

UTAH
HOSPITAL
EMERGENCY DEPARTMENT
PATIENT ENCOUNTER DATA
SUBMITTAL MANUAL

**DATA ELEMENT
DESCRIPTIONS AND DEFINITIONS**

April 2002

BEMS

**Utah Department of Health
Bureau of Emergency Medical Services**

**288 North 1460 West
P. O Box 142004
Salt Lake City, UT 84114-2004**

Hospital Emergency Department Patient Encounter Data Submittal Manual

TABLE OF CONTENTS

	PAGE
Introduction	1
Data Reporting Source	1
Data Submittal Schedule	1
Data Transfer	2
Data Transfer Formats	3
Data Element Layout and Descriptions	7
Patient's Header Record-Record Type 1	16
Introduction	16
Data Elements Description	16
Patient's Revenue Record-Record Type 2	27
Introduction	27
Data Elements Description	27
Revenue Codes	30
Introduction	30
Data Elements Description	30
Patients Trailing Record-Record Type 3	31
Introduction	31
Data Elements Description	31
Editing, Validation, and Errors	52
Editing and Validation	53
Error Rates	54
Request for Exemption, Extension, or Waiver	55
Introduction	56
Form	58

TABLES

Table 1: Submittal Schedule	2
Table 2: Required Level 1 - EDPD Elements	5
Table 3: Required Level 2 - EDPD Elements	6
Table 4: Record Layout	8

INTRODUCTION

The Utah Emergency Medical Services Systems Act, 26-8, Utah Code Annotated, authorizes the Bureau of Emergency Medical Services (BEMS) to establish an emergency medical services data system, which shall provide for the collection of data, as defined by the State Emergency Medical Services Committee (the Committee), relating to the treatment and care of patients, who use or have used, the emergency medical services system (26-8-4(11) and 26-8-5(5)). In addition, 26-8-7(4) states the following:

“Persons (defined as “any individual, firm, partnership, association, corporation, company, group of individuals acting together for a common purpose, agency or organization of any kind, public or private”) providing emergency medical services shall provide to the department information for the emergency medical services information system established pursuant to Subsection 26-8-5(5).”

Administrative Rule R426-1-7(I), mandates that all Utah licensed hospitals report information on emergency department patient encounters. This manual defines the data elements which hospitals are required to submit to BEMS under statute and administrative rules specifically for the purpose of constructing a statewide Emergency Department Patient Data (EDPD) base.

BEMS gives hospitals some leeway in determining how to comply with the technical specifications. Some options hospitals may choose to use: case mix file, uniform billing process, or an unanticipated source for the data. Each hospital should evaluate their possible data source and, if needed, consult the exemption section of the rules and consult with BEMS for assistance.

Although BEMS wishes to be flexible, data must be received in usable formats from all hospitals. Upon request, BEMS is willing to provide technical consultation and assistance to the extent of its resources. The consultation or assistance is limited to activities that specifically enable the hospital to submit data which will meet the requirements of the rules. Each of the following sections provides guidance in defining the reporting source, the submittal schedule, the preferred transfer method, the format and data elements to be transferred, editing/validation/error processing, and finally a sample of the request form.

DATA REPORTING SOURCE

Licensed hospital facilities are the source for EDPD. This includes both general acute care and specialty hospitals. All hospitals shall report EDPD for each emergency department patient served. EDPD means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single emergency department patient encounter. The consolidation of patient data is a patient data record and its format which is defined later in this manual. A patient data record is submitted for each encounter, not for each bill generated. A hospital may submit EDPD directly to BEMS or designate a submitting intermediary, such as the Utah Association of Healthcare Providers. Designation of an intermediary does not remove the hospital from its responsibility to submit and correct the information as outlined.

For communication and problem solving, each hospital shall provide BEMS with the name, telephone number, and job title of the person assigned the reporting responsibility.

DATA SUBMITTAL SCHEDULE

Patient data records are to be submitted to BEMS as specified in Table 1. The data elements to be submitted are based on the encounter occurring in a calendar quarter. It should be noted that deadlines for data submission are 45 days after the end of the quarter.

**TABLE 1
SUBMITTAL SCHEDULE**

<u>DATE OF ENCOUNTER</u>	<u>ENCOUNTER DATA RECEIVED BY</u>
January 1 through March 31	May 15
April 1 through June 30	August 15
July 1 through September 30	November 15
October 1 through December 31	February 15

DATA TRANSFER

These technical specifications must be met when submitting data on magnetic tape, diskette, or other media. Data transfers not in compliance with these specifications will be rejected unless prior approval is obtained. A rejected submittal will need to conform to the specifications before resubmitting the data.

All tapes, EBCDIC, ZIP, JAZ Cartridges, and diskettes must have an external label containing the following information:

- a. Name of the data supplier
- b. Date of submittal as MM/DD/YYYY
- c. Beginning and ending dates of the calendar quarter contained in the transferred file.
For example, 04/01/1998 - 06/30/1998.
- d. The total number of records contained in the file.
- e. An unduplicated count of the patients contained in the file.
- f. The name and telephone number of a contact person for problem solving.
- g. If multiple tapes, cartridges, CD-ROMs or diskettes are submitted, the processing order must be indicated by a sequence number.
- h. For tape(s), state the BPI.

Example of a tape/diskette label:

```

+-----+
| Name: _____ |
| Date: mm/dd/yyyy   Quarter: mm/dd/yyyy-mm/dd/yyyy |
| Total Record Count: ##### |
| Patient Count: ##### |
| Contact Person: _____ Phone: _____ |
| Sequence #: ####   BPI: #### |
+-----+

```

The totals indicated on the external label (items d and e) must balance with the detail count obtained when processed. If the counts do not agree the complete submittal will be rejected.

All data submittals are to be mailed to the following address:

Utah Department of Health
 Bureau of Emergency Medical Services
 288 North 1460 West
 P. O. Box 142004
 Salt Lake City, Utah 84114-2004

BEMS will provide an explanation when a data transfer is rejected. The most likely reasons are:

- detail count does not agree with label counts
- data elements do not conform to edit specifications

The physical characteristics of the transfer media must have the following attributes:

- a. Tape
 1. Non-labeled, 9 track, written at 6250 (preferred) or 1600 BPI
 2. 1128 or 274 byte fixed length records
 3. Blocking factor of 20 records per block
 4. EBCDIC code

2. 3490 Cartridges:
 1. Non-labeled, written at 6250 (preferred) or 1600 BPI
 2. 1128 or 274 byte fixed length records
 3. Blocking factor of 20 records per block
 4. EBCDIC code

- c. Floppy Diskette (3 1/2), IOMEGA® ZIP (100 MB) and JAZ (1.0 Gig) Cartridges, and CD-ROM (650 MB) must be:
 1. IBM compatible, PC/MS-DOS format with no format label;
 2. 1128 or 274 byte fixed length records;
 3. ASCII code.

- d. All data fields are to be initialized as follows:
 - Numeric fields are to be initialized to zeros (0)
 - Alphanumeric fields are to be initialized as spaces

DATA TRANSFER FORMATS

The form of data submitted to BEMS is intended to minimize the reporting burden. The data supplier may choose to perform internal procedures to limit the data elements in the data record to those specified, or choose to submit more data requiring BEMS to extract the data elements. For example, a complete copy of the patient's uniform billing record (UB-92) will fit the record formats and satisfy the requirements.

The technical specifications for magnetic diskette or magnetic tape transfers generally conform to the specification required for direct computer billing of Medicaid claims. This transfer format was chosen for two important reasons: first, to minimize new programming by hospitals currently utilizing computerized billing of Medicaid claims; and second, to provide a usable by-product to any hospital not currently benefitting from direct billing of Medicaid claims.

