Chapter 6
Finance

6.1 PURPOSE

The Finance chapter describes Patient Accounting transactions. Other financial transactions may be added in the future.

Financial transactions can be sent between applications either in batches or online. As defined in Chapter 2, multiple transactions may be grouped and sent through all file transfer media or programs when using the HL7 Encoding Rules.

This chapter defines the transactions at the seventh level, i.e., the abstract messages. The examples included in this chapter were constructed using the HL7 Encoding Rules.

6.3 PATIENT ACCOUNTING MESSAGE SET

The patient accounting message set provides for the entry and manipulation of: charge, payment, adjustment, demographic, insurance, other related patient billing, and accounts receivable information.

The specification includes all data defined in the National Uniform Billing Data Element Specifications (as adapted by the National Uniform Billing Commission, May 21, 1982 and revised November 8, 1984 and 1992). We have excluded state-specific coding and suggest that, where required, it be implemented in site-specific 'Z' segments. State-specific fields may be included in the specification at a later time. In addition, no attempt has been made to define data traditionally required for the proration of charges. The requirement for this is unique to a billing system and not a part of an interface.

It is recognized that a wide variety of billing and accounts receivable systems exist today. Therefore, in an effort to accommodate the needs of the most comprehensive systems, an extensive set of transaction segments has been defined.

6.5 TRIGGER EVENTS AND MESSAGE DEFINITIONS

The triggering events that follow are served by the Detail Financial Transaction (DFT), Add/Change Billing Account (BAR), and General Acknowledgement (ACK) messages.

Each trigger event is documented below, along with the applicable form of the message exchange. The notation used to describe the sequence, optionality, and repetition of segments is described in Chapter 2, "Format for Defining Abstract Messages."

6.6.1 Add and update patient accounts (event code P01)

Data is sent from some application (usually a Registration or an ADT system) to the patient accounting system to establish an account for a patient's billing/accounts receivable record. Many of the segments associated with this event are optional. This optionality allows those systems needing these fields to set up transactions which fulfill their requirements yet satisfy the HL7 requirements. Sample event codes are in *table 0003 - event type code*.

BAR	Add/Change Billing Account		Chapter
MSH	Message Header		2
EVN	Event Type		3
PID	Patient ID Information	3	
{			
[PV1]	Patient Visit		3
[PV2]	Patient Visit - Additional Info	3	
[{ OBX }]	Observation/Result	7	
[{ AL1 }]	Allergy Information	3	
[{ DG1 }]	Patient Diagnosis	6	
[{ PR1 }]	Procedures	6	
[{ GT1 }]	Guarantor	6	
[{ NK1 }]	Next of Kin	3	
[			
{			
IN1	Insurance		6
[IN2]	Insurance - Additional Info.	6	
[IN3]	Insurance - Add'l Info. - Cert.	6	
}			
]			
[ACC]	Accident Information	6	
[UB1]	Universal Bill Information	6	
[UB2]	Universal Bill 92 Information	6	
}			

The Set ID field in the insurance, diagnosis, and procedures segments will be set the first time these segments are sent and can be used in subsequent transactions to update them.

ACK	General Acknowledgement	Chapter
MSH	Message Header	2
MSA	Message Acknowledgement	2
[ERR]	Error	2

The error segment will indicate the fields that caused a transaction to be rejected.

6.6.3 Purge patient accounts (event code P02)

Generally, the elimination of all billing/accounts receivable records will be an internal function controlled by the financial system. However, on occasion, there is a need to correct an account, or series of accounts, which may require a notice of account deletion to be sent from another sub-system and processed by the financial system. Although a series of accounts may be purged within this one event, it is recommended that only one PID segment per event be sent.

BAR	Add/Change Billing Account		Chapter
MSH	Message Header		2
EVN	Event Type		3
{			
PID	Patient ID Information	3	
[PV1]	Patient Visit		3
}			

ACK	General Acknowledgement	Chapter
MSH	Message Header	2
MSA	Message Acknowledgement	2
[ERR]	Error	2

The error segment indicates the fields that caused a transaction to be rejected.

6.6.5 Post detail financial transactions (event code P03)

The Detail Financial Transaction is used to describe a financial transaction transmitted between systems, ie., to HIS for ancillary charges, ADT to HIS for patient deposits, etc.

DFT	Detail Financial Transaction		Chapter
MSH	Message Header		2
EVN	Event Type		3
PID	Patient ID Information	3	
[PV1]	Patient Visit		3
[PV2]	Patient Visit - Additional Info	3	
[{ OBX }]	Observation/Result	7	
{ FT1 }	Financial Transaction	6	

Special codes in the Event Type record are used for updating.

ACK	General Acknowledgement	Chapter
MSH	Message Header	2
MSA	Message Acknowledgement	2
[ERR]	Error	2

The error segment indicates the fields that caused a transaction to be rejected.

6.6.7 Generate bills and accounts receivable statements (event code P04)

For patient accounting systems that support demand billing, the QRY/DSP transaction defined in Chapter 2 will provide the mechanism to request a copy of the bill for printing or viewing by the requesting system.

Note: This is a display-oriented response. That is why the associated messages are defined in Chapter 2.

6.7 MESSAGE SEGMENTS

6.8.1 FT1 - financial transaction

The FT1 segment contains detail data necessary to post charges, payments, adjustments, etc. to patient accounting records.

Figure 6-1 FT1 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI				00355	Set ID - financial transaction
2	12	ST				00356	Transaction ID
3	10	ST				00357	Transaction batch ID
4	8	DT	R			00358	Transaction date
5	8	DT				00359	Transaction posting date
6	8	ID	R		0017	00360	Transaction type
7	20	ID	R		0132	00361	Transaction code
8	40	ST				00362	Transaction description
9	40	ST				00363	Transaction description - alt
10	4	NM				00364	Transaction quantity
11	12	NM				00365	Transaction amount - extended
12	12	NM				00366	Transaction amount - unit
13	60	CE			0049	00367	Department code
14	8	ID			0072	00368	Insurance plan ID
15	12	CM				00369	Insurance amount
16	12	NM			0079	00133	Assigned Patient location
17	1	ID			0024	00370	Fee schedule
18	2	ID			0018	00148	Patient type
19	8	CE		Y	0051	00371	Diagnosis code
20	60	CN			0084	00372	Performed by code
21	60	CN				00373	Ordered by code
22	12	NM				00374	Unit cost
23	75	CM				00217	Filler order number

6.4.1.0 FT1 field definitions

6.8.2.1 Set ID - financial transaction (SI) 00355

Definition: number that uniquely identifies this transaction for the purpose of adding, changing, or deleting the transaction.

6.8.2.2 Transaction ID (ST) 00356

Definition: number assigned by the sending system for control purposes. The number can be returned by the receiving to identify errors.

6.8.2.3 Transaction batch ID (ST) 00357

Definition: uniquely identifies the batch in which this transaction belongs.

6.8.2.4 Transaction date (DT) 00358

Definition: date of transaction. For example, this field would be used to identify the date a procedure, item, or test was conducted or used. May be defaulted to today's date.

6.8.2.5 Transaction posting date (DT) 00359

Definition: date the transaction was sent to the financial system for posting.

6.8.2.6 Transaction type (ID) 00360

Definition: code that identifies the type of transaction. e.g., charge, credit, payment, etc. Refer to *user-defined table 0017 - transaction type*.

