

INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS  
 (P)

DATA ELEMENT DEFINITION

<b>ELEMENT NAME: PATIENT CO-INSURANCE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-140	1	Yes
Non-Institutional	2-140	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Eight (8) signed numeric digits including two (2) decimal places.		
<b>DEFINITION</b>	The amount of allowed charges that beneficiaries are required to pay under TRICARE.		
<b>CODE/VALUE SPECIFICATIONS</b>	N/A		
<b>ALGORITHM</b>	For standard TRICARE program the co-insurance must be calculated in accordance with the TRICARE Reimbursement Manual, <a href="#">Chapter 2, Section 1</a> .		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>		<b>GROUP</b>	
N/A		PATIENT COST-SHARE	
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PATIENT CO-PAYMENT**

**RECORDS/LOCATOR NUMBERS**

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-145	1	Yes
Non-Institutional	2-145	1	Yes

**PRIMARY PICTURE (FORMAT)** Eight (8) signed numeric digits including two (2) decimal places.

**DEFINITION** A fixed amount charged by the contractor that the beneficiary is liable for paying for covered services.

**CODE/VALUE SPECIFICATIONS** N/A

**ALGORITHM** For standard TRICARE program, co-payment must be calculated in accordance with the TRICARE Reimbursement Manual, [Chapter 2, Section 1](#). Co-payment must be calculated in accordance with established fees for service, if other than standard TRICARE program.

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	PATIENT COST-SHARE

**NOTES AND SPECIAL INSTRUCTIONS:**

N/A

**DATA ELEMENT DEFINITION****ELEMENT NAME: PATIENT COST-SHARE****RECORDS/LOCATOR NUMBERS**

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-135	1	Yes
Non-Institutional	2-135	1	Yes

**PRIMARY PICTURE (FORMAT)** Group

**DEFINITION** Two (2) element field reporting the amount of money the beneficiary is responsible for paying in connection with covered services, other than the annual fiscal year deductible and any disallowed amounts.

**CODE/VALUE SPECIFICATIONS** N/A**ALGORITHM** N/A**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
PATIENT CO-INSURANCE	N/A
PATIENT CO-PAYMENT	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

N/A

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PATIENT DATE OF BIRTH**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-085	1	Yes
Non-Institutional	2-085	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Eight (8) numeric characters, YYYYMMDD.		
<b>DEFINITION</b>	Date of birth of patient.		
<b>CODE/VALUE SPECIFICATIONS</b>	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A

**NOTES AND SPECIAL INSTRUCTIONS:**  
 Download field from DEERS. For specific instructions, refer to [Chapter 9](#)

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PATIENT NAME</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-075	1	Yes <sup>1</sup>
Non-Institutional	2-075	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	Twenty-seven (27) alphanumeric characters.		
<b>DEFINITION</b>	Name of patient. Last name must be at least one (1) character, followed by a comma.		
<b>CODE/VALUE SPECIFICATIONS</b>	N/A		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Download field from DEERS. For specific instructions, refer to <a href="#">Chapter 9</a>			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PATIENT RELATIONSHIP TO SPONSOR**

**RECORDS/LOCATOR NUMBERS**

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-070	1	Yes
Non-Institutional	2-070	1	Yes

**PRIMARY PICTURE (FORMAT)** One (1) alphanumeric character.

**DEFINITION** Code that defines the relationship of the patient to the sponsor.

CODE/VALUE SPECIFICATIONS		
	b	Sponsor
	C	Child (includes adopted) <b>or Step Child</b>
	F	Unremarried Widow(er)
	G	Unmarried Widow(er)
	H	Unmarried Former Spouse meeting 20/20/20 criteria
	L	Parent-in-law <b>(Terminated 10/16/2003)<sup>1</sup></b>
	M	Step Parent-In-Law <b>(Terminated 10/16/2003)<sup>1</sup></b>
	P	<b>Dependent Parent, Dependent Step Parent, Dependent Parent-in-law, Dependent Step Parent-in-law</b>
	R	Unremarried Former Spouse divorced on or after April 1, 1985, meeting 20/20/15 criteria
	S	Spouse
	T	Unremarried Former Spouse
	U	Step Parent <b>(Terminated 10/16/2003)<sup>1</sup></b>
	V	Step Child <b>(Terminated 10/16/2003)<sup>1</sup></b>
	W	Ward (includes foster and preadoptive children)
	X	Other (includes good faith payments)
	Y	Unremarried Former Spouse divorced prior to April 1, 1985, meeting 20/20/15 criteria
	Z	Unknown

**NOTES AND SPECIAL INSTRUCTIONS:**

Download field from DEERS. For specific instructions, refer to [Chapter 9](#).