To accommodate the data elements for each patient, three record formats are required. The three formats are designed to have the same record length and must be written to the file in sequence. The three record formats appear in sequence starting with record format 1 (patient's header record), followed by 1 to "n" records of format 2 (patient's revenue record), followed by format 3 (patient's trailing record).

The revenue record, format 2, is designed to accommodate two revenue services. Each revenue record has space to record from 1 to 15 services. The record types are defined as:

1. Patient's Header Record: This record consists of the Committee's reportable data elements numbered: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 28 and 29 in Table 2; 1 in Table 3. The "Record type" field of this record must be set to "1" to indicate that the patient's header record is being processed. Each patient must have only one patient header record per encounter.
2. Patient's Revenue Record: These records must follow the patient's header record. They will contain the reportable revenue information for the patient's care. These are BEMS's reportable data elements numbered 15, 16 and 17 in Table 2. The record type field must be set to "2" to indicate that the patient's revenue record is being processed. A patient may have as many revenue records as required to record all the revenue activities associated with the hospital stay. Each revenue record accommodates from 1 to 15 revenue services. The last revenue entry must contain code "001" indicating the sum of revenue entries and the end of the revenue records.
3. Patient's Trailing Record: This record must follow at least one patient revenue record and indicate that the patient's record has ended. The record format consists of the committee's reportable data elements numbered 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 in Table 2; 2, 3, 4, 5, 6, 7, 8, 9, and 10 in Table 3. The record type field must be set to "3" for this record. There must be only one type 3 record per encounter.

Tables 2 and 3 display reportable data elements by defined level. Each hospital shall, as a minimum, report the required level 1 data elements shown in Table 2. Data elements that are submitted, but are not required as part of a data record, will be deleted by BEMS, before the records are saved.

The column headings used in the Data Elements Layout and Description section are as follows:

Field Name The words in this column are the data element names listed in tables 2, 3, and 4. The name "filler" is used to indicate areas in the record that may contain information but will not be processed by computer programs.

Class The letter in this column indicates the field's attribute.
A = Alphanumeric
N = Numeric

Position The number(s) in this column indicates the starting and ending position of the field in the record.

Length The number in this column indicates the field length in bytes.

The definition specified for each data element is in general agreement with the definition specified for the field entry in the uniform billing form (UB-92) Users Manual. Hospitals using data sources other than uniform billing should evaluate definitions for agreement with the definitions specified in this manual.

**TABLE 2
REQUIRED LEVEL 1
EMERGENCY DEPARTMENT PATIENT
ENCOUNTER DATA ELEMENTS**

DATA ELEMENT NAME

Provider	
1.	Provider Identifier
Patient	
2.	Patient's Control Number
3.	Patient's Medical Chart Number
4.	Patient's Level Identifier
5.	Patient's Address (Postal zip code is the minimum requirement for address)
6.	Patient's Date of Birth
7.	Patient's Gender
Service	
8.	Admission Date
9.	Admission Hour
10.	Type of Admission
11.	Source of Admission
12.	Release Hour
13.	Patient's Status
14.	Statement Covers Period (ending date equals encounter date)
Charge	
15.	Revenue Codes
16.	Units of Service
17.	Total Charges by Revenue Code
Payer	
18.	Payer's Identification
19.	Patient's Relationship to Insured
Diagnosis and Treatment	
20.	Principal Diagnosis
21.	Other Diagnosis Codes
22.	External Cause of Injury Code (E-code)
23.	Principal Procedure Code
24.	Other Procedure Codes
25.	Procedure Coding Method (required if coding is <u>NOT</u> ICD-9-CM)
Physician	

- 26. Attending Physician's Identifier
 - 27. Other Physicians' Identifier
- Other
- 28. Type of Bill
 - 29. Patient's Social Security Number

TABLE 3
AS AVAILABLE LEVEL 2
EMERGENCY DEPARTMENT PATIENT
ENCOUNTER DATA ELEMENTS

DATA ELEMENT NAME

Patient

1. Patient's Marital Status
2. Patient's Race and Ethnicity

Payer

3. Insured Group Name
4. Insured's Name
5. Certificate/Social Security Number/
Health Insurance Claim/Identification Number

Employer

6. Employment Status Code
7. Employer's Name
8. Employer's Location

Charge

9. Prior Payment

Payment

10. Estimated Amount Due

**DATA ELEMENTS LAYOUT
AND DESCRIPTION**

PATIENT'S HEADER RECORD RECORD TYPE 1

INTRODUCTION

The header record indicates the starting of a patient's encounter record. A single type 1 record is followed by revenue and a trailing record to complete the encounter record.

DATA ELEMENTS DESCRIPTION

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Unique Patient Control Number	N	1-9	9
<u>Data Reporting Level:</u> Required.			
<u>Definition:</u>	A unique identification number assigned by the hospital to each encountered patient's record.		
<u>General Comments:</u>	The only use of this number is to ensure that the three types of records are processed as one record.		
<u>Edit:</u>	The number must be present in each record and be unique within the batch of hospital records processed.		
Record Type	N	10	1
<u>Data Reporting Level:</u> Required.			
<u>Definition:</u>	The record format type indicator.		
<u>General Comments:</u>	This field must equal 1 indicating that the record is a Patient's Header Record.		
<u>Edit:</u>	The number must be present, and there can only be one record with record type equal 1 to for each Unique Patient Control Number.		
Provider Identifier	A	11-110 100	
- Provider name		11-35	25
- Line 2 Filler		36-60	25
- Line 3 Filler		61-85	25
- Line 4 Filler		86-110	25
<u>Data Reporting Level:</u> Required.			
<u>Definition:</u>	The name of the hospital submitting the record.		

General Comments: The hospital name is entered in the first 25 character positions and may be followed by space filler or the address and telephone number in lines 2-4. The hospital name must be entered in to each Patient Header Record using the same form and spelling. The name of the hospital is converted into a code to protect their identity.

Edit: The name must be present and match a name in a coding table.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	A	111-127	17

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Patient's Social Security Number	A	128-140	13
----------------------------------	---	---------	----

Data Reporting Level: Required.

Definition: The social security number of the patient receiving emergency department patient care.

General Comments: This field is to be left-justified with spaces to the right to complete the field. The format of SSN is 777777777 without hyphens. Apply the following codes for appropriate situations:

100=a newborn who has not obtained a SSN

200=a patient who has no SSN

300=a patient who chooses not to provide his/her SSN

Edit: The field is edited for a valid entry.

Patient's Control Number	A	141-157	17
--------------------------	---	---------	----

Data Reporting Level: Required.

Definition: A patient's unique alphanumeric number assigned by the hospital to facilitate retrieval of individual encounter records, if editing or correction is required.

General Comments: This number may be the same as the Unique Patient Control Number. This number will be used for reference in correspondence, problem solving, or edit corrections. This is NOT the same as the control number assigned by BEMS to protect the patient level identifier.

Edit: The number must be present and should be unique within a hospital.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Type of Bill	A	158-160	3

Data Reporting Level: Required for any record not consolidated into an encounter data record.

Definition: A code indicating the specific type of emergency department patient billing. For example if a hospital is submitting uniform billing records to meet its reporting requirements, this code will indicate interim billings.

General Comments: BEMS is interested in collecting all emergency department patient records that indicate that the patient was treated in the emergency department. All records that have a value of "131" in the Type of Bill field and a value of "450" in at least one of the Revenue Code fields should be submitted to BEMS. The processing of non-consolidated records will use the type of bill code to adjust previously submitted records. The code structure of this field is as follows:

First position indicates type of facility:

1=Hospital

Second position indicates billing classification:

3=Emergency department patient

Third position represents a total confinement or course of treatment:

1=Admit through encounter claim

Edit: The following apply: the first digit must be 1; the second digit must be 3; the third digit must be 1.