6.8.2.7 Transaction code (CE) 00361

Components: <identifier> ^ <text> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: code assigned by the institution for the purpose of uniquely identifying the transaction. For example, this field would be used to uniquely identify a procedure, item, or test for charging purposes. Refer to *user-defined table 0132 - transaction code*. See Chapter 7 for discussion on the univeral service ID.

6.8.2.8 Transaction description (ST) 00362

Definition: description of the transaction associated with the code entered in *FT1-7-transaction code*. This field is no longer needed as it is now part of *FT1-7-transaction code*. It has been kept for backwards compatibility.

6.8.2.9 Transaction description - alt (ST) 00363

Definition: alternate financial transaction description to be used on a site specific basis. This field is no longer needed as it is now part of *FT1-7-transaction code*. It has been kept for backwards compatibility.

6.8.2.10 Transaction quantity (NM) 00364

Definition: quantity of items associated with this transaction. This field is no longer needed as it is now part of *FT1-7-transaction code*. It has been kept for backwards compatibility.

6.8.2.11 Transaction amount - extended (NM) 00365

Definition: amount of transaction. This field may be blank if the transaction is automatically priced. Total price for multiple items.

6.8.2.12 Transaction amount - unit (NM) 00366

Definition: unit price of transaction. Price of a single item.

6.8.2.13 Department code (CE) 00367

Components: <identifier> ^ <text> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: department code which controls the transaction code described above. Refer to *user-defined table 0049 - department code*.

6.8.2.14 Insurance plan ID (ID) 00368

Definition: ID of the primary insurance plan this transaction should be associated with. Refer to *user-defined table 0072 - insurance plan ID*.

6.8.2.15 Insurance amount (NM) 00369

Definition: amount to be posted to the insurance plan referenced above.

6.8.2.16 Assigned patient location (CM) 00133

Components: <nurse unit> ^ <room> ^ <bed> ^ < facility ID> ^ <bed status>

Definition: current patient location. Refer to *user-defined table 0079-location*.

6.8.2.17 Fee schedule (ID) 00370

Definition: code used to select the appropriate fee schedule to be used for this transaction posting. Refer to *user-defined table 0024 - fee schedule*.

6.8.2.18 Patient type (ID) 00148

Definition: type code assigned to the patient for this visit. Refer to *user-defined table 0018 - patient type*.

6.8.2.19 Diagnosis code (CE) 00371

Components: <identifier - diagnosis code> ^ <text - diagnosis description> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: ICD9-CM is assumed for all diagnosis codes. This diagnosis code is the most current diagnosis code assigned to the patient. ICD10 can also be used. Refer to user-defined *table 0051 - diagnosis code.*

6.8.2.20 Performed by code (CN) 00372

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: composite number/name of the person/group which performed the test/procedure/transaction, etc. Refer to user defined *table 0084 - performed by table??]]*.

6.8.2.21 Ordered by code (CN) 00373

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: composite number/name of person/group which ordered the test/procedure/transaction, etc.

6.8.2.22 Unit cost (NM) 00374

Definition: unit price of transaction. The cost of a single item.

6.8.2.23 Filler order number (CM) 00217

Components: <unique filler ID> ^ <filler app ID>

Definition: used when the billing system is requesting observational reporting justification for a charge. This is the number used by a filler to uniquely identify a result. See Chapter 4 for a complete description.

6.8.3 DG1 - Diagnosis

The DG1 segment contains patient diagnosis information of various types. For example: Admitting, Current, Primary, Final, etc. Coding methodologies are also defined.

Figure 6-2 DG1 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00375	Set ID - diagnosis
2	2	ID	R		0053	00376	Diagnosis coding method
3	8	ID			0051	00377	Diagnosis code
4	40	ST				00378	Diagnosis description
5	26	TS				00379	Diagnosis date/time
6	2	ID	R		0052	00380	Diagnosis/DRG type
7	60	CE			0118	00381	Major diagnostic category
8	4	ID			0055	00382	Diagnostic related group
9	2	ID				00383	DRG approval indicator
10	2	ID			0056	00384	DRG grouper review code
11	60	CE			0083	00385	Outlier type
12	3	NM				00386	Outlier days
13	12	NM				00387	Outlier cost
14	4	ST				00388	Grouper version and type
15	2	NM				00389	Diagnosis/DRG priority
16	60	CN				00390	Diagnosing clinician

6.4.2.0 DG1 field definitions

6.8.4.1 Set ID - diagnosis (SI) 00375

Definition: sequence number that uniquely identifies the individual transaction for adding, deleting, and updating the diagnosis in the patient's record.

6.8.4.2 Diagnosis coding method (ID) 00376

Definition: ICD9 is the recommended coding methodology. Refer to *user-defined table 0053- diagnosis coding method*.

User-defined Table 0053 Diagnosis coding method

Value	Description
I9	ICD9

6.8.4.3 Diagnosis code (ID) 00377

Definition: diagnosis code assigned to this diagnosis. Refer to *user-defined table 0051- diagnosis code*. See Chapter 7 for suggested diagnosis codes.

6.8.4.4 Diagnosis description (ST) 00378

Definition: description that best describes the diagnosis.

6.8.4.5 Diagnosis date/time (TS) 00379

Definition: date/time the diagnosis was determined.

6.8.4.6 Diagnosis/DRG type (ID) 00380

Definition: code identifies the type of diagnosis being sent. Valid types could include: Admitting, Final, etc. Refer to *user-defined table 0052- diagnosis type*.

6.8.4.7 Major diagnostic category (CE) 00381

Components: <identifier> ^ <text> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: refer to *user-defined table 0118 - major diagnostic category*.

6.8.4.8 Diagnostic related group (ID) 00382

Definition: DRG for the transaction. Interim DRG's could be determined for an encounter. Refer to *user-defined table 0055- DRG code*.

6.8.4.9 DRG approval indicator (ID) 00383

Definition: indicates if the DRG has been approved by a reviewing entity

6.8.4.10 DRG grouper review code (ID) 00384

Definition: refer to *user-defined table 0056 - DRG grouper review code*. This code indicates that the grouper results have been reviewed and approved.

6.8.4.11 Outlier type (ID) 00385

Definition: refer to *user-defined table 0083 - outlier type*. The type of outlier that has been paid.

6.8.4.12 Outlier days (NM) 00386

Definition: number of days that have been approved as an outlier payment.

6.8.4.13 Outlier cost (NM) 00387

Definition: amount of money that has been approved as a payment.

6.8.4.14 Grouper version and type (ST) 00388

Definition: grouper version and type.

6.8.4.15 Diagnosis/DRG priority (NM) 00389

Definition: number which identifies the significance or priority of the diagnosis or DRG code.

6.8.4.16 Diagnosing clinician (CN) 00390

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: individual responsible for generating the diagnosis information.

6.8.5 PR1 - Procedures

The PR1 segment contains information relative to various types of procedures that can be performed on a patient. For example: Surgical, Nuclear Medicine, X-Ray with contrast, etc.

