Health Statistics

Tennessee Department of Health

Hospital Discharge Data System

User Manual

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Hospital Discharge Data System
User Manual

STATE OF TENNESSEE
Department of Health
Office of Policy Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 4th Floor
425 Fifth Avenue North
Nashville, TN 37247-5262
615-741-1954

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SECTION I

Introduction

Background

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

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

Tennessee law (Tennessee Code Annotated (T.C.A.), Section 68-1-108), prior to July 1994 required insurance companies to submit UB-92 claims data to the Department of Health. However, in July 1994, the law was revised and T.C.A., Section 68-1-108 now requires each licensed hospital to report all claims data found on the UB-92 form or a successor form on every inpatient and outpatient discharge to the commissioner of health. Also, after receiving the claims data, the commissioner shall promptly make such data available for review and copying by the Tennessee Hospital Association (THA).

Hospital Discharge Data System

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

As required by Tennessee law, all hospitals licensed by the Tennessee Department of Health (TDH) report patient-level discharge information to the Department. Discharges from rehabilitation hospitals, from rehabilitation and psychiatric units within acute care hospitals, and from free-standing ambulatory surgical treatment centers that are part of a hospital, should all be reported if they are from a TDH licensed hospital and meet the requirements for “Reportable Records” as defined in Section II, page 13. Discharges for charity or free care are included in the reporting requirement and they are handled similarly.

Since there already exists a strong emphasis on the UB-92 form as a common, uniform billing form for Tennessee hospitals, it was quite logical to predicate this new data system on the UB-92 form. Therefore, this system has been developed in accordance with UB-92 definitions, layouts and standards. In addition to the UB-92 format, an effort has also been made to define commonly used health claim data items into the standard UB-92 coding structure for those health care facilities whose data systems contain the information being requested, but such information is not organized according to UB-92 definitions and standards.

Reporting Requirements

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

1) Hospitals (non-HIN) or their designated data vendor create data files in the UB-92 format with standard codes and submit them to the Tennessee Department of Health's Hospital Discharge Data System staff. Allowable data submission media are described in Section II of this manual.

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

For data submission 1) above, the Department will coordinate quality control procedures and communicate with the hospitals in order to improve data quality.

For data submission 2) the THA-HIN vendor will be responsible for all data quality processes and procedures used to finalize data for their client hospitals each quarter provided the data submitted by the vendor to the Department does not exceed the allowed error margins.

For discharges occurring during 2005 and subsequent years, the following discharge records are required:

- All inpatient records.

- All emergency room records. These are defined as having a revenue code in the range of 0450 through 0459 in any revenue code field.

- All outpatient observation records. These are defined as having a revenue code of 0760, 0762, or 0769 in any revenue code field. (These are also known as twenty-three hour observation records).

- All ambulatory surgery records. These are defined as having a procedure code in the range 00.01 through 86.99. These records should be reported for the specified procedure codes whether found in the Principal Procedure Code field or in any of the Other Procedure Code fields.

- Selected Diagnostic Services discharges. These discharges include five diagnostic services that require certificate of need (CON) approval. This new requirement in 2005 adds outpatient discharges with several new bill types to the reporting requirement. However, the

submission of discharges with these newly added bill types only apply to the reporting of these five selected diagnostic services.

Bill type 12X indicates "Hospital Inpatient – Medicare Part B"; bill type 14X indicates "Hospital – other (for hospital referenced diagnostic services)"; and bill type 7XX indicates services provided by hospital clinics. If records with these bill types or any other previously required record includes the following diagnostic services (as defined by revenue codes), this discharge is required effective with January 1, 2005 discharges.

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

See Section II for additional details on reporting requirements.

Changes to the Manual Since Last Version

This manual incorporates all clarifications and changes implemented since the 2001 manual was published. Principal changes to the 2005 manual:

The reporting requirements have changed.

- Selected Diagnostic Services have been added to the list of required reporting for 2005.
- The range for ambulatory surgery ICD-9 procedure codes has been expanded for 2005. (The lower limit is now 00.01, to allow for several new procedures with codes less than 01.01 to be reported.)
- The Payer Classification Code has been updated. The use of detail codes has been discontinued. See pages 42 – 44 for the current code structure for Payer fields. See pages 111-114 for older codes.

Entirely new codes have been provided for Patient Relationship to Insured and several new codes have been added to Patient Status.

- The codes used for Patient Relationship to Insured changed dramatically effective October 16, 2003. See pages 54 - 55 for the current code structure for these fields. See pages 115 - 116 for the older codes.
- Patient Status codes 10, 71 and 72 were discontinued; codes 43 and 64 were added. See page 34 for the current code structure for patient status. See page 117 for the older codes.

SECTION II

Data System Summary

Data Set Name: Hospital Discharge Data System (HDDS)

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

Contact Person(s): George Wade (615) 532-7883 or Glenn Baker (615) 532-7861

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

Restrictions on Data Use: Confidential data is restricted and is not released or sold to the public. Non-confidential data can be sold to the public for research and commercial use.

Process for Accessing Data: Requests for data are handled by Statistical Services. Contact Tom Spillman at (615) 741-4861.

Description:
Method of Data Collection: UB-92 forms
Percent Return: 95% - 99%
Frequency of Updating: Annually
Years of Data: 1995 to present (1995 - 2002 final data)

Types of Data Output Available: Fixed format text files on CD-ROM or 3480 tape cartridge

Cost for Data Output: Yes

Standard Reports Generated: None currently

Current Data Elements*:

Patient Control Number
Type of Bill
Federal Tax Number
Federal Tax Sub ID Number
Statement Covers Period
State of Patient
City of Patient
Zip Code of Patient
Birth Date of Patient
Sex of Patient
Admission Date
Type of Admission
Source of Admission
Status of Patient
Medical/Health Record Number
Revenue Codes
Units of Service
Service Date(s)
Total Charges by Revenue Code Category
Classification of Payer(s)
Provider Number(s)
Patient's Relationship to Insured(s)
Certificate/SSN/Health Insurance Claim/ID Number
Insurance Group Number(s)

* Previous years may vary.

Current Data Elements* (continued):

Employment Status Code
Name of Insured's Employer
Zip Code of Insured's Employer
Principal Diagnosis Code
Other Diagnosis Codes
External Cause of Injury Code (E-Code)
Principal Procedure Code
Principal Procedure Date
Other Procedure Codes and Dates
Attending Physician ID Number
Other Physician(s) ID Number
Social Security Number of Patient
Race/Ethnicity of Patient

* Previous years may vary

Timing and Frequency of Data Submission

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

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

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

Data reported directly to the Department should be sent to:

Hospital Discharge Data System
Division of Health Statistics
Cordell Hull Building
425 5th Avenue North, 4th Floor
Nashville, Tennessee 37247-5262

Format for Data Submission

Data Submission Media

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

- PC Compatible CD-ROM
- PC Compatible 3.5 Inch Diskette,
- ASCII - File E-Mail Attachment
- IBM Mainframe Cartridge 3480

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

All CD-ROM's, diskettes, and cartridges must contain an external label including the hospital name, address, number of records; block size (if cartridge), and the reporting time frame for the data (i.e., 4th quarter, 2001). Data sent via e-mail attachment must contain this information in the e-mail.

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

Data Submission Forms:

Reporting Method Form: This form tells how data will be reported to the HDDS each quarter. This form is required for hospitals reporting directly to HDDS. A copy of the form is in Section IV.3.2.

Transmittal Information Form: This form is required for hospitals reporting directly to the HDDS and must be included with each data submission. A copy of the form is in Section IV.3.1.

Any respondents with non-UB-92 standard computerized data systems or any other special problems or circumstances should check with the HDDS staff in advance of data reporting.

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

HDDS Contacts

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

George Wade
Program Director, Hospital Discharge Data System
Division of Health Statistics
(615) 532-7883

or

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

Other Information

UB-92 Billing Contact

Additional information on the use of the UB-92 billing form in Tennessee as well as the Tennessee Uniform Billing Guide UB-92 manual can be obtained by contacting:

David McClure
Director of Finance
Tennessee Hospital Association
500 Interstate Blvd. South
Nashville, Tennessee 37210
(615) 256-8240

There is a charge for this publication. The Tennessee Uniform Billing Guide UB-92 is not necessary, however, for data reporting. Tennessee's UB-92 format follows the national standard.

Reportable Records

For discharges occurring during 2005 and subsequent years, reporting of the following records is required:

- All inpatient records.

- All emergency room records. These are defined as having a revenue code in the range of 0450 through 0459 in any revenue code field.

- All outpatient observation records. These are defined as having a revenue code of 0760, 0762, or 0769 in any revenue code field. (These are also known as twenty-three hour observation records.)

- All ambulatory surgery records. These are defined as having a procedure code in the range 00.01 through 86.99. These records should be reported for the specified procedure codes whether found in the Principal Procedure Code field or in any of the Other Procedure Code fields.

- Selected Diagnostic Service records. These records require several new outpatient bill types (12X, 14X and 7XX) in addition to any discharges that would have met the previous definition for required reporting. However, the submission of discharges with these newly added bill types only apply to the reporting of five new selected diagnostic services.

  Bill type 12X indicates "Hospital Inpatient – Medicare Part B"; bill type 14X indicates "Hospital – other (for hospital referenced diagnostic services)"; and bill type 7XX indicates services provided by hospital clinics. If records with these bill types or any

other previously required record includes the following diagnostic services (as defined by revenue codes), this discharge is required effective with January 1, 2005 discharges.

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

Special Reporting Requirements

- Newborn admissions should generate a separate record from that of the mother, even for normal well newborns. The appropriate codes are admission type "4", admission source "1", "4" or "9" and the appropriate primary diagnosis code.

- For any bill of two or more pages, submit a separate electronic record for each page. The total charge for the bill (denoted by revenue code 0001 should be the last charge on the last record for that bill.

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

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

- Charity/free discharges are required to be reported. Like other discharges, the physician ID number(s) reported on these records should be the ID number for the physician(s) who attended the patient while in the hospital. Physician ID numbers are required for the attending physician and other physicians involved in the management of the patient's medical care. The physician's UPIN is preferred. If the physician has no UPIN, the state license number may be substituted.

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

- Satellite hospitals licensed under a parent facility must file separate UB-92 claims data from the parent hospital. The UB-92 data for a parent and its satellite can be submitted together as long as the records from each facility are in separate files and identified separately.

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

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

Data Editing and Quality Control

The Hospital Discharge Data System staff will review and edit data submitted directly to the Department. If errors or inconsistencies are identified when UB-92 data are edited, the Hospital Discharge Data System staff will report the errors to the appropriate hospital in writing. The hospital will be asked to investigate these errors and to supply correct information **within 15 working days** of the date that the error is reported to the hospital.