<sup>1</sup> **As of 10/16/2003, DEERS will no longer be supplying these codes.**

**DATA ELEMENT DEFINITION****ELEMENT NAME: PATIENT RELATIONSHIP TO SPONSOR (CONTINUED)****ALGORITHM** N/A**SUBORDINATE AND/OR GROUP ELEMENTS****SUBORDINATE****GROUP**

N/A

BENEFICIARY CATEGORY

**NOTES AND SPECIAL INSTRUCTIONS:**Download field from DEERS. For specific instructions, refer to [Chapter 9](#).<sup>1</sup> As of 10/16/2003, DEERS will no longer be supplying these codes.

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PATIENT SEX</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-095	1	Yes <sup>1</sup>
Non-Institutional	2-095	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	One (1) alphanumeric character.		
<b>DEFINITION</b>	Code defining sex of patient.		
<b>CODE/VALUE SPECIFICATIONS</b>	DEERS/Claim	F	Female
		M	Male
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Download field from DEERS. For specific instructions, refer to <a href="#">Chapter 9</a> .			



**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PATIENT SSN</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-080	1	No <sup>1</sup>
Non-Institutional	2-080	1	No <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	Nine (9) alphanumeric characters.		
<b>DEFINITION</b>	Patient Social Security Number.		
<b>CODE/VALUE SPECIFICATIONS</b>	If unknown, blank fill.		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Optional. If entered, must be valid.			

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PATIENT ZIP CODE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-100	1	Yes
Non-Institutional	2-100	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Nine (9) alphanumeric characters.		
<b>DEFINITION</b>	US Postal Zip Code or foreign country code for patient's legal residence at the time service was rendered and must not be the zip code of a P.O. Box.		
<b>CODE/VALUE SPECIFICATIONS</b>	Valid 5 or 9 digit zip code. If only 5 digit, left justify and blank fill to right. If foreign country, must be 2 character foreign country code, left justified and blank filled. See <a href="#">Addendum A</a> .		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PCM LOCATION DMIS-ID</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-205	1	No
Non-Institutional	2-211	1	No
<b>PRIMARY PICTURE (FORMAT)</b>	Four (4) alphanumeric characters. <sup>1</sup>		
<b>DEFINITION</b>	This code identifies and distinguishes MTF/Clinic enrollments from network enrollments primarily for reporting on Enrollment Based Capitation (EBC). EBC became operational on 10/01/1997. The code designations vary based on type of Prime enrollment and begin work dates of new programs such as TRICARE Prime Remote (TPR) which has an effective date of 10/01/1999. The codes also vary based on the individual requirements of enrolling platforms used by the Managed Care Support regions.		
<b>CODE/VALUE SPECIFICATIONS</b>	For detailed instructions on how this field is used turn to <a href="#">Chapter 9, Section 2</a> .		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	PCM LOCATION DMIS-ID CODE		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PLACE OF SERVICE**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-320	Up to 25	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Two (2) alphanumeric characters.		
<b>DEFINITION</b>	Code to indicate the location of provided health care.		
<b>CODE/VALUE SPECIFICATIONS</b>	1-Digit Place of Service codes <sup>1</sup>		
	1	Inpatient Hospital (Terminated 10/13/2000)	
	2	Outpatient Hospital (Terminated 10/13/2000)	
	3	Doctor's Office (Terminated 10/13/2000)	
	4	Patient's Home (Terminated 10/13/2000)	
	5	Day Care Facility (Terminated 10/13/2000)	
	6	Night Care Facility (Terminated 10/13/2000)	
	7	Nursing Home (Terminated 10/13/2000)	
	8	Skilled Nursing Facility/Extended Care Facility (Terminated 10/13/2000)	
	9	Ambulance (Terminated 10/13/2000)	
	0	Other Locations (Terminated 10/13/2000)	
	A	Independent Laboratory (Terminated 10/13/2000)	
	B	Ambulatory Surgical Center (Terminated 10/13/2000)	
	C	Residential Treatment Center (Terminated 10/13/2000)	
	D	Other Specialized Treatment Facility (e.g. Drug and Alcohol Treatment Facility, etc.) (Terminated 10/13/2000)	
	E	Birthing Center - Free Standing (Terminated 10/13/2000)	
	F	Independent Kidney Disease Treatment Center (Terminated 10/13/2000)	

