Indiana Hospital Data Submission Portal

of the Indiana Hospital Association

INHDS-Indiana Hospital Data Submission Manual

INTRODUCTION

Pursuant to Indiana Code IC 16-21-6-6, Indiana Hospitals are required to submit monthly "patient information" to the Indiana State Department of Health. The Indiana Hospital Association is the named vendor to complete this data transaction effort. Indiana hospitals are required to submit inpatient and outpatient claim information on patient encounters that match the Indiana Hospital Association's (IHA) definition (Appendix I) for inclusion in the statewide databases, including self-pay and no-pay claims. These format changes explained in this document are effective for discharges of ***January 1, 2021***, and after.

These specifications are to be used as a companion guide to the corresponding ASC Health Care Claim: Institutional Consolidated Guide, version 005010X223A2. Reference the ASC X12 837I Technical Reports Type 3 (TR3) and modify specific data elements to create the Indiana-specific transaction for submission. IHA does not provide the TR3 documents, but they are available from the Washington Publishing Company at www.wpc-edi.com.

Modifications to the X12 837I v5010 are specified to ensure hospital compliance for submitting to IHA through electronic administrative data. The modifications do not, however, contradict or otherwise modify the X12 837 v5010 in a manner that will make its use noncompliant. In addition, these changes are separate from and do not impact how claims are submitted to for payment.

IHA also aligns with the Official UB-04 Data Specifications Manual, published and maintained by the National Uniform Billing Committee (NUBC), for claim-specific codes where applicable.

Due Dates

The INHDS program operates two reporting intervals. Data meeting the requirements specified in this manual are required monthly by the 1st of the month. Quarterly data due dates are 60 days from the end of a quarter with an additional two-week verification* period for data correction:

Discharges	Due Date	Quarterly Verification Due
January	April 1st	Due June 1st*
February	May 1st	
March	June 1st	
April	July 1st	Due September 1st*
May	August 1st	
June	September 1st	

July	October 1st	Due December 1st*
August	November 1st	
September	December 1st	
October	January 1st	Due March 1st*
November	February 1st	
December	March 1st	

Quarterly verifications are required for full release of INHDS data into all of IHA's Data Assets for use by membership.

Minimum compliance levels for quarterly data submission are as follows:
Inpatient – 100%
Outpatient – 100%

General Rules for Submission of INHDS Data

Data fields are transmitted to INHDS using an Indiana-specific X12 837I v5010. General rules for X12 837I v5010 compliance are required for batch acceptance.

Compliance with X12 837I v5010 includes but is not limited to:

- Batches need to be submitted according to standard with header (ST = beginning of transaction) and trailer (SE= end of transaction) sets.
- Required GS08 in the Functional Group Header uses code 005010X223A2.
- ISA and IEA must have exactly same control numbers.
- Detail information on the claim is comprised of hierarchical structure in a series of loops. Hierarchical level segments (HL) indicate the provider, subscriber and patient information.
- HL segments are numbered sequentially within a transaction set (ST to SE) with the sequential number found in HL01, the first data element in the HL segment. HL segments must be unique.
- HLs may contain multiple 'child' HLs which indicate an HL nested within the previous HL. 'Parent' HLs are required when a 'child' HL exists.

Batch failures include but are not limited to:

- File is not compliant with X12 837I v5010 format.
- File does not have required data elements (i.e. Facility NPI).

- More than 50% of batch contains duplicate records.

Indiana-specific X12 837I v5010 modifications include:

- Hospital Number – Each facility must coordinate with IHA on a single NPI to be used for submitting required INHDS data.
- Bill Type – As detailed on page 5, Bill Type will determine Patient Type (either Inpatient or Outpatient) AND inpatient Place of Service. See Appendix II.
- Patient SSN – Last 4 digits of Patient SSN are required, if unknown, populate **9999**. For newborns report, **0000**.
- Patient's Gender Identity – The gender of the patient. Map hospital-system codes to Appendix VII.
- Race – Required on all records. Map hospital-system codes to Appendix V.
- Ethnicity – Required on all records. Map hospital-system codes to Appendix VI.
- Patient's Primary Spoken Language – Required on all records. Map hospital-system codes to Appendix XV.
- Primary Expected Source of Pay, Second Expected Source of Pay and Third Expected Source of Pay – Map to Appendix VIII.
- Patient's First Name, Patient Last Name and Patient Address #1– Required on all records.
- Admission Date – Required on all records.
- Admission Hour – Required on all records.
- Priority (Type) of Admission – Required on all records. See Appendix X.
- Point of Origin/Source of Admission – Required on all records. See Appendix XI.
- POA – Required on ALL Inpatient Types, E-code and other/additional diagnoses unless the ICD-10 code is exempt. See Appendix XIII.

Assignment of Patient Type/Inpatient Place of Service

ASSIGNMENT OF PATIENT TYPE

Each facility determines whether a record is inpatient or outpatient. Inpatient Place of Service is also determined by each facility. Bill Type will define the Patient Type and the inpatient Place of Service of submitted records. Extreme care is required to assign patient records to the service they receive.

Inpatient Patient Type and Place of Service assignment must occur as follows.

* Place of Service 1 – **Acute Inpatient/Surgical Unit** – Bill Type **0111**
* Place of Service 2 – **Psychiatric Unit** – Bill Type **0171**
* Place of Service 3 – **Rehabilitation Unit** – Bill Type **0151**
* Place of Service 4 – **SNF/ICF/Other LTC/Hospice/Subacute/Swing Bed** - Bill Types **0181,0211** or **0821**
* Place of Service 5 **– Drug/Alcohol Rehabilitation Unit** - Bill Type **0241**

* Place of Service 6 **– Pediatric Unit–** Bill Type **0311**

Any other Bill Type will identify a record as Outpatient. This includes records submitted with invalid Bill Types. Outpatient Place of Service is determined in a hierarchical fashion depending on the Revenue Codes on each claim.

Other reporting rules:

- Inpatient
  - Service line information (revenue portion) should be summary level claim information where all the charges are summarized (rolled-up) by revenue code.
    - Inpatient procedure information is reported using ICD-10 procedure codes (Loop 2300, HI segment).
  - Repeat HI segments to report ALL inpatient ICD-10 diagnoses and ALL inpatient ICD-10 procedures codes associated with each claim.

- Outpatient
  - Service line information (revenue portion) should be detail level claim information where all revenue lines are submitted.
  - Outpatient procedure information is reported using CPT and/or HCPCS (Loop 2400, SV2 segment).
  - Repeat HI segments to report ALL outpatient ICD-10 diagnoses associated with each claim.
  - Repeat SV2 segments to report ALL outpatient CPT/HCPCS procedure codes associated with each outpatient claim.

FILE FORMAT DATA DICTIONARY

INHDS Description	INHDS Field Name	INHDS Field Description	Data Type*	Instructions	INHDS Required (R)/ Situational (S)		Inpt(I)/ Out(O)	NUBC FL
Hospital Number	HNUM	The NPI assigned to the facility. Hospital must coordinate with IHA on a single NPI to be used for submitting required INHDS information.	N		R		I/O	56
Patient Last Name	PTLASTNAME	The Last Name of the patient.	A		R		I/O	8b
Patient First Name	PTFIRSTNAME	The First Name of the patient.	A		R		I/O	8b
Patient Middle Name	PTMIDDLENAME	The Middle Name of the patient.	A		S	Required if available.	I/O	8b
Patient Name Suffix	PTNAMESUFFIX	The Name Suffix of the patient.	A		S	Required if available.	I/O	8b
Patient Address 1	PTADDRESS1	The first mailing address of the patient. Enter the complete mailing address including street number and name.	AN		R		I/O	9a
Patient Address 2	PTADDRESS2	The second mailing address of the patient. Enter the complete mailing address including street number and name.	AN		S	Required if available.	I/O	9a
Patient City	PTCITY	The City where the patient resides.		Will be derived from ZIP code. No action necessary.				