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

Default Values

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

SECTION III

Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type **N:** Numeric **A:** Alpha-Numeric	UB-92 Form Locator*	Page No.
1	Patient Control Number	A	Form Locator 3	20
2	Type of Bill	N	Form Locator 4	21
3	Federal Tax Number	A	Form Locator 5	22
4	Federal Tax Sub ID Number	A	Form Locator 5	23
5	Statement Covers Period	N	Form Locator 6	24
6	Patient's Address: State	A	Form Locator 13	25
7	Patient's Address: City	A	Form Locator 13	26
8	Patient's Address: Zip Code	A	Form Locator 13	27
9	Patient's Date of Birth	N	Form Locator 14	28
10	Patient's Sex	A	Form Locator 15	29
11	Admission Date	N	Form Locator 17	30
12	Type of Admission	A	Form Locator 19	31
13	Source of Admission	A	Form Locator 20	32
14	Patient Status	N	Form Locator 22	34
15	Medical/Health Record Number	A	Form Locator 23	35
16 - 38	Revenue Codes	N	Form Locator 42	36
39 - 61	Service Date(s)	N	Form Locator 45	38
62 - 84	Unit(s) of Service	N	Form Locator 46	39
85 - 107	Total Charges (By Revenue Code Category)	N	Form Locator 47	40
108	Payer Classification-Primary	A	Form Locator 50A	42
109	Payer Classification-Secondary	A	Form Locator 50B	45
110	Payer Classification-Tertiary	A	Form Locator 50C	48
111	Provider Number-Primary	A	Form Locator 51A	51

Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type **N**: Numeric **A**: Alpha-Numeric	UB-92 Form Locator*	Page No.
112	Provider Number-Secondary	A	Form Locator 51B	52
113	Provider Number-Tertiary	A	Form Locator 51C	53
114	Patient's Relationship to Insured-Primary	A	Form Locator 59A	54
115	Patient's Relationship to Insured-Secondary	A	Form Locator 59B	56
116	Patient's Relationship to Insured-Tertiary	A	Form Locator 59C	58
117	Certificate/SSN/Health Insurance Claim/ID Number-Primary	A	Form Locator 60A	60
118	Certificate/SSN/Health Insurance Claim/ID Number-Secondary	A	Form Locator 60B	61
119	Certificate/SSN/Health Insurance Claim/ID Number-Tertiary	A	Form Locator 60C	62
120	Insurance Group Number-Primary	A	Form Locator 62A	63
121	Insurance Group Number-Secondary	A	Form Locator 62B	64
122	Insurance Group Number-Tertiary	A	Form Locator 62C	65
123	Employment Status Code	A	Form Locator 64A	66
124	Name of the Insured's Employer	A	Form Locator 65A	67
125	Zip Code of the Insured's Employer	A	Form Locator 66A	68
126	Principal Diagnosis Code	A	Form Locator 67	69
127 – 134	Other Diagnosis Codes	A	Form Locator 68-75	70

Required Data Elements and Codebook Definitions

Field No.	Field Description	Field Type **N:** Numeric **A:** Alpha-Numeric	UB-92 Form Locator*	Page No.
135	External Cause Of Injury Code (E Code)	A	Form Locator 77	72
136	Principal Procedure Code	A	Form Locator 80	74
137	Principal Procedure Date	N	Form Locator 80	75
138-142	Other Procedure Codes	A	Form Locator 81	76
143-147	Other Procedure Dates	N	Form Locator 81	77
148	Attending Physician ID Number	A	Form Locator 82	78
149	First Other Physician ID Number	A	Form Locator 83	79
150	Second Other Physician ID Number	A	Form Locator 83	80
151	Medicaid Provider Number	A	--	81
152	Medicare Provider Number	A	--	82
153	Patient's Social Security Number	A	--	83
154	Patient's Race/Ethnicity	N	--	84

* A number that specifies the location of the data field on the paper UB-92 form.

Data Dictionary

Field No.	Field Description
1	Patient Control Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	20	1-20	Left Justified	Yes	3

Description:
Patient's unique identification number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

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

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

Data Dictionary

Field No.	Field Description
2	Type of Bill

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	3	21-23	Right Justified	Yes	4

Description:
A three-digit code indicating the specific type of facility, bill classification, and the frequency of billing.

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

Valid Values:

First Digit: Type of Facility	Second Digit: Inpatient or Outpatient	Third Digit: Frequency of Bill
1 = Hospital 4 = Christian Science Hospital 8 = Special Facility	1 = Inpatient 3 = Outpatient or Ambulatory Surgery Center 4 = Outpatient – Other (Observation) 5 = Critical Access Hospital	0 = Nonpayment 1 = Admission through Discharge Claim 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 5 = Late Charge(s) – Only Claim 6 = Adjustment of Prior Claim 7 = Replacement of Prior Claim 8 = Void/Cancel of Prior Claim 9 = Reserved for National Assignment

Example: 111 = Hospital, Inpatient, Admission through Discharge Claim

Comments:
The discharge date is not included on the UB-92 form. The Type of Bill and the Statement Covers Period data elements are used to determine the discharge date.

Three special outpatient bill types (12X, 14X and 7XX) are used only to report records indicating the use of selected diagnostic services. See Selected Diagnostic Service records under Reportable Records (page 13-14).

Data Dictionary

Field No.	Field Description
3	Federal Tax Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	10	24-33	Left Justified	Yes	5

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

The format for the data is: AA-AAAAAAA.

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

Data Dictionary

Field No.	Field Description
4	Federal Tax Sub ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	4	1264-1267	Left Justified	Yes	5

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

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

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

Data Dictionary

Field No.	Field Description
5	Statement Covers Period

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	16	34-49	Right Justified	Yes	6

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

If this is an interim bill (denoted by a "2" or "3" in the third digit of Type of Bill), the ending date would not be considered the discharge date. An individual may receive several interim bills before they are discharged. Interim bills should be held until they can be combined and submitted as a final bill. See Special Reporting Requirements on page 14.

The format for both Beginning Service Date (34-41) and Ending Service Date (42-49) is MMDDYYYY. Use leading zeroes when appropriate.

This data element is used in conjunction with Type of Bill (Field Number 2, Form Locator Number 4) to validate admission date and determine discharge date. This information is used to verify reporting period of data and for calculating length of stay of patient hospitalization.

Comments:
This data element can be used to assure that the claim is for the appropriate time period. The claims records should be admission through discharge; however, if this is an interim bill the Statement Covers Period will not be the beginning and ending date of this hospitalization. Discharge date is not indicated explicitly on the UB-92 forms, therefore the fields Type of Bill and Statement Covers Period are used to determine length of stay and discharge date.

Note:
For services received on a single date, both the dates will be the same. These two dates are also known as "from" and "through" dates.

Data Dictionary

Field No.	Field Description
6	Patient's Address: State

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	2	1299-1300	Left Justified	Yes	13

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

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

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

Comments:
Use the standard Post Office State Abbreviations for state addresses. These abbreviations are listed in Section IV.4.

Data Dictionary

Field No.	Field Description
7	Patient's Address: City

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	15	1301-1315	Left Justified	Yes	13

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

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

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

Data Dictionary

Field No.	Field Description
8	Patient's Address: Zip Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	9	50-58	Left Justified	Yes	13

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

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

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

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

Comments:
Do not include hyphen; it is implied.

Data Dictionary

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

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	8	59-66	Right Justified	Yes	14

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

Use leading zeroes when appropriate.

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

Data Dictionary

Field No.	Field Description
10	Patient's Sex

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	1	67	Left Justified	Yes	15

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

F = Female
M = Male
U = Unknown

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

Data Dictionary

Field No.	Field Description
11	Admission Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	8	68-75	Right Justified	Yes	17

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

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

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

Data Dictionary

Field No.	Field Description
12	Type of Admission

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	1	78	Left Justified	Yes	19

Description:
A code indicating the priority of the hospitalization.

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

Valid Values:

Code	Type	Description
1	Emergency	The patient requires immediate intervention as a result of a severe, life threatening or potentially disabling condition.
2	Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder.
3	Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4	Newborn	This code is for a baby born within the facility and it necessitates the use of special Source Of Admission Codes, Form Locator 20.
5	Trauma Center	This code is for a visit to a trauma center/hospital as designated by the state or local government authority or as verified by the American College of Surgeons and involving a trauma activation.
9	Unknown	Information not available.

Comments:
There are special instructions for Mother/Baby claims, see Form Locator 20 (Source of Admission). Source of Admission and Type of Admission should be used together when reviewing records. Form Locator 19 (Type of Admission) can be used independently of Form Locator 20 (Source of Admission) but not vice versa.

Data Dictionary

Field No.	Field Description
13	Source of Admission

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	1	79	Left Justified	Yes	20

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

Valid Values:
If Type of Admission (Form Locator 19) equals: "1" (Emergency), "2" (Urgent), "3" (Elective), "5" (Trauma Center) or "9" (Unknown), use the following codes:

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

Data Dictionary

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

If Type of Admission (Form Locator 19) equals: "1" (Emergency), "2" (Urgent), "3" (Elective), "5" (Trauma Center) or "9" (Unknown), use the following codes (continued):

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

If Type of Admission (Form Locator 19) equals "4", (Newborn), use the following codes:

Code	Source	Description
1	Normal Delivery	A baby delivered without complications.
2	Premature	A baby delivered with time and/or weight factors qualifying it for premature status.
3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
4	Extramural Birth	A newborn born in a non-sterile environment.
9	Unknown	Information not available.

Data Dictionary

Field No.	Field Description
14	Patient Status *

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	2	80-81	Right Justified	Yes	22

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

Valid Values:

Code	Patient Status
01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short term general hospital for inpatient care.
03	Discharged/transferred to a skilled nursing facility (SNF).
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under the care of a Home IV provider.
09	Admitted as an inpatient to this hospital (only for Medicare outpatient claims).
20	Deceased.
30	Still a patient or expected to return for outpatient services.
40	Expired at home (Medicare and CHAMPUS claims for hospice care).
41	Expired in a medical facility (Medicare and CHAMPUS claims for hospice care).
42	Expired - place unknown (Medicare and CHAMPUS claims for hospice care).
43	Discharged/transferred to a Federal hospital.
50	Hospice - home.
51	Hospice - medical facility.
61	Discharged/transferred to a hospital-based swing bed within this institution.
62	Discharged/transferred to another rehabilitation facility including rehabilitation distinct parts units of a hospital.
63	Discharged/transferred to a long-term care hospital.
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

For interim bills, patient status should be "30". But these bills are not currently collected (see Special Reporting Requirements on page 14).

* See Appendix for codes used in 1995 – 2004.

Note: As of January 1, 2006 code 66 indicates discharge or transfer to a critical access hospital (CAH).

Data Dictionary

Field No.	Field Description
15	Medical/Health Record Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	17	82-98	Left Justified	Yes	23

Description:
The number assigned to the patient's medical/health record by the hospital.

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

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

Comments:
Do not substitute Patient Control Number. Both fields must be provided.

Data Dictionary

Field No.	Field Description
16-38	Revenue Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	4	See Below	Right Justified	Yes	42

Description:
This code identifies a specific accommodation, ancillary service, or billing calculation. The individual revenue code indicates that a part of the total charge claimed is categorized under a specific revenue source.

The UB-92 form allows for 23 revenue codes. The last code for a particular bill should indicate the Total Charges (Revenue Code 0001). Total Charges for a one-record bill could be indicated on the UB-92 form anywhere from line 2 through line 23. A second record may be necessary if there are more than 23 charges.

The revenue code field is four digits, however, the first digit of the code is "0" for all revenue codes. The second and third digits indicate the service and the fourth digit indicates the sub-category within the service.

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

Field Number	Field Name	UB-92 Form Locator Number 42	HDDS File Positions
16	Revenue Codes	Revenue Code 1, Line 1	99-102
17		Revenue Code 2, Line 2	113-116
18		Revenue Code 3, Line 3	127-130
19		Revenue Code 4, Line 4	141-144
20		Revenue Code 5, Line 5	155-158
21		Revenue Code 6, Line 6	169-172
22		Revenue Code 7, Line 7	183-186
23		Revenue Code 8, Line 8	197-200
24		Revenue Code 9, Line 9	211-214
25		Revenue Code 10, Line 10	225-228
26		Revenue Code 11, Line 11	239-242
27		Revenue Code 12, Line 12	253-256
28		Revenue Code 13, Line 13	267-270
29		Revenue Code 14, Line 14	281-284
30		Revenue Code 15, Line 15	295-298

Data Dictionary

Field No.	Field Description
16-38	Revenue Codes (continued from previous page)

Field Number	Field Name	UB-92 Form Locator Number 42	HDDS File Positions
31	Revenue Codes	Revenue Code 16, Line 16	309-312
32		Revenue Code 17, Line 17	323-326
33		Revenue Code 18, Line 18	337-340
34		Revenue Code 19, Line 19	351-354
35		Revenue Code 20, Line 20	365-368
36		Revenue Code 21, Line 21	379-382
37		Revenue Code 22, Line 22	393-396
38		Revenue Code 23, Line 23	407-410

Comments:
Note that for any bill of two or more pages, a separate electronic record should be submitted for each page. The Total Charges (Revenue Code 0001) will be the last charge on the last record of multi-record bills.

Example:

Revenue Code	Service Date	Service Units	Total Charges
0252 (Pharmacy/Non-Generic Drugs)		1	13.00
0261 (IV Therapy/Infusion Pump)		1	10.00
0001 (Total Charges)			23.00

Data Dictionary

Field No.	Field Description
39-61	Service Date(s)

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	6	See Below	Right Justified	Yes	45

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

The date should be in the following format: MMDDYY.

The UB-92 form allows 23 lines for Service Date(s).

