11. Patient Referral

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11.1 CHAPTER 11 CONTENTS

11.2 PURPOSE

The Patient Referral chapter defines the message set used in patient referral communications between mutually exclusive healthcare entities. These referral transactions frequently occur between entities with different methods and systems of capturing and storing data. Such transactions frequently traverse a path connecting primary care providers, specialists, payors, government agencies, hospitals, labs, and other healthcare entities. The availability, completeness, and currency of information for a given patient will vary greatly across such a spectrum.

The referral in this specification is viewed from the perspective of the provider as an individual, irrespective of his/her affiliation with a specific institution or campus. Events triggering this kind of message are not restricted to a hospital environment, but have a community-wide area of impact in which more extensive identification of patients and healthcare providers is needed. Therefore, a referral must contain adequate identification information to meet the broadly varying requirements of the dissimilar systems within the community.

This chapter describes the various events and resulting transactions that make up the referral message set. Examples have been provided to demonstrate the use of this specification within the events described. Each event example centers on a primary care provider's encounter with a patient. All of the examples in this chapter have been constructed using the HL7 Encoding Rules.

11.2.1 Patient Referral and Responses

When a patient is referred by one healthcare entity (e.g., a primary care provider) to another (e.g., a specialist or lab) or when a patient inquiry is made between two separate entities, little is known about the information each party requires to identify or codify the patient. The receiving entity may have no knowledge of the patient and may require a full set of demographics, subscriber and billing information, eligibility/coverage information, pre-authorization information, and/or clinical data to process the referral. If the receiving entity already has a record of the patient, the precise requirements for identifying that patient record will vary greatly from one entity to another. The existing record of a patient residing in the database of a specialist, a lab, or a hospital may require updating with more current information. In addition, providers receiving a referral often require detailed information about the provider making the referral, such as a physician's name and address.

For example, a primary care provider making a referral may need to obtain insurance information or pre-authorization from a payor prior to making a referral. Getting this information requires an inquiry and a response between the primary care provider and the payor. In addition, the primary care provider may request results from a lab to accompany the referral. Getting these results may require an inquiry and a response between the primary care provider and the lab. The information could then be incorporated into a referral sent from the primary care provider to the specialist. As the referral is processed, requested procedures are performed, the results are observed, and the relevant data must be returned to the primary care provider. Such a response may frequently take the form of multiple responses as results become available.

The message set that encompasses these transactions includes the referral (REF), requests for information (RQA, RQC, RQP, RQI) and the returned patient information (RCI, RCL, RPA, RPI, RPL, RRI). The referral message originates a transaction and a return patient information message concludes the transaction. At least one RPA/RPI is required to complete a patient referral or a patient request transaction, although multiple RPI messages may be returned in response to a single REF message. The segments used in the REF, RQA, RQI, RQP, RRI, RPH, RCI, RCL, RPA and RPI messages encompass information about patient, guarantor and next of kin demographics, eligibility/coverage information, accident, diagnosis, requested procedures, payor pre-authorization, notes, and referring and consulting provider data.

11.2.1.1 Patient referral

There are clear distinctions between a referral and an order. An order is almost always an intra-enterprise transaction and represents a request from a patient's active provider to supporting providers for clearly defined services and/or results. While the supporting provider may exercise great discretion in the performance of an order, overall responsibility for the patient's plan of treatment remains with the ordering provider. As such, the ordering provider retains significant control authority for the order and can, after the fact, cause the order to be canceled, reinstated, etc. Additionally, detailed results produced by the supporting provider are always reported back to the ordering provider, who remains ultimately responsible for evaluating their value and relevance. A referral, on the other hand, can be either an intra- or an inter-enterprise transaction and represents not only a request for additional provider support but also a transfer of a portion or all of the responsibility for the patient's plan of treatment. Once the referral is made, the referring provider, during the transfer period, retains almost no control of any resulting actions. The referred-to provider becomes responsible for placing any additional orders and for evaluating the value and relevance of any results, which may or may not be automatically passed back to the referring provider. A referred-to provider may, in turn, also become a referring provider.

A referral message is used to support transactions related to the referral of a patient from one healthcare provider to another. This kind of message will be particularly useful from the perspective of a primary care provider referring a patient to a specialist. However, the application of the message should not be limited to this model. For example, a referral may be as simple as a physician sending a patient to another physician for a consultation or it may be as complex as a primary care provider sending a patient to a specialist for specific medical procedures to be performed and attaching the payor authorizations for those requested procedures as well as the relevant clinical information on the patient's case.

In a community model, stringent security requirements will need to be met when dealing with the release of clinical information. This message set facilitates the proper qualification of requests because the message packet will contain all the data required by any application in the community, including the necessary patient demographic information and the proper identification of the party requesting the information.

11.2.1.2 Responding to a patient referral

When a patient is referred by one provider to another or is pre-admitted, there is a great likelihood that subsequent transactions will take place between the initiating entity (the referring or admitting physician) and the responding entity (the specialist or hospital). The subsequent transactions might include a variety of queries, orders, etc. Within those subsequent transactions, there must be a way for the initiating system to refer to the patient. The "generic" patient information included in the original referral or the pre-admit Patient Identification (PID) segment may not be detailed enough to locate the patient in the responding facility's database, unless the responding facility has assigned a unique identifier to the new patient. Similarly, the responding system may not have record retrieval capabilities based on any of the unambiguous, facility-neutral data elements (like the Social Security Number) included in the original referral or pre-admit PID segment. This problem could result in the responding system associating subsequent orders or requests with the wrong patient. One solution to this potential problem is for the responding system to utilize the RRI message and return to the initiating system the unique internal identifier it assigns to the patient, and with which it will primarily (or even exclusively) refer to that patient in all subsequent update operations. However, the intent of the RRI message is that it will supply the originator of the referral type message with sufficient patient demographic and/or clinical information to properly process continued transactions.

11.2.1.3 Communicating Collaborative Care of a Patient

When providers collaborate in the sharing of patient care there can be many types of communications involved, and the expectations, roles and responsibilities may not always be clear and explicit; they may vary in different jurisdictions or work practice environments.

The use of HL7 Version 2.x in clinical messaging has involved the use of segments in ways for which they were not originally intended, as well as the development of the REL segment to express important relationships between clinical data components. Such use has also necessitated the introduction of mood codes to allow for the richer representation of intent, purpose, timing, and other event contingencies that such concepts required. When these extensions are applied to segments in messages which predate them

there is the risk that a message generated by a system compliant with an earlier release could be misinterpreted by a system which interprets the segments in the wider context. The approach to this has been to constrain the use of the enhancements to these segments to new messages, or to newer versions of existing messages. The REF message has been in releases which pre-date the v2.6 clinical enhancements and its limitations in this regard, together with the need for a range of new Collaborative Care interactions, have led to the need for the Collaborative Care Message. Being developed to use the clinical v2.6 enhancements from the outset, the collaborative care messages do not need these versioning constraints around their use.

11.2.2 Application Roles and Data Process

11.2.2.1 Application roles

This Standard assumes that there are four roles that an application can take on: a referring or referred-by provider application role, a referred-to provider application role, a querying application role, and an auxiliary application role. These application roles define the interactions an application will have with other applications in the messaging environment. In many environments, any single application may take on more than one application role.

This Standard's definition of application roles does not intend to define or limit the functionality of specific products developed by vendors of such applications. Instead, this information is provided to help define the model used to develop this Standard, and to provide an unambiguous way for applications to communicate with each other.

11.2.2.2 The referring provider application role

A referring provider application requests the services of another healthcare provider (a referred-to provider) application. There may or may not be any association between the referring provider application and the receiving entity. Although in most cases a referral environment will be inter-enterprise in nature, it is not limited to that model and applies to intra-enterprise situations also. Because the referring provider application cannot exert any control over the referred-to provider application, it must send requests to modify the status of the referred-to provider application. The referring provider application will often assume an auxiliary application role once a patient has been accepted by another application. Once this happens, the referring provider application may receive unsolicited status updates from the referred-to provider application concerning the care of a patient.

The analog of a referring provider application in a non-automated environment might be a primary care provider diagnosing a patient with a problem that must in turn be referred to a specialist for a service. The primary care provider would contact the specialist and refer the patient into his care. Often, the specialist may not receive the patient into his care, preferring instead to refer the patient to another healthcare provider. The referring provider will indicate the diagnosis and any requested services, and the specialist to whom the patient is referred will indicate whether the referral will be accepted as specified. Once a patient referral has been accepted by the specialist, the specialist may send out updates to the primary care provider concerning the status of the patient as regards any tests performed, their outcomes, etc.

11.2.2.3 The referred-to provider application role

A referred-to provider application, in the referral model, is one that performs one or more services requested by another healthcare provider (referring provider). In other words, a referred-to provider application exerts control over a certain set of services and defines the availability of those services. Because of this control, no other application has the ability to accept, reject, or otherwise modify a referral accepted by a particular referred-to provider application.

Other applications can, on the other hand, make requests to modify the status of an accepted referral "owned by" the referred-to provider application. The referred-to provider application either grants or denies requests for information, or otherwise modifies the referrals for the services over which it exerts control.

Finally, the referred-to provider application also provides information about the referral encounter to other applications. The reasons that an application may be interested in receiving such information are varied. An application may have previously requested the status of the referral encounter, or it may simply be

interested in the information for its own clinical reporting or statistical purposes. There are two methods whereby the referred-to provider applications disseminate this information: by issuing unsolicited information messages to auxiliary applications, or by responding to queries made by querying applications.

The analog of a referred-to provider application in a non-automated environment might be a specialist such as a cardiologist. A patient does not generally go to a cardiologist for routine health care. Instead, a patient generally goes to a primary care provider, who may diagnose the patient with a heart ailment and refer that patient to a cardiologist. The cardiologist would review the information provided with the referral request and determine whether or not to accept the patient into his care. Once the cardiologist accepts the patient, anyone needing information on the status of the patient must then make requests to the cardiologist. In addition, the cardiologist may forward unsolicited information regarding the treatment of the patient back to the primary care provider. Once the cardiologist accepts the referred patient, he/she may determine that additional information regarding the patient is needed. It will often take the role of a querying application by sending a query message to the patient's primary care provider and requesting additional information on demographics, insurance information, laboratory test results, etc.

11.2.2.4 The querying application role

A querying application neither exerts control over, nor requests changes to a referral. Rather than accepting unsolicited information about referrals, as does an auxiliary application, the querying application actively solicits this information using a query mechanism. It will, in general, be driven by an entity seeking information about a referral such as a referring provider application or an entity seeking information about a referred patient such as a referred-to provider application. The information that the querying application receives is valid only at the exact time that the query results are generated by the provider applications. Changes made to the referral or the referred patient's status after the query results have been returned are not communicated to the querying application until it issues another query transaction.

The analog of a querying application in a non-automated environment might be a primary care provider seeking information about a specific patient who has been referred to a specialist. For example, a patient may have been referred to a specialist in order that a specific test be performed, following which, the patient would return to the primary care provider. If the specialist has not forwarded information regarding the testing procedures for the patient to the primary care provider, the primary care provider would then query the specialist for the outcome of those procedures. Likewise, if a specialist received a referred patient without the preliminary diagnoses of test results, he/she might in turn query the primary care provider for the information leading to the diagnoses and subsequent referral.

11.2.2.5 The auxiliary application role

Like querying applications, an auxiliary application neither exerts control over nor requests changes to a referral or a referred patient. They, too, are only concerned with gathering information about a particular referral. An auxiliary application is considered an "interested third-party," in that it is interested in any changes to a particular referral or referred patient, but has no interest in changing it or controlling it in any way. An auxiliary application passively collects information by receiving unsolicited updates from a provider application.

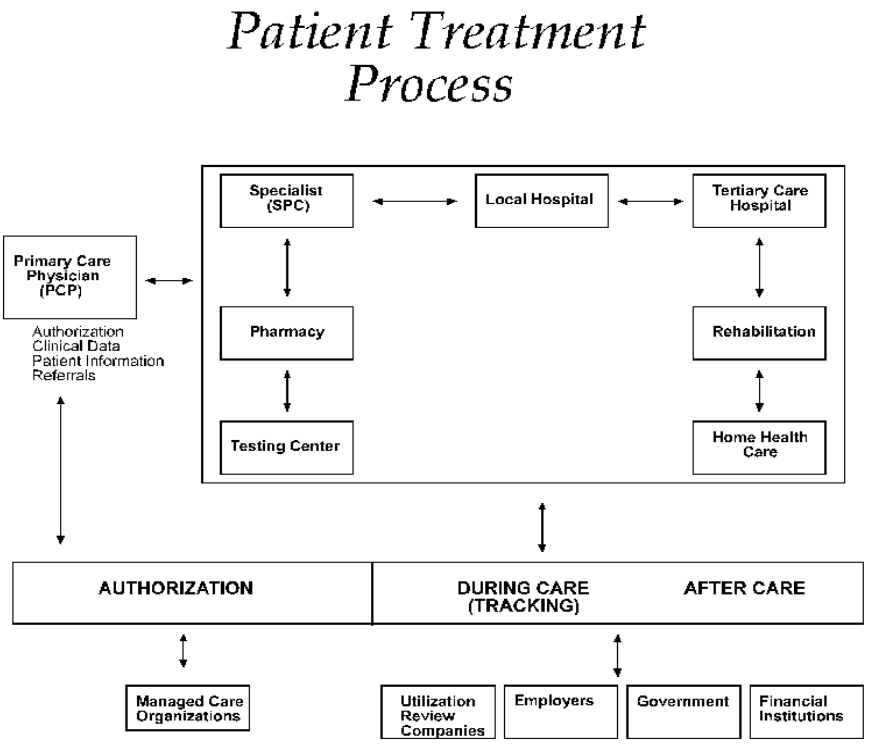
The analog of an auxiliary application in a non-automated environment might be any person receiving reports containing referral information. For example, an insurance company may need information about the activities a patient experiences during specific referral encounters. Primary care providers may need to forward information regarding all referred patients to a payor organization.

In turn, a primary care provider may have the ability to track electronically a patient's medical record. The provider would then be very interested in receiving any information regarding a patient referred to a specialist.

11.2.2.6 Application roles in a messaging environment

In a messaging environment, these four application roles communicate using specific kinds of messages and trigger events. The following figure illustrates the relationships between these application roles in a messaging environment:

Figure 11-1. Application role messaging relationships



11.2.3 Glossary

11.2.3.1 Benefits:

The services payable under a specific payor plan. They are also referred to as an insurance product, such as professional services, prescription drugs, etc.

11.2.3.2 Clinical information:

Refers to the data contained in the patient record. The data may include such things as problem lists, lab results, current medications, family history, etc. For the purposes of this chapter, clinical information is limited to diagnoses (DG1& DRG), results reported (OBX/OBR), and allergies (AL1).

11.2.3.3 Dependent:

Refers to a person who is affiliated with a subscriber, such as spouse or child.

11.2.3.4 Eligibility/coverage:

Refers to the period of time a subscriber or dependent is entitled to benefits.

11.2.3.5 Encounter:

Refers to a meeting between a covered person and a healthcare provider whose services are provided.

11.2.3.6 Guarantor:

Refers to a person who has financial responsibility for the payment of a patient account.

11.2.3.7 Healthcare provider:

Refers to a person licensed, certified or otherwise authorized or permitted by law to administer health care in the ordinary course of business or practice of a profession, including a healthcare facility.

11.2.3.8 Payor:

Indicates a third-party entity that pays for or underwrites coverage for healthcare expenses. A payor may be an insurance company, a health maintenance organization (HMO), a preferred provider organization (PPO), a government agency or an agency such as a third-party administrator (TPA).

11.2.3.9 Pre-authorization:

Refers to the process of obtaining prior approval as to the appropriateness of a service. Pre-authorization does not guarantee coverage.

11.2.3.10 Primary care provider:

Indicates the provider responsible for delivering care as well as authorizing and channeling care to specialists and other providers in a gatekeeper system. The provider is also referred to as a case manager or a gatekeeper.

11.2.3.11 Referral:

Means a provider's recommendation that a covered person receive care from a different provider.

11.2.3.12 Referring provider:

Indicates the provider who requests services from a specialist or another primary care provider. A referring provider may, in fact, be a specialist who is referring a patient to another specialist.

11.2.3.13 Referred-to-provider:

Typically indicates a specialty care provider who provides services at the request of a primary care provider or another specialty care provider.

11.2.3.14 Specialist:

Means a provider of services which are beyond the capabilities or resources of the primary care provider. A specialist is also known as a specialty care provider who provides services at the request of a primary care provider or another specialty care provider.

11.2.3.15 Subscriber:

Refers to a person who elects benefits and is affiliated with an employer or insurer.

11.3 PATIENT INFORMATION REQUEST MESSAGES AND TRIGGER EVENTS

Patient information may need to be retrieved from various enterprises. The definition of these enterprises often varies greatly. Some enterprises may be providers or reference laboratories, while others may be payors providing insurance information. In the first case, the message definitions will focus on patient and provider information, while in the latter case, the message definition will deal primarily with patient and subscriber identification.

11.3.1 RQI/RPI - Request for Insurance Information (Event I01)

This event triggers a message to be sent from one healthcare provider to another to request insurance information for a specified patient.

RQI^I01^RQI_I01: Request Patient Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
{	--- PROVIDER begin		

Segments	Description	Status	Chapter
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[	--- GUARANTOR_INSURANCE begin		
[{GT1}]	Guarantor		6
{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info - Cert		6
}	--- INSURANCE end		
]	--- GUARANTOR_INSURANCE end		
[{NTE}]	Notes and Comments		2

RPI^I01^RPI_I01: Return Patient Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		3
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[	--- GUARANTOR_INSURANCE begin		
[{GT1}]	Guarantor		6
{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info - Cert		6
}	--- INSURANCE end		

Segments	Description	Status	Chapter
]	--- GUARANTOR_INSURANCE end		
[{NTE}]	Notes and Comments		2

11.3.2 RQI/RPL - Request/Receipt of Patient Selection Display List (Event I02)

This trigger event occurs when the inquirer specifies a request for a name lookup listing. Generally, this request is used by the responder when insufficient data is on hand for a positive match. In this case, the requester may ask for a list of possible candidates from which to make a selection. This event code is also used by the responder to signify that the return information contains a list of information rather than information specific to a single patient.