Filler	A	161-210	50
--------	---	---------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Patient's Level Identifier (Patient's Name)	A	211-241	31
--	---	---------	----

Data Reporting Level: Required.

Definition: The name of the patient in last, first, and middle initial order.

General Comments: Use a comma and space to separate last and first names. No space should be left between a prefix and a name, as in MacBeth, VonSchmidt, or McEnroe. Titles such as Sir, Msgr., or Dr. should not be recorded. Record hyphenated names with the hyphen as in Smith-Jones, Rebecca. To record the suffix of a name, write the last name, leave a space then write the suffix, followed by the comma, then write the first name. For example: Snyder III, Harold or Addams Jr., Glen.

Edit: The name will be edited for the presence of the space and comma separating the last name from first name.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Patient's Address (Postal zip code is the minimum required for address)	A	242-287	46

Data Reporting Level: Required.

Definition: The address including postal zip code or only the postal zip code of the patient, as defined by the payer organization.

General Comments: The order of the complete address if provided should be street number, apartment number, city, state and zip code left-justified with spaces to the right to complete the field. The state, if entered, must be the standard post office abbreviations (UT for Utah). If postal zip code is the only part of the address provided it must be left-justified with spaces to complete the field. If the complete address is present the postal zip code must be the last item entered in the field. If a nine-digit zip code is used, it must be entered in the form of "XXXXX-YYYY" where "X" is the five digit zip code and "Y" is the zip code extension. The zip code must be followed by space filler to the end of the field. If the address exceeds 46 characters in length, abbreviate parts of the address so that the zip code can occupy the last five (5) positions e.g. 283-287.

Edit: This field is edited for the presence of a postal zip code.

Patient's Date of Birth	N	288-295	8
-------------------------	---	---------	---

Data Reporting Level: Required.

Definition: The date of birth of the patient in the order of month, day, and year.

General Comments: The date of birth must be present and recorded in an eight-digit format of month, day, and year (MMDDYYYY). The month is recorded as two digits ranging from 01 through 12. The day is recorded as two digits ranging from 01 through 31. The year is recorded as four digits ranging from 1800 through 2000. Each of the three components

(month, day, year) must be right-justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 1982 is entered as 02071982. If the birth date is unknown, then the field must contain "00000000".

Edit: This field is edited for the presence of a valid date and that it is not equal to the billing dates or the current date. Age is calculated and used in the clinic code edit to identify age diagnosis conflicts and invalid or unknown age.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Patient's Gender	A	296	1

Data Reporting Level: Required.

Definition: The gender of the patient as recorded at date of admission or start of care.

General Comments: This is a one character code. The sex is to be reported as male, female, or unknown using the following coding:

M = Male
 F = Female
 U = Unknown

Edit: A valid code must be present. The gender of the patient is checked for consistency with diagnosis and procedure codes. The clinic code edit is to identify gender diagnosis conflicts and invalid or unknown gender.

Patient's Marital Status	A	297	1
--------------------------	---	-----	---

Data Reporting Level: As Available.

Definition: The marital status of the patient at date of admission, or start of care.

General Comments: The marital status of the patient is to be reported as a one character code whenever the information is recorded in the patient's hospital record. The following codes apply:

S = Single
 M = Married
 X = Legally Separated
 D = Divorced
 W = Widowed
 U = Unknown
 Space = Not present in Patient's Record

Edit: This field is edited for a valid entry.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Admission Date	N	298-303	6

Data Reporting Level: Required.

Definition: The date the patient was admitted to the emergency department for emergency treatment.

General Comments: The admission date is to be entered as six digits in the order of month, day, and year. The format is MMDDYY. The month is recorded as two digits ranging from 01 through 12. The day is recorded as two digits ranging from 01 through 31. The year is recorded as two digits ranging from 00 through 99. Each of the three components (month, day, year) must be right-justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 1992 is entered as 020792.

Edit: The admission date must be present with a valid date. The date cannot be before date of birth or be after ending date in Statement Covers Period.

Admission Hour	N	304-305	2
----------------	---	---------	---

Data Reporting Level: Required.

Definition: The hour during which the patient was admitted to the emergency department for emergency treatment.

General Comments: This field is to be right-justified (all positions fully coded). Apply the following codes for appropriate situations:

Code	Time AM	Code	Time PM
00	12:00-12:59	Midnight	12
	12:00-12:59	Noon	
01	01:00-01:59	13	01:00-01:59
02	02:00-02:59	14	02:00-02:59
03	03:00-03:59	15	03:00-03:59
04	04:00-04:59	16	04:00-04:59
05	05:00-05:59	17	05:00-05:59
06	06:00-06:59	18	06:00-06:59
07	07:00-07:59	19	07:00-07:59
08	08:00-08:59	20	08:00-08:59
09	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

Edit: Must be a valid code that represents the time frame during which the patient was admitted to the hospital for emergency department patient care.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Type of Admission	N	306	1

Data Reporting Level: Required.

Definition: A code indicating the priority of the admission.

General Comments: This is a one digit code ranging from 1 through 4 or may be a 9. The code structure is as follows:

1 = Emergency

Definition: 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 department.

2 = Urgent

Definition: 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

Definition: The patient's condition permits adequate time to schedule the availability of a suitable accommodation. An elective admission can be delayed without substantial risk to the health of the individual.

4 = Newborn

Definition: Use of this code requires the use of special source of admission codes, see Source of Admission below. Generally, the child is born within the facility.

9 = Information not available

Edit: The field must be present and have a valid code 1 through 4 or 9. If the code entered is 4 (newborn) the Source of Admission codes will be checked for consistency as well as the date of birth and diagnosis.

Source of Admission	A	307	1
---------------------	---	-----	---

Data Reporting Level: Required.

Definition: A code indicating the source of the admission.

General Comments: This is a single digit code whose meaning is dependent on the code entered for Type of Admission. For Type of Admission codes 1, 2, or 3, Source of Admission codes 1 through 9 are valid. For Type of Admission code 4 (newborn), Source of Admission codes 1 through 4 are valid, and have different meanings than when Type of Admission code is a 1, 2, or 3. The code structure is as follows.

CODE STRUCTURE FOR EMERGENCY (1), URGENT (2), AND ELECTIVE (3)

1 = Physician Referral

Definition: The patient was admitted to this facility upon the recommendation of his or her personal physician. (See code 3 if the physician has an HMO affiliation.)

2 = Clinic Referral

Definition: The patient was admitted to this facility upon recommendation of this facility's clinic physician.

3 = HMO referral

Definition: The patient was admitted to this facility upon the recommendation of a health maintenance organization (HMO) physician.

4 = Transfer from a hospital

Definition: The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.

5 = Transfer from a skilled nursing facility

Definition: The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.

6 = Transfer from another health care facility

Definition: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.

7 = Emergency department

Definition: The patient was admitted to this facility upon the recommendation of this facility's emergency department physician.

8 = Court/Law enforcement

Definition: 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.

9 = Information not available

Definition: The means by which the patient was admitted to this hospital is not known.

CODE STRUCTURE FOR NEWBORN (4)

If Type of Admission is a 4 the following codes apply.

1 = Normal delivery

Definition: A baby delivered without complications.

2 = Premature delivery

Definition: A baby delivered with time or weight factors qualifying it for premature status.

3 = Sick baby

Definition: A baby delivered with medical complications, other than those relating to premature status.