Field Number	Field Name	UB-92 Form Locator Number 45	HDDS File Positions
39	Service Date(s)	Service Date(s) 1, Line 1	754-759
40		Service Date(s) 2, Line 2	767-772
41		Service Date(s) 3, Line 3	780-785
42		Service Date(s) 4, Line 4	793-798
43		Service Date(s) 5, Line 5	806-811
44		Service Date(s) 6, Line 6	819-824
45		Service Date(s) 7, Line 7	832-837
46		Service Date(s) 8, Line 8	845-850
47		Service Date(s) 9, Line 9	858-863
48		Service Date(s) 10, Line 10	871-876
49		Service Date(s) 11, Line 11	884-889
50		Service Date(s) 12, Line 12	897-902
51		Service Date(s) 13, Line 13	910-915
52		Service Date(s) 14, Line 14	923-928
53		Service Date(s) 15, Line 15	936-941
54		Service Date(s) 16, Line 16	949-954
55		Service Date(s) 17, Line 17	962-967
56		Service Date(s) 18, Line 18	975-980
57		Service Date(s) 19, Line 19	988-993
58		Service Date(s) 20, Line 20	1001-1006
59		Service Date(s) 21, Line 21	1014-1019
60		Service Date(s) 22, Line 22	1027-1032
61		Service Date(s) 23, Line 23	1040-1045

Data Dictionary

Field No.	Field Description
62-84	Unit(s) of Service

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	7	See Below	Right Justified	Yes	46

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

The UB-92 form allows 23 lines for Unit(s) of Service.

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

Field Number	Field Name	UB-92 Form Locator Number 46	HDDS File Positions
62	Unit(s) of Service	Unit(s) of Service 1, Line 1	747-753
63		Unit(s) of Service 2, Line 2	760-766
64		Unit(s) of Service 3, Line 3	773-779
65		Unit(s) of Service 4, Line 4	786-792
66		Unit(s) of Service 5, Line 5	799-805
67		Unit(s) of Service 6, Line 6	812-818
68		Unit(s) of Service 7, Line 7	825-831
69		Unit(s) of Service 8, Line 8	838-844
70		Unit(s) of Service 9, Line 9	851-857
71		Unit(s) of Service 10, Line 10	864-870
72		Unit(s) of Service 11, Line 11	877-883
73		Unit(s) of Service 12, Line 12	890-896
74		Unit(s) of Service 13, Line 13	903-909
75		Unit(s) of Service 14, Line 14	916-922
76		Unit(s) of Service 15, Line 15	929-935
77		Unit(s) of Service 16, Line 16	942-948
78		Unit(s) of Service 17, Line 17	955-961
79		Unit(s) of Service 18, Line 18	968-974
80		Unit(s) of Service 19, Line 19	981-987
81		Unit(s) of Service 20, Line 20	994-1000
82		Unit(s) of Service 21, Line 21	1007-1013
83		Unit(s) of Service 22, Line 22	1020-1026
84		Unit(s) of Service 23, Line 23	1033-1039

Data Dictionary

Field No.	Field Description
85-107	Total Charges (by Revenue Code Category)

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	10	See Below	Right Justified	Yes	47

Description:
Total Charges pertaining to the related Revenue Code for the current billing period as reflected by the statement covers period.

The UB-92 form allows 23 lines for Charges.

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

Field Number	Field Name	UB-92 Form Locator Number	HDDS File Positions
85	Total Charges (by Revenue Code Category)	Charges 1, Line 1	103-112
86		Charges 2, Line 2	117-126
87		Charges 3, Line 3	131-140
88		Charges 4, Line 4	145-154
89		Charges 5, Line 5	159-168
90		Charges 6, Line 6	173-182
91		Charges 7, Line 7	187-196
92		Charges 8, Line 8	201-210
93		Charges 9, Line 9	215-224
94		Charges 10, Line 10	229-238
95		Charges 11, Line 11	243-252
96		Charges 12, Line 12	257-266
97		Charges 13, Line 13	271-280
98		Charges 14, Line 14	285-294
99		Charges 15, Line 15	299-308
100		Charges 16, Line 16	313-322
101		Charges 17, Line 17	327-336
102		Charges 18, Line 18	341-350
103		Charges 19, Line 19	355-364
104		Charges 20, Line 20	369-378
105		Charges 21, Line 21	383-392
106		Charges 22, Line 22	397-406
107		Charges 23, Line 23	411-420

Data Dictionary

Field No.	Field Description
85-107	Total Charges (by Revenue Code Category) (continued from previous page)

Comments:
The last charge listed for each bill should be the sum of all the previous revenue categories. It should be associated with a Revenue Code of 0001.

For any bill of two or more pages, a separate record should be submitted for each page if submission is via magnetic medium. The total charge for a multi-record bill will be the last charge on the last record of the bill. It will be associated with a Revenue Code of 0001.

The COBOL format for electronic reporting is PIC S9 (8) V99. The first eight digits are for dollar amounts. The last two digits are for cents. The decimal point is implicit; it is not written in the field. Negative values (i.e. credits) are denoted by special characters in the right-most cents position as per the COBOL PIC S9 (8) V99 format.

(Note for data analysts: The data sets compiled by the Department for data analysis have had all charge fields converted to the standard numeric format.)

Data Dictionary

Field No.	Field Description
108	Payer Classification – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	2	1213-1214	Left Justified	Yes	50A

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

The UB-92 form has three lines for Form Locator 50. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

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

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (not managed care)
C	Federal, Champus (military)
D	Medicaid (not TennCare)
I	Commercial Insurance (not managed care)
M	Medicare (not managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self Pay
S	Self Insured, Self Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
	TennCare Codes
T	TennCare-Plan Unspecified
5	Omni Care
7	VHP Community Care
8	John Deere/Heritage
9	Preferred Health Partnership

Data Dictionary

Field No.	Field Description
108	Payer Classification – Primary (continued from previous page)

Code	Payer Classification
	TennCare Codes (cont'd.)
F	TLC Family Care Healthplan
J	Blue Care
Q	TennCare Select
R	Better Health Plans, Inc.
V	Universal Care of Tennessee
	TennCare Behavioral Codes
E	BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	**Blue Cross Managed Care – HMO/PPO/Other Managed Care** Payer may be listed as, but is not limited to, names such as: HMO Blue Blue Preferred TPN BC Memphis/Apple Blue Classic Blue Select
L	**Commercial (Managed Care – HMO/PPO/Other Managed Care)** Payer may be listed as, but is not limited to, names such as: United Healthcare Aetna/US Healthcare Cigna and/or Healthsource Cariten Health Net Prudential John Deere/Heritage Tripoint Private HealthCare Systems Affordable/First Health

Data Dictionary

Field No.	Field Description
108	Payer Classification – Primary (continued from previous page)

Code	Payer Classification
K	**Medicare (HMO/PSO)** Payer may be listed as, but is not limited to, names such as: Health Net Cariten United Healthcare Blue Cross Heritage/John Deere Cigna

Data Dictionary

Field No.	Field Description
109	Payer Classification – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	2	1215-1216	Left Justified	Yes	50B

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

The UB-92 form has three lines for Form Locator 50. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

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

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (not managed care)
C	Federal, Champus (military)
D	Medicaid (not TennCare)
I	Commercial Insurance (not managed care)
M	Medicare (not managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self Pay
S	Self Insured, Self Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
	TennCare Codes
T	TennCare-Plan Unspecified
5	Omni Care
7	VHP Community Care
8	John Deere/Heritage
9	Preferred Health Partnership

Data Dictionary

Field No.	Field Description
109	Payer Classification – Secondary (continued from previous page)

Code	Payer Classification
	TennCare Codes (cont'd.)
F	TLC Family Care Healthplan
J	Blue Care
Q	TennCare Select
R	Better Health Plans, Inc.
V	Universal Care of Tennessee
	TennCare Behavioral Codes
E	BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	**Blue Cross Managed Care – HMO/PPO/Other Managed Care** Payer may be listed as, but is not limited to, names such as: HMO Blue Blue Preferred TPN BC Memphis/Apple Blue Classic Blue Select
L	**Commercial (Managed Care – HMO/PPO/Other Managed Care)** Payer may be listed as, but is not limited to, names such as: United Healthcare Aetna/US Healthcare Cigna and/or Healthsource Cariten Health Net Prudential John Deere/Heritage Tripoint Private HealthCare Systems Affordable/First Health

Data Dictionary

Field No.	Field Description
109	Payer Classification – Secondary (continued from previous page)

Code	Payer Classification
K	**Medicare (HMO/PSO)** Payer may be listed as, but is not limited to, names such as: Health 123 Health Net Cariten United Healthcare Blue Cross Heritage/John Deere Cigna

Comments:
Many bills will not have a Secondary Payer.

Data Dictionary

Field No.	Field Description
110	Payer Classification – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	2	1217-1218	Left Justified	Yes	50C

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

The UB-92 form has three lines for Form Locator 50. The appropriate source may be entered in one or more of the three lines. Each line represents whether the payer is primary, secondary, or tertiary; line one indicating primary, line two indicating secondary, and line three indicating tertiary.

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

Valid Values:

Code	Payer Classification
B	Blue Cross/Blue Shield (not managed care)
C	Federal, Champus (military)
D	Medicaid (not TennCare)
I	Commercial Insurance (not managed care)
M	Medicare (not managed care)
N	Division of Health Services (Voc. Rehab.)
O	Other, Unknown
P	Self Pay
S	Self Insured, Self Administered
W	Workers/State Compensation
Z	Medically Indigent/Free
	TennCare Codes
T	TennCare-Plan Unspecified
5	Omni Care
7	VHP Community Care
8	John Deere/Heritage
9	Preferred Health Partnership

Data Dictionary

Field No.	Field Description
110	Payer Classification – Tertiary (continued from previous page)

Code	Payer Classification
	TennCare Codes (cont'd)
F	TLC Family Care Healthplan
J	Blue Care
Q	TennCare Select
R	Better Health Plans, Inc.
V	Universal Care of Tennessee
	TennCare Behavioral Codes
E	BHO – plan unspecified
U	Tennessee Behavioral Health, Inc.
X	Premier Behavioral Systems of TN
H	**Blue Cross Managed Care – HMO/PPO/Other Managed Care** Payer may be listed as, but is not limited to, names such as: HMO Blue Blue Preferred TPN BC Memphis/Apple Blue Classic Blue Select
L	**Commercial (Managed Care – HMO/PPO/Other Managed Care)** Payer may be listed as, but is not limited to, names such as: United Healthcare Aetna/US Healthcare Cigna and/or Healthsource Cariten Health Net Prudential John Deere/Heritage Tripoint Private HealthCare Systems Affordable/First Health

Data Dictionary

Field No.	Field Description
110	Payer Classification – Tertiary (continued from previous page)

Code	Payer Classification
K	**Medicare (HMO/PSO)** Payer may be listed as, but is not limited to, names such as: Health 123 Health Net Cariten United Healthcare Blue Cross Heritage/John Deere Cigna

Comments:
Many bills will not have a Tertiary Payer.

Data Dictionary

Field No.	Field Description
111	Provider Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	13	446-458	Left Justified	Yes	51A

Description:
The number assigned to the hospital by the payer indicated in Form Locator 50A (Primary Payer). The number in Form Locator 51A corresponds to Form Locator 50A. **If this code is unknown or not applicable, the field should be completely filled with 9's.**

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

Data Dictionary

Field No.	Field Description
112	Provider Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	13	1071-1083	Left Justified	Yes	51B

Description:
The number assigned to the hospital by the payer indicated in Form Locator 50B (Secondary Payer). The number in Form Locator 51B corresponds to Form Locator 50B. **If this code is unknown the field should be completely filled with 9's. If there is no Secondary Payer this field should be left blank.**

This data is used to properly classify the source of the payer indicated in Form Locator 50B (Payer Identification).

Comments:
Many bills will lack a Secondary Payer and will have no Secondary Provider Number.

Data Dictionary

Field No.	Field Description
113	Provider Number – Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	13	1150-1162	Left Justified	Yes	51C

Description:
The number assigned to the hospital by the payer indicated in Form Locator 50C (Tertiary Payer). The number in Form Locator 51C corresponds to Form Locator 50C. **If this code is unknown the field should be completely filled with 9's. If there is no Tertiary Payer this field should be left blank.**

This data is used to properly classify the source of the payer indicated in Form Locator 50C (Payer Identification).