RQI^I02^RQI_I01: Request Patient Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[	--- GUARANTOR_INSURANCE begin		
[{GT1}]	Guarantor		6
{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info - Cert		6
}	--- INSURANCE end		
]	--- GUARANTOR_INSURANCE end		
[{NTE}]	Notes and Comments		2

RPL^I02^RPL_I02: Return Patient Display List

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		3

Segments	Description	Status	Chapter
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
[{NTE}]	Notes and Comments		2
[{DSP}]	Display Data		5
[DSC]	Continuation Pointer		2

11.3.3 RQI/RPR - Request/Receipt of Patient Selection List (Event I03)

This trigger event occurs when the inquirer specifies a request for a listing of patient names. This event differs from event I02 (request/receipts of patient selection display list) in that it returns the patient list in repeating PID segments instead of repeating DSP segments.

RQI^I03^RQI_I01: Request Patient Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[	--- GUARANTOR+INSURANCE begin		
[{GT1}]	Guarantor		6
{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info - Cert		6
}	--- INSURANCE end		
]	--- GUARANTOR_INSURANCE end		
[{NTE}]	Notes and Comments		2

RPR^I03^RPR_I03: Return Patient List

Segments	Description	Status	Chapter
MSH	Message Header		2

Segments	Description	Status	Chapter
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		3
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
[{PID}]	Patient Identification		3
[{NTE}]	Notes and Comments		2

11.3.4 RQP/RPI - request for patient demographic data (Event I04)

This event triggers a request from one healthcare provider to another for patient demographic information, including insurance and billing information. Typically, this transaction would occur between one provider to another, but it could also be directed to a payor.

RQP^I04^RQP_I04: Request Patient Demographics

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[{GT1}]	Guarantor		6
[{NTE}]	Notes and Comments		2

RPI^I04^RPI_I04: Return Patient Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		3
{	--- PROVIDER begin		
PRD	Provider Data		11

Segments	Description	Status	Chapter
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[	--- GUARANTOR_INSURANCE begin		
[{GT1}]	Guarantor		6
{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info - Cert		6
}	--- INSURANCE end		
]	--- GUARANTOR_INSURANCE end		
[{NTE}]	Notes and Comments		2

11.3.5 RQC/RCI - Request for Patient Clinical Information (Event I05)

Retained for backwards compatibility only in version 2.4 and removed from the standard as of v2.8; refer to Chapter 5 section 5.4, "Query Response Message Pairs." The original mode query and the QRD/QRF segments have been replaced.

11.3.6 RQC/RCL - Request/Receipt of Clinical Data Listing (Event I06)

Retained for backwards compatibility only in version 2.4 and removed from the standard as of v2.8; refer to Chapter 5 section 5.4, "Query Response Message Pairs." The original mode query and the QRD/QRF segments have been replaced.

11.3.7 PIN/ACK - Unsolicited Insurance Information (Event I07)

This trigger event is used by an entity or organization to transmit to a healthcare provider the insurance information on a specific patient. Typically, the healthcare provider will be a primary care provider.

PIN^I07^RQI_I01: Patient Insurance Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[	--- GUARANTOR_INSURANCE begin		

Segments	Description	Status	Chapter
[{GT1}]	Guarantor		6
{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info -Cert		6
}	--- INSURANCE end		
]	--- GUARANTOR_INSURANCE end		
[{NTE}]	Notes and Comments		2

ACK^I07^ACK: General Acknowledgment

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		2
[{ ERR }]	Error		2

11.4 PATIENT TREATMENT AUTHORIZATION REQUESTS

This functional definition applies to a request for treatment authorization. Although this message also pertains to the payor, it differs greatly from that of an insurance information request. This message is used to request an authorization for specific procedures. Just as patient identification was important in an insurance information request, the focus of this functional area is provider identification, requested treatments/procedures and, in many cases, clinical information on a patient needed to fulfill review or certification requirements.

11.4.1 RQA/RPA - Request Patient Authorization Message (Event I08)

All trigger events in this group use the following message definition.

RQA^I08-I11^RQA_I08: Request Patient Authorization

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
[RF1]	Referral Information		11
[	--- AUTHORIZATION begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11

Segments	Description	Status	Chapter
]	--- AUTHORIZATION end		
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[	--- GUARANTOR_INSURANCE begin		
[{GT1}]	Guarantor		6
{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info - Cert		6
}	--- INSURANCE end		
]	--- GUARANTOR_INSURANCE end		
[ACC]	Accident Information		6
[{DG1}]	Diagnosis		6
[{DRG}]	Diagnosis Related Group		6
[{AL1}]	Allergy Information		3
[{	--- PROCEDURE begin		
PR1	Procedure		6
[	--- AUTHORIZATION begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11
]	--- AUTHORIZATION end		
}]	--- PROCEDURE end		
[{	--- OBSERVATION begin		
OBR	Observation Request		4
[{NTE}]	Notes and Comments		2
[{	--- RESULTS begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
[{NTE}]	Notes and Comments		2
}]	--- RESULTS end		
}]	--- OBSERVATION end		

Segments	Description	Status	Chapter
[	--- VISIT begin		
PV1	Patient Visit		3
[PV2]	Patient Visit Additional Info		3
]	--- VISIT end		
[{NTE}]	Notes and Comments		2

RPA^I08-I11^RPA_I08: Return Patient Authorization

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		3
[RF1]	Referral Information		11
[	--- AUTHORIZATION begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11
]	--- AUTHORIZATION end		
{	--- PROVIDER begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[{GT1}]	Guarantor		6
[{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info - Cert		6
}]	--- INSURANCE end		
[ACC]	Accident Information		6
[{DG1}]	Diagnosis		6
[{DRG}]	Diagnosis Related Group		6
[{AL1}]	Allergy Information		3
{	--- PROCEDURE begin		

Segments	Description	Status	Chapter
PR1	Procedure		6
[	--- AUTHORIZATION begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11
]	--- AUTHORIZATION end		
}	--- PROCEDURE end		
[{	--- OBSERVATION begin		
OBR	Observation Request		4
[{NTE}]	Notes and Comments		2
[{	--- RESULTS begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
[{NTE}]	Notes and Comments		2
}]	--- RESULTS end		
}]	--- OBSERVATION end		
[	--- VISIT begin		
PV1	Patient Visit		3
[PV2]	Patient Visit Additional Info		3
]	--- VISIT end		
[{NTE}]	Notes and Comments		2

Note: The abstract message definitions for both the RPA and RQA include the patient visit segments (PV1 and PV2). The PV1 and PV2 segments appear in the RPA and RQA as an optional grouping to specify the visit or encounter that generated the referral authorization request. The PV1 and PV2 should not be used to provide suggested information for a future encounter or visit generated by the referral authorization request.

The trigger events that use this message definition are described in sections *11.4.2*, "*RQA/RPA – Request for Treatment Authorization Information (Event I08)*," through *11.4.5*, "*RQA/RPA - Request for Cancellation of an Authorization (Event I11)*."

11.4.2 RQA/RPA – Request for Treatment Authorization Information (Event I08)

This event triggers a message to be sent from a healthcare provider to a payor requesting authorization to perform specific medical procedures or tests on a given patient. The specific medical procedures must be filled out in the PR1 segments. Each repeating PR1 segment may be paired with an AUT segment so that authorization information can be given regarding dollar amounts, number of treatments, and perhaps the estimated length of stay for treatment. The OBR and OBX segments should be used to include any relevant clinical information that may be required to support or process the authorization.

11.4.3 RQA/RPA - Request for Modification to an Authorization (Event I09)

This event triggers a message sent from a healthcare provider to a payor requesting changes to a previously referenced authorization. For example, a provider may determine that a substitute testing or surgical procedure should be performed on a specified patient.

11.4.4 RQA/RPA - Request for Resubmission of an Authorization (Event I10)

If a previously submitted request for treatment authorization is rejected or canceled, this event could trigger a resubmission message for a referenced authorization. For example, the payor may have rejected a request until additional clinical information is sent to support the authorization request.

11.4.5 RQA/RPA - Request for Cancellation of an Authorization (Event I11)

This event may trigger the cancellation of an authorization. It may be used by the provider to indicate that an authorized service was not performed, or perhaps that the patient changed to another provider. A payor may use this request to reject a submitted authorization request from a provider.

11.5 PATIENT REFERRAL MESSAGES AND TRIGGER EVENTS

These message definitions and event codes define the patient referral. Although only three trigger events are defined, the abstract message is very versatile and can provide for a wide variety of inter-enterprise transactions.

11.5.1 REF/RRI - Patient Referral Message

The trigger events that use this message definition are described in Sections *11.5.2*, "*REF/RRI - Patient Referral (Event I12)*," through *11.5.5*, "*REF/RRI - Request Patient Referral Status (Event I15)*."

REF^I12-I15^REF_I12: Patient Referral

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
[RF1]	Referral Information		11
[	--- AUTHORIZATION_CONTACT2 begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11
]	--- AUTHORIZATION_CONTACT2 end		
{	--- PROVIDER_CONTACT begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER_CONTACT end		
PID	Patient Identification		3
[{NK1}]	Next of Kin/Associated Parties		6
[{GT1}]	Guarantor		6
[{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info		6
[IN3]	Insurance Add'l Info -Cert		6

Segments	Description	Status	Chapter
}]	--- INSURANCE end		
[ACC]	Accident Information		6
[{DG1}]	Diagnosis		6
[{DRG}]	Diagnosis Related Group		6
[{AL1}]	Allergy Information		3
[{	--- PROCEDURE begin		
PR1	Procedure		6
[	--- AUTHORIZATION_CONTACT2 begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11
]	--- AUTHORIZATION_CONTACT2 end		
}]	--- PROCEDURE end		
[{	--- OBSERVATION begin		
OBR	Observation Request		4
[{NTE}]	Notes and Comments		2
[{	--- RESULTS_NOTES begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
[{NTE}]	Notes and Comments		2
}]	--- RESULTS_NOTES end		
}]	--- OBSERVATION end		
[	--- PATIENT_VISIT begin		
PV1	Patient Visit		3
[PV2]	Patient Visit Additional Info		3
]	--- PATIENT_VISIT end		
[{NTE}]	Notes and Comments		2

RRI^I12-I15^RRI_I12: Return Referral Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software segment		2
[UAC]	User Authentication Credential		2
[MSA]	Message Acknowledgment		3
[RF1]	Referral Information		11

Segments	Description	Status	Chapter
[	--- AUTHORIZATION_CONTACT2 begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11
]	--- AUTHORIZATION_CONTACT2 end		
{	--- PROVIDER_CONTACT begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER_CONTACT end		
PID	Patient Identification		3
[ACC]	Accident Information		6
[{DG1}]	Diagnosis		6
[{DRG}]	Diagnosis Related Group		6
[{AL1}]	Allergy Information		3
[{	--- PROCEDURE begin		
PR1	Procedure		6
[	--- AUTHORIZATION_CONTACT2 begin		
AUT	Authorization Information		11
[CTD]	Contact Data		11
]	--- AUTHORIZATION_CONTACT2 end		
}]	--- PROCEDURE end		
[{	--- OBSERVATION begin		
OBR	Observation Request		4
[{NTE}]	Notes and Comments		2
[{	--- RESULTS_NOTES begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
[{NTE}]	Notes and Comments		2
}]	--- RESULTS_NOTES end		
}]	--- OBSERVATION end		
[	--- PATIENT_VISIT begin		
PV1	Patient Visit		3
[PV2]	Patient Visit Additional Info		3
]	--- PATIENT_VISIT end		
[{NTE}]	Notes and Comments		2

Note: The abstract message definitions for both the REF and RRI include the patient visit segments (PV1 and PV2). The PV1 and PV2 segments appear in the REF as an optional grouping to specify the visit or encounter that generated the referral. The PV1 and PV2 should not be used to provide suggested information for a future encounter or visit generated by the referral.

The PV1 and PV2 are also included in the RRI message definition. It should be noted that these segments do not merely mirror the segments in the originating REF message. Rather, they may contain information regarding the visit or encounter that **resulted** from the referral.

11.5.2 REF/RRI - Patient Referral (Event I12)

This event triggers a message to be sent from one healthcare provider to another regarding a specific patient. The referral message may contain patient demographic information, specific medical procedures to be performed (accompanied by previously obtained authorizations) and relevant clinical information pertinent to the patient's case.

11.5.3 REF/RRI - Modify Patient Referral (Event I13)

This event triggers a message to be sent from one healthcare provider to another regarding changes to an existing referral. Changes in a referral may include additional instructions from the referring provider, additional clinical information, and even additional information on patient demographics.

11.5.4 REF/RRI - Cancel Patient Referral (Event I14)

This event triggers a message to be sent from one healthcare provider to another canceling a referral. A previous referral may have been made in error, or perhaps the cancellation has come from the patient.

11.5.5 REF/RRI - Request Patient Referral Status (Event I15)

This event triggers a message to be sent between healthcare providers regarding the status of a patient referral request. A previous referral has been made and acknowledged; however, no response has been received to indicate results and/or procedures performed.

11.6 COLLABORATIVE CARE MESSAGES AND TRIGGER EVENTS

These message definitions and event codes define the collaborative care exchanges, including patient referral, discharge summary and infectious diseases notifications. Although only seven trigger events are defined, the abstract message is very versatile and can provide for a wide variety of exchanges of information between care entities.

11.6.1 CCM/ACK – Collaborative Care Message (Event I21)

This event triggers a message to be sent from one healthcare provider to another healthcare provider, clinical repository or regulatory body regarding a specific patient. The collaborative care message may contain patient demographic information, a full history of appointments, specific medical procedures that have been performed, a full clinical history, an administrative history of patient visits, a full medication history, all relevant problems, pathways and goals. This message fulfills the role of a notification of a single patient's health status and history. It is usable for discharge summaries, disease notifications or just moving a patient's electronic medical record from one the place to another. This message uses the REL segment to express the relationships between clinical histories.

CCM^I21^CCM_I21: Collaborative Care Message

Segments	Description	Status	Chapter
MSH	Message Header		2
[{SFT}]	Software Segment		2

Segments	Description	Status	Chapter
[UAC]	User Authentication Credential		2
PID	Patient Identification		3
[PD1]	Additional Demographics		3
[{NK1}]	Next of Kin / Associated Parties		3
[{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info.		6
[IN3]	Insurance Additional Info – Cert.		6
}]	--- INSURANCE end		
[{	--- APPOINTMENT_HISTORY begin		
SCH	Schedule Activity Information		10
[{	--- RESOURCES begin		
RGS	Resource Group Segment		10
[{	--- RESOURCE_DETAIL begin		
<	--- RESOURCE_OBJECT begin		
AIS|	Appointment Information - Service		10
AIG|	Appointment Information – General Resource		10
AIL|	Appointment Information – Location		10
AIP	Appointment Information – Personnel		10
>	--- RESOURCE_OBJECT end		
[{	--- RESOURCE_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- RESOURCE_OBSERVATION end		
}]	--- RESOURCE_DETAIL end		
}]	--- RESOURCES end		
}]	--- APPOINTMENT_HISTORY end		
[{	--- CLINICAL_HISTORY begin		
ORC	Common Order		4
[{	--- CLINICAL_HISTORY_DETAIL begin		
<	--- CLINICAL_HISTORY_OBJECT begin		
OBR|	Observation		4

Segments	Description	Status	Chapter
ODS|	Dietary Order, Suppl., Prefer.		4
PR1|	Procedure		6
RF1|	Referral Information		11
AL1|	Allergy Information		3
IAM|	Patient adverse reaction information		3
ACC|	Accident Information		6
RMI|	Risk Management Incident		6
DB1|	Disability Information		3
DG1|	Diagnosis		6
DRG|	Diagnosis Related Group		6
PDA	Patient Death and Autopsy		3
>	--- CLINICAL_HISTORY_OBJECT end		
[{	--- CLINICAL_HISTORY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- CLINICAL_HISTORY_OBSERVATION end		
}]	--- CLINICAL_HISTORY_DETAIL end		
[{	--- ROLE_CLINICAL_HISTORY begin		
<	--- ROLE_CLINICAL_HISTORY_OBJECT begin		
ROL|	Role (CLINICAL_HISTORY)		15
PRD	Provider Data (CLINICAL_HISTORY)		11
>	--- ROLE_CLINICAL_HISTORY_OBJECT end		
[{VAR}]	Variance (CLINICAL_HISTORY)		15
}]	--- ROLE_CLINICAL_HISTORY end		
[{CTI}]	Clinical Trial Identification		7
}]	--- CLINICAL_HISTORY end		
{	--- PATIENT_VISITS begin		
PV1	Patient Visit		3
[PV2]	Patient Visit - Additional Info.		3
}	--- PATIENT_VISITS end		
[{	--- MEDICATION_HISTORY begin		
ORC	Common Order		4

Segments	Description	Status	Chapter
[	--- MEDICATION_ORDER_DETAIL begin		
RXO	Pharmacy/Treatment Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXO)		4
[{	--- MEDICATION_ORDER_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ORDER_OBSERVATION end		
]	--- MEDICATION_ORDER_DETAIL end		
[	--- MEDICATION_ENCODING_DETAIL begin		
RXE	Pharmacy/Treatment Encoded Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXE)		4
[{	--- MEDICATION_ENCODING_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ENCODING_OBSERVATION end		
]	--- MEDICATION_ENCODING_DETAIL end		
[{	--- MEDICATION_ADMINISTRATION_DETAIL begin		
{RXA}	Pharmacy/Treatment Administration		4
RXR	Pharmacy/Treatment Route		4
[{	--- MEDICATION_ADMINISTRATION_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ADMINISTRATION_OBSERVATION end		
}]	--- MEDICATION_ADMINISTRATION_DETAIL end		
[{CTI}]	Clinical Trial Identification		7
}]	--- MEDICATION_HISTORY end		
[{	--- PROBLEM begin		
PRB	Problem		12
[{VAR}]	Variance (Problem)		15