Figure 6-3 PR1 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00391	Set ID - procedure
2	2	ID	R	Y	0089	00392	Procedure coding method
3	10	ID	R	Y	0088	00393	Procedure code
4	40	ST		Y		00394	Procedure description
5	26	TS	R			00395	Procedure date/time
6	2	ID	R		0090	00396	Procedure type
7	4	NM				00397	Procedure minutes
8	60	CN				00398	Anesthesiologist
9	2	ID			0019	00399	Anesthesia code
10	4	NM				00400	Anesthesia minutes
11	60	CN				00401	Surgeon
12	60	CM		Y		00402	Procedure Practitioner
13	2	ID			0059	00403	Consent code
14	2	NM				00404	Procedure priority

6.4.3.0 PR1 field definitions

6.8.6.1 Set ID - procedure (SI) 00391

Definition: unique number that is used to identify a transaction for the purpose of adding, changing or deleting entries.

6.8.6.2 Procedure coding method (ID) 00392

Definition: methodology used to assign a code to the procedure (CPT4 for example). If more than one coding method is needed for a single procedure, this field and associated *PR1-3-procedure code* and *PR1-4-procedure description* may repeat. In this instance, the three fields (*PR1-2 through 4*) are directly associated with one another. Refer to *user-defined table 0089 - procedure coding method* for suggested values.

6.8.6.3 Procedure code (ID) 00393

Definition: unique identifier assigned to the procedure. Refer to *user-defined table 0088 - procedure code* for suggested values.

6.8.6.4 Procedure description (ST) 00394

Definition: text description that describes the procedure.

6.8.6.5 Procedure date/time (TS) 00395

Definition: date/time the procedure was performed.

6.8.6.6 Procedure type (ID) 00396

Definition: optional code that further defines the type of procedure. Refer to *user-defined table 0090 - procedure type* for suggested values.

6.8.6.7 Procedure minutes (NM) 00397

Definition: length of time in whole minutes that the procedure took to complete.

6.8.6.8 Anesthesiologist (CN) 00398

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: Anesthesiologist who administered the anesthesia. It is recommended that *PR1-12-procedure MD* be used instead of this field. This field remains only for backward compatibility. Refer to user-defined *table 0010 - physician ID*.

6.8.6.9 Anesthesia code (ID) 00399

Definition: uniquely identifies the anesthesia used during the procedure. It is recommended that *PR1-12-procedure MD* be used instead of this field. This field remains only for backward compatibility.

6.8.6.10 Anesthesia minutes (NM) 00400

Definition: length of time in minutes that the anesthesia was administered.

6.8.6.11 Surgeon (CN) 00401

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: surgeon who performed the procedure. It is recommended that *PR1-12-procedure MD* be used instead of this field. This field remains only for backward compatibility. Refer to user-defined *table 0010 - physician ID*.

6.8.6.12 Procedure Practitioner (CM) 00402

Components: <procedure practitioner ID>(CN) ^ <procedure practitioner type>(ID)

Definition: different types of practitioners associated with this procedure. The ID and name components follow the standard rules defined for a composite name (CN) field. If the procedure type component is unvalued, it is assumed that the physician identified is a resident. Refer to user-defined *table 0010 - physician ID*. Refer to *user-defined table 0133 - procedure practitioner type* for suggested entries.

User-defined Table 0133 Procedure practitioner type

Value	Description
AN	Anesthesiologist
PR	Procedure MD (surgeon)
RD	Radiologist
RS	Resident
NP	Nurse Practitioner
CM	Certified Nurse Midwife

6.8.6.13 Consent code (ID) 00403

Definition: type of consent that was obtained for permission to treat the patient. Refer to *user-defined table 0059 - consent code*.

6.8.6.14 Procedure priority (NM) 00404

Definition: number which identifies the significance or priority of the procedure code.

6.8.7 GT1 - guarantor

The GT1 segment contains guarantor (e.g., person with financial responsibility for payment of a patient account) data for patient and insurance billing applications.

Figure 6-4 GT1 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00405	Set ID - guarantor
2	20	CK				00406	Guarantor number
3	48	PN	R			00407	Guarantor name
4	48	PN				00408	Guarantor spouse name
5	106	AD				00409	Guarantor address
6	40	TN		Y/3		00410	Guarantor ph num- home
7	40	TN		Y/3		00411	Guarantor ph num-business
8	8	DT				00412	Guarantor date of birth
9	1	ID			0001	00413	Guarantor sex
10	2	ID			0068	00414	Guarantor type
11	2	ID			0063	00415	Guarantor relationship
12	11	ST				00416	Guarantor SSN
13	8	DT				00417	Guarantor date - begin
14	8	DT				00418	Guarantor date - end
15	2	NM				00419	Guarantor priority
16	45	ST				00420	Guarantor employer name
17	106	AD				00421	Guarantor employer address
18	40	TN		Y/3		00422	Guarantor employ phone number
19	20	ST				00423	Guarantor employee ID num
20	2	ID			0066	00424	Guarantor employment status
21	60	ST				00425	Guarantor organization

6.4.4.0 GT1 field definitions

6.8.8.1 Set ID - guarantor (SI) 00405

Definition: number that uniquely identifies the transaction for the purpose of adding, changing, or deleting a transaction.

6.8.8.2 Guarantor number (CK) 00406

Definition: unique number assigned to the guarantor.

6.8.8.3 Guarantor name (PN) 00407

Components: <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)>

Definition: name of the guarantor.

6.8.8.4 Guarantor spouse name (PN) 00408

Components: <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)>

Definition: name of the guarantor's spouse.

6.8.8.5 Guarantor address (AD) 00409

Components: <street address> ^ < other designation> ^ <city> ^ <state or province> ^ <zip or postal code> ^ <country> ^ <type> ^ <other geographic designation>

Definition: guarantor's address.

6.8.8.6 Guarantor ph num - home (TN) 00410

Definition: guarantor's home phone number.

6.8.8.7 Guarantor ph. num-business (TN) 00411

Definition: guarantor's business phone number.

6.8.8.8 Guarantor date of birth (DT) 00412

Definition: guarantor's date of birth.

6.8.8.9 Guarantor sex (ID) 00413

Definition: refer to *table 0001 - sex* for valid entries.

6.8.8.10 Guarantor type (ID) 00414

Definition: type of guarantor, e.g., individual, institution, etc. Refer to *user-defined table 0068 - guarantor type*.

6.8.8.11 Guarantor relationship (ID) 00415

Definition: relationship of the guarantor with the patient, e.g., parent, child, etc. Refer to *user-defined table 0063 - guarantor relationship*.

6.8.8.12 Guarantor SSN (ST) 00416

Definition: guarantor's social security number.

6.8.8.13 Guarantor date - begin (DT) 00417

Definition: date the guarantor becomes responsible for the patient's account.

6.8.8.14 Guarantor date - end (DT) 00418

Definition: date the guarantor stops being responsible for the patient's account.

6.8.8.15 Guarantor priority (NM) 00419

Definition: used to determine the order in which the guarantors will be responsible for the patient's account.

6.8.8.16 Guarantor employer name (ST) 00420

Definition: name of the guarantor's employer.

6.8.8.17 Guarantor employer address (AD) 00421

Components: <street address> ^ < other designation> ^ <city> ^ <state or province> ^ <zip or postal code> ^ <country> ^ <type> ^ <other geographic designation>

Definition: guarantor's employer's address.

6.8.8.18 Guarantor employ phone number (TN) 00422

Definition: guarantor's employer phone number.

6.8.8.19 Guarantor employee ID num (ST) 00423

Definition: guarantor's employee number.