Comments:
Many bills will lack a Tertiary Payer and will have no Tertiary Provider Number.

Data Dictionary

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

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	2	459-460	Left Justified	Yes	59A

Description:
The code number indicates the relationship of the patient to the insured individual named in Form Locator 58A. (NOTE: These codes underwent a major revision effective October 16, 2003. Several code values were reused, several codes were discontinued, and several new codes were added.)

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward (of the insured as a result of court order)
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped dependent
23	Sponsored dependent
24	Dependent of a minor dependent

Data Dictionary

Field No.	Field Description
114	Patient's Relationship to Insured - Primary (continued from previous page)

Code	Patient's Relationship to Insured
29	Significant other
32	Mother
33	Father
36	Emancipated minor
39	Organ donor
40	Cadaver donor
41	Injured plaintiff
43	Child (Insured has no financial responsibility.)
53	Life partner
G8	Other relationship

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

*See Appendix for codes used prior to October 16, 2003.

Data Dictionary

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

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	2	1084-1085	Left Justified	Yes	59B

Description:
The code number indicates the relationship of the patient to the insured individual named in Form Locator 58B. **If there is no second payer this field should be left blank.** (NOTE: These codes underwent a major revision effective October 16, 2003. Several code values were reused, several codes were discontinued, and several new codes were added.)

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward (of the insured as a result of court order)
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped dependent
23	Sponsored dependent
24	Dependent of a minor dependent

Data Dictionary

Field No.	Field Description
115	Patient's Relationship to Insured - Secondary (continued from previous page)

Code	Patient's Relationship to Insured
29	Significant other
32	Mother
33	Father
36	Emancipated minor
39	Organ donor
40	Cadaver donor
41	Injured plaintiff
43	Child (Insured has no financial responsibility.)
53	Life partner
G8	Other relationship

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

*****See Appendix for codes used prior to October 16, 2003.

Data Dictionary

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

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	2	1163-1164	Left Justified	Yes	59C

Description:
The code number indicates the relationship of the patient to the insured individual named in Form Locator 58C. **If there is no third payer this field should be left blank.** (NOTE: These codes underwent a major revision effective October 16, 2003. Several code values were reused, several codes were discontinued, and several new codes were added.)

Valid Values:

Code	Patient's Relationship to Insured
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward (of the insured as a result of court order)
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped dependent
23	Sponsored dependent
24	Dependent of a minor dependent

Data Dictionary

Field No.	Field Description
116	Patient's Relationship to Insured - Tertiary (continued from previous page)

Code	Patient's Relationship to Insured
29	Significant other
32	Mother
33	Father
36	Emancipated minor
39	Organ donor
40	Cadaver donor
41	Injured plaintiff
43	Child (Insured has no financial responsibility.)
53	Life partner
G8	Other relationship

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

*See Appendix for codes used prior to October 16, 2003.

Data Dictionary

Field No.	Field Description
117	Certificate/SSN/Health Insurance Claim/ID Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	19	461-479	Left Justified	Yes	60A

Description:
A unique identification number assigned to the insured by the payer organization indicated in Form Locator 50A (Primary Payer).

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

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

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

Data Dictionary

Field No.	Field Description
118	Certificate/SSN/Health Insurance Claim/ID Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	19	1086-1104	Left Justified	Yes	60B

Description:
A unique identification number assigned to the insured by the payer organization indicated in Form Locator 50B (Secondary Payer).

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

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

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

Data Dictionary

Field No.	Field Description
119	Certificate/SSN/Health Insurance Claim/ID Number - Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	19	1165-1183	Left Justified	Yes	60C

Description:
A unique identification number assigned to the insured by the payer organization indicated in Form Locator 50C (Tertiary Payer).

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

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

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

Data Dictionary

Field No.	Field Description
120	Insurance Group Number – Primary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	20	480-499	Left Justified	Yes	62A

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

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

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

Data Dictionary

Field No.	Field Description
121	Insurance Group Number – Secondary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	20	1105-1124	Left Justified	Yes	62B

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

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

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

Data Dictionary

Field No.	Field Description
122	Insurance Group Number - Tertiary

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	20	1184-1203	Left Justified	Yes	62C

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

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

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

Data Dictionary

Field No.	Field Description
123	Employment Status Code of the Insured

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	1	500	Left Justified	Yes	64A

Description:
The code used to define the employment status of the individual who is insured. (This person may or may not be the patient). The code assigned reflects the employment status of the person identified in Form Locator 58A.

This data is used for statistical analysis.

Valid Values:

Code	Employment Status
1	Full Time
2	Part Time
3	Not Employed
4	Self-Employed
5	Retired
6	Active Military Duty
7-8	Reserved for future use
9	Unknown

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

Data Dictionary

Field No.	Field Description
124	Name of the Insured's Employer

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	24	501-524	Left Justified	Yes	65A

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

Comments:
This field should be filled with 9's if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9's may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error. This field may also be filled with 9's if the Employment Status Code is "3" (not employed), "5" (retired), or "9" (unknown).

Data Dictionary

Field No.	Field Description
125	Zip Code of the Insured's Employer

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	9	525-533	Left Justified	Yes	66A

Description:
The zip code address of the employer who provides health care coverage for the insured person (who may or may not be the patient).

The code assigned references the name of insured in Form Locator 58A.

This data is used for statistical analysis.

Comments:
This field allows nine digits for zip code in the format XXXXXyyyy. The first five digits are usually present with the last four digits indicating building or a specific location. If the last four digits are unavailable, leave them blank.

This field should be filled with 9's if unknown. Note that with corresponding payer codes of "O" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) all 9's may be used in this field or the field may be left blank. For all other payer codes, blank in this field is considered an error. This field may also be filled with 9's if the Employment Status Code is "3" (not employed), "5" (retired), or "9" (unknown).

Do not include hyphen; it is implied.

Data Dictionary

Field No.	Field Description
126	Principal Diagnosis Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	6	534-539	Left Justified	Yes	67

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

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

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

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

Comments:
Must be present. All valid ICD-9-CM codes are appropriate. Include all leading zeros so that the code appears exactly as represented by the ICD-9-CM codes. If a V code is used, the "V" should be in the first position and left justified.

Do not include decimal point; it is implied.

Data Dictionary

Field No.	Field Description
127-134	Other Diagnosis Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	6	See Below	Left Justified	Yes	68-75 (See Below)

Description:

Field Number	Field Name	UB-92 Form Locator Number	HDDS File Positions
127	Other Diagnosis Codes	FL-68, Other Diagnosis 1	540-545
128		FL-69, Other Diagnosis 2	546-551
129		FL-70, Other Diagnosis 3	552-557
130		FL-71, Other Diagnosis 4	558-563
131		FL-72, Other Diagnosis 5	564-569
132		FL-73, Other Diagnosis 6	570-575
133		FL-74, Other Diagnosis 7	576-581
134		FL-75, Other Diagnosis 8	582-587

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

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

Comments:
Include all leading zeros so that the code appears exactly as represented by the ICD-9-CM codes. When coded, the letters “V” or “E” should be in the first position of the field and left justified. The reporting of the decimal between the third and fourth digits is unnecessary because it is implied.

The record layout does not allow for an extra E or V code field so the other diagnosis fields will have to be used when these conditions exist. The other diagnosis code fields will permit the use of ICD-9-CM V and E codes where appropriate. Note that the V code may also be in the principal diagnosis field. Note also that Form Locator 77 is the E code field, however, in some cases more than one E code is appropriate.

E codes are provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. See Field No. 135 (External Cause of Injury Code) for a more complete description of E Code usage.

Field No.	Field Description
127-134	Other Diagnosis Codes (continued from previous page)

The V code can appear in the following situations:

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

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

Data Dictionary

Field No.	Field Description
135	External Cause of Injury Code (E Code)

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	6	594-599	Left Justified	Yes	77

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

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

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

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

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

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

(1) Principal diagnosis of an injury or poisoning.

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

(3) Other diagnosis with an external code.

Record any additional E codes in the Other Diagnosis Fields (FL 68 through FL 75).

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

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

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

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

Data Dictionary

Field No.	Field Description
136	Principal Procedure Code

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	7	600-606	Left Justified	Yes	80

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

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

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

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

Data Dictionary

Field No.	Field Description
137	Principal Procedure Date

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	6	607-612	Right Justified	Yes	80

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

The date should be in MMDDYY format.

Data Dictionary

Field No.	Field Description
138-142	Other Procedure Codes

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	7	See Below	Left Justified	Yes	81

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

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

Field Number	Field Name	UB-92 Form Locator Number	HDDS File Positions
138	Other Procedure Codes	Other Procedure Code 1, FL-81	613-619
139		Other Procedure Code 2, FL-81	626-632
140		Other Procedure Code 3, FL-81	639-645
141		Other Procedure Code 4, FL-81	652-658
142		Other Procedure Code 5, FL-81	665-671

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

Other Information:
Number of positions:
- FL-81 Other Procedure Code 1 (7)
- FL-81 Other Procedure Code 2 (7)
- FL-81 Other Procedure Code 3 (7)
- FL-81 Other Procedure Code 4 (7)
- FL-81 Other Procedure Code 5 (7)

Data Dictionary

Field No.	Field Description
143-147	Other Procedure Dates

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	6	See Below	Right Justified	Yes	81

Description:
The dates on which the Other Procedures Codes identified in Form Locator 81 were performed.

These dates together with their associated procedure codes can be used to analyze medical practice patterns.

Field Number	Field Name	UB-92 Form Locator Number	HDDS File Positions
143	Other Procedure Dates	Other Procedure Date 1, FL-81	620-625
144		Other Procedure Date 2, FL-81	633-638
145		Other Procedure Date 3, FL-81	646-651
146		Other Procedure Date 4, FL-81	659-664
147		Other Procedure Date 5, FL-81	672-677

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

Other Information:
Number of positions:
- FL-81 Other Procedure Date 1: MMDDYY (6)
- FL-81 Other Procedure Date 2: MMDDYY (6)
- FL-81 Other Procedure Date 3: MMDDYY (6)
- FL-81 Other Procedure Date 4: MMDDYY (6)
- FL-81 Other Procedure Date 5: MMDDYY (6)

Data Dictionary

Field No.	Field Description
148	Attending Physician ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	22	678-699	Left Justified	Yes	82

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

A unique number used to identify an attending physician on a claim form. This should be the UPIN if the physician has a UPIN. The correct format for a UPIN is an alphabetic character followed by 5 numeric digits.

If the physician has no UPIN, the appropriate Tennessee physician state license number should be reported. The correct format for the Tennessee license number is a ten digit number with leading zeroes. The default codes for Physician ID Number are "OTH000", "SLF000", and "RES000" (3 alphabetic characters followed by 3 numeric zeros).

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

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

Special Note Regarding a Nurse Midwife Attending a Birth:
If there is a nurse midwife attending a birth, the unique number reported in the Attending Physician ID Number field must be that of the **nurse midwife's supervising physician**. The state license number for the nurse midwife can be reported in the First Other Physician ID Number field (see next page).

Data Dictionary

Field No.	Field Description
149	First Other Physician ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	22	700-721	Left Justified	Yes	83

Description:
Generally, this is the identification number of the licensed physician who performed the principal procedure. Sometimes, the identification number of another physician involved with this case. This field can be left blank.

A unique number used to identify this physician on a claim form. This should be the UPIN if the physician has a UPIN. The correct format for a UPIN is an alphabetic character followed by 5 numeric digits.

If the physician has no UPIN, the appropriate Tennessee physician state license number should be reported. The correct format for the Tennessee license number is a ten digit number with leading zeroes. The default codes for Physician ID Number are "OTH000", "SLF000", and "RES000" (3 alphabetic characters followed by 3 numeric zeros).

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

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

Special Note Regarding a Nurse Midwife Attending a Birth:
If there is a nurse midwife attending a birth, the unique number reported in the Attending Physician ID Number field (see the previous page) must be that of the **nurse midwife's supervising physician**. The state license number for the nurse midwife can be reported in the First Other Physician ID Number field.

Data Dictionary

Field No.	Field Description
150	Second Other Physician ID Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	22	722-743	Left Justified	Yes	83

Description:
The identification number of a licensed physician (other than the attending physician or the first other physician) involved with the case. This field can be left blank.