4 = Extramural birth

Definition: A baby delivered in a non-sterile environment.

9 = Information not available.

Edit: The code must be present and valid and agree with the Type of Admission code entered.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Release Hour	N	308-309	2

Data Reporting Level: Required.

Definition: The hour during which the patient was released from the emergency department after receiving emergency treatment.

General Comments: This field is to be right-justified (all positions fully coded). Apply the following codes for the appropriate situations:

Code	Time AM	Code	Time PM
00	12:00-12:59 Midnight	12	12:00-12:59 Noon
01	01:00-01:59	13	01:00-01:59
02	02:00-02:59	14	02:00-02:59
03	03:00-03:59	15	03:00-03:59
04	04:00-04:59	16	04:00-04:59
05	05:00-05:59	17	05:00-05:59
06	06:00-06:59	18	06:00-06:59
07	07:00-07:59	19	07:00-07:59
08	08:00-08:59	20	08:00-08:59
09	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
		99	Hour Unknown

Edit: Must be a valid code that represents the time frame during which the patient was released from emergency department patient care.

Filler	A	310-311	2
--------	---	---------	---

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Patient's Status	N	312-313	2
------------------	---	---------	---

Data Reporting Level: Required.

Definition: A code indicating patient status as of the date the statement covers through. Generally, it is the arrangement or event ending a patient's stay in the hospital.

General Comments: This is a code with a length of two bytes. If the record is a consolidation of the patient's stay codes 30-39 should not apply. The patient's status is coded as follows:

- 01 = Released to home or self care, routine release. If a patient is released from an inpatient program to an emergency department-patient program, code the case as '01'.
- 02 = Released/transferred to another short-term general hospital.
- 03 = Released/transferred to skilled nursing facility.
- 04 = Released/transferred to an intermediate care facility.
- 05 = Released/transferred to another type of institution. If a patient is released from an inpatient program to a residential program, code as '05'.
- 06 = Released/transferred to home under care of organized home health service organization.
- 07 = Left against medical advice or discontinued care.
- 08 = Released/transferred to home under care of a home IV provider.
- 09 = Admitted as an inpatient to this hospital.
- 20 = Expired.
- 30 = Still patient (will be excluded from the database).
- 40 = Expired at home.
- 41 = Expired in a medial facility; i.e. hospital, skilled nursing facility, intermediate care facility, or free standing hospice.
- 42 = Expired (place unknown).

Edit: The patient status code must be present and have a valid code as defined. If patient status code is 30 the Type of Bill code must indicate that the record is still open.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
-------------------	--------------	-----------------	---------------

Statement Covers Period	N	314-325	12
- Beginning Date	N	314-319	6
- Through Date	N	320-325	6

Data Reporting Level: Required.

Definition: The beginning and ending service dates of the patient's care. The ending date is the release date.

General Comments: The two dates are MMDDYY formats and the "through" date must be the last date of encounter, unless the Type of Billing field indicates an interim record. The months are recorded as two digits ranging from 01 through 12. The days are recorded as two digits ranging from 01 through 31. The years are recorded as two digits ranging from 00 through 99. Each of the three components of both dates (month, day, year) must be right-justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 1992 through March 1, 1992 is entered as 020792030192.

Edit: These dates must be present and be valid. The beginning date must precede the through date and the difference between the two date should be at least one day.

Filler	A	326-335	10
--------	---	---------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Patient's Medical/Health Record Number	A	336-352	17
--	---	---------	----

Data Reporting Level: Required.

Definition: A unique identifier assigned by the hospital to a patient at the time of the first admission, and used for all subsequent admissions.

General Comments: This number is assigned by the hospital for each patient.

Edit: The field must be present.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
-------------------	--------------	-----------------	---------------

Filler	A	353-571	219
--------	---	---------	-----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Patient's Race

N

572

1

Data Reporting Level: As Available.

Definition: This item gives the race of the patient. The information is based on self identification, and is to be obtained from the patient, a relative, or a friend. The hospital is not to categorize the patient based on observation or personnel judgement.

General Comments: The patient may choose not to provide the information. If the patient chooses not to answer, the hospital should enter the code for unknown. If the hospital fails to request the information, the field should be space filled.

1=American Indian or Alaskan Native

Definition: A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

2=Asian or Pacific Islander

Definition: A person having origins in any of the original oriental peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. These areas include for example: China, India, Japan, Korea, the Philippine Islands, and Samoa.

3=Black

Definition: A person having origins in any of the black racial groups of Africa.

4=White

Definition: A person having origins in any of the original Caucasian peoples of Europe, North Africa, or the Middle East.

5=Other

Definition: Any possible options not covered in the above categories.

6=Unknown

Definition: A person who chooses not to answer the question.

Blank Space

Definition: The hospital made no effort to obtain the information.

Edit: If the data field contains an entry, it must be a valid code.

Field Name

Class

Position

Length

Filler

A

573-587

15

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Patient's Ethnicity

N

588

1

Data Reporting Level: As Available.

PATIENT'S REVENUE RECORD RECORD TYPE 2

INTRODUCTION

Each of the revenue records may contain from 1 to 15 revenue services. If a patient has more than 15 revenue services a second record must be created. There is no limit to the number of revenue records allowed before the trailing record is written. Each record must contain the same "Unique Patient Control Number", record type must contain a number "2", and have at least one revenue entry. If only one revenue record is needed, it must have at least two revenue entries. The first entry records the service provided. The second entry would have revenue code "001" to indicate the sum of all revenue services, see Revenue Codes and Units of Service section below for the complete list of revenue codes and definitions.

DATA ELEMENTS DESCRIPTION

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Unique Patient Control Number	N	1-9	9

Data Reporting Level: Required.

Definition: A unique identification number assigned by the hospital to each released patient's record.

General Comments: Its use is to ensure that the three types of formats are processed as one record.

Edit: The number must be present in each record and be unique within the hospital's transferred batch of records. Each Revenue Record's Unique Patient Control Number must match one and only one Unique Patient Control Number in a Patient's Header Record.

Record Type	N	10	1
-------------	---	----	---

Data Reporting Level: Required.

Definition: The record type indicator.

General Comments: This field must equal 2 for a revenue record.

Edit: The number must be present in each record and equal 2.

Revenue Service 1 of 2

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
-------------------	--------------	-----------------	---------------

Filler	A	11-41	31
--------	---	-------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Revenue Code	A	42-44	3
--------------	---	-------	---

Data Reporting Level: Required.

Definition: A three-digit code that identifies a specific accommodation, ancillary service or billing calculation.

General Comments: For every patient there must be at least one revenue service entered and an entry representing the sum of all revenue services. If the patient has only one service, such as room and board, it is entered as the first of 15 possible in the record. The second entry will be "001" indicating the entry represents the sum of the single room and board entry.

Edit: This field must be present and contain a valid revenue code as defined in Revenue Codes and Units of Service section of the (UB-92) form.

Units of Service	N	45-47	3
------------------	---	-------	---

Data Reporting Level: Required if the revenue code needs units, see Revenue Codes and Units of Service section below.

Definition: A quantitative measure of services rendered by revenue category to or for the patient. It includes such items as the number of days, number of hours, number of items, number of tests, number of scans, number of pints, number of treatments, number of encounters, number of miles, or number of sessions.

General Comments: This is a three-digit number that qualifies the revenue service. The presence of this code ensures that charges per revenue service are adjusted to a common base for comparison. Revenue Codes and Units of Service section below defines the appropriate units for each revenue codes.

Edit: The units of service must be present for those revenue services that require a unit, see Revenue Codes and Units of Service section of the (UB-92) form.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Total Charges by Revenue Code	N	48-55	8

Data Reporting Level: Required.