6.8.8.20 Guarantor employment status (ID) 00424

Definition: code that indicates the guarantor's employment status. e.g., Full Time, Part Time, Self Employed, etc. Refer to user-defined *table 0066 - employment status.*

6.8.8.21 Guarantor organization (ST) 00425

Definition:

6.8.9 IN1 - insurance

The IN1 segment contains insurance policy coverage information necessary to produce properly pro-rated and patient and insurance bills.

Figure 6-5 IN1 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00426	Set ID - insurance
2	8	ID	R		0072	00368	Insurance plan ID
3	6	ST	R			00428	Insurance company ID
4	45	ST				00429	Insurance company name
5	106	AD				00430	Insurance company address
6	48	PN				00431	Insurance co. Contact pers
7	40	TN		Y/3		00432	Insurance co phone number
8	12	ST				00433	Group number
9	35	ST				00434	Group name
10	12	ST				00435	Insured's group emp ID
11	45	ST				00436	Insured's group emp Name
12	8	DT				00437	Plan effective date
13	8	DT				00438	Plan expiration date
14	55	CM				00439	Authorization information
15	2	ID			0086	00440	Plan type
16	48	PN				00441	Name of insured
17	2	ID			0063	00442	Insured's relationship to patient
18	8	DT				00443	Insured's date of birth
19	106	AD				00444	Insured's address
20	2	ID			0135	00445	Assignment of benefits
21	2	ID			0173	00446	Coordination of benefits
22	2	ST				00447	Coord of ben. Priority
23	2	ID				00448	Notice of admission code
24	8	DT				00449	Notice of admission date
25	2	ID				00450	Rpt of eligibility code
26	8	DT				00451	Rpt of eligibility date
27	2	ID			0093	00452	Release information code
28	15	ST				00453	Pre-admit cert (PAC)
29	26	TS				00454	Verification date/time
30	60	CN				00455	Verification by
31	2	ID			0098	00456	Type of agreement code
32	2	ID			0022	00457	Billing status
33	4	NM				00458	Lifetime reserve days
34	4	NM				00459	Delay before L. R. day
35	8	ID			0042	00460	Company plan code
36	15	ST				00461	Policy number
37	12	NM				00462	Policy deductible
38	12	NM				00463	Policy limit - amount
39	4	NM				00464	Policy limit - days
40	12	NM				00465	Room rate - semi-private
41	12	NM				00466	Room rate - private
42	60	CE			0066	00467	Insured's employment status

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
43	1	ID			0001	00468	Insured's sex
44	106	AD				00469	Insured's employer address
45	2	ST				00470	Verification status
46	8	ID			0072	00471	Prior insurance plan ID

6.4.5.0 IN1 field definitions

6.8.10.1 Set ID - insurance (SI) 00426

Definition: sequence number which uniquely identifies this transaction for the purpose of adding, changing, or deleting the transaction.

6.8.10.2 Insurance plan ID (ST) 00427

Definition: uniquely identifies the insurance plan. Refer to *user-defined table 0072 - insurance plan ID*. To eliminate a plan, the plan could be sent with null values in each subsequent element. If the respective systems can support it, a null value can be sent in the plan field.

6.8.10.3 Insurance company ID (ST)00428

Definition: uniquely identifies the insurance company.

6.8.10.4 Insurance company name (ST) 00429

Definition: name of the insurance company.

6.8.10.5 Insurance company address (AD) 00430

Components: <street address> ^ < other designation> ^ <city> ^ <state or province> ^ <zip or postal code> ^ <country> ^ <type> ^ <other geographic designation>

Definition: address of the insurance company.

6.8.10.6 Insurance co contact pers (PN) 00431

Components: <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)>

Definition: name of the person who should be contacted at the insurance company.

6.8.10.7 Insurance co phone number (TN) 00432

Definition: phone number of the insurance company.

6.8.10.8 Group number (ST)00433

Definition: group number of the insured's insurance.

6.8.10.9 Group name (ST) 00434

Definition: group name of the insured's insurance.

6.8.10.10 Insured's group emp. ID (ST) 00435

Definition: group employer ID of the insured's insurance.

6.8.10.11 Insured's group emp name (ST) 00436

Definition: name of the employer which provides the employee's insurance.

6.8.10.12 Plan effective date (DT) 00437

Definition: date that the insurance goes into effect.

6.8.10.13 Plan expiration date (DT) 00438

Definition: last date of service that the insurance will cover or be responsible for.

6.8.10.14 Authorization information (CM) 00439

Components: <authorization number>(ST) ^ <date> ^ <source>

Definition: based on the type of insurance, some coverages require that an authorization number or code be obtained prior to all non emergency admissions and within 48 hours of an emergency admission. Insurance billing would not be permitted without this number. Date and source of authorization are sub-fields.

6.8.10.15 Plan type (ID) 00440

Definition: coding structure that identifies the various plan types. Refer to user-defined *table 0086 - plan ID*.

6.8.10.16 Name of insured (PN) 00441

Components: <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)>

Definition: name of the insured person.

6.8.10.17 Insured's relationship to patient (ID) 00442

Definition: insured's relationship to the patient. Refer to user-defined *table 0063 - relationship*.

6.8.10.18 Insured's date of birth (DT) 00443

Definition: date of birth of insured.

6.8.10.19 Insured's address (AD) 00444

Components: <street address> ^ < other designation> ^ <city> ^ <state or province> ^ <zip or postal code> ^ <country> ^ <type> ^ <other geographic designation>

Definition: address of insured person.

6.8.10.20 Assignment of benefits (ID) 00445

Definition: has the insured agreed to assign the insurance benefits to the healthcare provider? If so, the insurance will pay the provider directly. Refer to *user-defined table 0135 - assignment of benefits* for suggested values.

User-defined Table 0135 Assignment of benefits

Value	Description
Y	Yes
N	No
M	Modified assignment

6.8.10.21 Coordination of benefits (ID) 00446

Definition: does this insurance work in conjunction with other insurance plans, or does it provide independent coverage and payment of benefits regardless of other insurance that might be available to the patient? Refer to *user-defined table 0173 - coordination of benefits* for suggested values.

User-defined Table 0173 Coordination of benefits

Value	Description
CO	Coordination
IN	Independent

6.8.10.22 Coord of ben priority (ST) 00447

Definition: if the insurance works in conjunction with other insurance plans, what is priority sequence? Values are: 1, 2, 3, etc.

6.8.10.23 Notice of admission code (ID) 00448

Definition: does the insurance require a written notice of admission from the healthcare provider? Refer to *table 0136 - Y/N indicator* for valid values.

6.8.10.24 Notice of admission date (DT) 00449

Definition: if a notice is required, this is the date that it was sent.

6.8.10.25 Rpt of eligibility code (ID) 00450

Definition: does this insurance carrier send a report which indicates that the patient is eligible for benefits and identifies those benefits? Refer to *table xxxx - Y/N indicator* for valid values.

6.8.10.26 Rpt of eligibility date (DT) 00451

Definition: if a report of eligibility (ROE) was received, this indicates the date it was received.

6.8.10.27 Release information code (ID) 00452

Definition: can the healthcare provider release information about the patient, and what information can be released. Refer to user-defined *table 0093 - release information code* for suggested values.