A unique number used to identify this physician on a claim form. This should be the UPIN if the physician has a UPIN. The correct format for a UPIN is an alphabetic character followed by 5 numeric digits.

If the physician has no UPIN, the appropriate Tennessee physician state license number should be reported. The correct format for the Tennessee license number is a ten digit number with leading zeroes. The default codes for Physician ID Number are "OTH000", "SLF000", and "RES000" (3 alphabetic characters followed by 3 numeric zeros).

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

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

Data Dictionary

Field No.	Field Description
151	Medicaid Provider Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	12	1219-1230	Left Justified	No*	--

Description:
The Medicaid Provider Number assigned to the hospital. This number should be provided for all records regardless of the actual payers.

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

Comments:
*Optional, but requested for those hospitals where the same Federal Tax ID is used in satellite facilities. **This field is required for hospitals reporting through the THA-HIN.**

Data Dictionary

Field No.	Field Description
152	Medicare Provider Number

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	12	1231-1242	Left Justified	No*	--

Description:
The Medicare Provider Number assigned to the hospital by Health Care Financing Administration. This number should be provided for all records regardless of the actual payers.

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

Comments:
*Optional, but requested for those hospitals where the same Federal Tax ID is used in satellite facilities. **This field is required for hospitals reporting through the THA-HIN.**

Data Dictionary

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

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Alpha-Numeric	9	1243-1251	Left Justified	Yes	--

Description:
This field is not specifically included on the UB-92 form. However, since the patient's social security number may or may not be included as part of another field (Certificate Number/ID Number/SSN-Form Locator-60), this field should be used only to collect and report the actual SSN of the patient.

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

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

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

Data Dictionary

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

Field Detail:

Field Type	Width	Position	Format	Required	UB-92 Form Locator
Numeric	1	1212	Right Justified	Yes	--

Description:
This field is not included on the UB-92 form. This field is required to be reported in addition to the data elements contained on the UB-92.

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

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

Valid Values:

Code	Description
0	White, Not Hispanic
1	Black, Not Hispanic
2	Other than codes 0, 1, 3-8
3	Asian or Pacific Islander
4	American Indian/Alaskan Native
5	White, Hispanic
6	Black, Hispanic
7	White, Hispanic Origin Unknown
8	Black, Hispanic Origin Unknown
9	Race/Ethnicity Unknown

UB-92 Data Record Format

(1600 Byte Record Length)

Field No.	Field Description	COBOL Format	Position From	Position Thru
1	FL 3 Patient Control Number	PIC X (20)	1	20
2	FL 4 Type of Bill	PIC 9 (3)	21	23
3	FL 5 Federal Tax Number	PIC X (10)	24	33
5	FL 6 Statement Covers Period	PIC 9 (16)	34	49
8	FL 13 Zip Code of Patient Address	PIC X (9)	50	58
9	FL 14 Patient Date of Birth: MMDDYYYY	PIC 9 (8)	59	66
10	FL 15 Patient Sex	PIC X	67	67
11	FL 17 Admission Date: MMDDYYYY	PIC 9 (8)	68	75
	FILLER	PIC 9 (2)	76	77
12	FL 19 Type of Admission	PIC X	78	78
13	FL 20 Source of Admission	PIC X	79	79
14	FL 22 Patient Status	PIC 9 (2)	80	81
15	FL 23 Medical/Health Record Number	PIC X (17)	82	98
16	FL 42 Revenue Code Line 1	PIC 9999	99	102
85	FL 47 Charges Line 1	PIC S9 (8) V99	103	112
17	FL 42 Revenue Code Line 2	PIC 9999	113	116
86	FL 47 Charges Line 2	PIC S9 (8) V99	117	126
18	FL 42 Revenue Code Line 3	PIC 9999	127	130
87	FL 47 Charges Line 3	PIC S9 (8) V99	131	140
19	FL 42 Revenue Code Line 4	PIC 9999	141	144
88	FL 47 Charges Line 4	PIC S9 (8) V99	145	154
20	FL 42 Revenue Code Line 5	PIC 9999	155	158
89	FL 47 Charges Line 5	PIC S9 (8) V99	159	168
21	FL 42 Revenue Code Line 6	PIC 9999	169	172
90	FL 47 Charges Line 6	PIC S9 (8) V99	173	182
22	FL 42 Revenue Code Line 7	PIC 9999	183	186
91	FL 47 Charges Line 7	PIC S9 (8) V99	187	196
23	FL 42 Revenue Code Line 8	PIC 9999	197	200
92	FL 47 Charges Line 8	PIC 9 (8) V99	201	210
24	FL 42 Revenue Code Line 9	PIC 9999	211	214
93	FL 47 Charges Line 9	PIC 9 (8) V99	215	224
25	FL 42 Revenue Code Line 10	PIC 9999	225	228
94	FL 47 Charges Line 10	PIC S9 (8) V99	229	238
26	FL 42 Revenue Code Line 11	PIC 9999	239	242
95	FL 47 Charges Line 11	PIC S9 (8) V99	243	252
27	FL 42 Revenue Code Line 12	PIC 9999	253	256
96	FL 47 Charges Line 12	PIC S9 (8) V99	257	266

UB-92 Data Record Format

(1600 Byte Record Length)

Field No.	Field Description	COBOL Format	Position From	Position Thru
28	FL 42 Revenue Code Line 13	PIC 9999	267	270
97	FL 47 Charges Line 13	PIC S9 (8) V99	271	280
29	FL 42 Revenue Code Line 14	PIC 9999	281	284
98	FL 47 Charges Line 14	PIC S9 (8) V99	285	294
30	FL 42 Revenue Code Line 15	PIC 9999	295	298
99	FL 47 Charges Line 15	PIC S9 (8) V99	299	308
31	FL 42 Revenue Code Line 16	PIC 9999	309	312
100	FL 47 Charges Line 16	PIC S9 (8) V99	313	322
32	FL 42 Revenue Code Line 17	PIC 9999	323	326
101	FL 47 Charges Line 17	PIC S9 (8) V99	327	336
33	FL 42 Revenue Code Line 18	PIC 9999	337	340
102	FL 47 Charges Line 18	PIC S9 (8) V99	341	350
34	FL 42 Revenue Code Line 19	PIC 9999	351	354
103	FL 47 Charges Line 19	PIC S9 (8) V99	355	364
35	FL 42 Revenue Code Line 20	PIC 9999	365	368
104	FL 47 Charges Line 20	PIC S9 (8) V99	369	378
36	FL 42 Revenue Code Line 21	PIC 9999	379	382
105	FL 47 Charges Line 21	PIC S9 (8) V99	383	392
37	FL 42 Revenue Code Line 22	PIC 9999	393	396
106	FL 47 Charges Line 22	PIC S9 (8) V99	397	406
38	FL 42 Revenue Code Line 23	PIC 9999	407	410
107	FL 47 Charges Line 23	PIC S9 (8) V99	411	420
	FILLER	PIC X (25)	421	445
111	FL 51A Provider Number – Primary	PIC X (13)	446	458
114	FL 59A Patient's Relationship to Insured	PIC X (2)	459	460
117	FL 60A Certificate No./ID No./ SS Number – Primary	PIC X (19)	461	479
120	FL 62A Insurance Group Number – Primary	PIC X (20)	480	499
123	FL 64A Employment Status Code	PIC X (1)	500	500
124	FL 65A Name of the Insured's Employer	PIC X (24)	501	524
125	FL 66A Zip Code of the Insured's Employer	PIC X (9)	525	533
126	FL 67 Principal Diagnosis Code	PIC X (6) Omit Decimal	534	539
127	FL 68 Other Diagnosis Code 1	PIC X (6) Omit Decimal	540	545
128	FL 69 Other Diagnosis Code 2	PIC X (6) Omit Decimal	546	551

UB-92 Data Record Format

(1600 Byte Record Length)

Field No.	Field Description	COBOL Format	Position From	Position Thru
129	FL70 Other Diagnosis Code 3	PIC X (6) Omit Decimal	552	557
130	FL 71 Other Diagnosis Code 4	PIC X (6) Omit Decimal	558	563
131	FL 72 Other Diagnosis Code 5	PIC X (6) Omit Decimal	564	569
132	FL 73 Other Diagnosis Code 6	PIC X (6) Omit Decimal	570	575
133	FL 74 Other Diagnosis Code 7	PIC X (6) Omit Decimal	576	581
134	FL 75 Other Diagnosis Code 8	PIC X (6) Omit Decimal	582	587
	FILLER	PIC X (6)	588	593
135	FL 77 External Cause of Injury Code (E Code)	PIC X (6) Omit Decimal	594	599
136	FL 80 Principal Procedure Code	PIC X (7) Omit Decimal	600	606
137	FL 80 Principal Procedure Date: MMDDYY	PIC 9 (6)	607	612
138	FL 81 Other Procedure Code 1	PIC X (7) Omit Decimal	613	619
143	FL 81 Other Procedure Date 1: MMDDYY	PIC 9 (6)	620	625
139	FL 81 Other Procedure Code 2	PIC X (7) Omit Decimal	626	632
144	FL 81 Other Procedure Date 2: MMDDYY	PIC 9 (6)	633	638
140	FL 81 Other Procedure Code 3	PIC X (7) Omit Decimal	639	645
145	FL 81 Other Procedure Date 3: MMDDYY	PIC 9 (6)	646	651
141	FL 81 Other Procedure Code 4	PIC X (7) Omit Decimal	652	658
146	FL 81 Other Procedure Date 4: MMDDYY	PIC 9 (6)	659	664
142	FL 81 Other Procedure Code 5	PIC X (7) Omit Decimal	665	671
147	FL 81 Other Procedure Date 5: MMDDYY	PIC 9 (6)	672	677
148	FL 82 Attending Physician ID Number	PIC X (22)	678	699
149	FL 83 First Other Physician ID Number	PIC X (22)	700	721
150	FL 83 Second Other Physician ID Number	PIC X (22)	722	743
	FILLER	PIC X (2)	744	745
	FILLER	PIC 9	746	746

UB-92 Data Record Format

(1600 Byte Record Length)

Field No.	Field Description	COBOL Format	Position From	Position Thru
62	FL 46 Units of Service Line 1	PIC 9 (7)	747	753
39	FL 45 Date of Service Line 1: MMDDYY	PIC 9 (6)	754	759
63	FL 46 Units of Service Line 2	PIC 9 (7)	760	766
40	FL 45 Date of Service Line 2: MMDDYY	PIC 9 (6)	767	772
64	FL 46 Units of Service Line 3	PIC 9 (7)	773	779
41	FL 45 Date of Service Line 3: MMDDYY	PIC 9 (6)	780	785
65	FL 46 Units of Service Line 4	PIC 9 (7)	786	792
42	FL 45 Date of Service Line 4: MMDDYY	PIC 9 (6)	793	798
66	FL 46 Units of Service Line 5	PIC 9 (7)	799	805
43	FL 45 Date of Service Line 5: MMDDYY	PIC 9 (6)	806	811
67	FL 46 Units of Service Line 6	PIC 9 (7)	812	818
44	FL 45 Date of Service Line 6: MMDDYY	PIC 9 (6)	819	824
68	FL 46 Units of Service Line 7	PIC 9 (7)	825	831
45	FL 45 Date of Service Line 7: MMDDYY	PIC 9 (6)	832	837
69	FL 46 Units of Service Line 8	PIC 9 (7)	838	844
46	FL 45 Date of Service Line 8: MMDDYY	PIC 9 (6)	845	850
70	FL 46 Units of Service Line 9	PIC 9 (7)	851	857
47	FL 45 Date of Service Line 9: MMDDYY	PIC 9 (6)	858	863
71	FL 46 Units of Service Line 10	PIC 9 (7)	864	870
48	FL 45 Date of Service Line 10: MMDDYY	PIC 9 (6)	871	876
72	FL 46 Units of Service Line 11	PIC 9 (7)	877	883
49	FL 45 Date of Service Line 11: MMDDYY	PIC 9 (6)	884	889
73	FL 46 Units of Service Line 12	PIC 9 (7)	890	896
50	FL 45 Date of Service Line 12: MMDDYY	PIC 9 (6)	897	902
74	FL 46 Units of Service Line 13	PIC 9 (7)	903	909
51	FL 45 Date of Service Line 13: MMDDYY	PIC 9 (6)	910	915
75	FL 46 Units of Service Line 14	PIC 9 (7)	916	922
52	FL 45 Date of Service Line 14: MMDDYY	PIC 9 (6)	923	928
76	FL 46 Units of Service Line 15	PIC 9 (7)	929	935
53	FL 45 Date of Service Line 15: MMDDYY	PIC 9 (6)	936	941
77	FL 46 Units of Service Line 16	PIC 9 (7)	942	948
54	FL 45 Date of Service Line 16: MMDDYY	PIC 9 (6)	949	954
78	FL 46 Units of Service Line 17	PIC 9 (7)	955	961
55	FL 45 Date of Service Line 17: MMDDYY	PIC 9 (6)	962	967
79	FL 46 Units of Service Line 18	PIC 9 (7)	968	974
56	FL 45 Date of Service Line 18: MMDDYY	PIC 9 (6)	975	980
80	FL 46 Units of Service Line 19	PIC 9 (7)	981	987
57	FL 45 Date of Service Line 19: MMDDYY	PIC 9 (6)	988	993
81	FL 46 Units of Service Line 20	PIC 9 (7)	994	1000