Segments	Description	Status	Chapter
[{	--- ROLE_PROBLEM begin		
<	--- ROLE_PROBLEM_OBJECT begin		
ROL|	Role (Problem Role)		15
PRD	Provider Data (Problem Role)		11
>	--- ROLE_PROBLEM_OBJECT end		
[{VAR}]	Variance (Problem Role)		15
}]	--- ROLE_PROBLEM end		
[{	--- PROBLEM_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PROBLEM_OBSERVATION end		
}]	--- PROBLEM end		
[{	--- GOAL begin		
GOL	Goal		12
[{VAR}]	Variance (Goal)		15
[{	--- ROLE_GOAL begin		
<	--- ROLE_GOAL_OBJECT begin		
ROL|	Role (Goal Role)		15
PRD	Provider Data (Goal Role)		11
>	--- ROLE_GOAL_OBJECT end		
[{VAR}]	Variance (Goal Role)		15
}]	--- ROLE_GOAL end		
[{	--- GOAL_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- GOAL_OBSERVATION end		
}]	--- GOAL end		
[{	--- PATHWAY begin		
PTH	Pathway		12
[{VAR}]	Variance (Pathway)		15
[{	--- ROLE_PATHWAY begin		
<	--- ROLE_PATHWAY_OBJECT begin		

Segments	Description	Status	Chapter
ROL|	Role (Pathway Role)		15
PRD	Provider Data (Pathway Role)		11
>	--- ROLE_PATHWAY_OBJECT end		
[{VAR}]	Variance (Pathway Role)		15
}]	--- ROLE_PATHWAY end		
[{	--- PATHWAY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PATHWAY_OBSERVATION end		
}]	--- PATHWAY end		
[{REL}]	Relationship		11

11.6.2 CCR/ACK – Collaborative Care Referral (Events I16, I17 and I18)

The trigger events that use this message are described in the sections below. The Collaborate Care Referral message is sent from one healthcare provider to another regarding a specific patient or group of patients. The collaborative care referral may contain specific clinical orders, patient demographic information, a full history of appointments, specific medical procedures that have been performed, a full clinical history, an administrative history of patient visits, a full medication history, all relevant problems, pathways and goal. This message uses the REL segment to express the relationships between patients and clinical orders and/or clinical histories, patients and patient visits, patients and medical histories, patients and problems, goals and pathways, as well as patients and providers, and providers and patient problems, goals and patient pathways. The REL segments can also be used to express the relationships between providers. The collaborative care referral message definitely implies intent to share, or transfer some, or all, of the care of the patient to the referred to provider or providers.

CCR^I16-I18^CCR_I16: Collaborative Care Referral

Segments	Description	Status	Chapter
MSH	Message Header		2
[{SFT}]	Software Segment		2
[UAC]	User Authentication Credential		2
{RF1}	Referral Information		11
{	--- PROVIDER_CONTACT begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}	--- PROVIDER_CONTACT end		
[{	--- CLINICAL_ORDER begin		
ORC	Common Order		7
[{	--- CLINICAL_ORDER_TIMING begin		

Segments	Description	Status	Chapter
TQ1	Timing/Quantity		4
[{TQ2}]	Timing/Quantity Order Sequence		4
}]	--- CLINICAL_ORDER_TIMING end		
{	--- CLINICAL_ORDER_DETAIL begin		
<	--- CLINICAL_ORDER_OBJECT begin		
OBR|	Observation		4
RXO|	Pharmacy/Treatment Order		4
ODS|	Dietary Order, Suppl., Prefer.		4
PR1	Procedure		6
>	--- CLINICAL_ORDER_OBJECT end		
[{	--- CLINICAL_ORDER_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- CLINICAL_ORDER_OBSERVATION end		
}	--- CLINICAL_ORDER_DETAIL end		
[{CTI}]	Clinical Trial Identification		11
}]	--- CLINICAL_ORDER end		
{	--- PATIENT begin		
PID	Patient Identification		3
[PD1]	Additional Demographics		3
}	--- PATIENT end		
[{NK1}]	Next of Kin / Associated Parties		3
[{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info.		6
[IN3]	Insurance Additional Info – Cert.		6
}]	--- INSURANCE end		
[{	--- APPOINTMENT_HISTORY begin		
SCH	Schedule Activity Information		10
[{	--- RESOURCES begin		
RGS	Resource Group Segment		10
[{	--- RESOURCE_DETAIL begin		
<	--- RESOURCE_OBJECT begin		
AIS|	Appointment Information - Service		10
AIG|	Appointment Information – General Resource		10

Segments	Description	Status	Chapter
AIL|	Appointment Information – Location		10
AIP	Appointment Information – Personnel		10
>	--- RESOURCE_OBJECT end		
[{	--- RESOURCE_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- RESOURCE_OBSERVATION end		
}]	--- RESOURCE_DETAIL end		
}]	--- RESOURCES end		
}]	--- APPOINTMENT_HISTORY end		
[{	--- CLINICAL_HISTORY begin		
ORC	Common Order		4
[{	--- CLINICAL_HISTORY_DETAIL begin		
<	--- CLINICAL_HISTORY_OBJECT begin		
OBR|	Observation		4
ODS|	Dietary Order, Suppl., Prefer.		4
PR1|	Procedure		6
RF1|	Referral Information		11
AL1|	Allergy Information		3
IAM|	Patient adverse reaction information		3
ACC|	Accident Information		6
RMI|	Risk Management Incident		6
DB1|	Disability Information		3
DG1|	Diagnosis		6
DRG	Diagnosis Related Group		6
>	--- CLINICAL_HISTORY_OBJECT end		
[{	--- CLINICAL_HISTORY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- CLINICAL_HISTORY_OBSERVATION end		
}]	--- CLINICAL_HISTORY_DETAIL end		
[{	--- ROLE_CLINICAL_HISTORY begin		
<	--- ROLE_CLINICAL_HISTORY_OBJECT begin		
ROL|	Role (CLINICAL_HISTORY)		15
PRD	Provider Data (CLINICAL_HISTORY)		11

Segments	Description	Status	Chapter
>	--- ROLE_CLINICAL_HISTORY_OBJECT end		
[{VAR}]	Variance (CLINICAL_HISTORY)		15
}]	--- ROLE_CLINICAL_HISTORY end		
[{CTI}]	Clinical Trial Identification		7
}]	--- CLINICAL_HISTORY end		
{	--- PATIENT_VISITS begin		
PV1	Patient Visit		3
[PV2]	Patient Visit - Additional Info.		3
}	--- PATIENT_VISITS end		
[{	--- MEDICATION_HISTORY begin		
ORC	Common Order		4
[	--- MEDICATION_ORDER_DETAIL begin		
RXO	Pharmacy/Treatment Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXO)		4
[{	--- MEDICATION_ORDER_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ORDER_OBSERVATION end		
]	--- MEDICATION_ORDER_DETAIL end		
[	--- MEDICATION_ENCODING_DETAIL begin		
RXE	Pharmacy/Treatment Encoded Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXE)		4
[{	--- MEDICATION_ENCODING_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ENCODING_OBSERVATION end		
]	--- MEDICATION_ENCODING_DETAIL end		
[{	--- MEDICATION_ADMINISTRATION_DETAIL begin		
{RXA}	Pharmacy/Treatment Administration		4
RXR	Pharmacy/Treatment Route		4
[{	--- MEDICATION_ADMINISTRATION_OBSERVATION begin		
OBX	Observation/Result		7

Segments	Description	Status	Chapter
[{PRT}]	Participation		7
}]	--- MEDICATION_ADMINISTRATION_OBSERVATION end		
}]	--- MEDICATION_ADMINISTRATION_DETAIL end		
[{CTI}]	Clinical Trial Identification		7
}]	--- MEDICATION_HISTORY end		
[{	--- PROBLEM begin		
PRB	Problem		12
[{VAR}]	Variance (Problem)		15
[{	--- ROLE_PROBLEM begin		
<	--- ROLE_PROBLEM_OBJECT begin		
ROL|	Role (Problem Role)		15
PRD	Provider Data (Problem Role)		11
>	--- ROLE_PROBLEM_OBJECT end		
[{VAR}]	Variance (Problem Role)		15
}]	--- ROLE_PROBLEM end		
[{	--- ROLE_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- ROLE_OBSERVATION end		
}]	--- PROBLEM end		
[{	--- GOAL begin		
GOL	Goal		12
[{VAR}]	Variance (Goal)		15
[{	--- ROLE_GOAL begin		
<	--- ROLE_GOAL_OBJECT begin		
ROL|	Role (Goal Role)		15
PRD	Provider Data (Goal Role)		11
>	--- ROLE_GOAL_OBJECT end		
[{VAR}]	Variance (Goal Role)		15
}]	--- ROLE_GOAL end		
[{	--- GOAL_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- GOAL_OBSERVATION end		

Segments	Description	Status	Chapter
}]	--- GOAL end		
[{	--- PATHWAY begin		
PTH	Pathway		12
[{VAR}]	Variance (Pathway)		15
[{	--- ROLE_PATHWAY begin		
<	--- ROLE_PATHWAY_OBJECT begin		
ROL|	Role (Pathway Role)		15
PRD	Provider Data (Pathway Role)		11
>	--- ROLE_PATHWAY_OBJECT end		
[{VAR}]	Variance (Pathway Role)		15
}]	--- ROLE_PATHWAY end		
[{	--- PATHWAY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PATHWAY_OBSERVATION end		
}]	--- PATHWAY end		
[{REL}]	Relationship		11

11.6.3 CCR/ACK – Collaborative Care Referral (Event I16)

This event triggers a message to be sent from one healthcare provider to another regarding a specific patient or group of patients. The intent is to create a collaborative relationship between the referring provider, the referred to provider or providers and the patient or patients, for the shared care of the patient or patients. Whilst the acknowledgment is a simple ACK message, the expectation is that the referred to provider(s) will send back a CCU – Asynchronous Collaborative Care Update at a later time to indicate acceptance or rejection of the referral.

11.6.4 CCR/ACK – Modify Collaborative Care Referral (Event I17)

This event triggers a message to be sent from one healthcare provider to another regarding changes to an existing Collaborative Care Referral. Changes may include additional instructions from the referring provider, additional clinical orders, additional clinical history, additional patient visits, additional medication history, or modifications to the problems, goals and/or pathways. Whilst the acknowledgment is a simple ACK message, the expectation is that the referred to provider(s) will send back a CCU – Asynchronous Collaborative Care Update at a later time to indicate acceptance or rejection of the modifications.

11.6.5 CCR/ACK – Cancel Collaborative Care Referral (Event I18)

This event triggers a message to be sent from one healthcare provider to another canceling an existing Collaborative Care Referral. A previous Collaborative Care Referral may have been made in error, or perhaps the cancellation has come from the patient. Whilst the acknowledgment is a simple ACK message, the expectation is that the referred to provider(s) will send back a CCU – Asynchronous Collaborative Care Update at a later time to indicate cancellation of the Collaborative Care Referral.

11.6.6 CCU/ACK – Asynchronous Collaborative Care Update (Event I20)

This event triggers a message to be sent from a referred to healthcare provider to the referring health care provider, regarding a specific, previously received collaborative care referral. The collaborative care update may contain patient demographic information, additional appointments, additional clinical history, additional patient visits and additional medication history. It may also contain updates of patient problems, pathways and goal. The information is similar to that which may have been provided in the original Collaborate Care Referral message, but significantly different, as it is information from the perspective of the referred to provider. Patient visits will be those visits by the patient, to the referred to provider, relating to the referral. Appointments will be appointments made for the patient, by the referred to provider, during those visits. Clinical history will be observations made during those visits and medication history will be medications prescribed, observed or recommended during those visits. This message is used to update the referring provider as to the current status of the referral. The referrer would also use this message to update of the status of a referral, such as accepted, rejected, patient put on waiting list, treatment completed etc.

CCU^I20^CCU_I20: Collaborative Care Referral

Segments	Description	Status	Chapter
MSH	Message Header		2
[{SFT}]	Software Segment		2
[UAC]	User Authentication Credential		2
RF1	Referral Information		11
[{	--- PROVIDER_CONTACT begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}]	--- PROVIDER_CONTACT end		
[{	--- PATIENT begin		
PID	Patient Identification		3
[PD1]	Additional Demographics		3
}]	--- PATIENT end		
[{NK1}]	Next of Kin / Associated Parties		3
[{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info.		6
[IN3]	Insurance Additional Info – Cert.		6
}]	--- INSURANCE end		
[{	--- APPOINTMENT_HISTORY begin		
SCH	Schedule Activity Information		10
[{	--- RESOURCES begin		
RGS	Resource Group Segment		10
[{	--- RESOURCE_DETAIL begin		
<	--- RESOURCE_OBJECT begin		
AIS|	Appointment Information - Service		10

Segments	Description	Status	Chapter
AIG|	Appointment Information – General Resource		10
AIL|	Appointment Information – Location		10
AIP	Appointment Information – Personnel		10
>	--- RESOURCE_OBJECT end		
[{	--- RESOURCE_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- RESOURCE_OBSERVATION end		
}]	--- RESOURCE_DETAIL end		
}]	--- RESOURCES end		
}]	--- APPOINTMENT_HISTORY end		
[{	--- CLINICAL_HISTORY begin		
ORC	Common Order		4
[{	--- CLINICAL_HISTORY_DETAIL begin		
<	--- CLINICAL_HISTORY_OBJECT begin		
OBR|	Observation		4
ODS|	Dietary Order, Suppl., Prefer.		4
PR1|	Procedure		6
RF1|	Referral Information		11
AL1|	Allergy Information		3
IAM|	Patient adverse reaction information		3
ACC|	Accident Information		6
RMI|	Risk Management Incident		6
DB1|	Disability Information		3
DG1|	Diagnosis		6
DRG |	Diagnosis Related Group		6
PDA	Patient Death and Autopsy		3
>	--- CLINICAL_HISTORY_OBJECT end		
[{	--- CLINICAL_HISTORY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- CLINICAL_HISTORY_OBSERVATION end		
}]	--- CLINICAL_HISTORY_DETAIL end		
[{	--- ROLE_CLINICAL_HISTORY begin		
<	--- ROLE_CLINICAL_HISTORY_OBJECT begin		

Segments	Description	Status	Chapter
ROL|	Role (CLINICAL_HISTORY)		15
PRD	Provider Data (CLINICAL_HISTORY)		11
>	--- ROLE_CLINICAL_HISTORY_OBJECT end		
[{VAR}]	Variance (CLINICAL_HISTORY)		15
}]	--- ROLE_CLINICAL_HISTORY end		
[{CTI}]	Clinical Trial Identification		7
}]	--- CLINICAL_HISTORY end		
{	--- PATIENT_VISITS begin		
PV1	Patient Visit		3
[PV2]	Patient Visit - Additional Info.		3
}	--- PATIENT_VISITS end		
[{	--- MEDICATION_HISTORY begin		
ORC	Common Order		4
[	--- MEDICATION_ORDER_DETAIL begin		
RXO	Pharmacy/Treatment Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXO)		4
[{	--- MEDICATION_ORDER_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ORDER_OBSERVATION end		
]	--- MEDICATION_ORDER_DETAIL end		
[	--- MEDICATION_ENCODING_DETAIL begin		
RXE	Pharmacy/Treatment Encoded Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXE)		4
[{	--- MEDICATION_ENCODING_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ENCODING_OBSERVATION end		
]	--- MEDICATION_ENCODING_DETAIL end		
[{	--- MEDICATION_ADMINISTRATION_DETAIL begin		
{RXA}	Pharmacy/Treatment Administration		4
RXR	Pharmacy/Treatment Route		4
[{	--- MEDICATION_ADMINISTRATION_OBSERVATION		

Segments	Description	Status	Chapter
	begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ADMINISTRATION_OBSERVATION end		
}]	--- MEDICATION_ADMINISTRATION_DETAIL end		
[{CTI}]	Clinical Trial Identification		7
}]	--- MEDICATION_HISTORY end		
[{	--- PROBLEM begin		
PRB	Problem		12
[{VAR}]	Variance (Problem)		15
[{	--- ROLE_PROBLEM begin		
<	--- ROLE_PROBLEM_OBJECT begin		
ROL|	Role (Problem Role)		15
PRD	Provider Data (Problem Role)		11
>	--- ROLE_PROBLEM_OBJECT end		
[{VAR}]	Variance (Problem Role)		15
}]	--- ROLE_PROBLEM end		
[{	--- PROBLEM_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PROBLEM_OBSERVATION end		
}]	--- PROBLEM end		
[{	--- GOAL begin		
GOL	Goal		12
[{VAR}]	Variance (Goal)		15
[{	--- ROLE_GOAL begin		
<	--- ROLE_GOAL_OBJECT begin		
ROL|	Role (Goal Role)		15
PRD	Provider Data (Goal Role)		11
>	--- ROLE_GOAL_OBJECT end		
[{VAR}]	Variance (Goal Role)		15
}]	--- ROLE_GOAL end		
[{	--- GOAL_OBSERVATION begin		
OBX	Observation/Result		7

Segments	Description	Status	Chapter
[{PRT}]	Participation		7
}]	--- GOAL_OBSERVATION end		
}]	--- GOAL end		
[{	--- PATHWAY begin		
PTH	Pathway		12
[{VAR}]	Variance (Pathway)		15
[{	--- ROLE_PATHWAY begin		
<	--- ROLE_PATHWAY_OBJECT begin		
ROL|	Role (Pathway Role)		15
PRD	Provider Data (Pathway Role)		11
>	--- ROLE_PATHWAY_OBJECT end		
[{VAR}]	Variance (Pathway Role)		15
}]	--- ROLE_PATHWAY end		
[{	--- PATHWAY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PATHWAY_OBSERVATION end		
}]	--- PATHWAY end		
[{REL}]	Relationship		11

11.7 COLLABORATIVE CARE INFORMATION REQUEST MESSAGES AND TRIGGER EVENTS

Collaborative care information may need to be retrieved from various entities, such as healthcare providers, clinical repositories or regulatory bodies. The definition of these entities often varies greatly. Some times the query will relate to a previous referral. At other times it will relate to a specific patient.