User-defined Table 0093 Release information

Value	Description
Y	Yes
N	No
	or user-defined codes

6.8.10.28 Pre-admit cert. (PAC) (ST) 00453

Definition: pre-admission certification code. If the admission must be certified before the admission, this is the code associated with the admission.

6.8.10.29 Verification date/time (TS) 00454

Definition: date/time that the healthcare provider verified that the patient has the indicated benefits.

6.8.10.30 Verification by (CN)00455

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: person that verified the benefits.

6.8.10.31 Type of agreement code (ID) 00456

Definition: used to further identify an insurance plan. Refer to *user-defined table 0098 - type of agreement code* for suggested values. Suggested values are standard, unified, or maternity.

6.8.10.32 Billing status (ID) 00457

Definition: has the particular insurance been billed and if so, what type of bill. Refer to *user-defined table 0022 - billing status* for suggested values.

6.8.10.33 Lifetime reserve days (NM) 00458

Definition: number of days left where a certain service may be provided or covered under an insurance policy.

6.8.10.34 Delay before LR Day (NM) 00459

Definition: delay before lifetime reserve days.

6.8.10.35 Company plan code (ID) 00460

Definition: Refer to *user-defined table 0042 - company plan code*. This table contains codes used to uniquely identify an insurance plan. Optional information to further define data in *IN1-3-insurance company ID*.

6.8.10.36 Policy number (ST) 00461

Definition: individual policy number of the insured.

6.8.10.37 Policy deductible (NM) 00462

Definition: amount specified by the insurance plan that is the responsibility of the guarantor.

6.8.10.38 Policy limit - amount (NM) 00463

Definition: maximum amount that the insurance policy will pay. In some cases, the limit may be for a single encounter.

6.8.10.39 Policy limit - days (NM) 00464

Definition: maximum number of days that the insurance policy will cover.

6.8.10.40 Room rate - semi-private (NM) 00465

Definition: average room rate that the policy will cover. It is recommended that *IN2-28-room coverage type/amount* be used instead of this field. This field remains only for backward compatibility.

6.8.10.41 Room rate - private (NM) 00466

Definition: maximum private room rate the policy will cover. It is recommended that *IN2-28-room coverage type/amount* be used instead of this field. This field remains only for backward compatibility.

6.8.10.42 Insured's employment status (CE) 00467

Components: <identifier> ^ <text> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: refer to *user-defined table 0066 - employment status* for valid codes.

6.8.10.43 Insured's sex (ID) 00468

Definition: refer to *table 0001 - sex* for valid codes.

6.8.10.44 Insured's employer address (AD) 00469

Components: <street address> ^ < other designation> ^ <city> ^ <state or province> ^ <zip or postal code> ^ <country> ^ <type> ^ <other geographic designation>

Definition: address of the insured employee.

6.8.10.45 Verification status (ST) 00470

Definition: status of this patient's relationship with this insurance carrier.

6.8.10.46 Prior insurance plan ID (ID) 00471

Definition: uniquely identifies the prior insurance plan when the plan ID changes. Refer to user-defined *table 0072 - insurance plan ID*.

6.8.11 IN2 - insurance additional info

The IN2 segment contains additional insurance policy coverage and benefit information necessary for proper billing and reimbursement. Fields used by this segment are defined by HICFA or other regulatory agencies.

Figure 6-6 IN2 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	15	ST				00472	Insured's employee ID
2	9	NM				00473	Insured's social security number
3	60	CN				00474	Insured's employer name
4	1	ID			0139	00475	Employer information data
5	1	ID			0137	00476	Mail claim party
6	15	NM				00477	Medicare health ins card number
7	48	PN				00478	Medicaid case name
8	15	NM				00479	Medicaid case number
9	48	PN				00480	Champus sponsor name
10	20	NM				00481	Champus ID number
11	1	ID				00482	Dependent of champus recipient
12	25	ST				00483	Champus organization
13	25	ST				00484	Champus station
14	14	ID			0140	00485	Champus service
15	2	ID			0141	00486	Champus rank/grade
16	3	ID			0142	00487	Champus status
17	8	DT				00488	Champus retire date
18	1	ID				00489	Champus non-avail cert on file
19	1	ID				00490	Baby coverage
20	1	ID				00491	Combine baby bill
21	1	NM				00492	Blood deductible
22	48	PN				00493	Special coverage approval name
23	30	ST				00494	Special coverage approval title
24	8	ID		Y	0143	00495	Non-covered insurance code
25	6	ST				00496	Payor ID
26	6	ST				00497	Payor subscriber ID
27	1	ID			0144	00498	Eligibility source
28	25	CM		Y		00499	Room coverage type/amount
29	25	CM		Y		00500	Policy type/amount
30	25	CM				00501	Daily deductible

6.4.6.0 IN2 field definitions

6.8.12.1 Insured's employee ID (ST) 00472

Definition: employee ID of insured.

6.8.12.2 Insured's social security number (NM) 00473

Definition: social security number of insured.

6.8.12.3 Insured's employer name (CN) 00474

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: name of insured's employer.

6.8.12.4 Employer information data (ID) 00475

Definition: required employer information data for UB82 form locator 71. Refer to *user-defined table 0139 - employer information data* for suggested values.

6.8.12.5 Mail claim party (ID) 00476

Definition: party to which the claim should be mailed.

Table 0137 Mail claim party

Value	Description
E	Employer
G	Guarantor
I	Insurance company
O	Other
P	Patient

6.8.12.6 Medicare health ins card number (NM) 00477

Definition: this field is defined by HCFA or other regulatory agencies.

6.8.12.7 Medicaid case name (PN) 00478

Components: <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)>

Definition: this field is defined by HCFA or other regulatory agencies.

6.8.12.8 Medicaid case number (NM) 00479

Definition: this field is defined by HCFA or other regulatory agencies.

6.8.12.9 Champus sponsor name (PN) 00480

Components: <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)>

Definition: this field is defined by HCFA or other regulatory agencies.

6.8.12.10 Champus ID number (NM) 00481

Definition: this field is defined by HCFA or other regulatory agencies.

6.8.12.11 Dependent of champus recipient (ID) 00482

Definition: defined by HCFA or other regulatory agencies.

6.8.12.12 Champus organization (ST) 00483

Definition: defined by HCFA or other regulatory agencies.

6.8.12.13 Champus station (ST) 00484

Definition: defined by HCFA or other regulatory agencies.

6.8.12.14 Champus service (ID) 00485

Definition: defined by HCFA or other regulatory agencies. Refer to *table 0140 - Champus service* for suggested values.

6.8.12.15 Champus rank/grade (ID) 00486

Definition: This user-defined field identifies the CHAMPUS military rank/grade of the insured. Refer to *table 0141 - Champus rank/grade* for suggested values.

6.8.12.16 Champus status (ID) 00487

Definition: defined by HCFA or other regulatory agencies. Refer to *table 0142 - Champus status* for suggested values.

6.8.12.17 Champus retire date (DT) 00488

Definition: defined by HCFA or other regulatory agencies.

6.8.12.18 Champus non-avail cert on file (ID) 00489

Definition: refer to *table 0136 - Y/N indicator*.

6.8.12.19 Baby coverage (ID) 00490

Definition: refer to *table 0136 - Y/N indicator*.

6.8.12.20 Combine baby bill (ID) 00491

Definition: refer to *table 0136 - Y/N indicator*.