UB-92 Data Record Format

(1600 Byte Record Length)

Field No.	Field Description	COBOL Format	Position From	Position Thru
58	FL 45 Date of Service Line 20: MMDDYY	PIC 9 (6)	1001	1006
82	FL 46 Units of Service Line 21	PIC 9 (7)	1007	1013
59	FL 45 Date of Service Line 21: MMDDYY	PIC 9 (6)	1014	1019
83	FL 46 Units of Service Line 22	PIC 9 (7)	1020	1026
60	FL 45 Date of Service Line 22: MMDDYY	PIC 9 (6)	1027	1032
84	FL 46 Units of Service Line 23	PIC 9 (7)	1033	1039
61	FL 45 Date of Service Line 23: MMDDYY	PIC 9 (6)	1040	1045
	FILLER	PIC X (25)	1046	1070
112	FL 51B Provider Number – Secondary	PIC X (13)	1071	1083
115	FL 59B Patient's Relationship to Insured – Secondary	PIC X (2)	1084	1085
118	FL 60B Certificate Number/ID No./SS No. – Secondary	PIC X (19)	1086	1104
121	FL 62B Insurance Group Number – Secondary	PIC X (20)	1105	1124
	FILLER	PIC X (25)	1125	1149
113	FL 51C Provider Number – Tertiary	PIC X (13)	1150	1162
116	FL 59C Patient's Relationship to Insured – Tertiary	PIC X (2)	1163	1164
119	FL 60C Certificate Number/ID No./SS No. – Tertiary	PIC X (19)	1165	1183
122	FL 62C Insurance Group Number – Tertiary	PIC X (20)	1184	1203
	FILLER	PIC 9 (4)	1204	1207
	FILLER	PIC 9 (4)	1208	1211
154	Patient's Race/Ethnicity	PIC 9 (1)	1212	1212
108	FL 50A Primary Payer – Payer Class. Code	PIC X (2)	1213	1214
109	FL 50B Secondary Payer – Payer Class. Code	PIC X (2)	1215	1216
110	FL 50C Tertiary Payer – Payer Class. Code	PIC X (2)	1217	1218
151	Medicaid Provider Number	PIC X (12)	1219	1230
152	Medicare Provider Number	PIC X (12)	1231	1242
153	Patient's Social Security Number	PIC X (9)	1243	1251
	FILLER	PIC X (12)	1252	1263
4	FL 5 Federal Tax Sub ID	PIC X (4)	1264	1267
	FILLER	PIC X (31)	1268	1298
6	FL 13 Patient's Address – State	PIC X (2)	1299	1300
7	FL 13 Patient's Address – City	PIC X (15)	1301	1315
	FILLER	PIC X (285)	1316	1600

Record Format Information

Alpha fields (PIC X):

Left justify and blank fill to the right.

Numeric fields (PIC 9):

Right justify, unpacked, unsigned, and zero filled to the left.

Signed fields (PIC S9):

Signed fields are only used for total charges (fields 85-107). See comments for these fields in the Data Dictionary. (Note for data analysts: The data sets compiled by the Department for data analysis have had all charge fields converted to the standard numeric format.)

Revenue code and charge values:

After the entry for the Total Charge (0001) Revenue Code, any remaining Revenue Code and Charge fields must be blank or zero filled. No zero filled, or space filled Revenue Code or Charge fields should precede the 0001 Revenue Code and Charge (except for items having a Charge of $0.00).

Multi-page claims:

Multi-page claims may be submitted by duplicating all data elements except Revenue Code and Charge fields (together with their associated Units and Dates of Service fields) on the second and subsequent record(s). All available Revenue Code and Charge fields should be completely filled on the first record and all non-final records for bills requiring more than two records. The 0001 Revenue Code and the Total Charges would be the last used field on the final record of the bill. This would be in any of the field positions on the final record depending on the number of Detail Charge fields/Revenue Codes on the bill. The Total Charge field is the Total Charge for all records of the bill.

SECTION IV

Enabling Legislation: T.C.A.-68-1-108
Rules and Regulations
Forms
U.S. Standard State Abbreviations
Reporting Requirements Prior to 2005

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

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

(a) Each licensed hospital shall report all claims data found on the UB-92 form or a successor form on every inpatient and outpatient discharge to the commissioner of health. A hospital shall report the claims data to the commissioner at least quarterly. After receiving the claims data, the commissioner shall promptly make such data available for review and copying by the Tennessee hospital association (THA). No information shall be made available to the public by either the commissioner or the THA that reasonably could be expected to reveal the identity of any patient. The claims data reported to the commissioner under this section are confidential and not available to the public until the commissioner processes and verifies such data. The commissioner shall prescribe conditions under which the processed and verified data are available to the public.

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

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

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

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

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

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
HEALTH STATISTICS AND INFORMATION

CHAPTER 1200-7-3
HOSPITAL DISCHARGE DATA SYSTEM

TABLE OF CONTENTS

1200-7-3-.01 DEFINITIONS.

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

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

(3) "Public" shall be defined as anyone other than the THA and the Department of Health.

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

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

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

(7) "UB-92" is defined to be UB-92 HCFA Form 1450, the Uniform Hospital Billing Form, as established by the National Committee and the State Uniform Billing Implementation Committee.

(8) "Processed Data" is defined as data that have been analyzed by the Department of Health and errors, inconsistencies, and/or incomplete elements in the data set, if any, have been identified.

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

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

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

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

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

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

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

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

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

(a) Patient Control Number

(b) Type of Bill

(c) Federal Tax Number

(d) Statement Covers Period

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

(f) Patient's Date of Birth

(g) Patient's Sex

(h) Admission Date

(i) Admission Type

(j) Source of Admission

(k) Patient's Status

(l) Medical/Health Record Number

(m) Revenue Codes

(n) Date(s) of Service

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

(o) Unit(s) of Service

(p) Charges Associated with Revenue Codes

(q) Payer Identification

(r) Provider Number

(s) Patient's Relationship to Insured

(t) Certificate Number/ID Number/SSN

(u) Insurance Group Number

(v) Employment Status Code

(w) Insured's Employer Name

(x) Insured's Employer Location: Zip Code

(y) Principal Diagnosis Codes

(z) Other Diagnosis Codes

(aa) E Code

(bb) Principal Procedure Code and Date

(cc) Other Procedure Codes and Dates

(dd) Attending Physician ID Number

(ee) Other Physician ID Numbers

(ff) Patient's Social Security Number

(gg) Patient's Race/Ethnicity

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

(4) Reporting of outpatient and emergency room discharge records initially will be limited to the outpatient and emergency room encounters that involve the specific procedures or conditions outlined in the Procedure Manual.

(5) Reporting of all other emergency room encounters will be required with emergency room discharges occurring on or after January 1, 1997.

(6) All hospitals which are required to report data by T.C.A. §68-1-108 shall designate one staff member to be responsible for reporting the UB-92 claims data.

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

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

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

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

(1) Frequency of data submission is as follows:

Paper UB-92's	Monthly
Computer Media	Quarterly

(2) Computer media submission of required data shall adhere to the following quarterly schedule:

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

(3) All required data must be received by Health Statistics within 60 days following the close of the quarter.

(4) As of July 1, 1997, all data submissions must be in the form of computer media (e.g., magnetic tape, diskettes). Paper UB-92 forms will no longer be accepted by the Department after June 30, 1997.

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

1200-7-3-.04 PENALTY ASSESSMENT.

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

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

(3) Penalties will be initially assessed for discharges due to be reported March 1, 1997, and every quarter thereafter. (Form UB-92 data for 4th quarter 1996 discharges are due to be reported March 1, 1997.)

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

The number of delinquent outpatient claims reports for a quarter will be determined by summing outpatient data from Schedule D for percutaneous lithotripsy procedures, renal dialysis patients, adult and pediatric cardiac catheterizations, adult and pediatric outpatient percutaneous transluminal coronary angioplasty, adult and pediatric streptokinase infusions, adult and pediatric other cardiac catheterizations, the number of outpatient surgery operations, the number of cryosurgery patients, the number of microsurgery patients, and from Schedule I, the number of emergency room visits from a facility's most recent, final

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

Joint Annual Report. (ER visits will not be used in the calculation until claims for services provided in 1997 are reported.) This estimate will be used to calculate the penalty assessed. Any positive or negative adjustments to the fine estimate, up to a maximum of ten (10) percent will be made once the actual claims reports are received by the Department of Health.

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

(6) The department will allow 5% error rate on data submitted for discharges occurring through calendar year 1997. For discharges occurring during calendar year 1998, the allowable error rate will be no more than 3%. For discharges occurring on or after January 1, 1999, the allowable error rate will be no more than 2%. Records that fall within the acceptable rate will not be subject to any penalties. Hospitals that exceed the acceptable error rate will be penalized based on total errors (not on errors minus 5% or error minus 3% or errors minus 2%).

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

(8) Upon receipt of the penalty assessment, the hospital has the right to an informal conference with the Commissioner. A written request for an informal conference must be received by the Commissioner within thirty (30) days of the assessment and with a copy being sent to the Director of Health Statistics and Information within the same time frame.

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

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

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

(12) After the conference with the Commissioner or the time frame for requesting a conference has expired, the Commissioner can collect the penalties unless the hospital appeals the Commissioner's decision. Penalties may be off set by funds owed to the hospital by the Department of Health and/or the Department of Finance and Administration. However, if the hospital wishes to appeal the decision of the Commissioner, a request in writing for a hearing before an Administrative Law Judge must be sent to the Commissioner within ten (10)

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

Joint Annual Report. (ER visits will not be used in the calculation until claims for services provided in 1997 are reported.) This estimate will be used to calculate the penalty assessed. Any positive or negative adjustments to the fine estimate, up to a maximum of ten (10) percent will be made once the actual claims reports are received by the Department of Health.

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

(6) The department will allow 5% error rate on data submitted for discharges occurring through calendar year 1997. For discharges occurring during calendar year 1998, the allowable error rate will be no more than 3%. For discharges occurring on or after January 1, 1999, the allowable error rate will be no more than 2%. Records that fall within the acceptable rate will not be subject to any penalties. Hospitals that exceed the acceptable error rate will be penalized based on total errors (not on errors minus 5% or error minus 3% or errors minus 2%).

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

(8) Upon receipt of the penalty assessment, the hospital has the right to an informal conference with the Commissioner. A written request for an informal conference must be received by the Commissioner within thirty (30) days of the assessment and with a copy being sent to the Director of Health Statistics and Information within the same time frame.

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

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

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

(12) After the conference with the Commissioner or the time frame for requesting a conference has expired, the Commissioner can collect the penalties unless the hospital appeals the Commissioner's decision. Penalties may be off set by funds owed to the hospital by the Department of Health and/or the Department of Finance and Administration. However, if the hospital wishes to appeal the decision of the Commissioner, a request in writing for a hearing before an Administrative Law Judge must be sent to the Commissioner within ten (10)

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

business days of the Commissioner's written determination. Issues involving collection of penalties directly from hospitals resolved by an Administrative Law Judge will be in accordance with the Uniform Administrative Procedures Act.