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Single digit codes were outdated in 1992, when the 1500 was modified. Adjustment/cancellation for the one-digit codes are valid through 11/01/2001, single-digit codes must be left justified and blank filled.

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PLACE OF SERVICE (CONTINUED)</b>		
<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>	G	Pharmacy (Outpatient) - Drugs Only Ambulance (Terminated 10/13/2000)
	2-digit Place Of Service codes for the revised HCFA 1500-1990 versions.	
	00	Unassigned
	11	Office
	12	Home
	10; 13-19	Unassigned
	21	Inpatient Hospital
	22	Outpatient Hospital
	23	Emergency Room - Hospital
	24	Ambulatory Surgical Center
	25	Birthing Center
	26	Military Treatment Facility
	20; 27-29	Unassigned
	31	Skilled Nursing Facility
	32	Nursing Facility
	33	Custodial Care Facility
	34	Hospice
	30; 35-39	Unassigned
	41	Ambulance - Land
	42	Ambulance - Air or Water
	40; 43-49	Unassigned
	51	Inpatient Psychiatric Facility
	52	Psychiatric Facility Partial Hospitalization
	53	Community Mental Health Center
	54	Intermediate Care Facility/Mentally Retarded
	55	Residential Substance Abuse Treatment Facility

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Single digit codes were outdated in 1992, when the 1500 was modified. Adjustment/cancellation for the one-digit codes are valid through 11/01/2001, single-digit codes must be left justified and blank filled.

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PLACE OF SERVICE (CONTINUED)</b>		
<b>CODE/VALUE SPECIFICATIONS</b>	56	Psychiatric Residential Treatment Center
<b>(CONTINUED)</b>	50; 57-59	Unassigned
	61	Comprehensive Inpatient Rehabilitation Facility
	62	Comprehensive Outpatient Rehabilitation Facility
	60; 63; 64	Unassigned
	65	End Stage Renal Disease Treatment Facility
	66-69	Unassigned
	71	State or Local Public Health Clinic
	72	Rural Health Clinic
	70; 73-79	Unassigned
	81	Independent Laboratory
	80; 82-89	Unassigned
	99	Other Unlisted Facility
	90-98	Unassigned
<b>ALGORITHM</b>	N/A	
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>		
<b>SUBORDINATE</b>	<b>GROUP</b>	
N/A	N/A	

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Single digit codes were outdated in 1992, when the 1500 was modified. Adjustment/cancellation for the one-digit codes are valid through 11/01/2001, single-digit codes must be left justified and blank filled.