Definition: Total dollars and cents amount charged for the related revenue service entered.

General Comments: The total allows for a 6-digit dollar amount followed by 2 digits for cents (no decimal point). All entries are right-justified. If the charge has no cents then the last two digits must be zero. For example, a charge of \$500.00 is entered as 50000 and a charge of \$37.55 is entered as 3755.

Edit: This field must be present and contain a value greater than 0 when revenue code field is greater than 0.

Filler	A	56-79	24
--------	---	-------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Revenue Service 2 of 2

Filler	A	80-110	31
Revenue Code	A	111-113	3
Units of Service	N	114-116	3
Total Charges by Revenue Code	N	117-124	8
Filler	A	125-179	55

REVENUE CODES

INTRODUCTION

This section defines acceptable revenue codes representing services provided to patients. Any codes not assigned are assumed to be nonapplicable. The source of the codes and definitions is the National Uniform Billing Committee's published manual.

Revenue Code: A three-digit code that identifies a specific accommodation, ancillary service or billing calculation. The first two digits of the three digit code indicate major category and the third digit, represented by "x" in the codes, indicates a subcategory.

Units of Service: A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints, or treatments.

DATA ELEMENT DESCRIPTION

<u>Code</u>	<u>Definition</u>
001	Total charges
45x	Emergency department - charges for emergency treatment to ill and injured persons, who require immediate, unscheduled medical or surgical care.

Subcategory "x"

0 = General classification

1 = Other Emergency room

PATIENT'S TRAILING RECORD RECORD TYPE 3

INTRODUCTION

The trailing record completes the individual patient's encounter data record. The trailing record must contain the "Unique Patient Control Number" entered as a field in the Patient's Header Record, and "Record type" must contain the number "3". Each encountered patient must have only one trailing record.

DATA ELEMENT DESCRIPTION

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Unique Patient Control Number	N	1-9	9

Data Reporting Level: Required.

Definition: A unique identification number assigned by the hospital to each encountered patient's record.

General Comments: Its use is to ensure that the three types of formats are processed as one record.

Edit: The number must be present in each record and be unique within the hospital's transferred batch of records, and equal to the number entered in the corresponding field in the Patient's Header Record.

Record Type	N	10	1
-------------	---	----	---

Data Reporting Level: Required.

Definition: The record type indicator.

General Comments: This field must equal 3 to indicate the end of the patient's encounter data record.

Edit: The number must be present and equal 3. The Unique Patient Control Number present in the Patient's Header Record must be the same as the number entered for the Unique Patient Control Number in the trailing record.

1st of Three Payers*

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Payer's Identification	A	11-35	25

Data Reporting Level: Required.

Definition: Name and if required by payer, a number identifying the primary payer organization from which the hospital might expect some payment for the bill.

General Comments: This field is to contain the complete name of the primary payer organization. The name should be spelled out completely when space allows. If the name has more than 25 characters, use abbreviations that can be used to uniquely identify the organization.

Edit: The name must be that of a verifiable organization.

Filler A 36-53 18

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Estimated Amount Due N 54-61 8

Data Reporting Level: As Available.

Definition: The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

General Comments: The format of this estimate is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal in entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and an estimate of \$50.55 is entered as 5055. The entry is right-justified within the field.

Edit: None.

Prior Payment N 62-69 8

Data Reporting Level: As Available

Definition: The amount the hospital has received toward payment of this bill, prior to the billing date from the indicated payer.

General Comments: The format of this payment is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal is entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and a payment of \$50.55 is entered as 5055. The entry is right-justified within the field.

Edit: None.

* The record accommodates from one to three payers and associated information.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	A	70-77	8
<u>Data Reporting Level:</u> Required.			
<u>Definition:</u> Space filler.			
<u>General Comments:</u> It is inserted into the record to maintain field positions.			
<u>Edit:</u> None.			

2nd of Three Payers

Payer's Identification	A	78-102	25
<u>Data Reporting Level:</u> Required if patient has more than one payer.			
<u>Definition:</u> Name and if required by payer, a number identifying the secondary payer organization from which the hospital might expect some payment for the bill.			
<u>General Comments:</u> This field is to contain the complete name of the secondary payer organization. The name should be spelled out completely when space allows. If the name has more than 25 characters, use abbreviations that can be used to uniquely identify the organization.			
<u>Edit:</u> The name must be that of a verifiable organization.			

Filler	A	103-120	18
<u>Data Reporting Level:</u> Required.			
<u>Definition:</u> Space filler.			
<u>General Comments:</u> It is inserted into the record to maintain field positions.			
<u>Edit:</u> None.			

Estimated Amount Due	N	121-128	8
<u>Data Reporting Level:</u> As Available.			
<u>Definition:</u> The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
<u>General Comments:</u> The format of this estimate is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal is entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and an estimate of \$50.55 is entered as 5055. The entry is right-justified within the field.			
<u>Edit:</u> None.			

Prior Payment N 129-136 8

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
-------------------	--------------	-----------------	---------------

Data Reporting Level: As Available.

Definition: The amount the hospital has received toward payment of this bill, from the secondary payer, prior to the billing date.

General Comments: The format of this payment is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal is entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and a payment of \$50.55 is entered as 5055. The entry is right-justified within the field.

Edit: None.

Filler	A	137-144	8
--------	---	---------	---

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

3rd of Three Payers

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
-------------------	--------------	-----------------	---------------

Payer's Identification	A	145-169	25
------------------------	---	---------	----

Data Reporting Level: Required if the patient has three payers.

Definition: Name and if required by payer, a number identifying the tertiary payer organization from which the hospital might expect some payment for the bill.

General Comments: This field is to contain the complete name of the tertiary payer organization. The name should be spelled out completely when space allows. If the name has more than 25 characters, use abbreviations that can be used to uniquely identify the organization.

Edit: The name must be that of a verifiable organization.

Filler	A	170-187	18
--------	---	---------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Estimated Amount Due	N	188-195	8

Data Reporting Level: As Available.

Definition: The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

General Comments: The format of this estimate is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal in entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and an estimate of \$50.55 is entered as 5055. The entry is right-justified within the field.

Edit: None.

Prior Payment	N	196-203	8
---------------	---	---------	---

Data Reporting Level: As Available.

Definition: The amount the hospital has received toward payment of this bill from the tertiary payer prior to the billing date.

General Comments: The format of this payment is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal is entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and a payment of \$50.55 is entered as 5055. The entry is right-justified within the field.

Edit: None.

Filler	A	204-211	8
--------	---	---------	---

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Patient as Payer*

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Estimated Amount Due	N	212-219	8

Data Reporting Level: As Available.

Definition:

The amount estimated by the hospital to be due from the patient (estimated responsibility less prior payments).

General Comments: The format of this estimate is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal in entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and an estimate of \$50.55 is entered as 5055. The entry is right-justified within the field.

Edit: None.

* The record allows additional entries for the estimated amount to be the patient's responsibility, and any prior payment made by the patient.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Prior Payment	N	220-227	8

Data Reporting Level: As Available.

Definition: The amount the hospital has received toward payment of this bill from the patient prior to the billing date.

General Comments: The format of this payment is dollars and cents. The dollar amount can be a maximum of six digits with two additional digits for cents (no decimal is entered). If the amount has no cents then the last two digits must be zeros. For example, an estimate of \$500 is entered as 50000 and a payment of \$50.55 is entered as 5055. The entry is right-justified within the field.

Edit: None.

Filler	A	228-235	8
--------	---	---------	---

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

1st of Three Insured Persons*

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Insured's Name	A	236-259	24

Data Reporting Level: As Available.