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

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

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

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

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

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

(4) After all data have been computerized, edited, updated, and determined to be the final corrected set by Health Statistics and Information, each hospital shall be given the opportunity to review the entire data set relating to their hospital, if they so desire. At the same time, they may review the tabulations based on that data set. The Tennessee Department of Health - Health Statistics and Information shall provide to the reporting hospitals tabulations of the facility-specific information at least thirty days (30) prior to release of printed information to the public.

(5) The hospital shall notify Health Statistics and Information in writing of any errors in the tabulations or the data set. Valid explanations of the errors and documentation including correct data must be provided with the notification. The hospital shall provide corrected records for the data set.

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

1200-7-3-.06 DATA AVAILABILITY.

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

(2) No facility data will be released to that particular facility until it has been processed by the Department of Health.

(3) No data will be released to the public until the verification process is completed.

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

(Rule 1200-7-3-.06, continued)

(5) Selected data of a non-confidential nature will be released to the public following verification by the hospital. A fee based on the content, use, and amount of data shall be charged to each person requesting the information.

(6) Three types of data files will be made available for release and purchase:

(a) Research-use files containing no physician identifiers will be available solely for use by the purchaser; the data may not be given or sold to another entity.

(b) General-use files containing reported physician identifiers will be available solely for use by the purchaser; the data may not be given or sold to another entity.

(c) Vendor-use files containing reported physician identifiers will be available and may be reedited and/or resold by the purchaser.

(7) Fees associated with the data files will be as follows. A higher fee will be charged for data files which contain physician identifiers, and for files which can be reedited and/or resold by the purchaser. No fee will be charged to a hospital for its own finalized data.

(a) The fee for a research-use file will be $625 per quarter of data.

(b) The fee for a general-use file will be $2,500 per quarter of data.

(c) The fee for a vendor-use file will be $12,500 per quarter of data.

The same fee will be charged for requests for inpatient-only files as for files including emergency room and outpatient discharges. The fee for a subset of a file, whether total or inpatient-only, will be based on the proportion of records selected plus 10% of the fee for the entire file.

(8) Publications containing summarization of quarterly data will be prepared and distributed by Health Statistics and Information following the end of each calendar quarter.

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

1200-7-3-.07 CONFIDENTIAL INFORMATION.

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

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

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

(4) Neither the Department of Health nor THA shall release information to the public in violation of any other statutory provisions for confidentiality of health related matters or the providers of health services.

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

(Rule 1200-7-3-.07, continued)

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

1200-7-3-.08 REPEALS.

(1) Reporting entities should be cognizant of the following repeals:

	Repeals
Rule 1200-7-3-.01	"Definitions" is repealed in its entirety.
Rule 1200-7-3-.02	"Advisory Committee" is repealed in its entirety.
Rule 1200-7-3-.03	"Data Elements and Submission of Data" is repealed in its entirety.
Rule 1200-7-3-.04	"Verification of Data" is repealed in its entirety.
Rule 1200-7-3-.05	"Confidentiality" is repealed in its entirety.
Rule 1200-7-3-.06	"Accessibility" is repealed in its entirety.
Rule 1200-7-3-.07	"Maintenance of Data" is repealed in its entirety.

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

FORMS

Transmittal Information Form
Reporting Method Form
UB-92 Reporting Form

HOSPITAL DISCHARGE DATA SYSTEM
TRANSMITTAL INFORMATION FORM

PLEASE COMPLETE & E-MAIL WITH DATA TO: Nerissa.Harvey@state.tn.us or Glenn.Baker@state.tn.us

Hospital Discharge Data System
Division of Health Statistics
Cordell Hull Building - 4th Floor
425 Fifth Avenue North
Nashville, TN 37247-5262

Date:

For State Use ONLY Facility ID#**:**

HOSPITAL IDENTIFICATION

Hospital Name:

Hospital Address:

Hospital Contact Person:

Phone No.: ( ) Fax No.: ( )

Vendor Name:

Vendor Add**:**

Vendor Contact Person:

Phone No.: ( ) Fax No.: ( )

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

1. **ORIGINAL** **REPLACE** **TEST** **2. QUARTER** **YEAR**

3. Format: ASCII EBCIDIC 4. **LABEL:** Standard Non Labeled

5. Record Length:

6. Blocksize: 7. Total Record Count:

8. Record Types: Inpatient Outpatient Amb-Surgery Other (Specify)

MEDIA SPECIFICATIONS: Check and enclose **ONLY one** type per transmittal.

E-Mail **M S Dos 3 ½ Diskette**

CD **Mag. Cartridge IBM 3840**

Instructions: Please complete in detail for each E-Mail, CD, Diskette or Cartridge Data having one or more files. List first (1st) file as primary or principal data file as it relates to hospital information given above; then list other files in order as they appear on the media.

File #	Facility Name/ with Medicare#	Number of Records/Cases	Internal File Name / Dataset Name (DSN)
1.			
2.			
3.			

HOSPITAL DISCHARGE DATA SYSTEM
REPORTING METHOD FORM

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

FACILITY NAME:

ADDRESS:

Person completing this form: **Telephone:**

Fax Number: **Signature:** **(int.):** **Date:**

For 4th quarter 2004, this facility will submit UB-92 data by the following method(s):

I. INPATIENT DISCHARGES:

1. Check one and provide date.

☐ Inpatient data will be submitted to **HIDI** by (date)

☐ Inpatient data will be submitted directly to the Tennessee Department of Health by (date)

2. If reporting inpatient data directly to the ***Department of Health***, check one method that will be used:

☐ E-Mail Attachment ☐ MS DOS 3.5" diskette

☐ CD-ROM ☐ Mag. cartridge IBM 3480

II. SELECTED OUTPATIENT/EMERGENCY ROOM DISCHARGES:

1. Check one and provide date.

☐ Outpatient/ER data will be submitted to **HIDI** by (date)

☐ Outpatient/ER data will be submitted directly to the Tennessee Department of Health by (date)

2. If reporting outpatient/ER data directly to the ***Department of Health***, check one method that will be used:

☐ E-Mail Attachment ☐ MS DOS 3.5" diskette

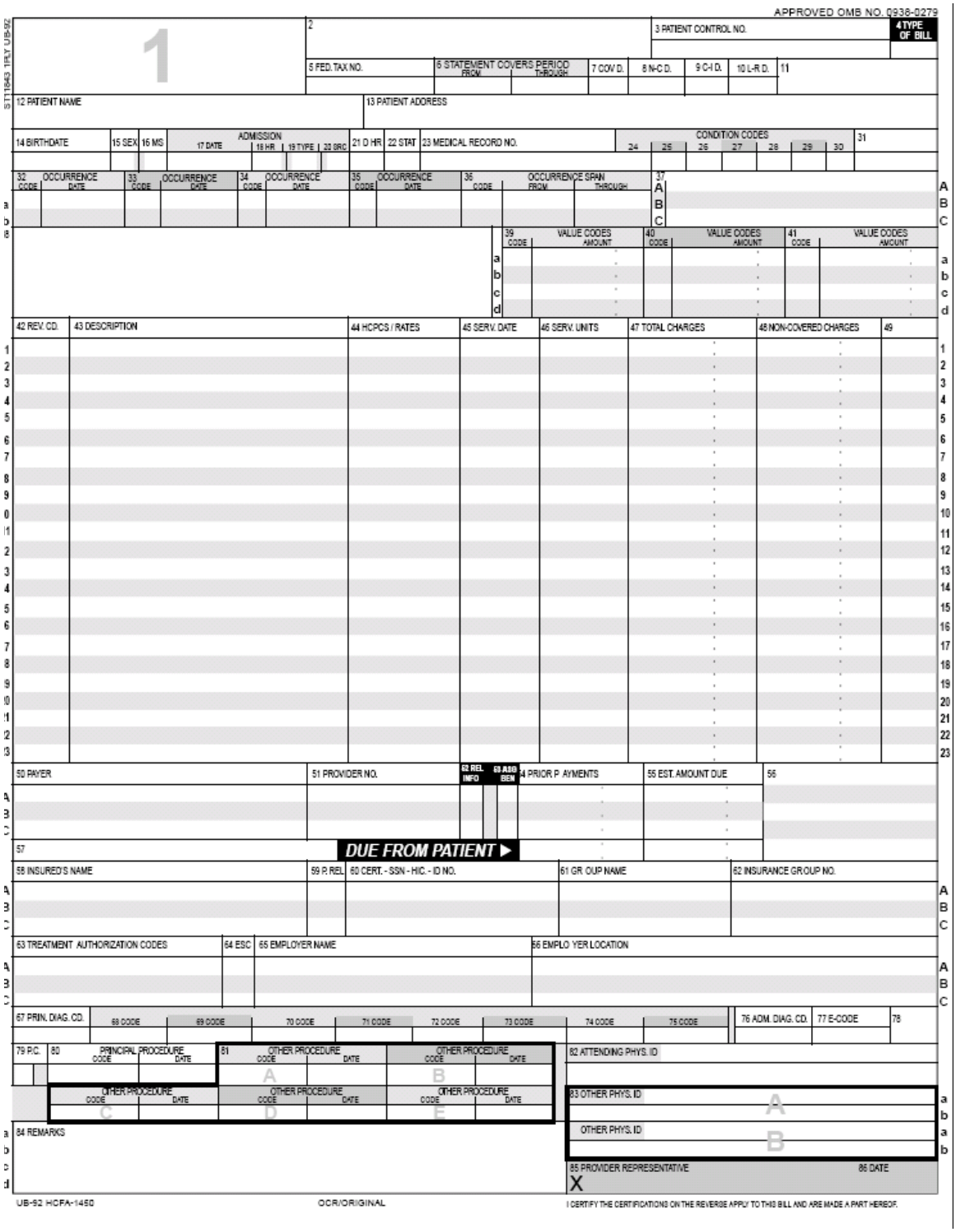
☐ CD-ROM ☐ Mag. cartridge IBM 3480

E-mail this completed form to: Nerissa.Harvey@state.tn.us by **February 15, 2005**.

You may also fax this completed form to Nerissa Harvey @ 615-253-1688.
Or mail the completed form to Nerissa D. Harvey at the address below:

Division of Health Statistics
Hospital Discharge Data System
Cordell Hull Building
425 5th Avenue North, 4th Floor
Nashville, TN 37247-5262

UB-92 FORM


APPROVED OMB NO. 0938-0279
1
2
3 PATIENT CONTROL NO.
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D.
8 N-C D.
9 C-I D.
10 L-R D.
11
12 PATIENT NAME
13 PATIENT ADDRESS
14 BIRTHDATE
15 SEX
16 MS
17 DATE
18 HR.
19 TYPE
20 SRC
ADMISSION
21 D HR
22 STAT
23 MEDICAL RECORD NO.
CONDITION CODES
24 25 26 27 28 29 30
31
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE CODE DATE
36 OCCURRENCE SPAN CODE FROM THROUGH
37
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
50 PAYER
51 PROVIDER NO.
62 REL INFO
63 A1B1 B1EM
64 PRIOR P AYMENTS
55 EST. AMOUNT DUE
56
57
DUE FROM PATIENT ▶
58 INSURED'S NAME
59 P. REL
60 CERT. - SSN - HIC. - ID NO.
61 GR OUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLO YER LOCATION
67 PRIN. DIAG. CD.
68 CODE
69 CODE
70 CODE
71 CODE
72 CODE
73 CODE
74 CODE
75 CODE
76 ADM. DIAG. CD.
77 E-CODE
78
79 P.C.
80 PRINCIPAL PROCEDURE CODE DATE
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS
85 PROVIDER REPRESENTATIVE
X
86 DATE
UB-92 HCFA-1450
OCR/ORIGINAL
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

U.S. STANDARD STATE ABBREVIATIONS

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

CANADIAN PROVINCES

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

IF OTHER THAN THE UNITED STATES OR CANADA, USE CODE – XX

REPORTING REQUIREMENTS PRIOR TO 2005

Reportable Records
ICD-9-CM Procedure Codes for 1995-1996
ICD-9-CM Procedure Codes for 1997-2004
ICD-9-CM Procedure Codes 2005 forward
Required Data Elements
TennCare Payer Codes 1994-1999
Payer Codes 2000-2004
Payer Codes 1995-1999
Patient Relationship to Insured Codes for 1995-2004
Patient Status Codes 1995-2004

Reportable Records

In earlier years of hospital discharge reporting there were fewer reporting requirements. Inpatient records were always reported, but fewer outpatient records were required. For 1995-1996 hospital records had to be reported if they met one of two reporting requirements. These were (1) all inpatient discharges, and (2) outpatient visits for selected ambulatory surgical procedures. The outpatient visits were selected for reporting if they had one or more procedures in any procedure code field that was listed in the table printed on the following page.