11.7.1 CCQ/CQU – Collaborative Care Query/Collaborative Care Query Update (Event I19)

This event triggers a query message to be sent from a referring healthcare provider to a referred to healthcare provider, regarding a specific, previously sent collaborative care referral. The Collaborative Care Query message must contain sufficient data for the referred to provider to be able to identify the specific referral being queried. The response to a Collaborative Care Query message is a CQU - Collaborative Care Query Update message. The meaning of the Collaborative Care Query Update message is identical to the meaning of the Asynchronous Collaborative Care Update message.

CCQ^I19^CCQ_I19: Collaborative Care Referral

Segments	Description	Status	Chapter
MSH	Message Header		2
[{SFT}]	Software Segment		2

Segments	Description	Status	Chapter
[UAC]	User Authentication Credential		2
RF1	Referral Information		11
[{	--- PROVIDER_CONTACT begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}]	--- PROVIDER_CONTACT end		
[{REL}]	Relationship		11

CQU^I19^CQU_I19: Collaborative Care Referral

Segments	Description	Status	Chapter
MSH	Message Header		2
[{SFT}]	Software Segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		2
[{ERR}]	Error		2
RF1	Referral Information		11
[{	--- PROVIDER_CONTACT begin		
PRD	Provider Data		11
[{CTD}]	Contact Data		11
}]	--- PROVIDER_CONTACT end		
[{	--- PATIENT begin		
PID	Patient Identification		3
[PD1]	Additional Demographics		3
}]	--- PATIENT end		
[{NK1}]	Next of Kin / Associated Parties		3
[{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info.		6
[IN3]	Insurance Additional Info – Cert.		6
}]	--- INSURANCE end		
[{	--- APPOINTMENT_HISTORY begin		
SCH	Schedule Activity Information		10
[{	--- RESOURCES begin		
RGS	Resource Group Segment		10
[{	--- RESOURCE_DETAIL begin		

Segments	Description	Status	Chapter
<	--- RESOURCE_OBJECT begin		
AIS|	Appointment Information - Service		10
AIG|	Appointment Information – General Resource		10
AIL|	Appointment Information – Location		10
AIP	Appointment Information – Personnel		10
>	--- RESOURCE_OBJECT end		
[{	--- RESOURCE_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- RESOURCE_OBSERVATION end		
}]	--- RESOURCE_DETAIL end		
}]	--- RESOURCES end		
}]	--- APPOINTMENT_HISTORY end		
[{	--- CLINICAL_HISTORY begin		
ORC	Common Order		4
[{	--- CLINICAL_HISTORY_DETAIL begin		
<	--- CLINICAL_HISTORY_OBJECT begin		
OBR|	Observation		4
ODS|	Dietary Order, Suppl., Prefer.		4
PR1|	Procedure		6
RF1|	Referral Information		11
AL1|	Allergy Information		3
IAM|	Patient adverse reaction information		3
ACC|	Accident Information		6
RMI|	Risk Management Incident		6
DB1|	Disability Information		3
DG1|	Diagnosis		6
DRG|	Diagnosis Related Group		6
PDA	Patient Death and Autopsy		3
>	--- CLINICAL_HISTORY_OBJECT end		
[{	--- CLINICAL_HISTORY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- CLINICAL_HISTORY_OBSERVATION end		
}]	--- CLINICAL_HISTORY_DETAIL end		

Segments	Description	Status	Chapter
[{	--- ROLE_CLINICAL_HISTORY begin		
<	--- ROLE_CLINICAL_HISTORY_OBJECT begin		
ROL|	Role (CLINICAL_HISTORY)		15
PRD	Provider Data (CLINICAL_HISTORY)		11
>	--- ROLE_CLINICAL_HISTORY_OBJECT end		
[{VAR}]	Variance (CLINICAL_HISTORY)		15
}]	--- ROLE_CLINICAL_HISTORY end		
[{CTI}]	Clinical Trial Identification		7
}]	--- CLINICAL_HISTORY end		
{	--- PATIENT_VISITS begin		
PV1	Patient Visit		3
[PV2]	Patient Visit - Additional Info.		3
}	--- PATIENT_VISITS end		
[{	--- MEDICATION_HISTORY begin		
ORC	Common Order		4
[	--- MEDICATION_ORDER_DETAIL begin		
RXO	Pharmacy/Treatment Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXO)		4
[{	--- MEDICATION_ORDER_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ORDER_OBSERVATION end		
]	--- MEDICATION_ORDER_DETAIL end		
[	--- MEDICATION_ENCODING_DETAIL begin		
RXE	Pharmacy/Treatment Encoded Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXE)		4
[{	--- MEDICATION_ENCODING_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ENCODING_OBSERVATION end		
]	--- MEDICATION_ENCODING_DETAIL end		
[{	--- MEDICATION_ADMINISTRATION_DETAIL begin		
{RXA}	Pharmacy/Treatment Administration		4

Segments	Description	Status	Chapter
RXR	Pharmacy/Treatment Route		4
[{	--- MEDICATION_ADMINISTRATION_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ADMINISTRATION_OBSERVATION end		
}]	--- MEDICATION_ADMINISTRATION_DETAIL end		
[{CTI}]	Clinical Trial Identification		7
}]	--- MEDICATION_HISTORY end		
[{	--- PROBLEM begin		
PRB	Problem		12
[{VAR}]	Variance (Problem)		15
[{	--- ROLE_PROBLEM begin		
<	--- ROLE_PROBLEM_OBJECT begin		
ROL|	Role (Problem Role)		15
PRD	Provider Data (Problem Role)		11
>	--- ROLE_PROBLEM_OBJECT end		
[{VAR}]	Variance (Problem Role)		15
}]	--- ROLE_PROBLEM end		
[{	--- PROBLEM_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PROBLEM_OBSERVATION end		
}]	--- PROBLEM end		
[{	--- GOAL begin		
GOL	Goal		12
[{VAR}]	Variance (Goal)		15
[{	--- ROLE_GOAL begin		
<	--- ROLE_GOAL_OBJECT begin		
ROL|	Role (Goal Role)		15
PRD	Provider Data (Goal Role)		11
>	--- ROLE_GOAL_OBJECT end		
[{VAR}]	Variance (Goal Role)		15
}]	--- ROLE_GOAL end		

Segments	Description	Status	Chapter
[{	--- GOAL_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- GOAL_OBSERVATION end		
}]	--- GOAL end		
[{	--- PATHWAY begin		
PTH	Pathway		12
[{VAR}]	Variance (Pathway)		15
[{	--- ROLE_PATHWAY begin		
<	--- ROLE_PATHWAY_OBJECT begin		
ROL|	Role (Pathway Role)		15
PRD	Provider Data (Pathway Role)		11
>	--- ROLE_PATHWAY_OBJECT end		
[{VAR}]	Variance (Pathway Role)		15
}]	--- ROLE_PATHWAY end		
[{	--- PATHWAY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PATHWAY_OBSERVATION end		
}]	--- PATHWAY end		
[{REL}]	Relationship		11

11.7.2 CCF/CCI – Collaborative Care Fetch / Collaborative Care Information (Event I22)

This event triggers a query message to be sent from one healthcare provider to another healthcare provider, clinical repository or regulatory body regarding a specific patient. The Collaborative Care Fetch message must contain sufficient information for the healthcare provider, clinical repository or regulatory body to be able to identify the specific patient. The response to a Collaborative Care Fetch is a CCI - Collaborative Care Information message. The meaning of the Collaborative Care Query Information message is identical to the meaning of the Collaborative Care Message message.

CCF^I22^CCF_I22: Collaborative Care Fetch

Segments	Description	Status	Chapter
MSH	Message Header		2
[{SFT}]	Software Segment		2
[UAC]	User Authentication Credential		2
PID	Patient Identification		3

CCI^I22^CCI_I22: Collaborative Care Information

Segments	Description	Status	Chapter
MSH	Message Header		2
[{SFT}]	Software Segment		2
[UAC]	User Authentication Credential		2
MSA	Message Acknowledgment		2
[{ERR}]	Error		2
PID	Patient Identification		3
[PD1]	Additional Demographics		3
[{NK1}]	Next of Kin / Associated Parties		3
[{	--- INSURANCE begin		
IN1	Insurance		6
[IN2]	Insurance Additional Info.		6
[IN3]	Insurance Additional Info – Cert.		6
}]	--- INSURANCE end		
[{	--- APPOINTMENT_HISTORY begin		
SCH	Schedule Activity Information		10
[{	--- RESOURCES begin		
RGS	Resource Group Segment		10
[{	--- RESOURCE_DETAIL begin		
<	--- RESOURCE_OBJECT begin		
AIS|	Appointment Information - Service		10
AIG|	Appointment Information – General Resource	10	
AIL|	Appointment Information – Location		10
AIP	Appointment Information – Personnel		10
>	--- RESOURCE_OBJECT end		
[{	--- RESOURCE_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- RESOURCE_OBSERVATION end		
}]	--- RESOURCE_DETAIL end		
}]	--- RESOURCES end		
}]	--- APPOINTMENT HISTORY end		
[{	--- CLINICAL_HISTORY begin		
ORC	Common Order		4
[{	--- CLINICAL_HISTORY_DETAIL begin		

Segments	Description	Status	Chapter
<	--- CLINICAL_HISTORY_OBJECT begin		
OBR|	Observation		4
ODS|	Dietary Order, Suppl., Prefer.		4
PR1|	Procedure		6
RF1|	Referral Information		11
AL1|	Allergy Information		3
IAM|	Patient adverse reaction information		3
ACC|	Accident Information		6
RMI|	Risk Management Incident		6
DB1|	Disability Information		3
DG1|	Diagnosis		6
DRG|	Diagnosis Related Group		6
PDA	Patient Death and Autopsy		3
>	--- CLINICAL_HISTORY_OBJECT end		
[{	--- CLINICAL_HISTORY_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- CLINICAL_HISTORY_OBSERVATION end		
}]	--- CLINICAL_HISTORY_DETAIL end		
[{	--- ROLE_CLINICAL_HISTORY begin		
<	--- ROLE_CLINICAL_HISTORY_OBJECT begin		
ROL|	Role (CLINICAL_HISTORY)		15
PRD	Provider Data (CLINICAL_HISTORY)		11
>	--- ROLE_CLINICAL_HISTORY_OBJECT end		
[{VAR}]	Variance (CLINICAL_HISTORY)		15
}]	--- ROLE_CLINICAL_HISTORY end		
[{CTI}]	Clinical Trial Identification		7
}]	--- CLINICAL_HISTORY end		
{	--- PATIENT_VISITS begin		
PV1	Patient Visit		3
[PV2]	Patient Visit - Additional Info.		3
}	--- PATIENT_VISITS end		
[{	--- MEDICATION_HISTORY begin		
ORC	Common Order		4
[	--- MEDICATION_ORDER_DETAIL begin		

Segments	Description	Status	Chapter
RXO	Pharmacy/Treatment Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXO)		4
[{	--- MEDICATION_ORDER_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ORDER_OBSERVATION end		
]	--- MEDICATION_ORDER_DETAIL end		
[	--- MEDICATION_ENCODING_DETAIL begin		
RXE	Pharmacy/Treatment Encoded Order		4
{RXR}	Pharmacy/Treatment Route		4
[{RXC}]	Pharmacy/Treatment Component (for RXE)		4
[{	--- MEDICATION_ENCODING_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ENCODING_OBSERVATION end		
]	--- MEDICATION_ENCODING_DETAIL end		
[{	--- MEDICATION_ADMINISTRATION_DETAIL begin		
{RXA}	Pharmacy/Treatment Administration		4
RXR	Pharmacy/Treatment Route		4
[{	--- MEDICATION_ADMINISTRATION_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- MEDICATION_ADMINISTRATION_OBSERVATION end		
}]	--- MEDICATION_ADMINISTRATION_DETAIL end		
[{CTI}]	Clinical Trial Identification		7
}]	--- MEDICATION_HISTORY end		
[{	--- PROBLEM begin		
PRB	Problem		12
[{VAR}]	Variance (Problem)		15
[{	--- ROLE_PROBLEM begin		
<	--- ROLE_PROBLEM_OBJECT begin		
ROL|	Role (Problem Role)		15

Segments	Description	Status	Chapter
PRD	Provider Data (Problem Role)		11
>	--- ROLE_PROBLEM_OBJECT end		
[{VAR}]	Variance (Problem Role)		15
}]	--- ROLE_PROBLEM end		
[{	--- PROBLEM_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PROBLEM_OBSERVATION end		
}]	--- PROBLEM end		
[{	--- GOAL begin		
GOL	Goal		12
[{VAR}]	Variance (Goal)		15
[{	--- ROLE_GOAL begin		
<	--- ROLE_GOAL_OBJECT begin		
ROL|	Role (Goal Role)		15
PRD	Provider Data (Goal Role)		11
>	--- ROLE_GOAL_OBJECT end		
[{VAR}]	Variance (Goal Role)		15
}]	--- ROLE_GOAL end		
[{	--- GOAL_OBSERVATION begin		
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- GOAL_OBSERVATION end		
}]	--- GOAL end		
[{	--- PATHWAY begin		
PTH	Pathway		12
[{VAR}]	Variance (Pathway)		15
[{	--- ROLE_PATHWAY begin		
<	--- ROLE_PATHWAY_OBJECT begin		
ROL|	Role (Pathway Role)		15
PRD	Provider Data (Pathway Role)		11
>	--- ROLE_PATHWAY_OBJECT end		
[{VAR}]	Variance (Pathway Role)		15
}]	--- ROLE_PATHWAY end		
[{	--- PATHWAY_OBSERVATION begin		

Segments	Description	Status	Chapter
OBX	Observation/Result		7
[{PRT}]	Participation		7
}]	--- PATHWAY_OBSERVATION end		
}]	--- PATHWAY end		
[{REL}]	Relationship		11

11.8 SEGMENTS

11.8.1 RF1 - Referral Information Segment

This segment represents information that may be useful when sending referrals from the referring provider to the referred-to provider.

HL7 Attribute Table - RF1 –Referral Information

SEQ	LEN	C.LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
1			CWE	O		0283	01137	Referral Status
2			CWE	O		0280	01138	Referral Priority
3			CWE	O		0281	01139	Referral Type
4			CWE	O	Y	0282	01140	Referral Disposition
5			CWE	O		0284	01141	Referral Category
6			EI	R			01142	Originating Referral Identifier
7			DTM	O			01143	Effective Date
8			DTM	O			01144	Expiration Date
9			DTM	O			01145	Process Date
10			CWE	O	Y	0336	01228	Referral Reason
11			EI	O	Y		01300	External Referral Identifier
12			CWE	O		0865	02262	Referral Documentation Completion Status
13	24		DTM	O	N		03400	Planned Treatment Stop Date
14	60		ST	O	N		03401	Referral Reason Text
15	721		CQ	O	N		03402	Number of Authorized Treatments/Units
16	721		CQ	O	N		03403	Number of Used Treatments/Units
17	721		CQ	O	N		03404	Number of Schedule Treatments/Units
18	20		M0	O	N		03405	Remaining Benefit Amount
19	250		XON	O	N		03406	Authorized Provider
20	250		XCN	O	N		03407	Authorized Health Professional
21	60		ST	O	N		03408	Source Text
22	24		DTM	O	N		03409	Source Date
23	250		XTN	O	N		03410	Source Phone
24	250		ST	O	N		03411	Comment
25	1		ID	O	N	0206	03412	Action Code

11.8.1.1 RF1-1 Referral Status (CWE) 01137

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the status of the referral as defined by either the referred-to or the referred-by provider. Refer to *User-defined Table 0283 - Referral Status* in Chapter 2C, Code Tables, for suggested values.

11.8.1.2 RF1-2 Referral Priority (CWE) 01138

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the urgency of the referral. Refer to *User-defined Table 0280 - Referral Priority* in Chapter 2C, Code Tables, for suggested values.

11.8.1.3 RF1-3 Referral Type (CWE) 01139

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the type of referral. It is loosely associated with a clinical specialty or type of resource. Refer to *User-defined Table 0281 - Referral Type* in Chapter 2C, Code Tables, for suggested values.

11.8.1.4 RF1-4 Referral Disposition (CWE) 01140

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the type of response or action that the referring provider would like from the referred-to provider. Refer to *User-defined Table 0282 - Referral Disposition* for suggested values.

11.8.1.5 RF1-5 Referral Category (CWE) 01141

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the location at which the referral will take place. Refer to *User-defined Table 0284 - Referral Category* for suggested values.

11.8.1.6 RF1-6 Originating Referral Identifier (EI) 01142

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: This field contains the originating application's permanent identifier for the referral. This is a composite field.

The first component is a string of up to 15 characters that identifies an individual referral. It is assigned by the originating application, and it identifies a referral, and the subsequent referral transactions, uniquely among all such referrals from a particular processing application.

The second component is optional because this field, itself, is already defined as a *referral identifier*.

The third component is optional. If used, it should contain the application identifier for the referred-to or external applications (i.e., *not* the originating application). The application identifier is a string of up to 15 characters that is uniquely associated with an application. A given healthcare provider facility, or group of intercommunicating healthcare provider facilities, should establish a unique list of applications that may be potential originators and recipients, and then assign unique application identifiers to each of those applications. This list of application identifiers becomes one of the healthcare provider facility's master dictionary lists. Since applications fulfilling different application roles can send and receive referral messages, the assigning authority application identifier may not identify the application sending or receiving a particular message. Data elements on the Message Header (MSH) segment are available to identify the actual sending and receiving applications.