6.8.12.21 Blood deductible (NM) 00492

Definition: it is recommended that this field be used instead of *UB2-2-blood deductible* as the blood deductible can be associated with the specific insurance plan via this field.

6.8.12.22 Special coverage approval name (PN) 00493

Components: <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)>

Definition: name of the individual that approves any special coverage.

6.8.12.23 Special coverage approval title (ST) 00494

Definition: title of the person that approves special coverage.

6.8.12.24 Non-covered insurance code (ID) 00495

Definition: code which describes why a service is not covered. Refer to *user-defined table 0143 - non-covered insurance code* for suggested values.

6.8.12.25 Payor ID (ST) 00496

Definition: required for NEIC processing, identifies the organization from which reimbursement is expected.

6.8.12.26 Payor subscriber ID (ST) 00497

Definition: required for NEIC processing, identifies the specific office within the insurance carrier designated as responsible for the claim.

6.8.12.27 Eligibility source (ID) 00498

Definition: required for NEIC processing, identifies the source of information about the insured's eligibility for benefits. Refer to *user-defined table 0144 - eligibility source* for suggested entries.

User-defined Table 0144 Eligibility source

Value	Description
1	Insurance company
2	Employer
3	Insured presented policy
4	Insured presented card
5	Signed statement on file
6	Verbal information
7	None

6.8.12.28 Room coverage type/amount (CM) 00499

Components: <room type (ID)> ^ <amount type (ID)> ^ <coverage amount(NM)>

Definition: room type (e.g., private, semi-private) and amount (e.g., rate, percentage, differential) covered by the insurance. It is recommended that this field be used instead of *IN1-40-room rate - semi-private* and *IN1-41-room rate - private*. Refer to *user-defined tables 0145 - room type* and *0146 - amount type* for suggested entries.

User-defined Table 0145 Room type

Value	Description
PRI	Private room
2PRI	Second private room
SPR	Semi-private room
2SPR	Second semi-private room
ICU	Intensive care unit
2ICU	Second intensive care unit

User-defined Table 0146 Amount type

Value	Description
DF	Differential
LM	Limit
PC	Percentage
RT	Rate
UL	Unlimited

6.8.12.29 Policy type/amount (CM) 00500

Components: <policy type (ID)> ^ <amount class (ID)> ^ <amount (NM)>

Definition: policy type (e.g., ancillary, major medical) and amount (e.g., amount, percentage, limit) covered by the insurance. It is recommended that this field is used instead of *IN1-38-policy limit - amount*. Refer to *user-defined tables 0147 - policy type* and *0193 - amount class* for suggested entries.

User-defined Table 0147 Policy Type

Value	Description
ANC	Ancillary
2ANC	Second ancillary
MMD	Major medical
2MMD	Second major medical
3MMD	Third major medical

User-defined Table 0193 Amount class

Value	Description
AT	Amount
LM	Limit
PC	Percentage
UL	Unlimited

6.8.12.30 Daily deductible (CM) 00501

Components: <delay days> ^ <amount> ^ <number of days>

Definition: number of days after which to begin the daily deductible, the amount of the deductible, and the number of days to apply the deductible.

6.8.13 IN3 - insurance additional info - certification

The IN3 segment contains additional insurance information for certifying the need for patient care. Fields used by this segment are defined by HICFA or other regulatory agencies.

Figure 6-7 IN3 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			00502	Set ID - insurance certification
2	25	ST				00503	Certification number
3	60	CN				00504	Certified by
4	1	ID				00505	Certification required
5	10	CM			0148	00506	Penalty
6	26	TS				00507	Certification date/time
7	26	TS				00508	Certification modify date/time
8	60	CN				00509	Operator
9	8	DT				00510	Certification begin date
10	8	DT				00511	Certification end date
11	3	CM			0149	00512	Days
12	60	CE				00513	Non-concur code/description
13	26	TS				00514	Non-concur eff date/time
14	60	CN				00515	Physician reviewer
15	48	ST				00516	Certification contact
16	40	TN		Y/3		00517	Certification contact phone number
17	60	CE				00518	Appeal reason
18	60	CE				00519	Certification agency
19	40	TN		Y/3		00520	Certification agency phone number
20	40	CM		Y	0150	00521	Pre-certification req/window
21	48	ST				00522	Case manager
22	8	DT				00523	Second opinion date
23	1	ID			0151	00524	Second opinion status
24	1	ID			0152	00525	Second opinion documentation received
25	60	CN				00526	Second opinion practitioner

6.4.7.0 IN3 field definitions

6.8.14.1 Set ID - insurance certification (SI) 00502

Definition: sequence number which uniquely identifies this segment for the purpose of adding, changing, or deleting a certification segment.

6.8.14.2 Certification number (ST) 00503

Definition: assigned by the certification agency.

6.8.14.3 Certified by (CN) 00504

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: party that approved the certification.

6.8.14.4 Certification required (ID) 00505

Definition: identifies whether certification is required. Refer to *table 0136 - Y/N indicator* for valid values.

6.8.14.5 Penalty (CM) 00506

Components: <penalty type (ID)> ^ <penalty amount>

Definition: the penalty, in dollars or a percentage, that will be assessed if the pre-certification is not performed. Refer to *user-defined table 0148 - penalty type* for suggested entries.

User-defined Table 0148 Penalty type

Value	Description
AT	Currency amount
PC	Percentage

6.8.14.6 Certification date/time (TS) 00507

Definition: date and time stamp when insurance was certified to exist for the patient.

6.8.14.7 Certification modify date/time (TS) 00508

Definition: date/time that the certification was modified.

6.8.14.8 Operator (CN) 00509

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: party that is responsible for sending this certification information.

6.8.14.9 Certification begin date (DT) 00510

Definition: date that this certification begins.

6.8.14.10 Certification end date (DT) 00511

Definition: date that this certification ends.

6.8.14.11 Days (CM) 00512

Components: <day type (ID)> ^ <number of days (NM)>

Definition: number of days for which this certification is valid. This field will apply to denied, pending, or approved days. Refer to *user-defined table 0149 - day type* for suggested entries.

User-defined Table 0149 Day type

Value	Description
AP	Approved
DE	Denied
PE	Pending

6.8.14.12 Non-concur code/desc (CE) 00513

Components: <identifier> ^ <text> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: non-concur code and description for a denied request.

6.8.14.13 Non-concur eff date/time (TS) 00514

Definition: effective date of the non-concurrence classification.

6.8.14.14 Physician reviewer (CN) 00515

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: physician who works with and reviews cases that are pending physician review for the certification agency.

6.8.14.15 Certification contact (ST) 00516

Definition: name of the party contacted at the certification agency who granted the certification and communicated the certification number.

6.8.14.16 Certification contact phone number (TN) 00517

Definition: phone number of the certification contact.

6.8.14.17 Appeal reason (CE) 00518

Components: <identifier> ^ <text> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: reason an appeal was made on a non-concur for certification.

6.8.14.18 Certification agency (CE) 00519

Components: <identifier> ^ <text> ^ <name of coding system>^<alternate identifier> ^ <alternate text> ^ <name of alternate coding system>

Definition: certification agency.

6.8.14.19 Certification agency phone number (TN) 00520

Definition: phone number of the Certification agency.