Definition: The name of the individual in whose name the insurance is carried.

General Comments: Enter the name of the insured individual in last name, first name, middle initial order. Use a comma and space to separate the last and first names. Allow one space between the first name and the middle initial. No space should be left between a prefix and name, as in MacBeth,

* The record accommodates from one to three insured individuals and the associated information. VonSchmidt, and McEnroe. Titles such as Sir, Msgr., or Dr. should not be recorded in this data field. Record hyphenated names with the hyphen as in Smith-Jones, Rebecca. To record the suffix of a name, write the last name, leave a space then write the suffix followed by a comma, then write the first name. For example: Snyder III, Harold E or Addams Jr., Glen.

Edit: The name will be edited for the presence of the space and comma separating the last name from first name.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	A	260	1

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Patient's Relationship to Insured	N	261-262	2
-----------------------------------	---	---------	---

Data Reporting Level: Required.

Definition: A code indicating the relationship (such as parent, spouse, child, etc.) of the patient to the identified insured person listed in the first of three Insured's Name fields in the (UB-92) form.

General Comments: Enter the two digit code representing the patient's relationship to the individual named. All codes are to be right-justified with a leading 0, if needed. The following codes apply:

01 = Patient is the named insured

Definition: Self-explanatory

02 = Spouse

Definition: Self-explanatory

03 = Natural Child/insured financial responsibility

Definition: Self-explanatory

04 = Natural Child/insured does not have financial responsibility

Definition: Self-explanatory

05 = Step Child

Definition: Self-explanatory

06 = Foster Child

Definition: Self-explanatory

07 = Ward of the Court

- Definition: Patient is ward of the insured as a result of a court order.
- 08 = Employee
Definition: The patient is employed by the named insured.
- 09 = Unknown
Definition: The patient's relationship to the named insured is unknown.
- 10 = Handicapped Dependent
Definition: Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage.
- 11 = Organ Donor
Definition: Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.
- 12 = Cadaver Donor
Definition: Code is used in cases where bill is submitted for procedures performed on cadaver donor, where such procedures are paid by the receiving patient's insurance coverage.
- 13 = Grandchild
Definition: Self-explanatory
- 14 = Niece or Nephew
Definition: Self-explanatory
- 15 = Injured Plaintiff
Definition: Patient is claiming insurance as a result of injury covered by insured.
- 16 = Sponsored Dependent
Definition: Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.
- 17 = Minor Dependent of a Minor Dependent
Definition: Code is used where patient is a minor and a dependent of another minor who in turn is a dependent, although not a child, of the insured.
- 18 = Parent
Definition: Self-explanatory
- 19 = Grandparent
Definition: Self-explanatory

Edit: A code must be present and valid if Insured's Name is entered.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Certificate/Social Security Number/Health Insurance Claim/ Identification Number	A	263-278	16

Data Reporting Level: As Available.

Definition: The insured's unique identification number assigned by the first listed payer organization, to the entry in the first Insured's Name fields in the (UB-92) form.

General Comments: The payer organization's assigned identification number is to be entered in this field. It should be entered exactly as printed on the Insured's Name identification card.

Edit: None.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Insured Group Name	A	279-294	16

Data Reporting Level: As Available.

Definition: Name of the group or plan through which the insurance is provided to the Insured's Name listed in the first Insured's Name fields in the (UB-92) form.

General Comments: Enter the complete name of the group or plan name. If the name exceeds 16 characters, truncate the excess.

Edit: None.

Filler	A	295-310	16
--------	---	---------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

2nd of Three Insured Persons

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Insured's Name	A	311-334	24

Data Reporting Level: As Available.

Definition: The name of the individual in whose name the insurance is carried.

General Comments: Enter the name of the insured individual in last name, first name, middle initial order. Use a comma and space to separate the last and first names. Allow one space between the first name and the middle initial. No space should be left between a prefix and name as in MacBeth, VonSchmidt, and McEnroe. Titles such as Sir, Msgr., and Dr. should not be recorded in this data field. Record hyphenated names with the hyphen as in Smith-Jones, Rebecca. To record the suffix of a name, write the last name, leave a space then write the

suffix followed by a comma, then write the first name. For example: Snyder III, Harold E or Addams Jr., Glen.

Edit: The name will be edited for the presence of the space and comma separating the last name from first name.

Filler	A	335	1
--------	---	-----	---

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
-------------------	--------------	-----------------	---------------

Patient's Relationship to Insured	A	336-337	2
-----------------------------------	---	---------	---

Data Reporting Level: Required.

Definition: A code indicating the relationship (such as parent, spouse, child, etc.) of the patient to the identified insured person listed in the second of three Insured's Name fields in the (UB-92) form.

General Comments: See comments for 1st insured person.

Edit: A code must be present and valid if Insured's Name is entered.

Certificate/Social Security Number/Health Insurance Claim /Identification Number	A	338-353	16
--	---	---------	----

Data Reporting Level: As Available.

Definition: The insured's unique identification number assigned by the second listed payer organization to the entry in the second Insured's Name field in the (UB-92) form.

General Comments: The payer organization's assigned identification number is to be entered in this field. It should be entered exactly as printed on the Insured's Name identification card.

Edit: None.

Insured Group Name	A	354-369	16
--------------------	---	---------	----

Data Reporting Level: As Available.

Definition: Name of the group or plan through which the insurance is provided to the Insured's Name listed in the second of three Insured's Name fields in the (UB-92) form.

General Comments: Enter the complete name of the group or plan name. If the name exceeds 16 characters, truncate the excess.

Edit: None.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	A	370-385	16

Data Reporting Level: Required.
Definition: Space filler.
General Comments: It is inserted into the record to maintain field positions.
Edit: None.

3rd of Three Insured Persons

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Insured's Name	A	386-409	24

Data Reporting Level: As Available.
Definition: The name of the individual in whose name the insurance is carried.
General Comments: Enter the name of the insured individual in last name, first name, middle initial order. Use a comma and space to separate the last and first names. Allow one space between the first name and the middle initial. No space should be left between a prefix and name, as in MacBeth, VonSchmidt, and McEnroe. Titles such as Sir, Msgr., or Dr. should not be recorded in this data field. Record hyphenated names with the hyphen as in Smith-Jones, Rebecca. To record the suffix of a name, write the last name, leave a space then write the suffix followed by a comma, then write the first name. For example: Snyder III, Harold E or Addams Jr., Glen.
Edit: The name will be edited for the presence of the comma and space separating the last name from first name.

Filler	A	410	1
--------	---	-----	---

Data Reporting Level: Required.
Definition: Space filler.
General Comments: It is inserted into the record to maintain field positions.
Edit: None.

Patient's Relationship to Insured	A	411-412	2
-----------------------------------	---	---------	---

Data Reporting Level: Required.

Definition: A code indicating the relationship (such as parent, spouse, child, etc.) of the patient to the identified insured person listed in the third of three Insured's Name fields in the (UB-92) form.

General Comments: See comments for 1st insured person.

Edit: The code must be present and a valid number.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Certificate/Social Security Number/Health Insurance Claim Identification Number	A	413-428	16

Data Reporting Level: As Available.

Definition: The insured's unique identification number assigned by the third listed payer organization to the entry in the third Insured's Name field in the (UB-92) form.

General Comments: The payer organization's assigned identification number is to be entered in this field. It should be entered exactly as printed on the Insured's Name identification card.

Edit: None.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Insured Group Name	A	429-444	16

Data Reporting Level: As Available.

Definition: Name of the group or plan through which the insurance is provided to the Insured's Name listed in the third of three Insured's Name fields.

General Comments: Enter the complete name of the group or plan name. If the name exceeds 16 characters, truncate the excess.