11.8.1.7 RF1-7 Effective Date (DTM) 01143

Definition: This field contains the date on which the referral is effective.

11.8.1.8 RF1-8 Expiration Date (DTM) 01144

Definition: This field contains the date on which the referral expires.

11.8.1.9 RF1-9 Process Date (DTM) 01145

Definition: This field contains the date on which the referral originated. It is used in cases of retroactive approval.

11.8.1.10 RF1-10 Referral Reason (CWE) 01228

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the reason for which the referral will take place. Refer to *User-defined Table 0336 - Referral Reason* for suggested values.

11.8.1.11 RF1-11 External Referral Identifier (EI) 01300

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: This field contains an external application's permanent identifier for the referral. That is, this referral identifier does not belong to the application that originated the referral and assigned the originating referral identifier.

The first component is a string of up to 15 characters that identifies an individual referral. It is typically assigned by the referred-to provider application responding to a referral originating from a referring provider application, and it identifies a referral, and the subsequent referral transactions, uniquely among all such referrals for a particular referred-to provider processing application. For example, when a primary care provider (referring provider) sends a referral to a specialist (referred-to provider), the specialist's application system may accept the referral and assign it a new referral identifier which uniquely identifies that particular referral within the specialist's application system. This new referral identifier would be placed in the external referral identifier field when the specialist responds to the primary care physician.

The second component is optional because this field, itself, is already defined as a *referral identifier*.

The third component is optional. If used, it should contain the application identifier for the referred-to or external application (i.e., not the originating application). The application identifier is a string of up to 15 characters that is uniquely associated with an application. A given healthcare provider facility, or group of intercommunicating healthcare provider facilities, should establish a unique list of applications that may be potential originators and recipients, and then assign unique application identifiers to each of those applications. This list of application identifiers becomes one of the healthcare provider facility's master dictionary lists. Since applications fulfilling different application roles can send and receive referral messages, the assigning authority application identifier may not identify the application sending or receiving a particular message. Data elements on the Message Header (MSH) segment are available to identify the actual sending and receiving applications.

11.8.1.12 RF1-12 Referral Documentation Completion Status (CWE) 02262

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field can be used to indicate to the receiving provider that the clinical history in the message is incomplete and that more will follow. Refer to *User-defined Table 0865 - Referral Documentation Completion Status* for suggested values.

11.8.1.13 RF1-13 Planned Treatment Stop Date (DTM) 03400

Definition: The planned treatment stop date is the date that the patient's treatment from this referral is expected to complete, based on procedural protocols. This value can be used to indicate that an extension to an authorization is necessary, if the treatment continues longer than expected.

11.8.1.14 RF1-14 Referral Reason Text (ST) 03401

Definition: The referral reason is a free text field allowing a user to capture, in a non-coded format, the reason for the referral. Typically this would describe the patient's condition or illness for which the referral is recorded.

11.8.1.15 RF1-15 Number of Authorized Treatments/Units (CQ) 03402

```
Components:  <Quantity (NM)> ^ <Units (CWE)>
```

```
Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
           System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
           of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
           <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
           Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
           Second Alternate Coding System (ID)> & <Second Alternate Coding System
           Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
           <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
           <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
           <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
           OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: The authorized duration is the amount of time, in days or visits, that the patient has been authorized for treatment for this referral. The duration of "days" is reserved for inpatient authorizations.

11.8.1.16 RF1-16 Number of Used Treatments/Units (CQ) 03403

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
           System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
           of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
           <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
           Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
           Second Alternate Coding System (ID)> & <Second Alternate Coding System
           Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
           <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
           <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
           <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
           OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: The used duration is the amount of time, in days or visits that the patient has used of the originally authorized duration. The duration of "days" is reserved for inpatient authorizations.

11.8.1.17 RF1-17 Number of Scheduled Treatments/Units (CQ) 03404

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
           System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
           of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
           <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
           Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
           Second Alternate Coding System (ID)> & <Second Alternate Coding System
           Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
           <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
           <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
           <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
           OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: The scheduled treatments is the amount of time, in days or visits that the patient has planned treatments scheduled. The duration of "days" is reserved for inpatient authorizations.

11.8.1.18 RF1-18 Remaining Benefit Amount (MO) 03405

```
Components:  <Quantity (NM)> ^ <Denomination (ID)>
```

Definition: The remaining benefit amount is the amount remaining from the insurance company related to this referral.

11.8.1.19 RF1-19 Authorized Provider (XON) 03406

```
Components:  <Organization Name (ST)> ^ <Organization Name Type Code (CWE)> ^
           <WITHDRAWN Constituent> ^ <WITHDRAWN Constituent> ^ <WITHDRAWN
           Constituent> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
           <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
           <Organization Identifier (ST)>
```

Subcomponents for Organization Name Type Code (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Authority (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Definition: This represents the organization to which the patient was referred to perform the procedure(s). The authorized provider represents the organization recognized by the insurance carrier that is authorized to perform the services for the patient specified on the referral.

11.8.1.20 RF1-20 Authorized Health Professional (XCN) 03407

Components: <Person Identifier (ST)> ^ <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and Further Given Names or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III) (ST)> ^ <Prefix (e.g., DR) (ST)> ^ <WITHDRAWN Constituent> ^ <DEPRECATED-Source Table (CWE)> ^ <Assigning Authority (HD)> ^ <Name Type Code (ID)> ^ <Identifier Check Digit (ST)> ^ <Check Digit Scheme (ID)> ^ <Identifier Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^ <Name Context (CWE)> ^ <WITHDRAWN Constituent> ^ <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date (DTM)> ^ <Professional Suffix (ST)> ^ <Assigning Jurisdiction (CWE)> ^ <Assigning Agency or Department (CWE)> ^ <Security Check (ST)> ^ <Security Check Scheme (ID)>

Subcomponents for Family Name (FN): <Surname (ST)> & <Own Surname Prefix (ST)> & <Own Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from Partner/Spouse (ST)>

Subcomponents for Source Table (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Authority (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Name Context (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

```
Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
          <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
          Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
          Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
          Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text
          (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate
          Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID
          (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)>
          & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)>
          & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
          (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
          <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
          System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
          <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second
          Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> &
          <Second Alternate Coding System Version ID (ST)> & <Coding System OID
          (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate
          Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate
          Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> &
          <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set
          Version ID (DTM)>
```

Definition: The authorized HP represents the specific health professional authorized to perform the services for the patient. This is a less frequently used field, as most often the authorization is for a group/organization and not a specific HP within that group.

11.8.1.21 RF1-21 Source Text (ST) 03408

Definition: The source text allows a user to capture information (such as the name) of the person contacted regarding the specific referral.

11.8.1.22 RF1-22 Source Date (DTM) 03409

Definition: The source date allows a user to capture the date the person was contacted regarding the specific referral.

11.8.1.23 RF1-23 Source Phone (XTN) 03410

```
Components:  <WITHDRAWN Constituent> ^ <Telecommunication Use Code (ID)> ^
          <Telecommunication Equipment Type (ID)> ^ <Communication Address (ST)> ^
          <Country Code (SNM)> ^ <Area/City Code (SNM)> ^ <Local Number (SNM)> ^
          <Extension (SNM)> ^ <Any Text (ST)> ^ <Extension Prefix (ST)> ^ <Speed
          Dial Code (ST)> ^ <Unformatted Telephone number  (ST)> ^ <Effective Start
          Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^
          <Protection Code (CWE)> ^ <Shared Telecommunication Identifier (EI)> ^
          <Preference Order (NM)>

Subcomponents for Expiration Reason (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

```
Subcomponents for Protection Code (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Shared Telecommunication Identifier (EI):  <Entity Identifier (ST)>
          & <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: The source phone number allows a user to capture the phone number of the person contacted regarding the specific referral.

11.8.1.24 RF1-24 Comment (TX) 03411

Definition: The comment allows for a free text capture of any notes the user wishes to capture related to the referral. This is a single notes field that allows the user to add additional text over time, or replace the text that already exists.

11.8.1.25 RF1-25 Action Code (ID) 03412

Definition: This field defines the action to be taken for this referral. Refer to *HL7 Table 0206 - Segment Action Code* in Chapter 2, Code Tables, for valid values. When this field is valued, the AUT segment is not in "snapshot mode", rather in "action mode".

11.8.2 AUT - Authorization Information Segment

This segment represents an authorization or a pre-authorization for a referred procedure or requested service by the payor covering the patient's health care.

HL7 Attribute Table - AUT – Authorization Information

SEQ	LEN	C.LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
1			CWE	O		0072	01146	Authorizing Payor, Plan ID
2			CWE	R		0285	01147	Authorizing Payor, Company ID
3		45#	ST	O			01148	Authorizing Payor, Company Name
4			DTM	O			01149	Authorization Effective Date
5			DTM	O			01150	Authorization Expiration Date
6			EI	C			01151	Authorization Identifier
7			CP	O			01152	Reimbursement Limit
8			CQ	O			01153	Requested Number of Treatments
9			CQ	O			01154	Authorized Number of Treatments
10			DTM	O			01145	Process Date
11			CWE	O	Y		02375	Requested Discipline(s)
12			CWE	O	Y		02376	Authorized Discipline(s)
13	250		CWE	R	N		03413	Authorization Referral Type
14	250		CWE	O	N		03414	Approval Status
15	24		DTM	O	N		03415	Planned Treatment Stop Date
16	250		CWE	O	N		03416	Clinical Service
17	60		ST	O	N		03417	Reason Text
18	721		CQ	O	N		03418	Number of Authorized Treatments/Units
19	721		CQ	O	N		03419	Number of Used Treatments/Units

SEQ	LEN	C.LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
20	721		CQ	O	N		03420	Number of Schedule Treatments/Units
21	250		CWE	O	N		03421	Encounter Type
22	20		MO	O	N		03422	Remaining Benefit Amount
23	250		XON	O	N		03423	Authorized Provider
24	250		XCN	O	N		03424	Authorized Health Professional
25	60		ST	O	N		03425	Source Text
26	24		DTM	O	N		03426	Source Date
27	250		XTN	O	N		03427	Source Phone
28	254		ST	O	N		03428	Comment
29	1		ID	O	N	0206	03429	Action Code

11.8.2.1 AUT-1 Authorizing Payor, Plan ID (CWE) 01146

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the ID of the coverage plan authorizing treatment. Values should be entries in a locally defined table of plan codes. *User defined Table 0072- Insurance Plan ID* is used as the HL7 identifier for the user-defined table of values for this field.

11.8.2.2 AUT-2 Authorizing Payor, Company ID (CWE) 01147

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the ID of the insurance company or other entity that administers the authorizing coverage plan. Values may be entries in a locally defined table of payor codes. *User-defined Table 0285 - Insurance Company ID Codes* is used as the HL7 identifier for the user-defined table of values for this field.

11.8.2.3 AUT-3 Authorizing Payor, Company Name (ST) 01148

Definition: This field contains the name of the insurance company or other entity that administers the authorizing coverage plan.

11.8.2.4 AUT-4 Authorization Effective Date (DTM) 01149

Definition: This field contains the effective date of the authorization.

11.8.2.5 AUT-5 Authorization Expiration Date (DTM) 01150

Definition: This field contains the expiration date after which the authorization to treat will no longer be in effect from the perspective of the coverage plan.

11.8.2.6 AUT-6 Authorization Identifier (EI) 01151

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: This field contains the coverage application's permanent identifier assigned to track the authorization and all related billing documents. This field is conditionally required. It is not required when authorization information is being requested. However, it is required when this segment is contained in a message which is responding to a request and contains the authorization information. This is a composite field.

The first component of this field is a string of up to 15 characters that identifies an individual authorization. It is assigned by the coverage application, and it identifies an authorization, and the subsequent billing transactions resulting from the given authorization, uniquely among all such authorizations granted from a particular processing application.

The second component is optional because this field, itself, is already defined as an *authorization identifier*.

The third component is optional. If used it should contain the application identifier for the coverage application. The application identifier is a string of up to six characters that is uniquely associated with an application. A given healthcare provider facility, or group of intercommunicating healthcare provider facilities, should establish a unique list of applications that may be potential originators and recipients, and then assign unique application identifiers to each of those applications. This list of application identifiers becomes one of the healthcare provider facility's master dictionary lists. Since applications fulfilling different application roles can send and receive referral messages containing authorizations, the coverage application identifier may not identify the application sending or receiving a particular message. Data elements on the Message Header (MSH) segment are available to identify the actual sending and receiving applications.

11.8.2.7 AUT-7 Reimbursement Limit (CP) 01152

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
             <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
             of Second Alternate Coding System (ID)> & <Second Alternate Coding System
             Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
             <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
             <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
             <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
             OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the dollar limit for reimbursement specified by the coverage plan for the authorized treatment.

11.8.2.8 AUT-8 Requested Number of Treatments (CQ) 01153

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
             System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
             of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
             <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
             Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
             Second Alternate Coding System (ID)> & <Second Alternate Coding System
             Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
             <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
             <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
             <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
             OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the *requested* number of times that the treatment may be administered to the patient without obtaining additional authorization.

11.8.2.9 AUT-9 Authorized Number of Treatments (CQ) 01154

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
          System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
          of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
          <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
          Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
          Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the number of times that the authorized treatment may be administered to the patient without obtaining additional authorization.

11.8.2.10 AUT-10 Process Date (DTM) 01145

Definition: This field contains the date that the authorization originated with the authorizing party.

11.8.2.11 AUT-11 Requested Discipline(s) (CWE) 02375

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
          <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
          Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
          System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
          Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
          Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
          (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
          Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
          Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
          Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
          Alternate Value Set Version ID (DTM)>
```

Definition: Discipline – The scope of medical service(s) for which reimbursement for services rendered is requested. Examples include Physiotherapy, Occupational Therapy, Speech, etc. This field contains the requested discipline(s).

11.8.2.12 AUT-12 Authorized Discipline(s) (CWE) 02376

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
          <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
          Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
          System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
          Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
          Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
          (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
          Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
          Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
          Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
          Alternate Value Set Version ID (DTM)>
```

Definition: Discipline – The scope of medical service(s) for which reimbursement for services rendered is authorized. Examples include Physiotherapy, Occupational Therapy, Speech, etc. This field contains the authorized discipline(s).

11.8.2.13 AUT-13 Authorization Referral Type (CWE) 03413

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: The authorization/referral type distinguishes the content of the segment as pertaining to an authorization vs a referral vs other types. HJB: I don't think we need this for HL7 as the segment is distinct from RF1.

11.8.2.14 AUT-14 Approval Status (CWE) 03414

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: The authorization/referral approval status indicates that status of an authorization

11.8.2.15 AUT-15 Planned Treatment Stop Date (DTM) 03415

Definition: The authorization planned treatment stop date is the date that the patient's treatment from this authorization is expected to complete, based on procedural protocols. This value can be used to indicate that an extension to an authorization is necessary, if the treatment continues longer than expected.

11.8.2.16 AUT-16 Clinical Service (CWE) 03416

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: The authorization clinical service provides a means of categorizing the authorization. This is especially valuable for differentiating authorizations that do not have specific procedure codes associated with them.

11.8.2.17 AUT-17 Reason Text (ST) 03417

Definition: The authorization reason is a free text field allowing a user to capture, in a non-coded format, the reason for the authorization. Typically this would describe the patient's condition or illness for which the authorization is recorded.

11.8.2.18 AUT-18 Number of Authorized Treatments/Units (CQ) 03418

```
Components:  <Quantity (NM)> ^ <Units (CWE)>
```

```
Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
          System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
          of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
          <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
          Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
          Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: The authorized duration is the amount of time, in days or visits, that the patient has been authorized for treatment by this authorization. The duration of "days" is reserved for inpatient authorizations.

11.8.2.19 AUT-19 Number of Used Treatments/Units (CQ) 03419

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
          System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
          of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
          <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
          Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
          Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: The used duration is the amount of time, in days or visits that the patient has used of the originally authorized duration. The duration of "days" is reserved for inpatient authorizations.

11.8.2.20 AUT-20 Number of Scheduled Treatments/Units (CQ) 03420

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
          System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
          of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
          <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second
          Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of
          Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: The scheduled treatments is the amount of time, in days or visits that the patient has planned treatments scheduled The duration of "days" is reserved for inpatient authorizations.