For 1997-1999 all hospital records had to be reported in they met one of three reporting requirements. These were (1) all inpatient discharges, (2) all emergency room visits, and (3) all outpatient visits for ambulatory surgery. An emergency room visit was defined as one in which the hospital bill had one or more charges with a revenue code of "450" or "459" in any revenue code field. An outpatient visit for ambulatory surgery was defined as one in which the hospital bill had one or more procedures with an ICD-9-CM procedure code in the range "01.01"-"86.99" in any procedure code field.

Beginning January 1, 2000, all hospital records must be reported to the Department which meet one or more of the four reporting requirements. The four reporting requirements are (1) all inpatient discharges, (2) all emergency room visits, (3) all outpatient visits for ambulatory surgery (see page 109), and (4) all outpatient observation stays. The details for these reporting requirements are given in Section II.5.2.

In January 2005, selected diagnostic services were added to the reporting requirement. The details for reporting these services are given in Section II.5.2.

ICD-9-CM Procedure Codes For 1995-1996

Reporting of 1995-1996 outpatient and emergency room discharges will be limited to the outpatient and emergency room encounters that involve specific procedures or conditions listed below:

01.01 – 12.40
12.42 – 12.72
12.74 – 14.22
14.26 – 14.32
14.39 – 14.52
14.59 – 16.91
16.93 – 16.98
18.01 – 18.09
18.45 – 21.1
21.22 – 22.12
22.2 – 29.0
29.12 – 31.3
31.45 – 33.1
33.25 – 33.26
33.28 – 34.1
34.23 – 35.99
36.03 – 36.04
36.10 – 37.12
37.24 – 38.89
38.94
38.98 – 39.58
39.61 – 39.94
39.96 – 42.19
42.24 – 44.03
44.15 – 45.03
45.15
45.26
45.31 – 45.41
45.49 – 48.1
48.25 – 48.32
48.34 – 49.12
49.22 – 49.29
49.39 – 51.03
51.12 – 51.13
51.15 – 51.22
51.31 – 51.43
51.51 – 51.63
51.69 – 51.83
51.89 – 51.95
51.99 – 52.12
52.19
52.22 – 52.92
52.95 – 52.96
52.99 – 54.0
54.22 – 54.23
54.25 – 55.03
55.11 – 55.12
55.23 – 55.99
56.1 – 56.2
56.32 – 56.99
57.1 – 57.22
57.33 – 58.21
58.23 – 59.94
59.99 – 66.19
66.31 – 67.0
67.12 – 67.33
67.4 – 68.11
68.13 – 68.14
68.19 – 68.22
68.3 – 69.09
69.21 – 69.23
69.3 – 69.97
70.0 – 70.14
70.23 – 80.19
80.3 – 86.99

ICD-9 Procedure codes 1997 – 2004

The definition of ambulatory surgery is any outpatient discharge with ICD-9 procedure code 01.01-86.99 in ANY procedure code field.

ICD-9 Procedure codes 2005 forward

The definition of ambulatory surgery is any outpatient discharge with ICD-9 procedure code 00.01-86.99 in ANY procedure code field.

Required Data Elements

Four data elements did not become part of the Hospital Discharge Data System reporting requirements until January 1, 1997:

1. Patient Address, City and State
2. Medical/Health Record Number
3. Patient Social Security Number
4. Patient Race/Ethnicity

These four elements are not present in Hospital Discharge Data System data for the years 1995 and 1996. They are present in 1997 data forward.

In January 2005, the "detail" payer codes in positions 1252 – 1253 of the 1600-character record will no longer be captured. "Basic" payer codes (primary, secondary and tertiary) will continue to be required and occupy positions 1213 –1218 in the 1600-character record. These detail codes were collected for 2000 – 2004 discharges.

TennCare Payer Codes 1994 -1999

The 1996 version of the Hospital Discharge Data System Procedure Manual listed a set of one-digit payer codes for use by reporting hospitals. However, hospitals were allowed to continue using a set of one- and two- digit payer codes that had been given in the 1994 version of the manual.

The following table gives both sets of these older payer codes and the meaning of each code:

1994 Code	1996 Code	Payer Classification
T	T	TennCare-Plan Unspecified
TA	2	Access-Med Plus
TB	3	Blue Cross
TC	4	Advantage Care/Phoenix
TD	5	Omni Care (formerly Affordable Health Care)
TE	6	Health Net
TF	7	VHP Community Care
TG	8	John Deere/Heritage
TH	9	Preferred Health Partnership
TI	A	Prudential Community Care
TJ	F	TLC Family Care Healthplan
TK	G	Tennsource
TL	J	Blue Care (formerly Total Health Plus)
-	U	Tennessee Behavioral Health, Inc.
-	X	Premier Behavioral Systems of Tennessee

The last two codes (U and X) are for organizations incorporated into the TennCare system to provide health care benefits including mental health and substance abuse services.

Payer Codes 2000 – 2004

Beginning January 1, 2000, all hospital records must be reported to the Department using the revised set of payer codes. In earlier years two different, but equivalent sets of payer codes were used.

Field Name	UB-92 Form Locator Number	HDDS File Positions	Format
Payer Classification	**Form Locator 50**		
	Primary 50A	1213-1214	Left Justified.
	Secondary 50B	1215-1216	
	Tertiary 50C	1217-1218	

CODE	DETAIL	PAYER CLASSIFICATION
B		Blue Cross/Blue Shield (not managed care)
C		Federal, Champus (military)
D		Medicaid (not TennCare)
I		Commercial Insurance (not managed care)
M		Medicare (not managed care)
N		Division of Health Services (Voc. Rehab.)
O		Other, Unknown
P		Self Pay
S		Self Insured, Self Administered
W		Workers/State Compensation
Z		Medically Indigent/Free
		TennCare Codes
T		TennCare-Plan Unspecified
2		Access-Med Plus
3		Blue Cross
4		Advantage Care/Phoenix/Xantus
5		Omni Care
6		Health Net
7		VHP Community Care
8		John Deere/Heritage
9		Preferred Health Partnership
A		Prudential Community Care
F		TLC Family Care Healthplan
G		Tennsource
J		Blue Care
Q		TennCare Select
R		Better Health Plans, Inc.
V		Universal Care of Tennessee

Payer Codes 2000 – 2004

(continued from previous page)

CODE	DETAIL	PAYER CLASSIFICATION
		TennCare Codes (cont'd.)
		TennCare Behavioral Codes
E		BHO – plan unspecified
U		Tennessee Behavioral Health, Inc.
X		Premier Behavioral Systems of TN
		Blue Cross Managed Care – HMO/PPO/Other Managed Care
H		Name of plan not specified
H	H01	HMO Blue
H	H02	Blue Preferred
H	H03	TPN
H	H04	BC Memphis/Apple
H	H05	Blue Classic
H	H06	Blue Select
		Commercial (Managed Care-HMO/PPO/Other Managed Care)
L		Name of plan not specified
L	L01	United Healthcare
L	L02	Aetna/US Healthcare
L	L03	Cigna and/or Healthsource
L	L04	Cariten
L	L05	Health Net
L	L06	Prudential
L	L07	John Deere/Heritage
L	L08	Tripoint
L	L09	Private HealthCare Systems
L	L10	Affordable/First Health
		Payer Classification Medicare (HMO/PSO)
K		Name of plan not specified
K	K01	Health 123
K	K02	Health Net
K	K03	Cariten
K	K04	United Healthcare
K	K05	Blue Cross
K	K06	Heritage/John Deere
K	K07	Cigna

Payer Codes 1995-1999

Field Name	UB-92 Form Locator Number	HDDS File Positions	Format
Payer Classification	**Form Locator 50** Primary 50A Secondary 50B Tertiary 50C	 1213-1214 1215-1216 1217-1218	Left Justified.

CODE	PAYER CLASSIFICATION	CODE	PAYER CLASSIFICATION
	Other Payer Codes		**TennCare Codes**
B	Blue Cross/Blue Shield	T	Tenncare-Plan Unspecified
C	Federal, Champus (Military)	2	Access-Med Plus
D	Medicaid	3	Blue Cross
E	County or State Employee	4	Advantage Care/Phoenix
H	HMO/Managed Care	5	Omni Care
I	Commercial Ins. (Indemnity Carrier)	6	Health Net
L	Managed Assistance	7	VHP Community Care
M	Medicare	8	John Deere/Heritage
1	Medicare Managed Care	9	Preferred Health Partnership
N	Div. of Health Services (Voc. Rehab.)	A	Prudential Community Care
O	Other, Unknown	F	TLC Family Care Healthplan
P	Self Pay	G	Tennsource
S	Self Insured	J	Blue Care
W	Workers/State Compensation		**TennCare Behavioral**
Z	Medically Indigent/Free	U	Tennessee Behavioral Health, Inc.
		X	Premier Behavior Systems of TN

PATIENT'S RELATIONSHIP TO INSURED 1995-2004

Field Description	UB-92 Form Locator Number	HDDS File Position	Format
Patient Relationship to Insured	59A	459-460	Left Justified

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

Valid Values:

Code	Patient's Relationship to Insured	Explanation
01	Patient is insured	Self-explanatory.
02	Spouse	Self-explanatory.
03	Natural Child/Insured has Financial Responsibility	Self-explanatory.
04	Natural Child/Insured does not Have Financial Responsibility	Self-explanatory.
05	Step Child	Self-explanatory.
06	Foster Child	Self-explanatory.
07	Ward of the Court	Patient is ward of the insured as a result of a court order.
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship is unknown.
10	Handicapped Dependent	Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage.
11	Organ donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.

PATIENT'S RELATIONSHIP TO INSURED 1995-2004

(continued from previous page)

Code	Patient's Relationship to Insured	Explanation
12	Cadaver donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's coverage.
13	Grandchild	Self-explanatory.
14	Niece/Nephew	Self-explanatory.
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insurance.
16	Sponsored Dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.
17	Minor Dependent of a Minor Dependent	Code is used where the patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured.
18	Parent	Self-explanatory.
19	Grandparent	Self-explanatory.
20	Life Partner	Self-explanatory.

Comments:

The code "09" should be used when this relationship is not known to the hospital. Note that Payer codes "0" (Other/Unknown), "P" (Self-Pay), and "Z" (Medically Indigent/Free) may use code "09" in this field, or this field may be left blank. For all other payer codes, blank in this field is considered an error.

PATIENT STATUS CODES 1995-2004

Field Description	UB-92 Form Locator Number	HDDS File Position	Format
Patient Status	22	80-81	Right Justified

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

Valid Values:

Code	Patient Status
01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short term general hospital for inpatient care.
03	Discharged/transferred to a skilled nursing facility (SNF).
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under the care of a Home IV provider.
09	Admitted as an inpatient to this hospital (only for Medicare outpatient claims).
10	Discharged/transferred to a Mental Health Center.
20	Deceased.
30	Still a patient or expected to return for outpatient services.
40	Expired at home (Medicare and CHAMPUS claims for hospice care).
41	Expired in a medical facility (Medicare and CHAMPUS claims for hospice care).
42	Expired-place unknown (Medicare and CHAMPUS claims for hospice care).
43*	Discharged/transferred to a Federal hospital.
50	Hospice – home.
51	Hospice – medical facility.
61	Discharged/transferred to a hospital-based swing bed within this institution.
62	Discharged/transferred to another rehabilitation facility including rehabilitation Distinct parts units of a hospital.
63	Discharged/transferred to a long-term care hospital.
64**	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
71***	To another institution for outpatient services.
72***	To this institution for outpatient services.

For interim bills, patient status should be "30".
* Effective 10/01/03
** Effective 10/01/02
*** Discontinued after 9/30/03