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PRICING CODE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-309	Up to 25	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	Two (2) alphanumeric characters <sup>2</sup> .		
<b>DEFINITION</b>	The code indicating the contractor's pricing methodology used in determining the amount allowed for the service(s)/supplies.		
<b>CODE/VALUE SPECIFICATIONS</b>	0	Pricing not applicable (denied service/supplies and allowed drugs)	
	1	Priced Manually	
	2	Prevailing charge (state)	
	3	Conversion factor(contractor)	
	4	Paid as billed	
	5	Paid on negotiated rate	
	6	Prevailing/conversion adjusted by the MEI - Primary Care	
	7	Prevailing/conversion adjusted by the MEI - Non-primary care, total charge subjected to MEI	
	8	Prevailing/conversion adjusted by the MEI - Non-primary care professional component only	
	9	Paid on surgical tier pricing (For use by CRI contractor only)	
	A	National prevailing charge	
	B	National conversion factor	
	C	Ambulatory surgery-facility payment rate.	
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Code '0' for all allowed drug charges. Use Pricing Code '1' (Priced Manually) for consultation procedures (procedure code* 906XX) for which the allowable charge is limited to that for a Limited Initial Visit, New Patient (procedure code* 90010).			
<sup>2</sup> When using single digit codes, left justify and blank fill.			
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**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PRICING CODE (CONTINUED)</b>		
<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>	D	Discounted ambulatory surgery-facility payment rate.
	E	Ambulatory surgery-paid as billed.
	F	TRICARE Claimcheck-added procedure, priced manually
	G	TRICARE Claimcheck-added procedure, prevailing charge (state)
	H	TRICARE Claimcheck-added procedure, conversion factor (contractor)
	I	TRICARE Claimcheck-added procedure, paid as billed
	J	TRICARE Claimcheck-added procedure, paid on negotiated rate
	K	TRICARE Claimcheck-added procedure, prevailing/conversion adjusted by MEI - primary care
	L	TRICARE Claimcheck-added procedure, prevailing/conversion adjusted by the MEI - non-primary care, total charge subject to MEI
	M	TRICARE Claimcheck-added procedure, prevailing/conversion adjusted by the MEI - non-primary care professional component only
	N	TRICARE Claimcheck-added procedure, national prevailing charge
	O	TRICARE Claimcheck-added procedure, national conversion factor
	P	TRICARE Claimcheck-added procedure, ambulatory surgery-facility payment rate

**NOTES AND SPECIAL INSTRUCTIONS:**

- <sup>1</sup> Code '0' for all allowed drug charges. Use Pricing Code '1' (Priced Manually) for consultation procedures (procedure code\* 906XX) for which the allowable charge is limited to that for a Limited Initial Visit, New Patient (procedure code\* 90010).
- <sup>2</sup> When using single digit codes, left justify and blank fill.

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**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PRICING CODE (CONTINUED)</b>		
<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>	Q	TRICARE Claimcheck-added procedure, discounted ambulatory surgery-facility payment rate
	R	TRICARE Claimcheck-added procedure, ambulatory surgery-paid as billed
	T	TRICARE Claimcheck-added procedure, allowed as billed but paid less than billed
	U	Medicare Reimbursement Used
	V	TRICARE Claim-added procedure, CMAC-priced laboratory code
	W	Priced Over CMAC
<b>ALGORITHM</b> N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>		
<b>SUBORDINATE</b>		<b>GROUP</b>
N/A		N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>		
<sup>1</sup> Code '0' for all allowed drug charges. Use Pricing Code '1' (Priced Manually) for consultation procedures (procedure code* 906XX) for which the allowable charge is limited to that for a Limited Initial Visit, New Patient (procedure code* 90010).		
<sup>2</sup> When using single digit codes, left justify and blank fill.		
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**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PRICING LOCALITY CODE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-208	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	Three (3) alphanumeric characters.		
<b>DEFINITION</b>	The TRICARE assigned locality code for the physical location where the provider is physically located/or rendered the service.		
<b>CODE/VALUE SPECIFICATIONS</b>	N/A		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> For Internal Partnership claims and Resource Sharing claims, the locality code must be the location of the MTF where services were rendered.			

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PRICING PROFILE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-331	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	Two (2) alphanumeric digits.		
<b>DEFINITION</b>	Number identifying the Pricing Profile used to determine the allowable charge.		
<b>CODE/VALUE SPECIFICATIONS</b>	88 = 88 Profile	10/01/1987 - 01/31/1989	
	89 = 89 Profile	02/01/1989 - 12/31/1989	
	11 = 11 Profile	01/01/1990 - 03/31/1990	
	90 = 90 Profile	04/01/1990 - 10/06/1991	
	91 = 91 Profile	10/07/1991 - 04/30/1992	
	92 = 92 Profile	05/01/1992 - 02/28/1993	
	93 = 93 Profile	03/01/1993 - 10/31/1993	
	14 = 14 Profile	11/01/1993 - 03/31/1994	
	94 = 94 Profile	04/01/1994 - 12/31/1994	
	15 = 15 Profile	01/01/1995 - 02/28/1995	
	95 = 95 Profile	02/01/1995 - 01/31/1996	
	16 = 16 Profile	01/01/1996 - 01/31/1996	
	96 = 96 Profile	02/01/1996 - 12/31/1996	
	17 = 17 Profile	01/01/1997 - 02/28/1997	
	97 = 97 Profile	03/01/1997 - 12/31/1997	
	18 = 98 Profile	01/01/1998 - 01/31/1998	
	98 = 98 Profile	02/01/1998 - 07/31/1998	
	28 = 98 Profile	08/01/1998 - 12/31/1998	
	19 = 99 Profile	01/01/1999 - 01/31/1999	
	99 = 99 Profile	02/01/1999 - 01/31/2000 And if Second Byte Type of Service = "7" (Anesthesia) with an end of care between 01/01/1999 and 03/31/2000	
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> Required if Pricing Code 2, 3, 6, 7, 8, A or B.			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PRICING PROFILE (CONTINUED)**

<b>CODE/VALUE SPECIFICATIONS (CONTINUED)</b>		
00 = 00 Profile	02/01/2000 - 01/31/2001	And if Second Byte Type of Service = "7" (Anesthesia) with an end of care ≥ 04/01/2000
01 = 01 Profile	02/01/2001 - 01/31/2002	
02 = 02 Profile	02/01/2002 - 03/31/2003	
03 = 03 Profile	(04/01/2003 - 02/29/2004)	
04 = 04 Profile	(03/01/2004 - 99/99/9999)	

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

<b>SUBORDINATE</b>	<b>GROUP</b>
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Required if Pricing Code 2, 3, 6, 7, 8, A or B.

**DATA ELEMENT DEFINITION****ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE****RECORDS/LOCATOR NUMBERS**

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-340	1	Yes <sup>1</sup>

**PRIMARY PICTURE (FORMAT)** Five (5) alphanumeric characters.**DEFINITION** The code that identifies the principal procedure performed during the period covered by this HCSR as coded on the UB-82 or UB-92.**CODE/VALUE SPECIFICATIONS** Must limit to 4 of the 5 positions available. Use the most current procedure code edition as directed by TMA. Must provide the most detailed code. Must be left justified and blank filled. Do not code the decimal point which, for ICD-9-CM, is always assumed to follow the second position. Blank fill if not applicable.**ALGORITHM** N/A**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**<sup>1</sup> Required if one of the following Revenue Codes are present 36X or 72X.

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS**

**RECORDS/LOCATOR NUMBERS**

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-315	1	Yes
Non-Institutional	2-255	1	Yes

**PRIMARY PICTURE (FORMAT)** Six (6) alphanumeric characters.

**DEFINITION** The condition established, after study, to be the major cause for the patient to obtain medical care as coded on the claim form or otherwise indicated by the provider.

**CODE/VALUE SPECIFICATIONS** Must limit to 5 of the 6 positions available. Use the most current diagnosis code edition, as directed by TMA. Must provide the most detailed code. Left justify and blank fill. Do not code the decimal point, which for ICD-9-CM is always assumed to be following the third position.

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**  
 N/A

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PROCEDURE CODE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-290	Up to 25	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Five (5) alphanumeric characters.		
<b>DEFINITION</b>	Code indicating the procedure which describes the care received.		
<b>CODE/VALUE SPECIFICATIONS</b>	See Physician's Current Procedure Terminology (CPT-4), or HCPCS National Level II Medicare Codes or TMA approved codes ( <a href="#">Figure 2-E-1</a> ).		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROCEDURE CODE MODIFIER**

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-333	2	No

**PRIMARY PICTURE (FORMAT)** Two (2) alphanumeric characters.

**DEFINITION** Two digit code which provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

**CODE/VALUE SPECIFICATIONS** Must be 21 - 27, 32, 47, 50 - 59, 62, 63, 66, 73 - 82, 90, 91, 99, D, E, G, H, I, J, N, P, R, S, X, AA, AD, AH, AJ, AM, AP, AS - AV, A1 - A9, BA, BP, BQ, BR, BU, CC, EJ, EM, EP, ET, EY, E1 - E4, FA, FP, F1 - F9, GA - GC, GE, GG, GH, GJ, GK, GL, GM, GN, GO, GP, GQ, GT, GV, GW, GY, GZ, G1 - G9, HA - HZ, H9, JW, KA, KB, KH, KI, KJ, KM - KS, KX, K0 - K4, LC, LD, LL, LR, LS, LT, MS, MR, NU, PL, P1 - P6, QA - QH, QJ - QQ, QS - QZ, Q2 - Q9, RC, RP - RT, SA - SH, SJ, SK, SL, ST - SV, TA, TC - TK, TL - TN, TP - TW, T1 - T9, UA - UE, U1 - U9, VP, or blank.

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**  
 Can report from 0 to 2 codes. Left justify and blank fill. When reporting more than one code, the more important code is to be reported first. Do not duplicate.



**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PROCEDURE TEXT IDENTIFIER</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-195	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	One (1) alphanumeric character.		
<b>DEFINITION</b>	Code identifying the edition number of the Physician's Current Procedure Terminology used in determining the procedure codes on the HCSR.		
<b>CODE/VALUE SPECIFICATIONS</b>	4	CPT-4, HCPCs (Levels I, II, and III)	
	8	ADA Dental Code	
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	PROCESSING CODE		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROCESSING CODE**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-165	1	Yes <sup>1</sup>
Non-Institutional	2-165	1	Yes <sup>1</sup>

**PRIMARY PICTURE (FORMAT) Group**

**DEFINITION** Field containing multiple elements that describe processing related to the HCSR.

**CODE/VALUE SPECIFICATIONS** N/A

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

<b>SUBORDINATE</b>	<b>GROUP</b>
OVERVERRIDE	N/A
TYPE OF SUBMISSION	N/A
NAS EXCEPTION REASON	N/A
HEALTH CARE PLAN CODE	N/A
DIAGNOSIS EDITION IDENTIFIER	N/A
PROCEDURE TEXT IDENTIFIER (NON-INSTITUTIONAL ONLY)	N/A
REASON FOR ADJUSTMENT	N/A
SPECIAL PROCESSING CODE	N/A
SPECIAL RATE CODE	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**  
<sup>1</sup> Required if applicable to HCSR conditions.

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PROGRAM INDICATOR</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-030	1	Yes <sup>1</sup>
Non-Institutional	2-030	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	One (1) alphanumeric character.		
<b>DEFINITION</b>	Code identifying which TMA program the services being reported relate to.		
<b>CODE/VALUE SPECIFICATIONS</b>	<b>Institutional HCSR</b>	<b>Non-Institutional HCSR</b>	
	I Institutional	D	Drug
	H Program for Persons with Disabilities	H	Program for Persons with Disabilities
		I	Institutional (excluding D, H, and T)
		N	Non-Institutional (excluding D, H, and T)
		T	Dental (excluding D and H)
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
<sup>1</sup> See the <a href="#">Chapter 1, Section 3</a> for further instructions.			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER CONTRACT AFFILIATION CODE**

<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-209	1	Yes <sup>1</sup>
Non-Institutional	2-214	1	Yes <sup>1</sup>

**PRIMARY PICTURE (FORMAT)** One (1) alphanumeric character.

**DEFINITION** Code indicates whether the provider is under contract with the contractor.

<b>CODE/VALUE SPECIFICATIONS</b>		
	0	Not applicable
	1	Contracted
	2	Not Contracted
	3	Contracted/Not Contracted
	4	Active Duty - TPR
	5	Non-Certified Providers (does not include sanctioned/suspended providers) (Effective 08/01/2003)

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

<b>SUBORDINATE</b>	<b>GROUP</b>
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> Codes '1', '2', and '3' apply only to at-risk contractors and subcontractors. All codes are irrespective of any Partnership Agreements. Report '0' if not an at-risk contractor.

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PROVIDER SPECIALTY</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Non-Institutional	2-235	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Two (2) alphanumeric characters.		
<b>DEFINITION</b>	Code describing the provider's major specialty.		
<b>CODE/VALUE SPECIFICATIONS</b>	See <a href="#">Addendum C</a> .		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>			<b>GROUP</b>
N/A			N/A
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR**

**RECORDS/LOCATOR NUMBERS**

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-225	1	Yes
Non-Institutional	2-230	1	Yes

**PRIMARY PICTURE (FORMAT)** One (1) alpha character.

**DEFINITION** Code indicating whether or not the provider accepted assignment of benefits for services rendered.

CODE/VALUE SPECIFICATIONS	N	No
	Y	Yes

**ALGORITHM** N/A

**SUBORDINATE AND/OR GROUP ELEMENTS**

SUBORDINATE	GROUP
N/A	N/A

**NOTES AND SPECIAL INSTRUCTIONS:**  
 N/A

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-210	1	Yes
Non-Institutional	2-215	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Two (2) alphanumeric characters.		
<b>DEFINITION</b>	Code assigned to identify the state or foreign country in which the care was <u>received</u> .		
<b>CODE/VALUE SPECIFICATIONS</b>	<a href="#">Addendum A</a> and <a href="#">Addendum B</a> .		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PROVIDER SUB-IDENTIFIER</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-215	1	Yes
Non-Institutional	2-220	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Four (4) alphanumeric characters.		
<b>DEFINITION</b>	Identification number that uniquely identifies multiple providers using the same Taxpayer Identification Number (TIN). Refer to ELN 3-010 for complete instructions.		
<b>CODE/VALUE SPECIFICATIONS</b>	Assigned as per TMA instructions. Must be zero-filled if there are no multiple providers within the TIN. Refer to ELN 3-010 for complete instructions.		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			



**DATA ELEMENT DEFINITION**

<b>ELEMENT NAME: PROVIDER TAXPAYER NUMBER</b>			
<b>RECORDS/LOCATOR NUMBERS</b>			
<b>RECORD NAME</b>	<b>LOCATOR#</b>	<b>OCCURRENCES</b>	<b>REQUIRED</b>
Institutional	1-212	1	Yes
Non-Institutional	2-217	1	Yes
<b>PRIMARY PICTURE (FORMAT)</b>	Nine (9) alphanumeric characters.		
<b>DEFINITION</b>	The IRS Taxpayer Identification Number (TIN) assigned to the institution/provider supplying the care.		
<b>CODE/VALUE SPECIFICATIONS</b>	For institutions must be 9-digit Employer Identification Number (EIN). For individual providers should be the 9-digit EIN or SSN, if available. If not available, report the contractor-assigned number. (See Provider File data element Provider Taxpayer Number 3-005 in the provider record for instructions). Report all nines for transportation services under Program for Persons with Disabilities and for Drug Program when the services are from a non-participating pharmacy.		
<b>ALGORITHM</b>	N/A		
<b>SUBORDINATE AND/OR GROUP ELEMENTS</b>			
<b>SUBORDINATE</b>	<b>GROUP</b>		
N/A	N/A		
<b>NOTES AND SPECIAL INSTRUCTIONS:</b>			
N/A			

**DATA ELEMENT DEFINITION**

**ELEMENT NAME: PROVIDER ZIP CODE**

RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-220	1	Yes <sup>1</sup>
Non-Institutional	2-225	1	Yes <sup>1</sup>
<b>PRIMARY PICTURE (FORMAT)</b>	Nine (9) alphanumeric characters.		
<b>DEFINITION</b>	Location of provider's business office where care is usually provided.		
<b>CODE/VALUE SPECIFICATIONS</b>	Must be valid zip code or blank if a foreign country. If all 9-digits are not available, code 5 digits, left justify and blank fill.		
<b>ALGORITHM</b>	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE			GROUP
N/A			N/A

**NOTES AND SPECIAL INSTRUCTIONS:**

<sup>1</sup> First 5 digits are required. For professional claims:

- P.O. Box zip codes may be used if the care provided is radiology, pathology or anesthesiology.
- Enter the MTF zip code if the care is rendered by a Partnership provider in an MTF.
- Enter the beneficiary's zip code if the Program Indicator is 'D' (Drug) and the pharmacy does not participate.