11.8.2.21 AUT-21 Encounter Type (CWE) 03421

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
          <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
          Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
          System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
          Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
          Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
          (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
          Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
          Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
          Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
          Alternate Value Set Version ID (DTM)>
```

Definition: The authorization encounter type provides a means of specifying the environment for the performance of the authorized services. For example, it is common for a procedure to be authorized only

for an outpatient environment. If something causes the procedure to be performed in an inpatient environment, a new authorization would be needed.

11.8.2.22 AUT-22 Remaining Benefit Amount (MO) 03422

```
Components: <Quantity (NM)> ^ <Denomination (ID)>
```

Definition: The authorization benefit amount is the amount remaining from the insurance company related to this authorization.

11.8.2.23 AUT-23 Authorized Provider (XON) 03423

```
Components: <Organization Name (ST)> ^ <Organization Name Type Code (CWE)> ^
            <WITHDRAWN Constituent> ^ <WITHDRAWN Constituent> ^ <WITHDRAWN
            Constituent> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
            <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
            <Organization Identifier (ST)>

Subcomponents for Organization Name Type Code (CWE): <Identifier (ST)> & <Text (ST)>
            & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
            Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
            Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
            Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text
            (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate
            Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID
            (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)>
            & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)>
            & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
            OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Authority (HD): <Namespace ID (IS)> & <Universal ID (ST)>
            & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD): <Namespace ID (IS)> & <Universal ID (ST)>
            & <Universal ID Type (ID)>
```

Definition: This represents the organization to which the patient was referred, or that is authorized to perform the procedure(s). The authorized provider represents the organization recognized by the insurance carrier that is authorized to perform the services for the patient specified on the authorization.

11.8.2.24 AUT-24 Authorized Health Professional (XCN) 03424

```
Components: <Person Identifier (ST)> ^ <Family Name (FN)> ^ <Given Name (ST)> ^
            <Second and Further Given Names or Initials Thereof (ST)> ^ <Suffix (e.g.,
            JR or III) (ST)> ^ <Prefix (e.g., DR) (ST)> ^ <WITHDRAWN Constituent> ^
            <DEPRECATED-Source Table (CWE)> ^ <Assigning Authority (HD)> ^ <Name Type
            Code (ID)> ^ <Identifier Check Digit (ST)> ^ <Check Digit Scheme (ID)> ^
            <Identifier Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Name
            Representation Code (ID)> ^ <Name Context (CWE)> ^ <WITHDRAWN Constituent>
            ^ <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date
            (DTM)> ^ <Professional Suffix (ST)> ^ <Assigning Jurisdiction (CWE)> ^
            <Assigning Agency or Department (CWE)> ^ <Security Check (ST)> ^
            <Security Check Scheme (ID)>

Subcomponents for Family Name (FN): <Surname (ST)> & <Own Surname Prefix (ST)> & <Own
            Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from
            Partner/Spouse (ST)>

Subcomponents for Source Table (CWE): <Identifier (ST)> & <Text (ST)> & <Name of
            Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
            & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
            & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
            <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
            of Second Alternate Coding System (ID)> & <Second Alternate Coding System
            Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
            <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
            <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
            <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
            OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Authority (HD): <Namespace ID (IS)> & <Universal ID (ST)>
            & <Universal ID Type (ID)>
```

```
Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
          & <Universal ID Type (ID)>

Subcomponents for Name Context (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
          <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
          Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
          Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
          Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text
          (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate
          Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID
          (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)>
          & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)>
          & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
          (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
          <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
          System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
          <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second
          Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> &
          <Second Alternate Coding System Version ID (ST)> & <Coding System OID
          (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate
          Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate
          Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> &
          <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set
          Version ID (DTM)>
```

Definition: The authorized HP represents the specific health professional being authorized to perform the services for the patient. This is a less frequently used field, as most often the authorization is for a group/organization and not a specific HP within that group.

11.8.2.25 AUT-25 Source Text (ST) 03425

Definition: The authorization source text allows a user to capture information (such as the name) of the person contacted regarding the specific authorization.

11.8.2.26 AUT-26 Source Date (DTM) 03426

Definition: The authorization source date allows a user to capture the date the person was contacted regarding the specific authorization.

11.8.2.27 AUT-27 Source Phone (XTN) 03427

```
Components:  <WITHDRAWN Constituent> ^ <Telecommunication Use Code (ID)> ^
          <Telecommunication Equipment Type (ID)> ^ <Communication Address (ST)> ^
          <Country Code (SNM)> ^ <Area/City Code (SNM)> ^ <Local Number (SNM)> ^
          <Extension (SNM)> ^ <Any Text (ST)> ^ <Extension Prefix (ST)> ^ <Speed
          Dial Code (ST)> ^ <Unformatted Telephone number  (ST)> ^ <Effective Start
          Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^
          <Protection Code (CWE)> ^ <Shared Telecommunication Identifier (EI)> ^
          <Preference Order (NM)>
```

```
Subcomponents for Expiration Reason (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Protection Code (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Shared Telecommunication Identifier (EI):  <Entity Identifier (ST)>
          & <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: The authorization source phone number allows a user to capture the phone number of the person contacted regarding the specific authorization.

11.8.2.28 AUT-28 Comment (TX) 03428

Definition: The authorization notes allow for a free text capture of any notes the user wishes to capture related to the authorization. This is a single notes field that allows the user to add additional text over time, or replace the text that already exists.

11.8.2.29 AUT-29 Action Code (ID) 03429

Definition: This field defines the action to be taken for this authorization. Refer to HL7 Table 0206 - Segment Action Code in Chapter 2 for valid values. When this field is valued, the AUT segment is not in "snapshot mode", rather in "action mode".

11.8.3 PRD - provider data segment

This segment will be employed as part of a patient referral message and its related transactions. The PRD segment contains data specifically focused on a referral, and it is inter-enterprise in nature. The justification for this new segment comes from the fact that we are dealing with referrals that are external to the facilities that received them. Therefore, using a segment such as the current PV1 would be inadequate for all the return information that may be required by the receiving facility or application. In addition, the PV1 does not always provide information sufficient to enable the external facility to make a complete identification of the referring entity. The information contained in the PRD segment will include the referring provider, the referred-to provider, the referred-to location or service, and the referring provider clinic address.

HL7 Attribute Table - PRD – Provider Data

SEQ	LEN	C.LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
1			CWE	R	Y	0286	01155	Provider Role
2			XPN	O	Y		01156	Provider Name
3			XAD	O	Y		01157	Provider Address
4			PL	O			01158	Provider Location
5			XTN	O	Y		01159	Provider Communication Information
6			CWE	O		0185	00684	Preferred Method of Contact
7			PLN	O	Y	0338	01162	Provider Identifiers

SEQ	LEN	C.LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
8			DTM	O			01163	Effective Start Date of Provider Role
9			DTM	O	Y		01164	Effective End Date of Provider Role
10			XON	O	N		02256	Provider Organization Name and Identifier
11			XAD	O	Y		02257	Provider Organization Address
12			PL	O	Y		02258	Provider Organization Location Information
13			XTN	O	Y		02259	Provider Organization Communication Information
14			CWE	O	N	0185	02260	Provider Organization Method of Contact

11.8.3.1 PRD-1 Provider Role (CWE) 01155

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the contact role that defines the relationship of the person or organization described in this segment to the patient being referred. When a referral is inter-enterprise in nature, there are several important relationships that must be identified. For example, the proper identification of both the referring and the referred-to provider is critical for proper processing of a referral. In addition, some enterprises may want information regarding a consulting provider or the identity of the person who actually prepared the referral. This contact role may also expand to represent affiliated persons to whom information regarding this referral must be forwarded or copied. Refer to *User-defined Table 0286 - Provider Role* for suggested values.

11.8.3.2 PRD-2 Provider Name (XPN) 01156

```
Components:  <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and Further Given Names
             or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III) (ST)> ^ <Prefix
             (e.g., DR) (ST)> ^ <WITHDRAWN Constituent> ^ <Name Type Code (ID)> ^ <Name
             Representation Code (ID)> ^ <Name Context (CWE)> ^ <WITHDRAWN Constituent>
             ^ <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date
             (DTM)> ^ <Professional Suffix (ST)> ^ <Called By (ST)>

Subcomponents for Family Name (FN):  <Surname (ST)> & <Own Surname Prefix (ST)> & <Own
             Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from
             Partner/Spouse (ST)>

Subcomponents for Name Context (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
             <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
             of Second Alternate Coding System (ID)> & <Second Alternate Coding System
             Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
             <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
             <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
             <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
             OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the name of the provider identified in this segment. Generally, this field will describe a physician associated with the referral. However, it is not limited to physicians. If the provider is an organization then *PRD-10 – Provider Organization Name and Identifier* will be used. This field may contain the name of any valid healthcare provider associated with this referral. If this Provider Name is a physician's name, you may refer to *PRD-7-Provider identifiers* for the physician identifier.

11.8.3.3 PRD-3 Provider Address (XAD) 01157

Components: <Street Address (SAD)> ^ <Other Designation (ST)> ^ <City (ST)> ^ <State or Province (ST)> ^ <Zip or Postal Code (ST)> ^ <Country (ID)> ^ <Address Type (ID)> ^ <Other Geographic Designation (ST)> ^ <County/Parish Code (CWE)> ^ <Census Tract (CWE)> ^ <Address Representation Code (ID)> ^ <WITHDRAWN Constituent> ^ <Effective Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^ <Temporary Indicator (ID)> ^ <Bad Address Indicator (ID)> ^ <Address Usage (ID)> ^ <Addressee (ST)> ^ <Comment (ST)> ^ <Preference Order (NM)> ^ <Protection Code (CWE)> ^ <Address Identifier (EI)>

Subcomponents for Street Address (SAD): <Street or Mailing Address (ST)> & <Street Name (ST)> & <Dwelling Number (ST)>

Subcomponents for County/Parish Code (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Census Tract (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Expiration Reason (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Protection Code (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Address Identifier (EI): <Entity Identifier (ST)> & <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Definition: This field contains the mailing address of the provider identified in this segment. One of the key components to completing the "circle of care" and provider/institution bonding is the issuance of follow-up correspondence to the referring provider.

11.8.3.4 PRD-4 Provider Location (PL) 01158

```
Components:  <Point of Care (HD)> ^ <Room (HD)> ^ <Bed (HD)> ^ <Facility (HD)> ^
             <Location Status (IS)> ^ <Person Location Type (IS)> ^ <Building (HD)> ^
             <Floor (HD)> ^ <Location Description (ST)> ^ <Comprehensive Location
             Identifier (EI)> ^ <Assigning Authority for Location (HD)>

Subcomponents for Point of Care (HD):  <Namespace ID (IS)> & <Universal ID (ST)> &
             <Universal ID Type (ID)>

Subcomponents for Room (HD):  <Namespace ID (IS)> & <Universal ID (ST)> & <Universal
             ID Type (ID)>

Subcomponents for Bed (HD):  <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID
             Type (ID)>

Subcomponents for Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)> &
             <Universal ID Type (ID)>

Subcomponents for Building (HD):  <Namespace ID (IS)> & <Universal ID (ST)> &
             <Universal ID Type (ID)>

Subcomponents for Floor (HD):  <Namespace ID (IS)> & <Universal ID (ST)> & <Universal
             ID Type (ID)>

Subcomponents for Comprehensive Location Identifier (EI):  <Entity Identifier (ST)> &
             <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Authority for Location (HD):  <Namespace ID (IS)> &
             <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: This field contains the location of the provider as needed when a provider that may be external to a given enterprise must be referenced. For example, if this provider represented the referred-to physician, the *PRD-4-Provider location* should identify the clinic of the physician or provider to whom this referral has been sent. An application and facility identifier carried in the facility field specifies the identification of the provider's location. The application ID and facility ID would be used in the same manner as their corresponding fields in the MSH segment (*MSH-3-Sending application, MSH-5-Receiving application, MSH-4-Sending facility, MSH-6-Receiving facility*). That is, the facility field will contain an application identifier and facility identifier which describe the location of this provider. However, it should be noted that they may describe a different location because the provider location being referenced in this field *may not be* the location from which the message originated, which is being described by the MSH.

11.8.3.5 PRD-5 Provider Communication Information (XTN) 01159

```
Components:  <WITHDRAWN Constituent> ^ <Telecommunication Use Code (ID)> ^
             <Telecommunication Equipment Type (ID)> ^ <Communication Address (ST)> ^
             <Country Code (SNM)> ^ <Area/City Code (SNM)> ^ <Local Number (SNM)> ^
             <Extension (SNM)> ^ <Any Text (ST)> ^ <Extension Prefix (ST)> ^ <Speed
             Dial Code (ST)> ^ <Unformatted Telephone number  (ST)> ^ <Effective Start
             Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^
             <Protection Code (CWE)> ^ <Shared Telecommunication Identifier (EI)> ^
             <Preference Order (NM)>

Subcomponents for Expiration Reason (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
             <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
             of Second Alternate Coding System (ID)> & <Second Alternate Coding System
             Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
             <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
             <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
             <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
             OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

```
Subcomponents for Protection Code (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Shared Telecommunication Identifier (EI):  <Entity Identifier (ST)>
          & <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: This field contains information, such as the phone number or electronic mail address, used to communicate with the provider or organization.

11.8.3.6 PRD-6 Preferred Method of Contact (CWE) 00684

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
          <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
          Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
          System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
          Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
          Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
          (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
          Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
          Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
          Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
          Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the preferred method to use when communicating with the provider. Refer to *User-defined Table 0185 - Preferred Method of Contact* in Chapter 2C, "Code Tables", for suggested values.

11.8.3.7 PRD-7 Provider Identifiers (PLN) 01162

```
Components:  <ID Number (ST)> ^ <Type of ID Number (CWE)> ^ <State/other Qualifying
          Information (ST)> ^ <Expiration Date (DT)>

Subcomponents for Type of ID Number (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: This repeating field contains the provider's unique identifiers such as UPIN, Medicare and Medicaid numbers. Refer to *User-defined Table 0338 - Practitioner ID Number Type* (in Chapter 2C, "Code Tables") for suggested values.

11.8.3.8 PRD-8 Effective Start Date of Provider Role (DTM) 01163

Definition: This field contains the date that the role of the provider effectively began. For example, this date may represent the date on which a physician was assigned as a patient's primary care provider.

11.8.3.9 PRD-9 Effective End Date of Provider Role (DTM) 01164

Definition: This field contains the date that the role of the provider effectively ended. For example, this date may represent the date that a physician was removed as a patient's primary care provider.

Note: The *PRD-8-Effective Start Date of Role* and *PRD-9-Effective End Date of Role* fields should *not* be used as trigger events. For example, they should not be used to trigger a change in role. These two dates are for informational purposes only.

11.8.3.10 PRD-10 Provider Organization Name and Identifier (XON) 02256

Components: <Organization Name (ST)> ^ <Organization Name Type Code (CWE)> ^ <WITHDRAWN Constituent> ^ <WITHDRAWN Constituent> ^ <WITHDRAWN Constituent> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^ <Organization Identifier (ST)>

Subcomponents for Organization Name Type Code (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Assigning Authority (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Definition: This field contains the name of the provider where the provider is an organization.

11.8.3.11 PRD-11 Provider Organization Address (XAD) 02257

Components: <Street Address (SAD)> ^ <Other Designation (ST)> ^ <City (ST)> ^ <State or Province (ST)> ^ <Zip or Postal Code (ST)> ^ <Country (ID)> ^ <Address Type (ID)> ^ <Other Geographic Designation (ST)> ^ <County/Parish Code (CWE)> ^ <Census Tract (CWE)> ^ <Address Representation Code (ID)> ^ <WITHDRAWN Constituent> ^ <Effective Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^ <Temporary Indicator (ID)> ^ <Bad Address Indicator (ID)> ^ <Address Usage (ID)> ^ <Addressee (ST)> ^ <Comment (ST)> ^ <Preference Order (NM)> ^ <Protection Code (CWE)> ^ <Address Identifier (EI)>

Subcomponents for Street Address (SAD): <Street or Mailing Address (ST)> & <Street Name (ST)> & <Dwelling Number (ST)>

Subcomponents for County/Parish Code (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Census Tract (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

```
Subcomponents for Expiration Reason (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Protection Code (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Address Identifier (EI):  <Entity Identifier (ST)> & <Namespace ID
          (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: This field contains the address of the provider if it is an organization.

11.8.3.12 PRD-12 Provider Organization Location Information (PL) 02258

```
Components:  <Point of Care (HD)> ^ <Room (HD)> ^ <Bed (HD)> ^ <Facility (HD)> ^
          <Location Status (IS)> ^ <Person Location Type (IS)> ^ <Building (HD)> ^
          <Floor (HD)> ^ <Location Description (ST)> ^ <Comprehensive Location
          Identifier (EI)> ^ <Assigning Authority for Location (HD)>

Subcomponents for Point of Care (HD):  <Namespace ID (IS)> & <Universal ID (ST)> &
          <Universal ID Type (ID)>

Subcomponents for Room (HD):  <Namespace ID (IS)> & <Universal ID (ST)> & <Universal
          ID Type (ID)>

Subcomponents for Bed (HD):  <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID
          Type (ID)>

Subcomponents for Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)> &
          <Universal ID Type (ID)>

Subcomponents for Building (HD):  <Namespace ID (IS)> & <Universal ID (ST)> &
          <Universal ID Type (ID)>

Subcomponents for Floor (HD):  <Namespace ID (IS)> & <Universal ID (ST)> & <Universal
          ID Type (ID)>

Subcomponents for Comprehensive Location Identifier (EI):  <Entity Identifier (ST)> &
          <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Authority for Location (HD):  <Namespace ID (IS)> &
          <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: This field contains the location details of the provider if it is an organization.

11.8.3.13 PRD-13 Provider Organization Communication Information (XTN) 02259

```
Components:  <WITHDRAWN Constituent> ^ <Telecommunication Use Code (ID)> ^
          <Telecommunication Equipment Type (ID)> ^ <Communication Address (ST)> ^
          <Country Code (SNM)> ^ <Area/City Code (SNM)> ^ <Local Number (SNM)> ^
          <Extension (SNM)> ^ <Any Text (ST)> ^ <Extension Prefix (ST)> ^ <Speed
          Dial Code (ST)> ^ <Unformatted Telephone number  (ST)> ^ <Effective Start
          Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^
          <Protection Code (CWE)> ^ <Shared Telecommunication Identifier (EI)> ^
          <Preference Order (NM)>
```

```
Subcomponents for Expiration Reason (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Protection Code (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Shared Telecommunication Identifier (EI):  <Entity Identifier (ST)>
          & <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: This field contains information, such as the phone number or electronic mail address, used to communicate with the provider if it is an organization.

11.8.3.14 PRD-14 Provider Organization Method of Contact (CWE) 02260

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
          <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
          Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
          System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
          Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
          Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
          (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
          Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
          Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
          Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
          Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the preferred method to use when communicating with the provider if provider is an organization. Refer to *User-defined Table 0185 - Preferred Method of Contact* in Chapter 2C, "Code Tables", for suggested values.

11.8.4 CTD - Contact Data Segment

The CTD segment may identify any contact personnel associated with a patient referral message and its related transactions. The CTD segment will be paired with a PRD segment. The PRD segment contains data specifically focused on provider information in a referral. While it is important in an inter-enterprise transaction to transmit specific information regarding the providers involved (referring and referred-to), it may also be important to identify the contact personnel associated with the given provider. For example, a provider receiving a referral may need to know the office manager or the billing person at the institution of the provider who sent the referral. This segment allows for multiple contact personnel to be associated with a single provider.