6.8.14.20 Pre-certification req/window (CM) 00521

Components: <pre-certification patient type (ID)> ^ <pre-certification required (ID)> ^ <pre-certification window (TS)>

Definition: identifies whether pre-certification is required for particular patient types and the time window for obtaining the certification. Refer to *user-defined table 0150 - pre-certification patient type* for suggested values. Valid values for the pre-certification required component are found in *table 0136 - Y/N indicator*. The pre-certification window is the amount of time needed to be certified from arrival at the institution. Its format follows the time stamp (TS) data type rules.

User-defined Table 0150 Pre-certification patient type

Value	Description
ER	Emergency
IPE	Inpatient elective
OPE	Outpatient elective
UR	Urgent

6.8.14.21 Case manager (ST) 00522

Definition: entity who/which is handling this particular patient's case (e.g., UR nurse, or a specific facility location).

6.8.14.22 Second opinion date (DT) 00523

Definition: date that the second opinion was obtained.

6.8.14.23 Second opinion status (ID) 00524

Definition: Code that represents the status of the second opinion. Refer to user-defined *table 0151 - second opinion status* for suggested values.

6.8.14.24 Second opinion documentation received (ID) 00525

Definition: if accompanying documentation has been received by the provider. Refer to *table 0152 - second opinion documentation received.*

6.8.14.25 Second opinion practitioner (CN) 00526

Components: <ID Number> ^ <family name> ^ <given name> ^ <middle initial or name> ^ <suffix (e.g., JR or III)> ^ <prefix (e.g., DR)> ^ <degree (e.g., MD)> ^ <source table>

Definition: ID and name of the physician who provided the second opinion.

6.8.15 ACC - accident

The ACC segment contains patient information relative to an accidentin which the patient has been involved.

Figure 6-8 ACC attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	26	TS				00527	Accident date/time
2	2	ID			0050	00528	Accident code
3	25	ST				00529	Accident location

6.4.8.0 ACC field definitions

6.8.16.1 Accident date/time (TS) 00527

Definition: date/time of the accident.

6.8.16.2 Accident code (ID) 00528

Definition: type of accident. Refer to *user-defined table 0050 - accident code*.

6.8.16.3 Accident location (ST) 00529

Definition: location of the accident.

6.8.17 UB1 - UB82 data

The UB1 segment contains data necessary to complete UB82 bills. Only UB82 data elements that do not exist in other HL7 defined segments will appear in this segment. Patient name and Date of Birth are required for UB82 billing, however, they are included in the PID segment and therefore do not appear here.

Figure 6-9 UB1 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI				00530	Set ID - UB82
2	1	NM				00531	Blood deductible (43)
3	2	NM				00532	Blood furn-pints of (40)
4	2	NM				00533	Blood replaced-pints (41)
5	2	NM				00534	Blood not rplcd-pints(42)
6	2	NM				00535	Co-insurance days (25)
7	2	ID		Y/5	0043	00536	Condition code (35-39)
8	3	NM				00537	Covered days - (23)
9	3	NM				00538	Non covered days - (24)
10	12	ID		Y/8	0153	00539	Value amount & code (46-49)
11	2	NM				00540	Number of grace days (90)
12	2	ID				00541	Spec program indicator (44)
13	1	ID				00542	PSRO/UR approval indicator (87)
14	8	DT				00543	PSRO/UR aprvd stay-fm (88)
15	8	DT				00544	PSRO/UR aprvd stay-to (89)
16	20	CM		Y/5		00545	Occurrence (28-32)
17	2	ID				00546	Occurrence span (33)
18	8	DT				00547	Occur span start date(33)
19	8	DT				00548	Occur span end date (33)
20	30	ST				00549	UB-82 locator 2
21	7	ST				00550	UB-82 locator 9
22	8	ST				00551	UB-82 locator 27
23	17	ST				00552	UB-82 locator 45

6.4.9.0 UB1 field definitions

6.8.18.1 Set ID - UB82 (SI) 00530

Definition: number used to uniquely identify the transaction for the purpose of adding, changing, or deleting the entry.

6.8.18.2 Blood deductible (NM) 00531

Definition: It is recommended that *IN2-21-blood deductible* be used instead of this field as the blood deductible can be associated with the specific insurance plan via that segment.

6.8.18.3 Blood furn-pints of (40) (NM) 00532

Definition: amount of blood furnished the patient for this visit. The (40) indicates the corresponding UB82 Data Element number.

6.8.18.4 Blood replaced-pints (41) (NM) 00533

Definition: UB82 Data Element 41.

6.8.18.5 Blood not rplcd-pints(42) (NM) 00534

Definition: Blood not replaced. Measured in pints. UB82 Data Element 42

6.8.18.6 Co-insurance days (25) (NM) 00535

Definition: UB82 Data Element 25.

6.8.18.7 Condition code (ID) 00536

Definition: repeats 5 times. UB82 Data Elements (35), (36), (37), (38),and (39). Refer to user-defined *table 0043 - condition code* for suggested values.

6.8.18.8 Covered days - (23) (NM) 00537

Definition: UB82 Data Element 23.

6.8.18.9 Non covered days - (24) (NM) 00538

Definition: UB82 Data Element 24.

6.8.18.10 Value amount & code (CM) 00539

Components: <value code (ID)> ^ <value amount (NM)>

Definition: pair can repeat up to eight times. (46A, 47A, 48A, 49A, 46B, 47B, 48B, and 49B). Refer to user-defined *table 0153 - value code* for suggested values.

6.8.18.11 Number of grace days (90) (NM) 00540

Definition: UB82 Data Element 90.

6.8.18.12 Spec program indicator (44) (ID) 00541

Definition: special program indicator. UB82 Data Element 44.

6.8.18.13 PSRO/UR approval indicator (87) (ID) 00542

Definition: PSRO/UR approval indicator. UB82 data element 87.

6.8.18.14 PSRO/UR aprvd stay-fm (88) (DT) 00543

Definition: PSRO/UR approved stay date (from). UB82 Data Element 88.

6.8.18.15 PSRO/UR aprvd stay-to (89) (DT) 00544

Definition: PSRO/UR approved stay date (to). UB82 Data Element 89.

6.8.18.16 Occurrence (28-32) (CM) 00545

Components: <occurrence code (ID)> ^ <occurrence date (DT)>

Definition: set of values can repeat up to five times. UB82 Data Elements 28-32.

6.8.18.17 Occurrence span (33) (ID) 00546

Definition: UB82 Data Element 33.

6.8.18.18 Occur span start date (33) (DT) 00547

Definition: occurrence span start date. UB82 Data Element 33.

6.8.18.19 Occur. Span end date (33) (DT) 00548

Definition: occurrence span end date. UB82 Data Element 33.

6.8.18.20 UB-82 locator 2 (ST) 00549

Definition: defined by UB-82 HICFA specification.

6.8.18.21 UB-82 locator 9 (ST) 00550

Definition: defined by UB-82 HICFA specification.

6.8.18.22 UB-82 locator 27 (ST) 00551

Definition: defined by UB-82 HICFA specification.

6.8.18.23 UB-82 locator 45 (ST) 00552

Definition: defined by UB-82 HICFA specification.

6.8.19 UB2 - UB92 data

The UB2 segment contains data necessary to complete UB92 bills. Only UB92 data elements that do not exist in other HL7 defined segments will appear in this segment. Just as with the UB82 billing, Patient Name and Date of Birth are required, they are included in the PID segment and therefore do not appear here. Where the field locators are different on the UB92, when compared to the UB82, the element is listed with its new location in parentheses ().