Patient State	ST	The State where the patient resides. Report "**88**" for foreign and "**99**" unknown addresses. For homeless patients report the state code "**77**".Refer to **Appendix IV.**	A		R		I/O	9c
Patient ZIP code	ZIP	The ZIP code where the patient resides. **'99999**' should be used for patients that do not reside in the United States. Use '**00000**' where the Zip code is unknown.	N		R		I/O	9d
Date of Birth	BDAT	The Birth Date of the patient.	N	CCYYMMDD	R		I/O	10
Patient Birth Gender	SEX	The Birth Gender of the patient. Refer to **Appendix VII.**	A	F, M, U	R		I/O	11
Patient Gender Identity		The Gender Identity of the patient. Refer to **Appendix VII.**		F, M, U, T	S		I/O	
Patient Race	RACE	The Race of the patient. Refer to **Appendix X**.	AN	Hospital Race codes must be mapped to IHA's race codes.	R		I/O	
Patient Ethnicity	ETHNICITY	The Ethnicity of the patient. Refer to **Appendix VI**.	AN	Hospital Ethnicity codes must be mapped to IHA's ethnicity codes.	R		I/O	
Patient Language	LANGUAGE	The Language of the patient. For Newborns use NA. Refer to **Appendix XV**.	A	Hospital Language codes must be mapped to IHA's language codes.	R		I/O	
Patient SSN	SSN	The Social Security Number (SSN) of the patient.	N	Last four digits of patient's Social Security ID number. Report '**0000**' for newborns, If Social	R		I/O	

				Security number is unknown report '**9999**'.				
Patient Relationship to Insured	RELATION	The patient's relationship to the primary insured.	AN		R		I/O	59
Expected Source of Pay	SOP	The Primary Expected Source of Payment for the claim. Refer to **Appendix VIII**.	AN	Hospital payer/ insurance tables must be mapped to IHA's expected source of pay codes.	R		I/O	51
Secondary Source of Pay	SOP2	Other Subscriber Information. Refer to **Appendix VIII**.			S	Required if available.	I/O	51
Tertiary Source of Pay	SOP3	Other Subscriber Information. Refer to **Appendix VIII**.			S	Required if available.	I/O	51
Type of Bill	BILLTYPE	Type of Bill will determine Patient Type. Refer to **Appendix II** for Patient Type assignment. **Appendix III** includes NUBC Bill Types. All hospital-based claims listed in **Appendix I** must be submitted, including self-pay and no-pay claims.	AN		R		I/O	4
Patient Control No.	PCONTROL	The patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services containing the financial billing records. Must	AN	Maximum number of characters supported in this field is 24.	R		I/O	3a

		be unique to avoid duplicate record edits.						
Medical/Health Record Number	MRN	The number assigned to the patient's medical/health record by the provider.	AN		R		I/O	3b
Admission Date/Hour	ADAT/AHOUR	The start date for this episode of care or the date of admission as an inpatient or outpatient visit. The 2-digit code referring to the hour during which the patient was admitted for admission. Refer to **Appendix IX**.	N	CCYYMMDDHHMM	R		I/O	12, 13
Priority (Type) of Admission	ADMT	The code indicating the priority of admission/visit. Refer to **Appendix X**.	AN		R		I/O	14
Point of Origin/Source of Admission	ADMS	The code indicating the point of patient origin for this admission/visit. Refer to **Appendix XI**.	AN	NOTE: Point of Origin code structure for Newborns is separate and specific to birth admissions.	R		I/O	15
Patient Discharge Status	PTSTATUS	The code indicating the disposition or discharge status of the patient at the end of the service for the period covered on the bill. Refer to **Appendix XII**.	N		R		I/O	17
Discharge Date/Hour	DDAT	The date of discharge as an inpatient or outpatient.	Will be derived from Statement Period Through date. No action necessary.					
	DHOUR	The 2-digit hour during which the patient was discharged. Refer to **Appendix IX**.	N	HH	R		I	16

Statement Covers Period From/Through Date	STPERIODF/ STPERIODT	The beginning and ending service dates of the period included on this bill.	N	CCYYMMDD-CCYYMMDD NOTE: Care should be taken to ensure that Statement Period Through Date is submitted properly to ensure that Discharge Date is correct.	R		I/O	6
Total Charges	TC	The total charge for primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Include both covered and non- covered.	N	Report as nnnnnnn.nn. Negative values must have leading minus sign (-). Absence of a sign indicates a positive value.	R		I/O	47
DRG	DRG	The MS-DRG associated with this claim for inpatient claims.	N		S	Required for inpatients if available.	I	
Principal Diagnosis Code	DXP	The ICD code that describes the principal diagnosis (i.e. the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.)	AN	Do not transmit decimal point.	R		I/O	67
POA - Principal Diagnosis Code	DXPPOA	The code indicating whether the principal diagnosis was present on admission. Refer to **Appendix XIII**.	A		S	Required for Inpatient.	I	67

Admitting Diagnosis	DXA	The ICD code that describes the patient's diagnosis at the time of inpatient admission.	AN	Do not transmit decimal point.	S		I	69
Patient Reason for Visit 1	REASVISIT1	The ICD code that describes the patient's primary reason for visit at the time of outpatient registration.	AN	Do not transmit decimal point.	S	Required for Outpatients if available.	O	70a
Patient Reason for Visit 2	REASVISIT2	The ICD code that describes the patient's second reason for visit at the time of outpatient registration.	AN	Do not transmit decimal point.	S	Required for Outpatients if available.	O	70b
Patient Reason for Visit 3	REASVISIT3	The ICD code that describes the patient's third reason for visit at the time of outpatient registration.	AN	Do not transmit decimal point.	S	Required for Outpatients if available.	O	70c
External Cause of Injury 1	DXECODE1	The ICD code pertaining to external cause of injury, poisoning or adverse effect.	AN	Do not transmit decimal point.	S	Required if available.	I/O	72a
POA - External Cause of Injury 1	DXECODE1POA	The code indicating whether a condition was present on admission. Refer to **Appendix XIII**.	A		S	Required for Inpatient.	I	72a
External Cause of Injury 2	DXECODE2	The ICD code pertaining to external cause of injury, poisoning or adverse effect.	AN	Do not transmit decimal point.	S	Required if available.	I/O	72b

POA - External Cause of Injury 2	DXECODE2POA	The code indicating whether a condition was present on admission. Refer to **Appendix XIII**.	A		S	Required for Inpatient.	I	72b
External Cause of Injury 3	DXECODE3	The ICD code pertaining to external cause of injury, poisoning or adverse effect.	AN	Do not transmit decimal point.	S	Required if available.	I/O	72c
POA - External Cause of Injury 3	DXECODE3POA	The code indicating whether a condition was present on admission. Refer to **Appendix XIII**.	A		S	Required for Inpatient.	I	72c
Other Diagnosis	DX	The ICD diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently or that affect the treatment received and/or the length of stay. Include any additional Ext Cause codes not reported in DXE1, DXE2 or DXE3.	AN	Repeat as needed to submit ALL other diagnoses. Do not transmit decimal point.	S	Required if available.	I/O	67a-q
POA - Other Diagnosis	DXPOA	The code indicating whether a condition was present on admission. Refer to **Appendix XIII**.	A		S	Required for Inpatient.	I	67a-q
Principal Procedure	PRP	The ICD procedure code that identifies the inpatient principal procedure performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes. If there appear to be two procedures that are principal, then the most	AN		S	Required for inpatients if available.	I	74

		related to the principal diagnosis should be selected as the principal procedure.						
Principal Procedure Date	PRPD	The date that the ICD inpatient principal procedure was performed.	N	CCYYMMDD	S	Required for inpatients if available.	I	
Other Procedure Code	PR	The ICD procedure codes that identify all significant procedures other than the principal procedure and the dates on which the procedures were performed.	AN	Repeat to submit ALL other procedure codes.	S	Required for inpatients if available.	I	74a - 74e
Other Procedure Date	PRD	The date of the ICD other procedure codes at the claim level during the period covered by this bill.	N	CCYYMMDD Repeat to submit ALL other procedure dates.	S	Required for inpatients if available.	I	
Attending Physician NPI	PINA	The individual NPI of the person who has overall responsibility for the patient's medical care and treatment reported in this claim. Submit 1234567890 when a valid individual NPI is not obtainable.	N		R		I/O	76
Operating Physician NPI	PINB	The individual NPI with primary responsibility for performing the principal procedure. Submit	N		S	Required when INPT or OUTPT surgery is	I/O	77