HL7 Attribute Table - CTD – Contact Data

SEQ	LEN	C.LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
1			CWE	R	Y	0131	00196	Contact Role
2			XPN	O	Y		01165	Contact Name
3			XAD	O	Y		01166	Contact Address
4			PL	O			01167	Contact Location

SEQ	LEN	C.LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
5			XTN	O	Y		01168	Contact Communication Information
6			CWE	O		0185	00684	Preferred Method of Contact
7			PLN	O	Y	0338	01171	Contact Identifiers

11.8.4.1 CTD-1 Contact Role (CWE) 00196

Components: <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^ <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second Alternate Value Set Version ID (DTM)>

Definition: This field contains the contact role that defines the relationship of the person described in this segment to the patient being referred. When a referral is inter-enterprise in nature, there are some important relationships that must be identified. For example, it may be necessary to identify the contact representative at the clinic that sent the referral. *User-defined Table 0131 - Contact Role* (in Chapter 3, "Patient Administration")is used as the HL7 identifier for the user-defined table of values for this field.

11.8.4.2 CTD-2 Contact Name (XPN) 01165

Components: <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and Further Given Names or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III) (ST)> ^ <Prefix (e.g., DR) (ST)> ^ <WITHDRAWN Constituent> ^ <Name Type Code (ID)> ^ <Name Representation Code (ID)> ^ <Name Context (CWE)> ^ <WITHDRAWN Constituent> ^ <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date (DTM)> ^ <Professional Suffix (ST)> ^ <Called By (ST)>

Subcomponents for Family Name (FN): <Surname (ST)> & <Own Surname Prefix (ST)> & <Own Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from Partner/Spouse (ST)>

Subcomponents for Name Context (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Definition: This field contains the name of the contact person identified in this segment. Generally, this field will describe a person or provider associated with the referral. If this contact name is a physician, you may refer to the *CTD-7-Contact identifiers* (section 11.8.4.7) for the physician identifier.

11.8.4.3 CTD-3 Contact Address (XAD) 01166

Components: <Street Address (SAD)> ^ <Other Designation (ST)> ^ <City (ST)> ^ <State or Province (ST)> ^ <Zip or Postal Code (ST)> ^ <Country (ID)> ^ <Address Type (ID)> ^ <Other Geographic Designation (ST)> ^ <County/Parish Code (CWE)> ^ <Census Tract (CWE)> ^ <Address Representation Code (ID)> ^ <WITHDRAWN Constituent> ^ <Effective Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^ <Temporary Indicator (ID)> ^ <Bad Address Indicator (ID)> ^ <Address Usage (ID)> ^ <Addressee (ST)> ^ <Comment (ST)> ^ <Preference Order (NM)> ^ <Protection Code (CWE)> ^ <Address Identifier (EI)>

Subcomponents for Street Address (SAD): <Street or Mailing Address (ST)> & <Street Name (ST)> & <Dwelling Number (ST)>

Subcomponents for County/Parish Code (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Census Tract (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Expiration Reason (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Protection Code (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> & <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name of Second Alternate Coding System (ID)> & <Second Alternate Coding System Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> & <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> & <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> & <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Address Identifier (EI): <Entity Identifier (ST)> & <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Definition: This field contains the mailing address of the contact person identified in this segment. One of the key components for completing the "circle of care" and provider/institution bonding is the issuance of follow-up correspondence to the referring provider.

11.8.4.4 CTD-4 Contact Location (PL) 01167

Components: <Point of Care (HD)> ^ <Room (HD)> ^ <Bed (HD)> ^ <Facility (HD)> ^ <Location Status (IS)> ^ <Person Location Type (IS)> ^ <Building (HD)> ^ <Floor (HD)> ^ <Location Description (ST)> ^ <Comprehensive Location Identifier (EI)> ^ <Assigning Authority for Location (HD)>

Subcomponents for Point of Care (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Room (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Bed (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Facility (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

```
Subcomponents for Building (HD):  <Namespace ID (IS)> & <Universal ID (ST)> &
          <Universal ID Type (ID)>

Subcomponents for Floor (HD):  <Namespace ID (IS)> & <Universal ID (ST)> & <Universal
          ID Type (ID)>

Subcomponents for Comprehensive Location Identifier (EI):  <Entity Identifier (ST)> &
          <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Authority for Location (HD):  <Namespace ID (IS)> &
          <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: This field contains the location of the contact, which is required when a contact that may be external to a given enterprise must be referenced. For example, if this contact represents the office manager of the referred-to physician, then the contact location should identify the clinic of the physician or provider to whom this referral has been sent. An application and facility identifier carried in the facility field specifies the identification of the contact's location. The application identifier and the facility identifier would be used in the same manner as their corresponding fields in the MSH segment (*MSH-3-Sending application, MSH-5-Receiving application, MSH-4-Sending facility, MSH-6-Receiving facility*). That is, the facility field will contain an application identifier and facility identifier which describe the location of this contact. However, it should be noted that they may describe a different location because the contact location being referenced in this field *may not be* the location from which the message originated, which is being described by the MSH.

11.8.4.5 CTD-5 Contact Communication Information (XTN) 01168

```
Components:  <WITHDRAWN Constituent> ^ <Telecommunication Use Code (ID)> ^
          <Telecommunication Equipment Type (ID)> ^ <Communication Address (ST)> ^
          <Country Code (SNM)> ^ <Area/City Code (SNM)> ^ <Local Number (SNM)> ^
          <Extension (SNM)> ^ <Any Text (ST)> ^ <Extension Prefix (ST)> ^ <Speed
          Dial Code (ST)> ^ <Unformatted Telephone number  (ST)> ^ <Effective Start
          Date (DTM)> ^ <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^
          <Protection Code (CWE)> ^ <Shared Telecommunication Identifier (EI)> ^
          <Preference Order (NM)>

Subcomponents for Expiration Reason (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Protection Code (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
          <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
          of Second Alternate Coding System (ID)> & <Second Alternate Coding System
          Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
          <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
          <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
          <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
          OID (ST)> & <Second Alternate Value Set Version ID (DTM)>

Subcomponents for Shared Telecommunication Identifier (EI):  <Entity Identifier (ST)>
          & <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: This field contains the information, such as the phone number or electronic mail address, used to communicate with the contact person or organization.

11.8.4.6 CTD-6 Preferred Method of Contact (CWE) 00684

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)> ^ <Second Alternate
             Identifier (ST)> ^ <Second Alternate Text (ST)> ^ <Name of Second
             Alternate Coding System (ID)> ^ <Second Alternate Coding System Version ID
             (ST)> ^ <Coding System OID (ST)> ^ <Value Set OID (ST)> ^ <Value Set
             Version ID (DTM)> ^ <Alternate Coding System OID (ST)> ^ <Alternate Value
             Set OID (ST)> ^ <Alternate Value Set Version ID (DTM)> ^ <Second Alternate
             Coding System OID (ST)> ^ <Second Alternate Value Set OID (ST)> ^ <Second
             Alternate Value Set Version ID (DTM)>
```

Definition: This field contains the preferred method to use when communicating with the contact person. Refer to *User-defined Table 0185 - Preferred Method of Contact* in Chapter 2C, "Code Tables", for suggested values.

11.8.4.7 CTD-7 Contact Identifiers (PLN) 01171

```
Components:  <ID Number (ST)> ^ <Type of ID Number (CWE)> ^ <State/other Qualifying
             Information (ST)> ^ <Expiration Date (DT)>