Figure 6-10 UB2 attributes

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI				00553	Set ID - UB92
2	3	ST				00554	Co-insurance days (9)
3	2	ID		Y/7	0043	00555	Condition code (24-30)
4	3	ST				00556	Covered days (7)
5	4	ST				00557	Non-covered days (8)
6	11	CM		Y/12		00558	Value amount & code (39-41)
7	11	CM		Y/8		00559	Occurrence code & date (32-35)
8	28	CM		Y/2		00560	Occurrence span code/dates (36)
9	29	ST		Y/2		00561	UB92 locator 2 (state)
10	12	ST		Y/2		00562	UB92 locator 11 (state)
11	5	ST				00563	UB92 locator 31 (national)
12	23	ST		Y/3		00564	Document control number (37)
13	4	ST		Y/23		00565	UB92 locator 49 (national)
14	14	ST		Y/5		00566	UB92 locator 56 (state)
15	27	ST				00567	UB92 locator 57 (national)
16	2	ST		Y/2		00568	UB92 locator 78 (state)

6.4.10.0 UB2 field definitions

6.8.20.1 Set ID - UB92 (SI) 00553

Definition: number used to uniquely identify the transaction for the purpose of adding, changing, or deleting the entry.

6.8.20.2 Co-insurance days (ST) 00554

Definition: UB92 data element 9.

6.8.20.3 Condition code (ID) 00555

Definition: repeats up to seven times. UB92 data elements 24-30. Refer to user-defined *table 0043 - condition code*.

6.8.20.4 Covered days (ST) 00556

Definition: UB92 data element 7.

6.8.20.5 Non-covered days (ST) 00557

Definition: UB92 data element 8.

6.8.20.6 Value amount & code (CM) 00558

Components: <value code> ^ <value amount>

Definition: pair can repeat up to 12 times. UB92 data elements 39a, 39b, 39c, 39d, 40a, 40b, 40c, 40d, 41a, 41b, 41c, 41d.

6.8.20.7 Occurrence code & date (CM) 00559

Components: <occurrence code (ID)> ^ <occurrence date (DT)>

Definition: set of values can repeat up to eight times. UB92 data elements 32a, 32b, 33a, 33b, 34a, 34b, 35a, 35b.

6.8.20.8 Occurrence span code and dates (CM) 00560

Components: <occurrence span code (ID)> ^ <occurrence span start date (DT)> ^ <occurrence span stop date (DT)>

Definition: can repeat up to two times. UB92 data element 36a, 36b.

6.8.20.9 UB92 data element 2, designated for state use (ST) 00561

Definition: may repeat up to two times.

6.8.20.10 UB92 data element 11, designated for state use (ST) 00562

Definition: may repeat up to two times.

6.8.20.11 UB92 data element 31, designated for national use (ST) 00563

Definition: defined by HICFA or other regulatory agencies.

6.8.20.12 Document control number (ST) 00564

Definition: number assigned by payor. Used for rebilling/adjustment purposes. May repeat up to 3 times. UB92 data element 37.

6.8.20.13 UB92 data element 49, designated for national use (ST) 00565

Definition: may repeat up to 23 times.

6.8.20.14 UB92 data element 56, designated for state use (ST) 00566

Definition: may repeat up to five times.

6.8.20.15 UB92 data element 57, designated for national use (ST) 00567

Definition: defined by UB-92 HICFA specification.

6.8.20.16 UB92 data element 78, designated for state use (ST) 00568

Definition: may repeat up to two times.

6.9
6.5 EXAMPLE TRANSACTIONS

6.10.1 Create a patient billing/accounts receivable record

```
MSH|^~\&|FDCHSG|01|ROUTER|01|19930908135031||ADT^AO1|641|P|2.1|0000000000000001|
EVN|A01|1993090813503||
PID||0008064993|0008064993||0006045681|SMITH^PAT^J^^^||19930506|F|^^^^^|1|1234
FANNIN^^HOUSTON^TX^77030^|USA|HAR||||S||6045681|000000000|^
GT1|001||JOHNSON^SAM^J||8339 MORVEN RD^BALTIMORE^MD^
    21234^""|||||193-22-1876<CR>
NK1|JOHNSON^WILLIAM|F|522 MAIN ST^CUMBERLAND^MD
    ^28765^""|(301)555-2134<CR> IN1|001|A|A357|BCMD|||||
    132987<CR>
```

A patient has been registered by the ADT system (PATA) and notification is sent to the Patient Billing system (PATB). The patient's name is Sam J. Johnson, a Male Caucasian, born on October 7, 1947. Living at 8339 Morven Rd, Baltimore, MD.

Mr. Johnson's patient number is 125976 and his billing number is 125976011. Mr. Johnson has provided his father's name and address as next of kin. Mr. Johnson is insured under plan ID A357 with an insurance company known to both systems as BCMD.

6.10.3 UB82 information updated from utilization review department

```
MSH|^~\&|UREV||PATB||||BAR^P01|MSG0018|P|VRS1.0<CR>
PID|||125976||JOHNSON^SAM^J|||||||||||||125976011<CR>
UB1|1|5|3|1||1^36|||220|76|1|19880501|19880522<CR>
```

Utilization review sends data for Patient Billing to the Patient Accounting system. The patient's insurance program has a 1 pint deductible for blood, the patient received 5 pints of blood, and 3 pints were replaced, with 1 pint not yet replaced. There is a UB82 Condition code 1.

The patient has been assigned to a Special Unit because no general care beds are available (UB82 condition code 36). Additionally, the patient has been scheduled for out-patient pre-admission diagnostic services in preparation for a previously scheduled admission, the cost of these services is $220. The patient's services are related to a special program, defined by the Insurance Plan as plan 76.

The services provided for the period 05/01/88 through 05/22/88 are fully approved (PSRO/UR Approval Code 1), including any day or cost outlier.

6.10.5 Diagnosis and DRG assignment

```
MSH|^~\&|UREV||PATB||||BAR^P01|MSG0018|P|VRS1.0<CR>
PID|||125976||JOHNSON^SAM^J||||||||||||125976011<CR>
DG1|001|I9|1550|MAL NEO LIVER, PRIMARY|19880501|DG<CR>
DG1|002||||19880501|DR||203|||DY|5<CR>
```

The first Diagnosis segment, contains the information that the patient has been diagnosed on May 1, as having a malignancy of the Hepatobiliary System or Pancreas (ICD9 code 1550). In the second segment, the patient has been assigned a Diagnostic Related Group (DRG) of 203 (corresponding to the ICD9 code of 1550). Also, the patient has been approved for an additional 5 days (5 day outlier).

ID Codes used:

element 3.0 Diagnosis Coding Methodology I9 = ICD9

element 8.0 Diagnosis/DRG Type
DG = Diagnosis
DR = DRG

element 13.0 Outlier type
DY = Day Outlier

6.11 IMPLEMENTATION CONSIDERATIONS

The SET-ID used to be needed to identify whether or not a record was to be used for deletion, update, or cancellation. This was redundant since the event type indicates this fact. Consequently, the SET-ID is now only used to uniquely identify a segment.

6.13 OUTSTANDING ISSUES

None.