		1234567890 when a valid individual NPI is not obtainable.				performed. Leave blank if no surgery.		
Referring Physician NPI	PINC	The individual NPI of the person who sends the patient to another provider for services.	N		S	Required when meets NUBC criteria for referring provider. Leave blank if not available.	I/O	78-79
Other Operating Physician NPI	PIND	The individual NPI of the person who performs a secondary surgical procedure or assisting the Operating Physician.	N		S	Required when meets NUBC criteria for other surgeon. Leave blank if not available.	I/O	78-79
Rendering Physician NPI	PINE	The individual NPI of the health care professional who delivers or completes a particular medical service or non-surgical procedure.	N		S	Required when meets NUBC criteria for rendering prov. Leave blank if not available.	I/O	78-79
NUBC Billing Codes	CONDITION	The code used to identify conditions or events relating to this bill that may affect processing.	AN	Report Condition Codes P7 (Direct Admission from Emergency Room) here.	S	Required when available.	I/O	18 - 28
	OCCURSPAN	The code and date that identifies an event that relates to payment of this claim.	AN/N	CCYYMMDD-CCYYMMDD	S	Required when available.	I/O	35 - 36
	OCCUR	The code and date range defining a significant event	AN/N	CCYYMMDD	S	Required when available.	I/O	31 - 34

		relating to this bill that may affect payer processing.						
	VALUE	The code structure and value to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization.	AN	Report Value Code 54 (NB birthweight) here.	S	Required when available.	I/O	39 - 41
Revenue Code	REVCODE	The code that identifies specific accommodation, ancillary service or unique billing calculations or arrangements.	AN		R		I/O	42
HCPCS/Rates and up to 4 Modifiers	HCPCSRATE	CPT/HCPCS codes applicable to ancillary service on outpatient bills.	AN	Repeat to submit ALL other revenue lines with outpatient CPT/HCPCS.	S	Required on Outpatients if available.	O	44
	MODIFIER1	The code that clarifies or improves the reporting accuracy of the associated procedure code.	AN		S	Required on Outpatients if available.	O	44
	MODIFIER2	The code that clarifies or improves the reporting accuracy of the associated procedure code.	AN		S	Required on Outpatients if available.	O	44
	MODIFIER3	The code that clarifies or improves the reporting accuracy of the associated procedure code.	AN		S	Required on Outpatients if available.	O	44
	MODIFIER4	The code that clarifies or improves the reporting accuracy of the associated procedure code.	AN		S	Required on Outpatients if available.	O	44

Revenue Charge	REVCHG	The line item charge for the associated revenue code for the current billing period as entered in the statement covers period. Include covered and non- covered charges.	N	Report as nnnnnnn.nn. Negative values must have leading minus sign (-). Absence of a sign indicates a positive value.	R		I/O	47
Units of Service	UNITSERV	The quantitative measure of services rendered by revenue code to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.	N		R		I/O	46
Service Date	SERVDATE	The date the outpatient service was provided.	N	CCYYMMDD	S	Required on Outpatients.	O	45

*Data Type: N=numeric, A=alpha or AN=alphanumeric

**Inpatient service line information should be summary level where all the charges are rolled up by revenue code.
**Outpatient service line information needs to be a detailed claim with all revenue codes and all CPT/HCPCS associated with the submitted claims

INDIANA-SPECIFIC 837I v5010 SPECIFICATIONS

INHDS Description	837 v5010 Ref Designator Name	837 v5010 Loop	Ref Design	Example	837 v5010 Instructions
Hospital Number	Billing Provider Identifier	2010AA	NM109	NM1*85*2*ABC HOSPITAL*****XX***FACILITY NPI**~ (NM1*85*2*ABC HOSPITAL*****XX***123456790**~)	Loop 2010AA, NM101 = 85. Loop 2010AA, NM102 = 2. Loop 2010AA, NM108 = XX.
Patient Last Name	Subscriber Last Name	2010BA	NM103	NM1*IL*1***PATIENT'S LAST NAME***JOHN*TYLER**JR**~ (NM1*IL*1***SMITH***JOHN*TYLER**JR**~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Last Name	2010CA	NM103	NM1*QC*1***PATIENT LAST NAME***SALLY*J*~ (NM1*QC*1***SMITH***SALLY*J*~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient First Name	Subscriber First Name	2010BA	NM104	NM1*IL*1*SMITH***PATIENT'S FIRST NAME***TYLER**JR**~ (NM1*IL*1*SMITH****JOHN***TYLER**JR**~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient First Name	2010CA	NM104	NM1*QC*1*SMITH***PATIENT FIRST NAME***J*~ (NM1*QC*1*SMITH****SALLY***J*~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient Middle Name	Subscriber Middle Name	2010BA	NM105	NM1*IL*1*SMITH*JOHN***PATIENT'S MIDDLE NAME****JR**~ (NM1*IL*1*SMITH*JOHN****TYLER****JR**~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Middle Name	2010CA	NM105	NM1*QC*1*SMITH*SALLY***PATIENT MIDDLE NAME****~ (NM1*QC*1*SMITH*SALLY****J***~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.

Patient Name Suffix	Subscriber Name Suffix	2010BA	NM107	NM1*IL*1*SMITH*JOHN*TYLER**PATIENT'S NAME SUFFIX**~ (NM1*IL*1*SMITH*JOHN*TYLER****JR****~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Name Suffix	2010CA	NM107	NM1*QC*1*SMITH*SAM*J*PATIENT NAME SUFFIX~ (NM1*QC*1*SMITH*SAM*J***JR**~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient Address 1	Subscriber Address Line	2010BA	N301	N3*PATIENT ADDRESS 1~ (N3****123 MAIN STREET****~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Address Line	2010CA	N301	N3*PATIENT ADDRESS 1~ (N3****123 MAIN STREET****~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient Address 2	Subscriber Address Line	2010BA	N302	N3*123 MAIN STREET*PATIENT ADDRESS 2~ (N3*123 MAIN STREET****APT 212****~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Address Line	2010CA	N302	N3*123 MAIN STREET*PATIENT ADDRESS 2~ (N3*123 MAIN STREET****APT 212****~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient City	Will be derived from ZIP code. No action necessary.				
Patient State	Subscriber State	2010BA	N402	N4*INDIANAPOLIS*PATIENT'S STATE*46077~ (N4*INDIANAPOLIS****IN****46077~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient State	2010CA	N402	N4*INDIANAPOLIS*PATIENT'S STATE*46077~ (N4*INDIANAPOLIS****IN****46077~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient ZIP code	Subscriber ZIP code	2010BA	N403	N4*INDIANAPOLIS*IN*PATIENT'S ZIP CODE~ (N4*INDIANAPOLIS*IN*****46077****~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient ZIP code	2010CA	N403	N4*INDIANAPOLIS*IN*PATIENT'S ZIP CODE~ (N4*INDIANAPOLIS*IN*****46077****~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.

Date of Birth	Subscriber Birth Date	2010BA	DMG02	DMG*D8***PATIENT'S DATE OF BIRTH***M**RX:EX:XXX~ (DMG*D8***19690815***M**R1:E1:ENG~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Birth Date	2010CA	DMG02	DMG*D8***PATIENT'S DATE OF BIRTH***M**RX:EX:XXX~ (DMG*D8***19690815***M**R1:E1:ENG~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient Birth Gender	Subscriber Gender Code	2010BA	DMG03	DMG*D8*19690815***PATIENT'S BIRTH GENDER** **RX:EX:XXX~ (DMG*D8*19690815***M****R1:E1:ENG~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Gender Code	2010CA	DMG03	DMG*D8*19690815***PATIENT'S BIRTH GENDER****RX:EX:XXX~ (DMG*D8*19690815***M****R1:E1:ENG~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient Gender Identity	Patient Gender Identity	2300	NTE02	NTE*GID***PATIENT'S GENDER IDENTITY**~ (NTE*GID*M~)	Loop 2300, NTE01 = GID
Patient Race	Subscriber Race Code	2010BA	DMG05 - 1	DMG*D8*19690815*M****PATIENT'S RACE**:EX:XXX~ (DMG*D8*19690815*M****R1:**E1:ENG~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Race Code	2010CA	DMG05 - 1	DMG*D8*19690815*M****PATIENT'S RACE**:EX:XXX~ (DMG*D8*19690815*M****R1:**E1:ENG~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient Ethnicity	Subscriber Ethnicity Code	2010BA	DMG05 - 2	DMG*D8*19690815*M****RX:PATIENT'S ETHNICITY:XXX**~ (DMG*D8*19690815*M****R1:E1**:ENG~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Ethnicity Code	2010CA	DMG05 - 2	DMG*D8*19690815*M****RX:PATIENT'S ETHNICITY:XXX**~ (DMG*D8*19690815*M****R1:E1**:ENG~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Patient Spoken Language	Subscriber Language Code	2010BA	DMG05 - 3	DMG*D8*19690815*M****RX:EX:PATIENT'S LANGUAGE**~ (DMG*D8*19690815*M****R1:E1:ENG**~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Patient Language Code	2010CA	DMG05 - 3	DMG*D8*19690815*M****RX:EX:PATIENT'S LANGUAGE**~ (DMG*D8*19690815*M****R1:E1:ENG**~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.

