care Plan physician.
4	Transfer from an Acute Care Facility	Patient was admitted to this facility as a hospital transfer from an acute care facility where he/she was an inpatient or was referred to this facility for outpatient services by (a physician of) another acute care facility.
5	Transfer from a Skilled Nursing Facility	Patient was admitted to this facility as a hospital transfer from a skilled nursing facility where he/she was an inpatient or was referred to this facility for outpatient services by (a physician of) a skilled nursing facility.
6	Transfer from Another Health Care Facility	Patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or skilled nursing facility, including transfers from nursing homes, long-term care facilities and

FROM 2007 MANUAL

Field No.	Field Description
18	Source of Admission (continued from previous page)

If Type of Admission (Form Locator 14) equals: "1" (Emergency), "2" (Urgent), "3" (Elective), "5" (Trauma Center) or "9" (Unknown), use the following codes (continued):

Code	Source	Description
		skilled nursing facility patients that are at a non-skilled level of care, or referred to this facility for outpatient services by (a physician of) another health care facility where he/she is an inpatient.
7	Emergency Room	Patient was admitted for inpatient services or referred for outpatient services upon the recommendation of this facility's emergency room physician.
8	Court/Law Enforcement	Patient was admitted for inpatient services or referred for outpatient services upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9	Unknown	Information not available.
A	Transfer from a Critical Access Hospital	Patient was admitted to this facility as a hospital transfer from a critical access facility where they were an inpatient or was referred to this facility for outpatient services by (a physician of) another critical access facility.
D	Transfer from Hospital Inpatient same Facility	The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

FROM 2007 MANUAL

Field No.	Field Description
165	Payer Classification Code – Primary, Secondary, Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-04 Form Locator
Alpha-Numeric	4	1440-1443	Left Justified	Yes	50A

Description:
The name or type of payer organization from which the hospital first expects some payment for the bill.

The UB-04 form has three **lines for Form Locator 50**. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

This data is used to identify and analyze data for a particular payer organization and to analyze hospital case mix data.

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (not managed care)
C	Federal, Tricare, Champus (Military)
D	Medicaid (not TennCare – see TennCare codes below)
I	Commercial Insurance (not managed care)
M	Medicare (not managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self Pay
S	Self Insured, Self Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
11	Cover TN (also known as Blue Cross InReach plan – new in 2007)
12	Cover Kids (new in 2007)
13	Access TN (new in 2007)
	TennCare Codes
T	TennCare-Plan Unspecified
5	UAHC (previously Omni Care)
7	Windsor Health Plan of TN, Inc. (previously VHP Community Care)
8	AmeriChoice (previously John Deere/Heritage)
9	Preferred Health Partnership
F	TLC Family Care
J	Blue Care (TennCare plan offered by Blue Cross/Blue Shield)
Q	TennCare Select (State's TennCare product administered by Blue Cross)
R	Unison Health Plan (previously Better Health Plans, Inc.)
10	AmeriGroup Community Care (new TennCare MCO *effective April 1, 2007)*

FROM 2007 MANUAL

Field No.	Field Description
165	Payer Classification Code – Primary, Secondary, Tertiary (continued)

Code	Payer Classification
	TennCare Behavioral Codes
E	BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	**Blue Cross Managed Care – HMO/PPO/Other Managed Care** Payer may be listed as, but is not limited to, names such as: • HMO Blue • Blue Preferred • TPN • BC Memphis/Apple • Blue Classic • Blue Select
L	**Commercial (Managed Care – HMO/PPO/Other Managed Care)** Payer may be listed as, but is not limited to, names such as: • United Healthcare • Aetna/US Healthcare • Cigna and/or Healthsource • Cariten • Health Net • Prudential • John Deere/Heritage • Tripoint • Private HealthCare Systems • Affordable/First Health
K	**Medicare (HMO/PSO)** Payer may be listed as, but is not limited to, names such as: • Health 123 • Health Net • Cariten • United Healthcare • Blue Cross • Heritage/John Deere • Cigna