Subcomponents for Type of ID Number (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)> &
             <Second Alternate Identifier (ST)> & <Second Alternate Text (ST)> & <Name
             of Second Alternate Coding System (ID)> & <Second Alternate Coding System
             Version ID (ST)> & <Coding System OID (ST)> & <Value Set OID (ST)> &
             <Value Set Version ID (DTM)> & <Alternate Coding System OID (ST)> &
             <Alternate Value Set OID (ST)> & <Alternate Value Set Version ID (DTM)> &
             <Second Alternate Coding System OID (ST)> & <Second Alternate Value Set
             OID (ST)> & <Second Alternate Value Set Version ID (DTM)>
```

Definition: This repeating field contains the contact's unique identifiers such as UPIN, Medicare and Medicaid numbers. Refer to *User-defined Table 0338 - Practitioner ID Number Type* (see Chapter 2, "Code Tables") for suggested values.

11.9 EXAMPLES

The following examples will demonstrate the proposed way in which the RQI, RQA and REF messages can be used with the I01 (request for insurance information), I08 (request for treatment authorization information), I15 (request patient referral status) and I06 (request/receipt of clinical data listing) event codes. The events are presented in the order in which they would occur in a typical patient encounter. The first event to occur when the patient visits the medical practice is the verification of eligibility/coverage information. Next, the patient will be diagnosed and may be referred to a specialist for further treatment. This procedure may require a request for pre-authorization from the payor, which will be forwarded to the referral provider. Once the referral provider begins treatment, messages regarding the status or outcome of the treatment will be sent to the referring provider. Queries may also be sent to the specialist and reference laboratories.

11.9.1 RQI Message Using an I01 Event with an Immediate Response

When a patient arrives for an appointment, the office staff will frequently need to verify the patient's insurance information. In the following RQI message example, Dr. Hippocrates is sending an insurance information request to the H. C. Payor Insurance Company for his patient, Adam A. Everyman. The response from the payor is shown in a more complete IN1 segment. However, it should be noted that in addition to the IN1 segment, this return information could have been placed in the NTE segment to serve as display data. This strategy would serve a broader community of diverse application systems that might have different levels of ability to process the record-formatted data.

MSH|^~\&|HIPPOCRATESMD|EWHIN|MSC|EWHIN|19940107155043||RQI^I01|HIPPOCRATESMD7888|P|2.8|||NE|AL<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD|1001 HEALTHCARE^DRIVE^ANN ARBOR^MI^99999|
^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATESMD7899<cr>

PRD|RT|HCIC||^^^MSC&EWHIN^^^^^H.C. PAYOR INSURANCE COMPANY<cr>

PID||| HL71001111111111^9^M10||EVERYMAN^ADAM^A||19600309||||||||||444-33-3333<cr>

IN1|1|PPO|HC02|HCIC (MI State Code)|<cr>

MSH|^~\&|MSC|EWHIN|HIPPOCRATESMD|EWHIN|19940107155212||RPI^I01|MSC2112|P|2.8|||ER|ER<cr>

MSA|AA|HIPPOCRATESMD7888|ELIGIBILITY INFORMATION FOUND<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|
^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATESMD7899<cr>

PRD|RT|HCIC||^^^MSC&EWHIN^^^^^H.C. PAYOR INSURANCE COMPANY<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A||19600301||||||||||444-33-333CR>

IN1|1|PPO|HC02|HCIC (MI State Code)|5555 INSURERS CIRCLE ^^ANN ARBOR^MI^99999^USA|CHRISTOPHER CLERK|(855)555-1234|987654321||||19901101||||EVERYMAN^ADAM^A|1|19600309|N. 2222 HOME STREET^^ANN ARBOR^MI^99999^USA|||||||||||||||||444333555||||||01|M<cr>

11.9.2 RQA Message Using an I08 Event with an Immediate Response

When the attending physician decides to refer the patient for treatment to another healthcare provider, pre-authorization may be required by the payor. In the following RQA example, Dr. Blake is requesting the appropriate pre-authorization from H.C Payor Insurance Company for a colonoscopy on Adam Everyman. The request includes the diagnosis, in case it is a factor in the approval decision. As shown below, the immediate response indicates approval of the request that was made on 01/10/94 and that expires on 05/10/94. In actuality, most payors require some human intervention in the pre-authorization process and would probably not respond immediately.

MSH|^~\&|HIPPOCRATESMD|EWHIN|MSC|EWHIN|19940110105307||RQA^I08|HIPPOCRATESMD7898|P|2.8|||NE|AL<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|
^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATESMD7899<cr>

PRD|RT|HIIC||^^^MSC&EWHIN^^^^^H.C.PAYOR INSURANCE COMPANY<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A||19600309||||||||||444-33-3333<cr>

IN1|1|PPO|HC02|HCIC (MI State Code)|5555 INSURERS CIRCLE^^ANN ARBOR^MI^99999^USA|CHRISTOPHER CLERK|(855)555-1234|(555)555-3002||||19901101||||EVERYMAN^ADAM^A|1|19600309|2222 HOME STREET^^ANN ARBOR^MI^99999^USA |||||||||||||||||444333555||||||01|M<cr>

DG1|1|I9|569.0|RECTAL POLYP|19940106103500|0<cr>

PR1|1|C4|45378|Colonoscopy|19940110105309|00<cr>

MSH|^~\&|MSC|EWHIN|HIPPOCRATESMD|EWHIN|19940110154812||RPA^I08|MSC2112|P|2.8|||ER|ER<cr>

MSA|AA|HIPPOCRATESMD7888<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999| ^^^
HIPPOCRATESMD &EWHIN^^^^^HIPPOCRATES MEDICAL CENTER| HIPPOCRATESMD7899<cr>

PRD|RT|HIIC||^^^MSC&EWHIN^^^^^H.C.PAYOR INSURANCE COMPANY<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A||19600301|||||||||| HL71001111111111<cr>

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DG1|1|I9|569.0|RECTAL POLYP|19940106103500|0<cr>

PR1|1|C4|45378|Colonoscopy|19940110105309|00<cr>

AUT|PPO|HC02|HIIC (MI State Code)|19940110|19940510|HL71001111111111|175|1<cr>

11.9.3 RQA Message Using an I08 Event with a Deferred Response

In the following example of a pre-authorization request, the payor indicates his receipt of the request (a standard acknowledgment message), but defers issuing a pre-authorization to a later time. This response represents a more typical payor transaction sequence. Note the use of the "Accept Acknowledgment Type," requiring the receiving system to respond in all cases to receipt of the message.

MSH|^~\&|HIPPOCRATESMD|EWHIN|MSC|EWHIN|19940110105307||RQA^I08|HIPPOCRATES7898|P|2.8|||AL|AL<cr>

PRD|RP| HIPPOCRATES^HAROLD ^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^HIPOOCRATES&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATESM7899<cr>

PRD|RT|HIIC||^^^MSC&EWHIN^^^^^H.C.PAYOR INSURANCE COMPANY<cr>

PID||| HL71001111111111^9^M10||EVERYMAN^ADAM^A||19600301|||||||||||| HL71001111111111<cr>

IN1|1|PPO|HC02|HCIC (MI State Code)|5555 INSURERS CIRCLE^^ANN ARBOR^MI^99999^USA|CHRISTOPHER CLERK|(855)555-1234|(555)555-3002||||19901101||||EVERYMAN^ADAM^A|1|19600309|2222 HOME STREET^^ANN ARBOR^MI^99999^USA||||||||||||||||444555333||||||01|M<cr>

PR1|1|C4|45378|Colonoscopy|19940110105309|00<cr>

MSH|^~\&|MSC|EWHIN|HIPPOCRATESMD|EWHIN|1994011015315||MCF|MSC2112|P|2.8|||ER|ER<cr>

MSA|AA|HIPPOCRATES7888<cr>

MSH|^~\&|MSC|EWHIN|HIPPOCRATESMD|EWHIN|19940111102304||RPA^I08|MSC2113|P|2.8|||ER|ER<cr>

MSA|AA|HIPPOCRATESM7888<cr>

PRD|RP| HIPPOCRATES^HAROLD ^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^HIPOOCRATES&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATESM7899<cr><cr>

PRD|RT|WSIC||^^^MSC&EWHIN^^^^^H.C.PAYOR INSURANCE COMPANY<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A ||19600301|||||||||||| HL71001111111111<cr>

IN1|1|PPO|HC02|HCIC (MI State Code)|5555 INSURERS CIRCLE^^ANN ARBOR^MI^99999^USA|CHRISTOPHER CLERK|(855)555-1234|(555)555-3002||||19901101||||EVERYMAN^ADAM^A|1|19600309|2222 HOME STREET^^ANN ARBOR^MI^99999^USA||||||||||||||||444555333||||||01|M<cr>

PR1|1|C4|45378|Colonoscopy|19940110105309|00<cr>

AUT|PPO|HC02|HIIC (MI State Code)|19940110|19940510|HL71001111111111|175|1<cr>

11.9.4 REF Message Using an I11 Event with an Immediate Response

Once pre-authorization has been received, the patient is referred to the referral provider. In the following example, Dr. Hippocrates is referring Adam Everyman to Dr. Tony Tum for a colonoscopy. The referral message includes the patient's demographic information, diagnosis and the pre-authorization information retrieved during the previous transaction. The dates contained in the pre-authorization segment (e.g., authorization date and authorization expiration date) pertain to the authorization, given by a payor, for a specified procedure. They are not intended to imply any kind of schedule request. Scheduling will be handled by the referral provider and the patient in a separate transaction. Not all referrals will require a detailed chain of response messages, so in this case, a simple acknowledgment in the form of an RPI is returned with a note from the referred-to provider.

MSH|^~\&|HIPPOCRATESMD|EWHIN|TUM|EWHIN|19940111113142||REF^I11|HIPPOCRATESM7899|P|2.8|||NE|AL<cr>

RF1||R|MED|RP|O|REF4502|19940111|19940510|19940111<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATES7899<cr>

CTD|PR|ENTER^ELLEN|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999^USA^|^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER<cr>

PRD|RT|TUM^TONY^^^DR||^^^JIME&EWHIN^^^^^TUM AND TUMOR|||531886<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A ||19600309|M||C|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|SPO|(555)555-2004|ENGL|M|M||HL71001111111111EVERYMAN*3-444-555^MI<cr>

NK1|1|EVERYMAN^BETTERHALF^W|2|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|(555)555-2004<cr>

GT1|1||EVERYMAN^ADAM^A||2222 HOME STREET^^ANN ARBOR^MI^99999^USA|(555)4555-2004|(555)555-2004|19600309|M||1|402941703||||CONTACT*CARRIE|||456789|01<cr>

IN1|1|PPO|HC02|HCIC (MI State Code)|5555 INSURERS CIRCLE^^ANN ARBOR^MI^99999^USA|CHRISTOPHER CLERK|(855)555-1234|(555)555-3002||||19901101||||EVERYMAN^ADAM^A|1|19600309|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|||||||||||||||||444555333||||||01|M<cr>

ACC|19940105125700|WR|ENTER*ELLEN<<cr>

DG1|1|I9|569.0|RECTAL POLYP|19940106103500|0<cr>

PR1|1|C4|45378|Colonoscopy|19940110105309|00<cr>

AUT|PPO|WA02|HCIC (MI State Code)|19940110|19940510|123456789|175|1<cr>

MSH|^~\&|TUM|EWHIN|HIPPOCRATESMD|EWHIN|19940111152401||RRI^I11|TUM1123|P|2.8|||ER|ER<cr>

MSA|AA|TUMM7900<cr>

RF1|A|R|MED|RP|O|REF4502|19940111|19940510|19940111<cr>

PRD|RP|TUM^TONY^^^DR^MD|1031 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^TUMMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|TUMMT7900<cr>

CTD|PR|ENTER^ELLEN|1021 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^TUMTMD&EWHIN^^^^^TUM MEDICAL CENTER<cr>

PRD|RT|TUM^TONY^^^DR||^^^TUM&EWHIN^^^^^TUM AND TUMOR|||531886<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A ||19600309|M||C|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|SPO|(555)555-2004|ENGL|M|M||HL71001111111111EVERYMAN*3-444-555^MI<cr>

DG1|1|I9|569.0|RECTAL POLYP|19940106103500|0<cr>

PR1|1|C4|45378|Colonoscopy|19940111141509|00<cr>

NTE|||Patient is doing well.~Full recovery expected.<cr>

11.9.5 REF Message Using an I11 Event with a Deferred Response

The following example demonstrates the ability of the referral provider to return a series of responses. For most referrals, multiple responses will be returned because referrals may contain multiple requested procedures that may be performed over a period of time. The referral provider determines the completion of this chain of messages and indicates that designation in the following example by setting the "Processed" flag in the MSA segment. This procedure will probably vary from network to network.

MSH|^~\&|TUMMD|EWHIN|HIPPOCRATESMD|EWHIN|19940111113142||REF^I11|TUMMM7899|P|2.8|||AL|AL<cr>

RF1||R|MED|RP|O|REF4502|19940111|19940510|19940111<cr>

PRD|RP|TUM^TONY^^^DR^MD|1031 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^TUMMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|TUMMT7900<cr>

CTD|PR|ENTER^ELLEN|1021 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^TUMTMD&EWHIN^^^^^TUM MEDICAL CENTER<cr>

PRD|RT|TUM^TONY^^^DR||^^^TUM&EWHIN^^^^^TUM AND TUMOR||||531886<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A ||19600309|M||C|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|SPO|(555)555-2004|ENGL|M|M||HL71001111111111EVERYMAN*3-444-555^MI<cr>

NK1|1|EVERYMAN^BETTERHALF^W|2|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|(555)555-2004<cr>

GT1|1||EVERYMAN^ADAM^A||2222 HOME STREET^^ANN ARBOR^MI^99999^USA|(555)4555-2004|(555)555-2004|19600309|M||1|402941703||||CONTACT*CARRIE|||456789|01<cr>

IN1|1|PPO|HC02|HCIC (MI State Code)|5555 INSURERS CIRCLE^^ANN ARBOR^MI^99999^USA|CHRISTOPHER CLERK|(855)555-1234|(555)555-3002||||19901101||||EVERYMAN^ADAM^A|1|19600309|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|||||||||||||||||444555333||||||01|M<cr>

ACC|19940105125700|WR|ENTER*ELLEN<cr>

DG1|1|I9|569.0|RECTAL POLYP|19940106103500|0<cr>

PR1|1|C4|45378|Colonoscopy|19940110105309|00<cr>

AUT|PPO|HC02|HCIC (MI State Code)|19940110|19940510|123456789|175|1<cr>

MSH|^~\&|TUMMD|EWHIN|HIPPOCRATESMD|EWHIN|19940111154812||MCF|TUMT1123|P|2.8|||ER|ER<cr>

MSA|AA|TUMM7899<cr>

MSH|^~\&|TUM|EWHIN|HIPPOCRATESMD|EWHIN|19940112152401||RRI^I11|TUMTE1124|P|2.8|||ER|ER<cr>

MSA|AA|HIPPOCRATESM7899<cr>

RF1|A|R|MED|RP|O|REF4502|19940111|19940510|19940111<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATESM7899<cr>

CTD|PR|ENTER^ELLEN|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER<cr>

PRD|RP|TUM^TONY^^^DR^MD|1031 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|^^^TUMMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|TUMMT7900<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A ||19600309|M||C|2222 HOME STREET^^ANN ARBOR^MI^99999^USA|SPO|(555)555-2004|ENGL|M|M||HL71001111111111EVERYMAN*3-444-555^MI<cr>

DG1|1|I9|569.0|RECTAL POLYP|19940106103500|0<cr>

PR1|1|C4|45378|Colonoscopy|19940111141509|00<cr>

NTE|||Patient is doing well.~Full recovery expected.<cr>

11.9.6 RQC Inquiry Message Using an I05 Event with an Immediate Response

Retained for backwards compatibility only in version 2.4 and later; refer to Chapter 5 section 5.4, "Query Response Message Pairs." The original mode query and the QRD/QRF segments have been replaced.

In this example, Dr. Hippocrates is querying a reference laboratory for the results of all lab work performed on Adam Everyman between the dates of 03/20/94 and 03/22/94 and requests that the data be returned in a record or data element format. The message request contains all of the patient identification, as well as the provider identification necessary for the responding facility to qualify the request.

MSH|^~\&|HIPPOCRATESMD|EWHIN|HL7_LAB|EWHIN|19940410113142||RQC^I05|HIPPOCRATES7899|P|2.8|||NE|AL<cr>

QRD|19940504144501|R|I|HIPPOCRATES7899|||5^RD|PATIENT|RES|ALL<cr>

QRF|HL7_LAB^EWHIN|19940320000000|19940322235959<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD|1001 HEALTHCARE DRIVE^^ANN ARBOR^MI^99999|
^^^HIPPOCRATESMD&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER|HIPPOCRATES7899<cr>

CTD|PR|ENTER^ELLEN|1001 HEALTHCARE DRIVE^^ANN
ARBOR^MI^99999|^^^HIPPOCRATES&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER<cr>

PRD|RT|HL7AB^HEALTH LEVEL LAB||^^^HL7_LAB&EWHIN^^^^^HEALTH LEVEL LABORATORIES<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A ||19600309|M||C|2222 HOME STREET^^ANN
ARBOR^MI^99999^USA|SPO|(555)555-2004|ENGL|M|M||HL71001111111111EVERYMAN*3-444-
555^MI<cr>

MSH|^~\&|HL7_LAB|EWHIN|HIPPOCRATESMD|EWHIN|19940411152401||RPI^I05|HL7LAB4250|P|2.8|||ER|ER
<cr>

MSA|AA|HIPPOCARATES7899<cr>

QRD|19940504144501|R|I|HIPPOCRATES7899|||5^RD|PATIENT|RES|ALL<cr>

QRF|HL7_LAB^EWHIN|19940320000000|19940322235959<cr>

PRD|RP|HIPPOCRATES^HAROLD^^^DR^MD||1001 HEALTHCARE DRIVE^^ANN
ARBOR^MI^99999|^^^HIPPOCRATES&EWHIN^^^^^HIPPOCRATES MEDICAL
CENTER|HIPPOCRATES7899<cr>

CTD|PR|ENTER^ELLEN|1001 HEALTHCARE DRIVE^^ANN
ARBOR^MI^99999|^^^HIPPOCRATES&EWHIN^^^^^HIPPOCRATES MEDICAL CENTER<cr>

PRD|RT|HL7LAB^HEALTH LEVEL LAB||^^^HL7_LAB&EWHIN^^^^^HEALTH LEVELLABORATORIES<cr>

PID|||HL71001111111111^9^M10||EVERYMAN^ADAM^A ||19600309|M||C|2222 HOME STREET^^ANN
ARBOR^MI^99999^USA|SPO|(555)555-2004|ENGL|M|M||HL71001111111111EVERYMAN*3-444-
555^MI<cr>

OBR|1||1045813^LAB|L1505.003^COMPLETE BLOOD COUNT (D)|||19940320104700|""|1^EA||||
|19940320112400||CARMI||||||19940320104955|||F<cr>

OBX|1|ST|L1550.000^HEMOGLOBIN, AUTO HEME||11.6|g/dl|12.0-16.0|L|||F<cr>

OBX|2|ST|L1551.003^HEMATOCRIT (D)||36.4|%|36-45||||F<cr>

OBX|3|ST|L1552.000^RBC, AUTO HEME||3.94|mil/ul|4.1-5.1|L|||F<cr>

OBX|4|ST|L1553.000^MCV, AUTO HEME||92.4|fl|80-100||||F<cr>

OBX|5|ST|L1554.000^MCH, AUTO HEME||29.3|pg|26-34||||F<cr>

OBX|6|ST|L1555.000^MCHC, AUTO HEME||31.8|g/dl|31-37||||F<cr>

OBX|7|ST|L1557.000^RBC DISTRIBUTION WIDTH||15.3|%|0-14.8|H|||F<cr>

OBX|8|ST|L1558.003^PLATELET COUNT (D)||279|th/ul|140-440||||F<cr>

OBX|9|ST|L1559.000^WBC, AUTO HEME||7.9|th/ul|4.5-11.0||||F<cr>

OBX|10|ST|L1561.100^NEUTROPHILS, % AUTO||73.8|%|||||F<cr>

OBX|11|ST|L1561.510^LYMPHOCYTES, % AUTO||16.6|%|||||F<cr>

OBX|12|ST|L1562.010^MONOCYTES, % AUTO||7.3|%|||||F<cr>

OBX|13|ST|L1563.010^EOSINOPHILS, % AUTO||1.7|%|||||F<cr>

OBX|14|ST|L1564.010^BASOPHILS, % AUTO||0.7|%|||||F<cr>

OBX|15|ST|L1565.010^NEUTROPHILS, ABS AUTO||5.8|th/ul|1.8-7.7||||F<cr>

OBX|16|ST|L1566.010^LYMPHOCYTES, ABS AUTO||1.3|th/ul|1.0-4.8||||F<cr>

OBX|17|ST|L1567.010^MONOYCYTES, ABS AUTO||0.6|th/ul|0.1-0.8||||F<cr>

OBX|18|ST|L1568.010^EOSINOPHILS, ABS AUTO||0.1|th/ul|0-0.7||||F<cr>

OBX|19|ST|L1569.000^BASOPHILS, ABS AUTO||0.1|th/ul|0-0.2||||F<cr>

OBX|20|ST|L2110.003^PROTHROMBIN TIME (D)||30.7|sec|11.1-14.0|HH|||F<cr>

NTE|1|L|COAGULATION CRITICAL VALUES CALLED TO VICKIE QUASCHNICK~AT 1130 BY VON~Therapeutic Ranges(oral anticoagulant):~Most clinical situations: 16.1 - 21.1 sec -~ (1.3 - 1.7 times the mean of the normal range)~Mech heart valve, recurrent embolism: 18.6 - 23.6 sec -~ (1.5 - 1.9 times the mean of the normal range)<cr>

OBX|21|ST|L2110.500^INR||5.95||||||F<cr>

NTE|1|L|Therapeutic Range (oral anticoagulant):~ Most clinical situations: 2.0 - 3.0~ Mech heart valve, recurrent embolism: 3.0 - 4.0<cr>

OBX|22|ST|L3110.003^SODIUM (D)||141|mmol/l|135-146||||F<cr>

OBX|23|ST|L3111.003^POTASSIUM (D)||3.8|mmol/l|3.5-5.1||||F<cr>

OBX|24|ST|L3112.003^CHLORIDE (D)||111|mmol/l|98-108|H|||F<cr>

OBX|25|ST|L3113.003^CO2 (TOTAL) (D)||23.7|mmol/l|23-30||||F<cr>

OBX|26|ST|L3114.000^ANION GAP||6||7-17|L|||F<cr>

OBX|27|ST|L3120.003^CREATININE (D)||1.4|mg/dl|0.5-1.2|H|||F<cr>

OBX|28|ST|L3121.003^UREA NITROGEN (D)||24|mg/dl|7-25||||F<cr>

OBX|29|ST|L3123.003^GLUCOSE (D)||123|mg/dl|65-115|H|||F<cr>

OBX|30|ST|L3126.003^CALCIUM (D)||8.7|mg/dl|8.4-10.2||||F<cr>

OBR|2||1045825^LAB|L2560.000^BLOOD GAS, ARTERIAL (R)|||19940320105800|""|1^EA|||||19940320105800||CARMI||||||19940320105844|||F<cr>

OBX|1|ST|L2565.000^PH, ARTERIAL BLD GAS (R)||7.46||7.35-7.45|H|||F<cr>

OBX|2|ST|L2566.000^PCO2, ARTERIAL BLOOD GAS||28|mm/Hg|35-45|LL|||F<cr>

NTE|1|L|BLOOD GAS ANALYSIS CRITICAL VALUE(S) CALLED TO~DR. CARLSON.<cr>

OBX|3|ST|L2567.000^PO2, ARTERIAL BLOOD GAS||83|mm/Hg|80-100||||F<cr>

OBX|4|ST|L2568.000^O2 SAT, ART BLD GAS (R)||96|%|95-99||||F<cr>

OBX|5|ST|L2569.000^BASE EX, ARTERIAL BLD GAS||-2.1|mEq/l|-2.0-2.0|L|||F<cr>

OBX|6|ST|L2570.000^HCO3, ARTERIAL BLD GAS||19.4|mEq/l|22-26|L|||F<cr>

OBX|7|ST|L2571.000^PATIENT TEMP, ABG||96.2|deg F|||||F<cr>

OBX|8|ST|L2572.000^MODE, ABG||ROOM AIR||||||F<cr>

OBR|3||1045812^LAB|L2310.003^URINALYSISD)|||19940320121800|""|1^EA||||19940320121800||CARMI||||||19940320104953|||F<cr>

OBX|1|ST|L2320.303^SPECIFIC GRAVITY, UR (D)||1.015||1.002-1.030||||F<cr>

OBX|2|ST|L2320.403^PH, UR (D)||7.0||5.0-7.5||||F<cr>

OBX|3|ST|L2320.503^PROTEIN, QUAL, UR (D)||NEG|mg/dl|||||F<cr>

OBX|4|ST|L2320.703^GLUCOSE, QUAL, UR (D)||0|mg/dl|0-30||||F<cr>

OBX|5|ST|L2320.803^KETONES, UR (D)||NEG|mg/dl|||||F<cr>

OBX|6|ST|L2320.903^OCCULT BLOOD, UR (D)||SMALL|||A|||F<cr>

OBX|7|ST|L2321.003^BILIRUBIN, UR (D)||NEG||||||F<cr>

OBX|8|ST|L2321.100^LEUKOCYTES, UR||MOD|||A|||F<cr>

OBX|9|ST|L2321.200^NITRITES, UR||NEG||||||F<cr>

OBX|10|ST|L2321.300^UROBILINOGEN, UR||NEG||||||F<cr>

OBX|11|ST|L2342.000^MICRO SPUN VOLUME, UR||8|ml|8-8||||F<cr>

OBX|12|ST|L2350.003^RBC, UR (D)||5-10|/hpf|||||F<cr>

OBX|13|ST|L2350.100^WBC, UR||>100|/hpf|||||F<cr>

OBX|14|ST|L2350.200^EPITHELIAL CELLS, UR||2+||||||F<cr>

OBX|15|ST|L2350.300^BACTERIA, UR||2+|||A|||F<cr>

11.10 OUTSTANDING ISSUES

11.10.1 HL7 Overlapping With ASC X12N

There have been discussions regarding overlap of the proposed Patient Referral Chapter with recent development efforts by a committee within the ASC X12N organization. In the Healthcare Task Group (Task Group 2) of the ASC X12N Insurance Subcommittee, the Services Review Working Group (Working Group 10) has been working on a referral transaction (Transaction 278). This transaction has been designed from a payor perspective by focusing on *certification* of a referral or *notification* that a referral took place. This focus deals primarily with the financial or reimbursement side of a referral. There are some similarities between the two messages. However, there are also some clear differences. For example, the ASC X12 transaction does not provide for provider-to-provider referrals containing clinical data. Referrals containing a patient's clinical record along with diagnoses and requested procedures are the major focus of the work being done by HL7. In an effort to alleviate some of the controversy that this issue has caused, sections of this HL7 Patient Referral chapter have been removed. These sections dealt primarily with eligibility and plan coverage information. That information will be specifically handled by ASC X12N transactions 271 and 272, and the new interactive transactions.

There are some convergence activities currently in progress. The HL7 - X12 Joint Coordinating Committee has been formed to facilitate efforts to unify these two standard development organizations as well as others. Work is in progress to harmonize HL7 trigger events within X12N transactions, as well as in joint data modeling. There has also been some work done at the working group level to harmonize the common data segments of the two respective referral messages. There is ongoing participation by both HL7 committees and X12N work groups to achieve a certain level of data compatibility.

The HL7 Board of Directors has directed HL7 to continue development of the Patient Referral Chapter for the following reasons:

The HL7 - X12 coordination is ongoing, but will not be complete in time for Standard Version 2.7.

The HL7 Patient Referral Chapter addresses business needs that the X12 transaction does not (e.g., transmission of codified clinical data).