Patient SSN	Subscriber Supplemental Identifier	2010BA	REF02	REF*SY*PATIENT'S LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER~ (REF*SY*1234~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1. Loop 2010BA, REF01 = SY.
	Patient Supplemental Identifier	2010CA	REF02	REF*SY*PATIENT'S LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER~ (REF*SY*1234~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1. Loop 2010CA, REF01 = SY.
Patient Relationship to Insured	Individual Relationship Code	2000B	SBR02	SBR*P*RELATIONSHIP CODE*******~ (SBR*P*18*******~)	Loop 2000B, SBR02 = 18. Loop 2010BA, NM101 = IL. Loop 2010BA, NM102 = 1.
	Individual Relationship Code	2000C	PAT01	PAT*RELATIONSHIP CODE~ (PAT*01~)	Loop 2000B, SBR02 not = 18. Loop 2010CA, NM101 = QC. Loop 2010CA, NM102 = 1.
Expected Source of Pay	Payer Identifier	2010BB	NM109	NM1*PR*2*ABC INSURANCE CO******PRIM EXPECTED SOURCE OF PAY~ (NM1*PR*2*ABC INSURANCE CO******01~)	Loop 2010BB, NM101 = PR. Loop 2010BB, NM102 = 2.
Secondary Source of Pay	Claim Filing Indicator Code	2320	SBR09	SBR*S*18**ABC INSURANCE CO******2ND EXPECTED SOURCE OF PAY~ (SBR*S*18*ABC INSURANCE CO******07~)	Loop 2320, SBR01 = S.
Tertiary Source of Pay	Claim Filing Indicator Code	2320	SBR09	SBR*T*01**ABC INSURANCE CO******3RD EXPECTED SOURCE OF PAY~ (SBR*T*01*ABC INSURANCE CO******11~)	Loop 2320, SBR01 = T.
Type of Bill	Facility Type Code	2300	CLM05 - 1	CLM*1234567890*1000000***TYPE OF BILL DIGITS 2-3:A:1****~ (CLM*1234567890*1000000***011:A:1****~)	Loop 2300, CLM05 -2 = A
	Claim Frequency Type Code	2300	CLM05 - 3	CLM*1234567890*1000000***011:A:TYPE OF BILL FREQUENCY****~ (CLM*1234567890*1000000***011:A:1****~)	

Patient Control No.	Patient Control Number	2300	CLM01	CLM*PATIENT CONTROL NUMBER*1000000***011:A:1****~ (CLM***1234567890***1000000***011:A:1****~)	
Medical/Health Record Number	Medical Record Number	2300	REF02	REF*EA*MEDICAL/HEALTH RECORD NUMBER~ (REF*EA***44444TH56**~)	Loop 2300, REF01 = EA.
Admission Date/Hour	Admission Date and Hour	2300	DTP03	DTP*435*DT*ADMISSION DATE AND HOUR~ (DTP*435*DT***201207091242**~)	Loop 2300, DTP01 = 435. Loop 2300, DTP02 = DT.
Priority (Type) of Admission	Admission Type Code	2300	CL101	CL1*PRIORITY (TYPE) OF ADMISSION*7*30~ (CL1***1***7*30~)	
Point of Origin/Source of Admission	Admission Source Code	2300	CL102	CL1*1*POINT OF ORIGIN/SOURCE OF ADMISSION*30~ (CL1*1***7***30~)	
Patient Discharge Status	Patient Status Code	2300	CL103	CL1*1*7*PATIENT DISCHARGE STATUS~ (CL1*1*7***30**~)	
Discharge Date	Will be derived from Statement Period Through date. No action necessary.				
Discharge Hour	Date Time Period Format Qualifier	2300	DTP02	DTP*096*TM*DISCHARGE HOUR~ (DTP*096*TM***11**01~)	Loop 2300, DTP01 = 096. Loop 2300, DTP02 = TM
Statement Covers Period From/Through	Statement From and To Date	2300	DTP03	DTP*434*RD8*STATEMENT PERIOD FROM/THROUGH DATES~ (DTP*434*RD8***20120701-20120709**~)	Loop 2300, DTP01 = 434. Loop 2300, DTP02 = RD8
Total Charges	Total Claim Charge Amount	2300	CLM02	CLM*1234567890*TOTAL CHARGE***011:A:1****~ (CLM*1234567890***1000000***011:A:1****~)	
DRG	DRG	2300	HI01 - 2	HI*DR:MS-DRG~ (HI*DR:**123**~)	Loop 2300; HI01 - 1 = DR.
Principal Diagnosis Code	Principal Diagnosis	2300	HI01 - 2	HI*ABK:PRINCIPAL DIAGNOSIS CODE~ (HI*ABK**:Z5189**~)	Loop 2300; HI01 - 1 = ABK (ICD-10)

POA - Principal Diagnosis Code	Present on Admission Indicator	2300	HI01 - 9	HI:*ABK:Z5189:::::::**PRESENT ON ADMISSION**~ (HI*ABK:Z5189:::::::**Y**~)	
Admitting Diagnosis	Admitting Diagnosis	2300	HI01 - 2	HI*ABJ:**ADMITTING DIAGNOSIS**~ (HI*ABJ:**M4644**~)	Loop 2300; HI01 - 1 = ABJ (ICD-10)
Patient Reason for Visit 1	Patient Reason for Visit	2300	HI01 - 2	HI*APR:**REASON FOR VISIT 1**~ (HI:APR:**Z5189**~)	Loop 2300; HI01 - 1 = APR (ICD-10)
Patient Reason for Visit 2	Patient Reason for Visit	2300	HI02 - 2	HI*APR:Z5189*APR: **REASON FOR VISIT 2**~ (HI:APR:**Z5189**~)	Loop 2300; HI02 - 1 = APR (ICD-10)
Patient Reason for Visit 3	Patient Reason for Visit	2300	HI03 - 2	HI*APR:Z5189*APR:Z5189 *APR:**REASON FOR VISIT 3**~ (HI:APR:Z5189*APR:Z5189*APR:**Z5189**~)	Loop 2300; HI03 - 1 = APR (ICD-10)
External Cause of Injury 1	External Cause of Injury	2300	HI03 - 2	HI*ABN:**EXT CAUSE CODE 1**~ (HI:ABN:**W1811XA**:::::::Y~)	Loop 2300; HI03 - 1 = ABN (ICD-10)
POA - External Cause of Injury 1	Present on Admission Indicator	2300	HI03 - 9	HI*ABN:W1811XA:::::::**EXT CAUSE CODE 1 POA INDICATOR**~ (HI*ABN:W1811XA:::::::**Y**~)	
External Cause of Injury 2	External Cause of Injury	2300	HI03 - 2	HI*ABN:W1811XA:::::::Y*ABN:**EXT CAUSE CODE 2**:::::::Y~ (HI:ABN:W1811XA:::::::Y*ABN:**Y846**:::::::N~)	Loop 2300; HI03 - 1 = ABN (ICD-10)
POA - External Cause of Injury 2	Present on Admission Indicator	2300	HI03 - 9	HI*ABN:W1811XA:::::::Y*ABN:Y846:::::::**EXT CAUSE CODE 2 POA INDICATOR**~ (HI:ABN:W1811XA:::::::Y*ABN:Y846:::::::**Y**~)	
External Cause of Injury 3	External Cause of Injury	2300	HI03 - 2	HI*ABN:W1811XA:::::::Y*ABN:Y846:::::::Y*ABN:**EXT CAUSE CODE 3**:::::::Y~ (HI:ABN:W1811XA:::::::Y*ABN:Y846:::::::Y*ABN:**Y846**:::::::Y~)	Loop 2300; HI03 - 1 = ABN (ICD-10)

POA - External Cause of Injury 3	Present on Admission Indicator	2300	HI03 - 9	HI* ABN:W1811XA:::::::Y*ABN:Y846:::::::Y*ABN:Y846:::::::**EXT CAUSE CODE 3 POA INDICATOR**~ (HI:ABN:W1811XA:::::::Y*ABN:Y846:::::::Y*ABN:Y846:::::::**Y**~)	
Other Diagnosis	Other Diagnosis	2300	HI0**X** - 2	HI*ABF:**OTHER DIAGNOSIS**:::::::N*(repeat)~ (HI*ABF:**J690**:::::::N*repeat~)	Loop 2300; HI0**X** - 1 = ABF (ICD-10)
POA - Other Diagnosis	Present on Admission Indicator	2300	HI0**X** - 9	HI*ABF:J690:::::::**POA INDICATOR***ABF:I959:::::::**POA INDICATOR**~ (HI*ABF:J690:::::::Y*ABF:I959:::::::**N**~)	
Principal Procedure	Principal Procedure	2300	HI01 - 2	HI*BBR:**PRINCIPAL PROCEDURE CODE**:D8:20120701~ (HI*BBR:**S066X9A**:D8:20120701~)	Loop 2300; HI01 - 1 = BBR (ICD-10)
Principal Procedure Date	Principal Procedure Date	2300	HI01 - 4	HI*BBR:S066X9A:D8:**PRINCIPAL PROCEDURE CODE DATE**~ (HI*BBR:S066X9A:D8:**20120701**~)	Loop 2300; HI01- 3 = D8.
Other Procedure Code	Other Procedure Code	2300	HI0**X** - 2	HI*BBQ:**OTHER PROC CODE**:D8:20120701*(repeat)~ (HI*BBQ:**0TPB70Z**:D8:20120701*repeat~)	Loop 2300; HI0**X** - 1 = BBQ (ICD-10)
Other Procedure Date	Procedure Date	2300	HI0**X** - 4	HI*BBQ:0TPB70Z:D8:**OTHER PROC CODE DATE***~ (HI*BBQ:0TPB70Z:D8:**20120701**~)	Loop 2300; HI0**X**- 3 = D8.
Attending Physician NPI	Attending Provider Primary Identifier	2310A	NM109	NM1*71*1*SMITH*JOHN****XX***ATTENDING NPI**~ (NM1*71*1*SMITH*JOHN****XX*1234567890~)	Loop 2310D, NM101 = 71. Loop 2310D, NM108 = XX.
Operating Physician NPI	Operating Physician Primary Identifier	2310B	NM109	NM1*72*1*SMITH*JOHN****XX***OPERATING NPI**~ (NM1*72*1*SMITH*JOHN****XX***1234567890**~)	Loop 2310D, NM101 = 72. Loop 2310D, NM108 = XX.
Referring Physician NPI	Referring Provider Primary Identifier	2310F	NM109	NM1*DN*1*SMITH*JOHN****XX***REFERRING NPI**~ (NM1*DN*1*SMITH*JOHN****XX***1234567890**~)	Loop 2310D, NM101 = DN. Loop 2310D, NM108 = XX.

Other Operating Physician NPI	Other Operating Physician Identifier	2310C	NM109	NM1*ZZ*1*SMITH*JOHN****XX***OTHER OPERATING NPI*~ (NM1*ZZ*1*SMITH*JOHN****XX***1234567890*~~)	Loop 2310D, NM101 = ZZ. Loop 2310D, NM108 = XX.
Rendering Physician NPI	Rendering Provider Primary Identifier	2310D	NM109	NM1*82*1*SMITH*JOHN****XX***RENDERING NPI*~ (NM1*82*1*SMITH*JOHN****XX*1234567890~)	Loop 2310D, NM101 = 82. Loop 2310D, NM108 = XX.
NUBC Billing Codes	Condition Code	2300	HI0**X** - 2	HI*BG:**CONDITION CODE***BG:67~ HI*BG:**P7***BG:**57**~	Loop 3200, HI0**X** - 1 = BG.
	Occurrence Span Code	2300	HI0**X** - 2	HI*BI:**OCCURRENCE SPAN CODE**:RD8:20051202-20051212~ HI*BI:**71**:RD8:20051202-20051212~	Loop 2300, HI0**X** -1 = BI.
	Range of Dates	2300	HI0**X** - 4	HI*BI:71:RD8:**OCCURRENCE SPAN DATES**~ HI*BI:71:RD8:**20051202-20051212**~	Loop 2300, HI0**X** -1 = BI. Loop 2300 HI0**X** - 3 - RD8.
	Occurrence Code	2300	HI0**X** - 2	HI*BH:**OCCURRENCE CODE**:D8:20051208* BH:A3:D8:20051203~ HI*BH:**01**:D8:20051208*BH:A3:D8:20051203~	Loop 2300, HI0**X** - 1 = BH.
	Date	2300	HI0**X** - 4	HI*BH:01:D8:**OCCURRENCE DATE***BH:A3:D8:20051203~ HI*BH:01:D8:**20051208***BH:A3:D8:20051203~	Loop 2300, HI0**X** -1 = BH. Loop 2300 HI0**X** - 3 - RD8.
	Value Code	2300	HI0**X** - 2	HI*BE:**VALUE CODE**:::2520*BE:A7::940~ HI*BE:**54**:::2520*BE:A7:::940~	Loop 3200, HI0**X** - 1 = BE.
	Value Amount	2300	HI0**X** - 5	HI*BE:54:::**VALUE CODE AMOUNT***BE:A7::940~ HI*BE:54:::**2520***BE:A7:::940~	
Revenue Code	Service Line Rev Code	2400	SV201	SV2***REVENUE CODE***HC:42820*15000*UN*1~ (SV2***0360***HC:42820*15000*UN*1~)	
HCPCS/Rates and up to 4 Modifiers	Procedure Code	2400	SV202 - 2	SV2*0360*HC:**CPT/HCPCS***150000*UN*1~ (SV2*0360*HC:**42820***150000*UN*1~)	Loop 2400; SV202 - 1 = HC
	Procedure Modifier	2400	SV202 - 3	SV2*0360*HC:42820:**FIRST MODIFIER***150000*UN*1~ (SV2*0360*HC:42820:**22***150000*UN*1~)	Loop 2400; SV202 - 1 = HC

	Procedure Modifier	2400	SV202 - 4	SV2*0360*HC:42820:22:**SECOND MODIFIER***150000*UN*1~ (SV2*0360*HC:42820:22:**59***150000*UN*1~)	Loop 2400; SV202 - 1 = HC
	Procedure Modifier	2400	SV202 - 5	SV2*0360*HC:42820:22:59:**THIRD MODIFIER***150000*UN*1~ (SV2*0360*HC:42820:22:59:**51***150000*UN*1~)	Loop 2400; SV202 - 1 = HC
	Procedure Modifier	2400	SV202 - 6	SV2*0360*HC:42820:22:59:51:**FOURTH MODIFIER***150000*UN*1~ (SV2*0360*HC:42820:22:59:51:**RT***150000*UN*1~)	Loop 2400; SV202 - 1 = HC
Revenue Charge	Line Item Charge Amount	2400	SV203	SV2*0360*HC:42820***LINE ITEM REVENUE CHARGE***UN*1~ (SV2*0360*HC:42820***150000***UN*1~)	
Units of Service	Service Unit Count	2400	SV205	SV2*0120**1500*DA***COUNT OF DAYS OR UNITS**~ (SV2*0120**1500*DA***10**~)	Loop 2400; SV204 = DA (Days) or UN (Units)
Service Date	Service Date	2400	DTP03	DTP*472*D8***SERVICE DATE**~ (DTP*472*D8***20120710**~)	Loop 2400; DTP01 = 472. Loop 2400; DTP02 = D8.

Definition of Inpatient and Outpatient Records

IHA Statewide Inpatient Database

The IHA Statewide Inpatient Database is to include discharges from **Acute Care/Surgical Unit, Psychiatric Unit, Rehabilitation Unit, SNF/ICF/Other LTC/Hospice/Subacute/Swing Bed, Inpatient Skilled Nursing Facility, Drug/Alcohol Rehabilitation Unit, and Pediatric Unit.** Submit all inpatient visits on discharge. NOTE: Inpatient records should not be submitted as interim or partial bills and only submitted upon discharge (including Med Rehab and SNF/Swing Beds). Discharges that should be excluded are:

- Intermediate Care (Long Term Care) Patients
- Custodial/Respite Patients
- Hospice Patients

IHA Statewide Outpatient Database

The IHA Statewide Outpatient Database is to include all outpatient visits to Indiana hospitals and those hospital's outpatient locations. Outpatient is defined as any patient visit that is not considered an inpatient.

Special Consideration: Reccurring Outpatients (Physical Therapy, Speech Therapy, Respiratory Therapy or other multi-episodic accounts).

The Indiana Hospital Association recognizes that reoccurring patient accounts billing procedures are different throughout membership. Because Outpatient claims for patients who are recurring or series may cross INHDS timelines, IHA asks that these records be submitted as follows:

- Submit by Date of Service (Revenue line information) into the quarter/year in which the service was provided.
- Records may be submitted individually or by a time frame (e.g. quarter, month, week, day) depending on hospital billing practices.
- For submission to INHDS, claims that cross from one quarter to another should be separated by Dates of Service to allow record to avoid edits for dates outside of quarter.
- Finally, upon discharge of a recurring/series account do not submit the total admit-to-discharge claim with all dates of service again but only the Dates of Service not already submitted.

Outpatient accounts that should be excluded from INHDS are:

- Reference Labs – Include only those patients with a “face-to-face encounter” in the hospital between the patient and the hospital personnel. (For example, a claim should be excluded if a patient’s specimen presents for analysis to the lab but the patient did not.)
- Home Health Claims – Exclude claims with Home Health Revenue Codes 0570-060X.
- Hospital-owned Clinic Claims – Exclude claims that are from Medicare-designated Provider Based Clinics and/or claims representing facility charges for visiting specialists. Do report any ancillary services provided as a result of these visits that were provided with the patient presenting to the hospital, for example, Labs, Radiology exams ordered during the physician visit.

IHA Databases

The statewide inpatient and outpatient databases are submitted monthly to the Indiana State Department of Health (ISDH) on behalf of the hospitals to comply with Indiana Hospital Financial Disclosure Law (IC-16-21-6). Indiana Hospital Association will provide ISDH quarterly verification files as well as an annual update file. IHA will release data generated from this database helps hospitals and health systems analyze market share as well as patient migration to and from their service area on a quarterly basis once 100% compliance has been met

To submit inpatient and outpatient data go to:

https://in-hds.org

Inpatient Patient Type/Place of Service

Inpatient Patient Type/Place of Service: *Identified by the submitting facility using associated Bill Types to determine where the inpatient received treatment.* ***Inpatient records MUST have these Bill Types to be placed in appropriate Place of Service.***

1 = Acute Inpatient/Surgical Unit – Bill Type 0111
Provides acute inpatient care to patients, including newborns, which receive care in the acute care areas of a short-term hospital and not included in any other described level of care.

2 = Psychiatric Unit – Bill Type 0171
Psychiatric Care: Provides acute or long-term care to emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment of psychiatric problems, on the basis of physician's orders and approved nursing care plans. Long term care may include intensive supervision to the chronically mentally ill, mentally disordered, or other mentally incompetent persons.

3 = Rehabilitation Unit– Bill Type 0151
Relatively intense program including cardiology rehab, physical therapy and/or occupational therapy that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function. Care is provided in an inpatient setting.

4 = SNF/ICF/Other LTC/Hospice/Subacute/Swing Bed – Bill Types 0181, 0211 or 0821
Maintains an organized professional staff and permanent facilities including inpatient beds that provide continuous nursing and other health-related psychosocial and personal services to patients who are not in an acute phase of illness but who primarily require continued care on an inpatient basis.

5 = Drug/Alcohol Rehabilitation Unit – Bill Type 0241
Chemical Dependency Care: Provides diagnostic and therapeutic services to patients with alcoholism or other drug dependencies. Includes care for inpatient/resident treatment for patients whose course of treatment involves more intensive care that provided in an outpatient setting or where patient requires supervised withdrawal.

6 = Pediatric Unit – Bill Type 0311
A physical unit dedicated solely to the care of pediatric patients, defined as patients under the age of 18. Patient care is provided by pediatric specialists (nursing and Pediatricians, Pediatric Hospitalists, Pediatric Specialists). Equipment is specialized for the care of patients under 18 years of age. Units defined as Pediatric ICU (PICU) and Neonatal ICU (NICU) should use this bill type. If a hospital treats pediatric patients outside of a defined pediatric unit (for example, on General Medical, Surgical, or ICU beds, please use bill type 111. (Source: American Academy of Pediatrics – Design of Pediatric and Neonatal Critical Care)

Outpatient Patient Type/Place of Service

Outpatient Patient Type: *Identifies outpatient areas of a facility where the patient received treatment. Any Type of Bill not specified on the Inpatient Patient Type/Place of Service Appendix will be considered to be outpatient.*
Outpatient Place of Service: *Outpatient Place of Service is determined by INHDS program in a hierarchical manner as follows:*

1=Emergency Department
Any record with a Revenue Code 0450, 0451, 0452, 0456, 0459, 0681, 0682, 0683, 0684 or 0689. This includes Emergency Room and Trauma Response.

2=Ambulatory Surgery
Any record not classified as Emergency Department **AND** with a revenue code in categories 0360, 0361, 0362, 0367, 0369, 0481, 0490, 0499, 0750 or 0790. This includes Operating Room Services, Cardiology Cath Lab, Ambulatory Surgical Care, Gastrointestinal Services and EWSL (Extra-Corporeal Shock Wave Therapy).

3=Observation
Any record not classified as Emergency Department or Ambulatory Surgery **AND** with a revenue code in category 0760, 0762 or 0769. This includes Specialty Services.

4=Therapies
Any record not classified as Emergency Department, Ambulatory Surgery or Observation **AND** with revenue codes in categories 0410, 0412, 0413, 0419, 0420, 0421, 0422, 0423, 0424, 0429, 0430, 0431, 0432, 0433, 0434, 0439, 0440, 0441, 0442, 0443, 0444, 0449, 0460, 0469, 0940, 0941, 0942, 0943, 0946, 0947, 0948, 0949, 0951 or 0952. This includes Respiratory, Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Function and Other Therapeutic Services respectively.

5 = Outpatient Laboratory
Any record not classified as Emergency Department, Ambulatory Surgery, Observation, or Therapies **AND** with revenue codes in categories 0300 - 0309, 0310 - 0319, 0482 - 0483, 0730 - 0739, 0740, 0920, 0929.

6 = Outpatient Radiology
Any record not classified as Emergency Department, Ambulatory Surgery, Observation, Therapies or Laboratory **AND** with revenue codes in categories 0320 - 0329, 0330 - 0339, 0340 - 0349, 0350 - 0359, 0400 - 0409, 0610 - 0619, 0860 – 0861 **exclusively**. This includes Laboratory, Pathology, Diagnostic Radiology, Therapeutic Radiology, Nuclear Medicine, CAT Scans, Other Imaging Services, Stress Test, Echo cardiology, MRIs, EKG/ECGs, EEGs, Magnetoencephalography and Other Diagnostic Services.

7=Other Outpatient
Includes records not previously designated and **may** include records in revenue categories not already mentioned. This includes Blood Products and Storage, Audiology and Pulmonary, Clinics, Medical/Surgical Supplies, Pharmacy, Home IV Therapy, Hospice and Preventative Care, Acquisition of Body Components, Hemodialysis, Behavioral Health Services, Professional Fees (if included), Patient Convenience and Alternative Therapy Services.

Type of Bill

UB-04 Form Locator 4

Definition: *NUBC codes specifying all valid Bill Types (e.g. inpatient, outpatient, adjustments, voids, etc.)*

NUBC Inpatient Bill Types may not appear as inpatient records when submitted. Refer to Appendix II for Indiana-specific Bill Types required to communicate Patient Type and inpatient Place of Service.

Type of Bill	Bill Types	In/Out General Designation
0000-010x	Reserved for assignment by NUBC	--
011x	Hospital Inpatient (including Medicare Part A)	IP
012x	Hospital Inpatient (Medicare Part B only)	OP
013x	Hospital Outpatient	OP
014x	Hospital - Laboratory Services provided to Non-patients	OP
015x-017x	Reserved for assignment by NUBC	--
018x	Hospital - Swing Beds	IP
019x-020x	Reserved for assignment by NUBC	--
021x	Skilled Nursing - Inpatient (Including Medicare Part A)	IP
022x	Skilled Nursing - Inpatient (Medicare Part B)	OP
023x	Skilled Nursing – Outpatient	OP
024x-027x	Reserved for assignment by NUBC	--
028x	Skilled Nursing - Swing Beds	IP
029x-031x	Reserved for assignment by NUBC	--
032x	Home Health Services under a Plan of Treatment (effective 10/1/2013)	OP
033x	Reserved for assignment by NUBC	--
034x	Home Health Services not under a Plan of Treatment (effective 10/1/2013)	OP

Type of Bill	Bill Types	In/Out General Designation
035x-040x	Reserved for assignment by NUBC	--
041x	Religious Non-medical Health Care Institutions - Inpatient	IP
042x	Reserved for assignment by NUBC	--
043x	Religious Non-medical Health Care Institutions – Outpatient	OP
044x-064x	Reserved for assignment by NUBC	--
065x	Intermediate Care - Level I	IP
066x	Intermediate Care - Level II	IP
067x-070x	Reserved for assignment by NUBC	--
071x	Clinic - Rural Health	OP
072x	Clinic - Hospital Based or Independent Renal Dialysis Center	OP
073x	Clinic – Freestanding	OP
074x	Clinic - Outpatient Rehabilitation Facility (ORF)	OP
075x	Clinic - Comprehensive Outpatient Rehabilitation Facility	OP
076x	Clinic - Community Mental Health Center	OP
077x	Clinic – Federally Qualified Health Center (FQHC)	OP
078x	Licensed Freestanding Emergency Medical Facility	OP
079x	Clinic – Other	OP
080x	Reserved for assignment by NUBC	--
081x	Special Facility - Hospice (non-hospital based)	OP
082x	Special Facility - Hospice (hospital based)	OP
083x	Special Facility - Ambulatory Surgery Center	OP
084x	Special Facility - Free Standing Birthing Center	OP
085x	Special Facility - Critical Access Hospital	OP
086x	Special Facility - Residential Facility	IP
087x-088x	Reserved for assignment by NUBC	--
089x	Special Facility – Other	OP

Type of Bill	Bill Types	In/Out General Designation
090x-9999	Reserved for assignment by NUBC	--

State Code Abbreviations

UB-04 Form Locator 9-2C

Definition: *The patient's state of residence.*

State - State Code	State - State Code	State - State Code
Alabama..... AL	Massachusetts..... MA	Tennessee ..... TN
Alaska ..... AK	Michigan ..... MI	Texas ..... TX
Arizona..... AZ	Minnesota ..... MN	Utah ..... UT
Arkansas..... AR	Mississippi ..... MS	Vermont ..... VT
California..... CA	Missouri ..... MO	Virginia..... VA
Colorado ..... CO	Montana..... MT	Washington..... WA
Connecticut..... CT	Nebraska ..... NE	West Virginia..... WV
Delaware..... DE	Nevada ..... NV	Wisconsin ..... WI
District of Columbia ..... DC	New Hampshire ..... NH	Wyoming..... WY
Florida..... FL	New Jersey ..... NJ	
Georgia ..... GA	New Mexico ..... NM	Puerto Rico ..... PR
Hawaii ..... HI	New York ..... NY	Virgin Islands.....VI
Idaho..... ID	North Carolina ..... NC	Guam ..... GU
Illinois..... IL	North Dakota..... ND	Armed Forces (APO/FPO)
Indiana ..... IN	Ohio ..... OH	In America..... AA
Iowa ..... IA	Oklahoma ..... OK	In Europe ..... AE
Kansas..... KS	Oregon..... OR	In Pacific ..... AP
Kentucky ..... KY	Pennsylvania ..... PA	Unknown..... 99
Louisiana ..... LA	Rhode Island..... RI	Foreign 88
Maine ..... ME	South Carolina ..... SC	Homeless.....77
Maryland ..... MD	South Dakota ..... SD	

Race Codes

Definition: *The Race code assigned to the patient's record.*

Race Code	Race Category	Race Description
R1	White	A person having origins in any of the peoples of Europe, North Africa or the Middle East.
R2	African American/ Black	A person having origins in any of the black racial groups of Africa. Terms such as "Haitian," "Dominican" or "Somali" can be used in addition to "African American" or "Black."
R3	American Indian/ Alaska Native	A person having origins in any of the people of North and South America (including Central America) and who maintains tribal or community attachment.
R4	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
R5	Native Hawaiian/ Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
R7	Multiracial /Two or More Races	A person having origins that include more than one of the above- stated categories.
R8	Declined	A person NOT wanting to respond to the question regarding race.
R9	Unavailable/ Unknown	Attempts to capture race were unattainable due to other circumstances.

Ethnicity Codes

Definition: *The Ethnicity code assigned to the patient's record.*

Ethnicity Code	Ethnicity Category	Ethnicity Description
E1	Hispanic or Latino	A person of Mexican, Puerto Rico, Cuban or South American or other Spanish culture or origin, regardless of race.
E2	Not Hispanic or Latino	A person not of Spanish culture or origin.
E3	Declined	A person NOT wanting to respond to the question regarding ethnicity.
E4	Unavailable/ Unknown	Attempts to capture ethnicity were unattainable due to other circumstances.

Patient Birth Gender/Patient Gender Identity Codes

Definition: *The birth gender and gender identity codes assigned to the patient's record.*

Patient Birth Gender	
Gender Code	**Gender Category**
M	Male
F	Female
U	Unknown

Patient Gender Identity	
Gender Code	**Gender Category**
M	Male
F	Female
U	Unknown
T	Transgender

Expected Source of Payment

UB-04 Form Locator 50A-50C

Definition: *The code(s) identifying the health plan(s), either primary or secondary that might be expected to pay on the hospital bill. Self-pay or no- pay claims must be included.* **Source of Payment codes need to be mapped from hospital system to this two-digit code.**

Payer Code	Payer Description
01	Medicare - Fee For Service (Traditional Medicare)
02	Medicare Advantage (Commercial gap plans, including Anthem, United Healthcare Medicare Advantage)
03	Medicaid - Fee For Service
04	Medicaid - Managed Care (ex. MDWise, CareSource, MHS, Anthem)
05	Medicaid - HIP Plans (ex. MDWise, CareSource, MHS, Anthem)
06	Medicaid – Out of State
07	Anthem Commercial (Anthem commercial private or group plans)
08	Other Commercial (United Healthcare, Cigna, all other private or group plans)
09	Workers Compensation
10	Other Federal Government (e.g. Champus, Veterans, Title V, Railroad, Crippled Children, DOD/Tricare, Veteran's Affairs, Indian health services, Black Lung)
11	Self Pay (The patient has no insurance, is ineligible for governmental assistance and is not a "no charge" patient.)
12	No Charge (The account has "$0.00" total charges and the patient is not billed for the admission, i.e. cancelled procedure, etc.)

Note: Crime Victims and Sexual Assault claims may be covered by different levels of government agencies and should be submitted under the Federal, State, or County/Local Government that is paying the bill.

Admission/Discharge Hour

UB-04 Form Locator 12/UB-04 Form Locator 16

Definition: *Two-digit code to use when submitting Admission Hour and Discharge Hour.*

Code	Time - AM		Code	Time - PM
0	12:00 - 12:59 Midnight		12	12:00 - 12:59 Noon
1	01:00 - 01:59		13	01:00 - 01:59
2	02:00 - 02:59		14	02:00 - 02:59
3	03:00 - 03:59		15	03:00 - 03:59
4	04:00 - 04:59		16	04:00 - 04:59
5	05:00 - 05:59		17	05:00 - 05:59
6	06:00 - 06:59		18	06:00 - 06:59
7	07:00 - 07:59		19	07:00 - 07:59
8	08:00 - 08:59		20	08:00 - 08:59
9	09:00 - 09:59		21	09:00 - 09:59
10	10:00 - 10:59		22	10:00 - 10:59
11	11:00 - 11:59		23	11:00 - 11:59

Priority (Type) of Admission

UB-04 Form Locator 14

Definition: *The code indicating the priority of the admission or visit.*

Priority of Admission Code	Priority of Admission Category	Priority of Admission Description
1	Emergency	The patient requires immediate medical intervention as a result of severe, life-threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
2	Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.
3	Elective	The patient's condition permits adequate time to schedule the services.
4	Newborn	Use of this code necessitates the use of special Source of Admission code. See Appendix X.
5	Trauma Center	Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation. (Use Revenue Code 068x to capture trauma activation charges involving pre-hospital notification.)
6-8		Reserved for national assignment.
9	Information Not Available	The hospital does not have this information in its records.

Point of Origin/Source of Admission

UB-04 Form Locator 15

Definition: *The code indicating the source of the referral for this admission or visit. This list is designed to focus on patients' place or point of origin rather than the source of a physician order or referral.*

NUBC Code	Description	Notes:
1	Non-health Care Facility Point of Origin	Inpatient: The patient was admitted to this facility.
		Outpatient: The patient presented for outpatient services.
		Examples: Includes patients coming from home or workplace and patients receiving care at home (such as home health services).
2	Clinic or Physician Office	Inpatient: The patient was admitted to this facility.
		Outpatient: The patient presented to this facility for outpatient services.
3	Reserved for assignment by the NUBC.	
4	Transfer from a Hospital (Different Facility)	Inpatient: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.
		Outpatient: The patient was transferred to this facility as an outpatient from an acute care facility.
		Usage notes: Excludes transfers from hospital inpatient in the same facility (see Code D).
5		Inpatient: The patient was admitted to this facility as a transfer from a SNF, ICF or ALF where he or she was a resident.

NUBC Code	Description	Notes:
	Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF)	Outpatient: The patient presented to this facility for outpatient or referenced diagnostic services from a SNF, ICF or ALF where he or she was a resident.
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.
		Outpatient: The patient presented to this facility for services from another health care facility not defined elsewhere in this code list.
7	Reserved for assignment by the NUBC.	
8	Court/Law Enforcement	Inpatient: The patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative.
		Outpatient: The patient presented to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
		Usage note: Includes transfers from incarceration facilities.
9	Information Not Available	Inpatient: The patient's Point of Origin is not known.
		Outpatient: The patient's Point of Origin is not known.
A	Reserved for assignment by the NUBC.	
B	Reserved for assignment by the NUBC.	
C	Reserved for assignment by the NUBC.	
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer	Inpatient: The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer.
		Outpatient: The patient received outpatient services in this facility as a transfer from within this hospital resulting in a separate claim to the payer.

NUBC Code	Description	Notes:
		Usage note: For purposes of this code, “Distinct Unit” is defined as a unique level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric services, rehab units, a unit in a critical access hospital or a swing bed located in an acute hospital.
E	Transfer from Ambulatory Surgery Center	Inpatient: The patient was admitted to this facility as a transfer from an ambulatory surgery center.
		Outpatient: The patient presented to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.
F	Transfer from Hospital Facility	Inpatient: The patient was admitted to this facility as a transfer from a hospice facility.
		Outpatient: The patient presented to this facility for outpatient or referenced diagnostic services from a hospice facility.
G-Z	Reserved for assignment by the NUBC.	

Newborn Point of Origin Codes

UB-04 Form Locator 15

Definition: *Newborn coding structure must be used when the Type of Admission Code 4 is used.*

Newborn Priority of Admission Codes	Newborn Priority of Admission Descriptions
1	Reserved for assignment by the NUBC.
2	Reserved for assignment by the NUBC.
3	Reserved for assignment by the NUBC.
4	Reserved for assignment by the NUBC.
5	A baby is born inside this hospital
6	A baby is born outside of this hospital.
6-8	Reserved for assignment by the NUBC.

Patient Discharge Status

UB-04 Form Locator 17

Definition: *A code indicating patient status as of the ending service date of the period covered on the record.*

Patient Discharge Status Code	Patient Discharge Status Description
01	Discharged to home or self-care (routine discharge). (see Code 81 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: Includes discharge to home, home on oxygen if DME only, any other DME only, group home, foster care, independent living and other residential care arrangements, outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.
02	Discharged/transferred to a Short Term General Hospital for inpatient care. (see Code 82 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013).
03	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare certification in anticipation of Skilled Care. (see Code 83 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013) Usage Note: Medicare – Indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61 - Swing Bed. For reporting other discharge/transfers to nursing facilities see 04 and 64.
04	Discharged/transferred to a facility that provides Custodial or Supportive Care. (see Code 84 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: Includes intermediate care facilities (ICFs) if specifically designated at the state level. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.
05	Discharged/transferred to a designated cancer center or children's hospital. (see Code 85 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: Transfers to non-designated cancer hospitals should use Code 02.

Patient Discharge Status Code	Patient Discharge Status Description
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care. (see Code 86 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services. Not used for home health services provided by a DME supplier or from a Home IV provider for home IV services.
07	Left against medical advice or discontinued care.
08	Reserved for national assignment.
09	Admitted as an Inpatient to this hospital. Usage Note: For use only on Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.
10-19	Reserved for national assignment.
20	Expired.
21	Discharged/transferred to Court/Law Enforcement. (see Code 87 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: Includes transfers to incarceration facilities such as jail, prison or other detention facilities.
22-29	Reserved for national assignment.
30	Still Patient. Usage Note: Used when the patient is still within the same facility, typically used when billing for leave of absence days or interim bills.
31-39	Reserved for national assignment.
40	Expired at home – Not accepted in INHDS as valid patient status code. Usage Note: For use only on Medicare and TRICARE claims for hospice care.
41	Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice) – Not accepted in INHDS as valid patient code. Usage Note: For use only on Medicare and TRICARE claims for hospice care.
42	Expired – Place unknown – Not accepted in INHDS as valid patient status code. (see Code 88 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: For use only on Medicare and TRICARE claims for hospice claims.

Patient Discharge Status Code	Patient Discharge Status Description
43	Discharged/transferred to a Federal Health Care Facility. (See Code 88 for a discharge with a Planned Acute Care Hospital Inpatient Readmission effective 10/1/2013). Usage Note: Discharges and transfers to a government operated health facility such as a Department of Defense Hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
44-49	Reserved for national assignment.
50	Hospice – Home.
51	Hospice - Medical facility (certified) providing hospice-level care.
52-60	Reserved for national assignment.
61	Discharged/transferred to a Hospital-based Medicare approved Swing Bed. (see Code 89 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: Medicare – Used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.
62	Discharged/ transferred to an Inpatient Rehabilitation Facility (IRF) including rehabilitation distinct part units of a hospital. (see Code 90 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013)
63	Discharged/transferred to a Medicare-certified Long-Term Care Hospital (LTCH). (see Code 91 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013). Usage Note: For hospitals that meet Medicare criteria for LTCH certification.
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. (see Code 92 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital. (see Code 93 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013)
66	Discharged/transferred to a Critical Access Hospital (CAH). (Effective 1/1/2006) (see Code 94 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013)
67-68	Reserved for national assignment.
69	Discharged/transferred to a Designated Disaster Alternative Care Site (Effective 10/1/13)

Patient Discharge Status Code	Patient Discharge Status Description
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list (see Code 95 for a discharge with a Planned Acute Care Hospital Readmission effective 10/1/2013)
71-72	Discontinued 4/1/03
73-80	Reserved for Assignment by the NUBC.
81	Discharged/transferred to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
82	Discharged/transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
83	Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
84	Discharged/transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
85	Discharged/transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
86	Discharged/transferred to Home Under the Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
87	Discharged/transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
88	Discharged/transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
89	Discharged/transferred to a Hospital-based Medicare Swing Bed with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
90	Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
91	Discharged/transferred to a Medicare Certified Long-Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)

Patient Discharge Status Code	Patient Discharge Status Description
92	Discharged/transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
93	Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
94	Discharged/transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
95	Discharged/transferred to Another Type or Health Care Institution not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission (Effective 10/1/13)
96-99	Reserved for Assignment by the NUBC.

Present on Admission

UB-04 Form Locator 67 and 67A-67Q (8th position)

Definition: *Present on Admission is required on all Inpatient records, E-codes and other/additional codes unless the ICD-10 code is exempt. Other inpatient Places of Service and Outpatient records should not have a POA indicator.*

POA Code	POA Description
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
Blank	Unreported/not used. Code exempt from Present on Admission Reporting.

Revenue Codes Requiring CPT/HCPCS

Definition: *The following Outpatient Revenue Codes require CPT/HCPCS codes.*

Revenue Code	Revenue Code Description	Place of Service
032X	Diagnostic X-ray	1-5
333	Radiation Therapy	1-5
339	Other Radiology – Therapeutic	1-5
034X	Nuclear Med	1-5
035X	CT scan	1-5
036X	Operating Room Services	2
040X	Imaging Services	1-5
045X	Emergency Room	1
480	Cardiology – General Classification	2
481	Cardiology – Cardiac Cath Lab	2
049X	Ambulatory Surgery	2
061X	MRT	1-5
075X	Gastrointestinal Services	2
079X	Extra-corporeal Shock Wave Therapy	5

Patient's Primary Language Codes

Definition: *The patient's primary spoken language. This data is not included on the UB-04; INHDS Specific. Must be mapped to match hospital definition.*

Language Code	Language Description
ARA	Arabic
ARM	Armenian
ASL	American Sign Language
CAM	Cambodian
CAN	Cantonese
CHA	Chamorro
CHI	Chinese
CHU	Chuukese
DAN	Danish
DUT	Dutch
ENG	English
FAR	Farsi (Persian)
FIL	Filipino
FLE	Flemish
FRE	French
GER	German
GRE	Greek
HAW	Hawaiian
HEB	Hebrew
HIN	Hindi
HMO	Hmong

Language Code	Language Description
HUN	Hungarian
ILO	Ilocano
IND	Indonesian
ITA	Italian
JAP	Japanese
KOR	Korean
LAO	Laotian
MAL	Malaysian
MAN	Mandarin
MAR	Marshallese
MIC	Micronesian
NA	Not Applicable (newborns only)
NOR	Norwegian
OTH	Other
OTP	Other Pacific Islander Language
PAL	Palauan (Belauan)
POB	Portuguese - Brazilian
POH	Pohnpeian
POL	Polish
POR	Portuguese
RUS	Russian

Language Code	Language Description
SAM	Samoan
SPA	Spanish
SWE	Swedish
TAG	Tagalog
TAH	Tahitian
TAI	Taiwanese
THA	Thai
TON	Tongan
TUR	Turkish
UNK	Unknown
VIE	Vietnamese
VIS	Visayan
YAP	Yapese

Release Notes

These release notes detail the modifications that have been made to the INHDS Submission Manual.
The original version 1.0 was released 10/1/2020.
Version 1.1 was released 12/13/2020
Version 1.2 was released 3/9/2021

Manual Version	Effective Date of Modification	Section	Description	Reason
1.2	10/1/2020	General Rules for Submission of INHDS Data Page 4	Corrected (SE = beginning of transaction) to (ST = beginning of transaction). Corrected (ST = end of transaction) to (SE = end of transaction).	To correct typographical error
1.2	10/1/2020	Patient ZIP Code Page 8	Changed "'99999' Should be used for foreign or non-Indiana residents." To "'99999' should be used for patients that do not reside in the United States."	The zip codes of patients living in US states other than Indiana should be reported.
1.2	10/1/2020	Discharge Date/Hour Page 10	Changed "The date of admission as an inpatient or outpatient." To "The date of discharge as an inpatient or outpatient."	To correct typographical error
1.1	10/1/2020	Indiana-Specific 837I v5010 Specifications Page 20	The example provided to *Patient Spoken Language* requires 2 asterisks following the M	To correct typographical error