Edit: None.

Filler	A	445-461	17
--------	---	---------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

1st of two Employments*

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Employment Status Code	A	462	1

Data Reporting Level: As Available.

Definition: A code used to define the employment status of the insured individual identified in the first of the two entries in the Employment Information Data fields in the (UB-92) form.

General Comments: This field contains the employment status of the person described in the first of the two entries in the Employment Information Data fields in the (UB-92) form. The codes to be used are:

- 1 = Employed full time - Individual states that he or she is employed full time.
- 2 = Employed part time - Individual states that he or she is employed part time.
- 3 = Not employed - Individual states that he or she is not employed full time or part time.
- 4 = Self employed
- 5 = Retired
- 6 = On active military duty
- 9 = Unknown - Individual's employment status is unknown.

Edit: If an entry is present it must be a valid code.

Employer Name	A	463-486	24
---------------	---	---------	----

Data Reporting Level: As Available.

Definition: The name of the employer that might or does provide health care coverage for the insured individual identified by the first of the two entries in the Employment Information Data fields in the (UB-92) form.

* The record accommodates one or two employer related lines of information. This employment information relates to individuals named in the Insured's Name fields.

General Comments: Enter the complete name of the employer providing health care coverage.

Edit: None.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	N	487-497	11

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Employer Location	A	498-534	37
-------------------	---	---------	----

Data Reporting Level: As Available.

Definition: The specific location represented by the address of the employer of the insured individual identified by the first of the two entries in the Employment Information Data fields in the (UB-92) form.

General Comments: This is to be the complete address of the employer of the individual.

Edit: None.

2nd of Two Employments

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	N	535	1

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Employment Status Code	A	536	1
------------------------	---	-----	---

Data Reporting Level: As Available

Definition: A code used to define the employment status of the insured individual identified in the second of the two entries in the Employment Information Data fields in the (UB-92) form.

General Comments: This field contains the employment status of the person described in the second of the two entries in the Employment Information Data fields in the (UB-92) form. The codes to be used are:

- 1 = Employed full time - Individual states that he or she is employed full time.
- 2 = Employed part time - Individual states that he or she is employed part time.
- 3 = Not employed - Individual states that he or she is not employed full time or part time.
- 4 = Self employed
- 5 = Retired
- 6 = On active military duty
- 9 = Unknown - Individual's employment status is unknown.

Edit: If an entry is present it must be a valid code.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Employer Name	A	537-560	24

Data Reporting Level: As Available

Definition: The name of the employer that might or does provide health care coverage for the insured individual identified by the second of the two entries in the Employment Information Data fields in the (UB-92) form.

General Comments: Enter the complete name of the employer providing health care coverage.

Edit: None.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	N	561-571	11

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Employer Location	A	572-608	37
-------------------	---	---------	----

Data Reporting Level: As Available.

Definition: The specific location, represented by the address, of the employer of the insured individual identified by the second of the two entries in the Employment Information Data fields in the (UB-92) form.

General Comments: This is to be the complete address of the employer of the individual.

Edit: None.

Filler	A	609-653	45
--------	---	---------	----

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Principal Diagnosis Code	A	654-659	6
--------------------------	---	---------	---

Data Reporting Level: Required.

Definition: The principal diagnosis is the condition established after study, to be chiefly responsible for occasioning the admission of the patient for care. An ICD-9-CM code describes the principal diagnosis.

General Comments: This field is to contain the appropriate ICD-9-CM code without a decimal. In the ICD-9-CM code book there are three, four, and five digit codes, plus "V" and "E" codes. The fourth and fifth digit, and "V" and "E" must be entered when present in the code. For example a five-digit code is entered as "12345", a "V" code is entered as "V270". All entries are to be left-justified with spaces to the right, to complete the field length. An "E" code should not be recorded as the principal diagnosis.

Edit: A principal diagnosis must be present and valid. When the principal diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

Other Diagnosis Code (1st of 8)*	A	660-665	6
----------------------------------	---	---------	---

Data Reporting Level: Required.

Definition: ICD-9-CM codes describing other diagnosis corresponding to additional conditions that coexist at the time of admission or develop subsequently, and which have an effect on the treatment received or the length of stay.

General Comments: The first of eight additional diagnosis. This field is to contain the appropriate ICD-9-CM code without a decimal. In the ICD-9-CM code book there are three, four, and five digit codes, plus "V" and "E" codes. The fourth and fifth digit, and "V" and "E" must be entered when present in the code. For example a five-digit code is entered as "12345", a "V" code is entered as "V270". All entries are to be left-justified with spaces to the right, to complete the field length.

* The record will accommodate from one to eight additional diagnosis when present in the patient record.

Edit: If other diagnosis are present they must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Other Diagnosis Code (2nd of 8)	A	666-671	6
Other Diagnosis Code (3rd of 8)	A	672-677	6
Other Diagnosis Code (4th of 8)	A	678-683	6
Other Diagnosis Code (5th of 8)	A	684-689	6
Other Diagnosis Code (6th of 8)	A	690-695	6
Other Diagnosis Code (7th of 8)	A	696-701	6
Other Diagnosis Code (8th of 8)	A	702-707	6

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
External Cause of Injury Code (E-code)	A	708-713	6

Data Reporting Level: Required.

Definition: The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

General Comments: Hospitals are encouraged to complete this field whenever there is a diagnosis of an injury, poisoning, or adverse effect. The priorities in which to record an E-code are: 1) Principal diagnosis of an injury or poisoning, 2) Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis, and 3) Other diagnosis with an external cause. All entries are to be left-justified without a decimal.

Edit: If other diagnosis are present, they must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

Procedure Coding Method Used	A	714	1
------------------------------	---	-----	---

Data Reporting Level: Required only if procedure coding is NOT ICD-9-CM.

Definition: An indicator that identifies the coding method used for procedure coding.

General Comments: The default value should be 9 for ICD-9-CM. If coding method is NOT ICD-9-CM, enter the appropriate code from the list:

3 = DSM-III-R

4 = CPT-4

5 = HCPCS (HCFA Common Procedure Coding System)

9 = ICD-9-CM

Edit: This field must agree with coding method used to code procedures.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	A	715-724	10

Data Reporting Level: Required.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Principal Procedure Code*	A	725-730	6
---------------------------	---	---------	---

Data Reporting Level: Required.

Definition: The code that identifies the principal procedure performed during the hospital stay covered by this encounter data record. The principal procedure is one which is performed for definitive treatment rather than for diagnostic or exploratory purposes, or is necessary as a result of complications. The principal procedure is that procedure most related to the principal diagnosis.

General Comments: The coding method used should be ICD-9-CM format. If another coding method is used, the Procedure Coding Method Used field must NOT be 9, but must indicate the code for the procedure coding used. Entries must include all digits and the decimal. In the ICD-9-CM there are three-digit procedure codes and four-digit procedure codes, use of the fourth digit is NOT optional, it must be present. Enter the code left-justified with a decimal.

Edit: This field must be present if other procedures are reported and must be a valid code. When a procedure is sex-specific, the sex code entered in the record must be consistent.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	A	731-736	6

Data Reporting Level: Required.
 * Six procedures (one principal and five others) are accommodated in the record. All procedures entered must be coded using the same method. If the coding is NOT ICD-9-CM, the Procedure Coding Method Used field must indicate the coding method.

Definition: Space filler.

General Comments: It is inserted into the record to maintain field positions.

Edit: None.

Other Procedure Code (1st of 5 others)	A	737-742	6
---	---	---------	---

Data Reporting Level: Required.

Definition: The code that identifies the first of two other procedures performed during the patient's hospital stay covered by this encounter record. This may include diagnosis or exploratory procedures.

General Comments: Procedures that make for accurate DRG Categorization must be included. The coding method used must agree with the coding method used for the principal procedure. Entries must include all digits and the decimal. In the ICD-9-CM format, there are three-digit procedure codes and four-digit procedure codes, use of the fourth digit is NOT optional, it must be present. Enter the code left-justified with a decimal.

Edit: If this field is present there must be a principal procedure entered. Codes entered must be valid. When a procedure is sex-specific, the sex code entered in the record must be consistent.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Filler	A	743-748	6

Data Reporting Level: Required.
Definition: Space filler.
General Comments: It is inserted into the record to maintain field positions.
Edit: None.

Other Procedure Code (2nd of 5)	A	749-754	6
Other Procedure Code (3rd of 5)	A	755-760	6
Other Procedure Code (4th of 5)	A	761-766	6
Other Procedure Code (5th of 5)	A	767-772	6

Filler	A	773-784	12
--------	---	---------	----

Data Reporting Level: Required.
Definition: Space filler.
General Comments: It is inserted into the record to maintain field positions.
Edit: None.

Attending Physician's License Number*	A	785-796	12
---------------------------------------	---	---------	----

Data Reporting Level: Required.
Definition: This is the license number of the physician who is expected to certify and recertify the medical necessity of the services rendered, or who has primary responsibility for the patient's medical care and treatment.
General Comments: This field is to be left-justified with spaces to the right to complete the field.
Edit: This field must contain a valid Utah State license number.

Filler	A	797-816	20
--------	---	---------	----

Data Reporting Level: Required.
Definition: Space filler.
General Comments: It is inserted into the record to maintain field positions.
Edit: None.

EDITING, VALIDATION, AND ERRORS

EDITING AND VALIDATION

Hospitals shall review the encounter data records prior to submission. The review shall consist of checks for accuracy and completeness. Data records received will be processed by computer edits that include the following:

AGREEMENT WITH DATA DEFINITION: The submitted encounter data is edited for consistency and conformity with the standards specified in this manual. Any record containing fields that fail to agree with the definition or edit criteria specified will be returned to the hospital.

Correction of records in error and validation of aggregate tabulation are performed by the hospital.

VALIDATION OF HOSPITAL DATA BY PROVIDERS:

- a. Any record failing to pass an edit check will be returned to the hospital for correction or comment. The records in error will be printed in a simplified format providing record identification, an indication of the error, an explanation of the error, and space to record corrections. Records flagged by the clinical code editor as having a high probability of error, will be highlighted for review, comment, and possible correction, during the data review process and prior to release.

All records requiring correction by the hospital will be returned by first class U.S. certified mail to the attention of the individual designated to receive the correspondence. Corrected records are to be returned within 35 days of the date of postmark. The corrected records are to be returned by first class U.S. certified mail, addressed as follows:

State of Utah Department of Health
Bureau of Emergency Medical Services
Attention: Information Analyst
288 North 1460 West
P.O. Box 142004
Salt Lake City, Utah 84114-2004

- b. Annual tabulations of the hospital specific data will be circulated for review, comment, and correction prior to public release. Hospitals will review only raw data tabulations of the data they have submitted. The hospital shall return the tabulations to the Committee, with their comments and corrections within 35 days of the date of postmark. If the hospital fails to return the tabulations within the 35-day period, BEMS shall conclude that the tabulations are correct and suitable for release.

ERROR RATES

After collection of each full calendar year of data, BEMS may calculate the number of encounter data records failing the edit checks. BEMS may also calculate the non-reporting rates for both level 1 and level 2 data elements. Based on these calculations BEMS may recommend changes in the rules to establish acceptable edit failure and non-reporting rates. The results may be used to establish acceptable guideline standards for completeness and accuracy for the following year. These guidelines may include:

1. The hospital's past rate and a new standard rate for non-reporting;
2. The hospital's past rate and a new standard rate for conformity to the definitions and edit criteria;
3. The hospital's past rate of clinical code edit errors classified as "true" errors and "highly probable" errors and a new standard rate for improvement.

**REQUEST FOR EXEMPTION, EXTENSION,
OR WAIVER**

INTRODUCTION

Hospitals may request an exemption, extension, or waiver to requirements established by the Bureau of Emergency Medical Services (BEMS). A "Request for Exemption, Extension, or Waiver Form," may be completed and submitted to:

Bureau of Emergency Medical Services
288 North 1460 West
P.O. Box 142004
Salt Lake City, Utah 84114-2004
Telephone number: (801) 538-6287

See the following page for an example of this form.

A request must contain documentation supporting the hospital's need for an exemption, extension, or waiver, and contain the data supplier's suggested alternative to the requirement. All requests will be reviewed for progress toward future compliance with the requirement.

EXEMPTION AND WAIVER REQUESTS

A request for an exemption or waiver should be submitted at least 60 days prior to the scheduled due date shown in Table 1 (page 2). Exemptions and waivers may be granted for a maximum of one calendar year. Requests for an exemption or waiver beyond one year must be made annually. Reasons for exemption and waiver requests may include, but are not limited to, the following:

- **All reporting requirements:** if the hospital makes no effort to charge any patient for service;
- **Reporting of a specific data element:** if a hospital can document a substantive difference that cannot be reconciled, in the definition of the collected and requested data element. (Separate requests must be made for additional data element exemption or waiver. The exemption period should be used to set up changes to allow future reporting).

BEMS will review all requests for exemptions, extensions, and waivers. Hospitals able to document that compliance to the reporting requirements imposes an unreasonable cost, are more likely to be granted an exemption or waiver. If BEMS determines that the burden on a hospital outweighs the public purpose, BEMS may: 1) alter the requirement, 2) grant the request, or 3) pay the unreasonable costs incurred.

EXTENSION REQUESTS

A request for an extension to the reporting schedule requirement should be submitted at least ten working days prior to the reporting deadline. Extensions may be granted for a maximum of thirty calendar days. Additional 30-day extensions must be requested separately. Extensions may be granted when the hospital documents that technical or unforeseen difficulties prevent compliance.

Questions regarding the request for exemption, extension, or waiver should be directed to the following contacts:

Donald Wood, MD, Director of Standards and Evaluation, Bureau of Emergency Medical Services

Phone number - (801) 538-6287

E-mail - dwood@doh.state.ut.us

John Morgan, Information Analyst Supervisor, Bureau of Health Care Statistics

Phone number - (801) 538-6700

E-mail - jmorgan@doh.state.ut.us

Gerald VanOrman, MA, IT Programmer Analyst, Bureau of Emergency Medical Services

Phone number - (801) 538-6721

E-mail - gvanorma@doh.state.ut.us

REQUEST FOR: EXEMPTION, EXTENSION OR WAIVER

(Please indicate which)

To:

Utah Dept. of Health
Bureau of Emergency Medical Services
P.O. Box 142004
Salt Lake City, Utah 84114-2004
Phone: (801) 538-6287

Please complete each section of this form. If more space is needed, use additional pages following the format indicated..

Requested by:

Name:
Address:
Contact Person:
Telephone:

Relief Requested

(Describe: include specific requirement - submittal schedule, data consolidation, etc.)

Request:

The Time Period Request Would Cover?

Starting date:	Ending date:
-----------------------	---------------------

(Maximums: Exemption - 1year, Extension - 30 calendar days, Waiver - 1 year)

Justification for Granting This Request

Facts:
Reasons:
Legal Authority:
Proposed Alternative:

**Other
Comments:**

Action by Health Data Committee:

Date:

Approved

Disapproved

Additional Conditions or Suggestions: