



**UTAH
HOSPITAL
INPATIENT DISCHARGE DATA
SUBMITTAL MANUAL**

**DATA ELEMENT
DESCRIPTIONS AND DEFINITIONS**

Version V, August 2004
(Short Version)

**Utah Health Data Committee
Utah Department of Health
Office of Health Care Statistics
288 North 1460 West
Salt Lake City, UT 84114-4004**

Hospital Inpatient Discharge Data Submittal Manual

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INTRODUCTION

Chapter 33a, Title 26, Utah Code Annotated established the Health Data Committee (committee). In accordance with the act the committee's purpose is to direct a statewide effort to collect, analyze, and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care and to facilitate interaction among those with concern for health care issues. This manual defines the data that hospitals are required to submit to the Office of Health Care Statistics (office) under statute and administrative rules for the specific purpose of constructing an inpatient hospital discharge data base.

Administrative Rule R413, effective December 1991, mandates all Utah licensed hospitals, both general acute care and specialty, to report information on inpatient discharges. This manual specifies the technical requirements for data Submittal, defines the data elements to be submitted, and outlines the edits to which the data elements may be subjected.

The committee's Health Data Plan gives hospitals some leeway in determining how to comply with the technical specifications. Some hospitals may choose to use their case mix file, some may choose their uniform billing process, some may need to submit the information on paper, while others may find an unanticipated form works best. Each hospital should evaluate their possible data source and, if needed, consult the exemptions section of the rules and consult with the office for assistance.

Although the committee wishes to be flexible, data must be received in usable formats from all hospitals. The office is willing to provide technical consultation and assistance, to the extent of its resources, upon request. The consultation or assistance is limited to activities that specifically enable the hospital to submit data that will meet the requirements of the rules. Each section that follows provide guidance in defining the reporting source, the submittal schedule, the preferred transfer method, the format and data elements to be transfer, editing/validation/error processing, and finally request forms.

DATA REPORTING SOURCE

Licensed hospital facilities are the source for inpatient discharge data. This includes both general acute care and specialty hospitals. All hospitals shall report "discharge data" for each inpatient served. "Discharge data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single inpatient hospital stay. The consolidation of discharge data is a discharge data record and its format is defined later in this manual. A discharge data record is submitted for each discharge, not for each bill generated. A hospital may submit inpatient discharge data directly to the office

or designate a submitting intermediary, such as the Utah Hospital Association. 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 the office the name, telephone number, and job title of the person assigned the reporting responsibility.

DATA SUBMITTAL SCHEDULE

Discharge data records are to be submitted to the office as specified in Table 1. The data elements to be submitted are based on the discharge occurring in a calendar quarter. If a patient has a bill generated during a quarter but has not yet been discharged by the end of the quarter, data for that stay should not be included in the quarter's data. It should be noted that deadlines for data submission are 45 days after the end of the quarter.

**TABLE 1
SUBMITTAL SCHEDULE**

<u>PERSON'S DATE OF DISCHARGE IS BETWEEN</u>	<u>DISCHARGE DATA MUST BE 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 or diskette. Data transfers not in compliance with these specifications will be rejected unless prior approval is obtained. Rejected Submittal will need to conform to the specifications before resubmitting the data. Specifications for other transfer formats, such as paper, must be worked out between the office and the hospital before the scheduled due date.

All tapes and diskettes must have an external label containing the following information:

- a. Name of data supplier
- b. Date of submittal as MM/DD/YY
- c. Beginning and ending dates of the calendar quarter contained in the transferred file. For example, 4/1/92 - 6/30/92.
- 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 problems solving.
- g. If multiple tapes 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/yy      Quarter: mmddyymmddy |
| 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 submittal are to be mailed to the following address:

Utah Department of Health
Office of Health Care Statistics
288 North 1460 West
P. O. Box 144004
Salt Lake City, Utah 84114-4004
Telephone: 538-7048

The office will provide reasons when it rejects a data transfer. 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 or 3490, written at 6250 (preferred) or 1600 BPI
 2. 1128 or 580 byte fixed length records
 3. Blocking factor of 20 record per block
 4. EBCDIC code
 - b. Diskette must be
 1. IBM compatible, 5 1/4 or 3 1/2, double sided high density, PC/MS-DOS format with no format label;
 2. 1128 or 580 byte fixed length records;
 3. ASCII code.
 - c. CD-ROM
 - d. Paper
- All required fields must be present and legible. The specifics of paper transfers will be negotiated between the office and the hospital.

DATA TRANSFER FORMATS

The form of the data submitted to the committee 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 the office 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 would satisfy the requirements.

The technical specifications for magnetic diskette or magnetic tape transfers conform, in general, 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 from 2 to an unknown number of revenue services. Each revenue record has space to record from 1 to 15 services. It is possible that a patient may have more revenue services than the 15 accommodated in a single record. This necessitates that multiple revenue records be written following a patient's header record and before the patient's trailing record.

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, 25, 26 in Table 2; 1 in Table 3; and 1, 2 in Table 4. 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 one and only one patient header record per discharge.
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 the committee's reportable data elements numbered 12, 13, 14 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 indicates that the patient's record has ended. The record format consists of the committee's reportable data elements numbered 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 in Table 2; 2, 3, 4, 5, 6, 7 in Table 3; and 3, 5 in Table 4. The "Record type" field must be set to "3" for this record. There must be one and only one type 3 record per discharge.

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. Each hospital shall report level 2 data elements, shown in Table 3, whenever the data element is a part of the patient's record. If additional data elements are submitted as part of a data record the office will delete it before data records are saved.

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

<u>Field Name</u>	The words in this column are the data element name 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.
<u>Class</u>	The letter in this column indicates the field's attribute. A = Alphanumeric N = Numeric
<u>Position</u>	The number(s) in this column indicates the starting and ending position of the field in the record.
<u>Length</u>	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
HOSPITAL INPATIENT DISCHARGE DATA ELEMENTS**

DATA ELEMENT NAME

Provider

1. Provider identifier

Patient

2. Patient control number
3. Patient's medical chart number
4. Patient's address (Postal zip code is the minimum requirement for address)
5. Patient's date of birth
6. Patient's gender

Service

7. Admission date
8. Type of admission
9. Source of admission
10. Patient's status
11. Statement covers period (ending date equals discharge date)

Charge

12. Revenue codes
13. Units of service
14. Total charges by revenue code

Payer

15. Payer's identification
16. Patient's relationship to insured

Diagnosis and Treatment

17. Principal diagnosis
18. Other diagnosis codes
19. External cause of injury code (E-code)
20. Principal procedure code
21. Other procedure codes
22. Procedure coding method (required if coding is NOT ICD-9)

Physician

23. Attending physician's Identifier
24. Other physicians' Identifier

Other

25. Type of bill
26. Patient Social Security Number (beginning /1/1/95)

**TABLE 3
AS AVAILABLE LEVEL 2
HOSPITAL INPATIENT DISCHARGE DATA ELEMENTS**

DATA ELEMENT NAME

Patient

1. Patient marital status
2. Patient Race and Ethnicity (Pending rule change (from level 2 to level 1) effective, January 1, 1995)

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 name
8. Employer location

Charge

9. Prior payment

Payment

10. Estimated amount due

Physician

11. Resident ID
12. Resident ID Type

DATA ELEMENTS LAYOUT AND DESCRIPTION

**PATIENT'S HEADER RECORD
RECORD TYPE 1**

INTRODUCTION

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

Data Reporting Level: Required

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

General Comments: The only use of this number is to ensure that the three types of records are processed as one record.

Edit: The number must be present in each record and be unique within the batch of hospital records processed.

Record Type	N	10	1
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Data Reporting Level: Required

Definition: The record format type indicator.

General Comments: This field must equal 1 indicating that the record is a Patient's Header Records.

Edit: The number must be present, and there can only be one record with record type equal 1 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

Data Reporting Level: Required

Definition: The name of the hospital submitting the record.

General Comments: The hospital's name is entered in the first 25 character position and may be followed by space filler or the address and telephone number in lines 2-4. The hospital's name must be entered in each Patient's Header Record using the same form and spelling. The name of the hospital is converted into a code to protect the hospital's 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>
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Patient Social Security Number	A	111-123	13
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Data Reporting Level: Required

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

General Comments: This field is to be left justified with spaces to the right to complete the field. The format of SSN is 123456789 without hyphens. If a patient does not have a social security number, use the following codes:

Mother's SSN + 100 (e.g., 123456789100) for a newborn who has not obtained a SSN. For multiple births, use 101 for the first baby and 102 for the second baby, etc.

200 for a patient who has no SSN,

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

Edit: The field is edited for a valid entry.

Patient Control Number	A	124-140	17
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Data Reporting Level: Required

Definition: A patient's unique alpha-numeric number assigned by the hospital to facilitate retrieval of individual discharge 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 the committee to protect the patient level identifier.

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

Type of Bill	A	141-143	3
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Data Reporting Level: Required for any record not consolidated into a discharge data record.

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

General Comments: The processing of non-consolidated records will use the type of bill code to adjusted previously submitted records. The code structure of this field is:

First position indicates type of facility:

1=Hospital

4=Christian Science (Hospital)

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Patient's Date of Birth	N	221-228	8

Data Reporting Level: Required

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

General Comments: The date of birth must be present and recorded in a eight digit format of month day 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 020782. 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.

Patient's Gender	A	229	1
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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	230	1
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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

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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W = Widowed
P = Life Partner
U = Unknown
Space = Not present in Patient's Record

Edit: This field is edited for a valid entry.

Admission Date	N	231-236	6
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Data Reporting Level: Required

Definition: The date the patient was admitted to the hospital for inpatient care.

General Comments: The admission date is to be entered as six digits as 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: Admission date must be present and a valid date. The date cannot be before date of birth or be after ending date in Statement Covers Period.

Type of Admission	N	237	1
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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 room.

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 necessitates the use of special source of admission codes, see Source of

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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Admission below. Generally, the child is born within the facility.

9 = Information not available

Edit: The field must be present and be 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	238	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 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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
institution.			
		If a patient is discharged from an inpatient program to a residential program, code it as '05'.	
		06 = Discharge/transferred to home under care of organized home health service organization	
		07 = Left against medical advice or discontinued care	
		08 = Discharged/transferred to home under care of a home IV provider	
		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	
<u>Edit:</u> The patient status code must be present and a valid code as defined. If patient status code is 30 the Type of Bill code must indicate that the record is still open.			

Statement Covers Period	N	241-252	12
- Beginning Date	N	241-246	6
- Through Date	N	247-252	6

Data Reporting Level: Required

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

General Comments: The two dates are to have MMDDYY formats and the through date must be the date of discharge 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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Patient's Medical/Health Record Number	A	253-269	17

Data Reporting Level: Required

Definition: A unique identifier assigned by the hospital to a patient at 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.

Patient's Race	N	270	1
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Data Reporting Level: As Available, pending rule change (from level 2 to level 1) effective, January 1, 1995.

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. This area includes, 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.

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, but 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 discharged 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
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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 15

Revenue Code	A	11-13	3
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Data Reporting Level: Required

Definition: A three digit code which 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"

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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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 below.

Units of Service	N	14-16	3
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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 visits, 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 which require a unit, see Revenue Codes and Units of Service section below.

Total Charges by Revenue Code	N	17-24	8
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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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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Revenue Service 2 of 15

Revenue Code	A	25-27	3
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Data Reporting Level: Required

Definition: A three digit code which identifies a specific accommodation, ancillary service or billing calculation. This field may contain the total of all revenue services provided if the patient had only one revenue service.

General Comments: For every patient there must be at least one revenue service entered and a total of all revenue 25 board, the revenue code for room and board is entered as the first of the 15 possible and the total revenue code "001" is entered in this the second field location. The third through the fifteenth fields would be their initialized values.

Edit: This field must be present and contain a valid revenue code as defined in Revenue Codes and Units of Service section below. If the patient received only one revenue service this field must contain "001" to indicate that the associated Total Charge by Revenue Code field contains the sum of the revenue charges.

Units of Service	N	28-30	3
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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 visits, 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 a revenue code.

Edit: The units of service must be present for those revenue services which require a unit.

Total Charges by Revenue Code	N	31-38	8
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Data Reporting Level: Required

Definition: Total dollars and cents amount charged for the related revenue service entered. If the patient received only one revenue service this, the second, entry would be the sum of the Total Charges by Revenue Code field's entry.

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

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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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. If the Revenue Code associated with this Total Charges by Revenue Code Service is "001" then the entry must equal the sum of all other Total Charges by Revenue Code entries.

Revenue Service 3 of 15

Revenue Code	A	39-41	3
Units of Service	N	42-44	3
Total Charges by Revenue Code	N	45-52	8

Revenue Service 4 of 15

Revenue Code	A	53-55	3
Units of Service	N	56-58	3
Total Charges by Revenue Code	N	59-66	8

Revenue Service 5 of 15

Revenue Code	A	67-69	3
Units of Service	N	70-72	3
Total Charges by Revenue Code	N	73-80	8

Revenue Service 6 of 15

Revenue Code	A	81-83	3
Units of Service	N	84-86	3
Total Charges by Revenue Code	N	87-94	8

Revenue Service 7 of 15

Revenue Code	A	95-97	3
Units of Service	N	98-100	3
Total Charges by Revenue Code	N	101-108	8

Revenue Service 8 of 15

Revenue Code	A	109-111	3
Units of Service	N	112-114	3
Total Charges by Revenue Code	N	115-122	8

Revenue Service 9 of 15

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Revenue Code	A	123-125	3
Units of Service	N	126-128	3
Total Charges by Revenue Code	N	129-136	8

<u>Revenue Service 10 of 15</u>			
Revenue Code	A	137-139	3
Units of Service	N	140-142	3
Total Charges by Revenue Code	N	143-150	8

<u>Revenue Service 11 of 15</u>			
Revenue Code	A	151-153	3
Units of Service	N	154-156	3
Total Charges by Revenue Code	N	157-164	8

<u>Revenue Service 12 of 15</u>			
Revenue Code	A	165-167	3
Units of Service	N	168-170	3
Total Charges by Revenue Code	N	171-178	8

<u>Revenue Service 13 of 15</u>			
Revenue Code	A	179-181	3
Units of Service	N	182-184	3
Total Charges by Revenue Code	N	185-192	8

<u>Revenue Service 14 of 15</u>			
Revenue Code	A	193-195	3
Units of Service	N	196-198	3
Total Charges by Revenue Code	N	199-206	8

<u>Revenue Service 15 of 15</u>			
Revenue Code	A	207-209	3
Units of Service	N	210-212	3
Total Charges by Revenue Code	N	213-220	8

REVENUE CODES AND UNITS OF SERVICE

INTRODUCTION

This section defines acceptable revenue codes representing services provided a patient, and the unit of measure associated with each revenue service. Any codes not assigned are assumed to be nonapplicable. The source of the codes and definitions are the National Uniform Billing Committee's published manual.

Revenue Code: A three digit code which identifies a specific accommodation, ancillary service or billing calculation. The first two digits of the three digit code indicate major category 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>UNIT</u>	<u>DEFINITION</u>
001	None	Total charges
10x	Days	All inclusive rate-a flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only. <u>Subcategory "x"</u> 0 = All inclusive room and board plus ancillary 1 = All inclusive room and board
11x	Days	Room and board - private medical or general. Routine service charges for single bed rooms. <u>Subcategory "x"</u> 0 = General Classification 1 = Medical/Surgical/Gyn 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice 6 = Detoxification 7 = Oncology 8 = Rehabilitation 9 = Other
12x	Days	Room and board - semi-private two beds medical or general. Routine service charges incurred for accommodations with two beds. <u>Subcategory "x"</u> 0 = General Classification 1 = Medical/Surgical/Gyn 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice

CODE UNIT DEFINITION

- 6 = Detoxification
- 7 = Oncology
- 8 = Rehabilitation
- 9 = Other

13x Days Semi-private three and four beds. Routine service charges incurred for accommodations with three and four beds.

Subcategory "x"

- 0 = General classification
- 1 = Medical/Surgical/Gyn
- 2 = OB
- 3 = Pediatric
- 4 = Psychiatric
- 5 = Hospice
- 6 = Detoxification
- 7 = Oncology
- 8 = Rehabilitation
- 9 = Other

14x Days Private deluxe - Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory "x"

- 0 = General classification
- 1 = Medical/Surgical/Gyn
- 2 = OB
- 3 = Pediatric
- 4 = Psychiatric
- 5 = Hospice
- 6 = Detoxification
- 7 = Oncology
- 8 = Rehabilitation
- 9 = Other

15x Days Room and board ward medical or general. Routine service charge for accommodations with five or more beds.

Subcategory "x"

- 0 = General classification
- 1 = Medical/Surgical/Gyn
- 2 = OB
- 3 = Pediatric
- 4 = Psychiatric
- 5 = Hospice
- 6 = Detoxification
- 7 = Oncology
- 8 = Rehabilitation
- 9 = Other

16x Days Other room and board - any routine service charges for accommodations that cannot be included in the

CODE UNIT DEFINITION

more specific revenue center codes.

Subcategory "x"

- 0 = General classification
- 4 = Sterile environment
- 7 = Self care
- 9 = Other

17x Days Nursery - charges for nursing care to newborn and premature infants in nurseries.

Subcategory "x"

- 0 = General classification
- 1 = Newborn
- 2 = Premature
- 5 = Neonatal ICU
- 9 = Other

18x Days Leave of absence - charges for holding a room while the patient is temporarily away from the provider.

Subcategory "x"

- 0 = General classification
- 2 = Patient Convenience
- 3 = Therapeutic leave
- 4 = ICF/MR (any reason)
- 5 = Nursing home (for hospitalization)
- 9 = Other leave of absence

20x Days Intensive care - routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Subcategory "x"

- 0 = General classification
- 1 = Surgical
- 2 = Medical
- 3 = Pediatric
- 4 = Psychiatric
- 6 = Post ICU
- 7 = Burn Care
- 8 = Trauma
- 9 = Other intensive care

21x Days Coronary care - routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Subcategory "x"

- 0 = General classification
- 1 = Myocardial infarction
- 2 = Pulmonary care
- 3 = Heart transplant
- 4 = Post CCU
- 9 = Other coronary care

CODE UNIT DEFINITION

22x None Special charges - charges incurred during an inpatient stay or on a daily basis for certain services.

Subcategory "x"

- 0 = General classification
- 1 = Admission charge
- 2 = Technical support charge
- 3 = U.R. service charge
- 4 = Late discharge, medically necessary
- 9 = Other special charges

23x None Incremental nursing charge rate - charge for nursing service assessed in addition to room and board.

Subcategory "x"

- 0 = General classification
- 1 = Nursery
- 2 = OB
- 3 = ICU
- 4 = CCU
- 5 = Hospice
- 9 = Other

24x None All inclusive ancillary - a flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Subcategory "x"

- 0 = General classification
- 9 = Other inclusive ancillary

25x None Pharmacy - charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.

Subcategory "x"

- 0 = General classification
- 1 = Generic drugs
- 2 = Non-generic drugs
- 3 = Take home drugs
- 4 = Less than effective drugs
- 5 = Drugs incident to radiology
- 6 = Experimental drugs
- 7 = Non-prescription
- 8 = IV solutions
- 9 = Other pharmacy

26x None IV therapy - equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

Subcategory "x"

- 0 = General classification
- 1 = Infusion pump
- 2 = IV therapy/pharmacy service

CODE UNIT DEFINITION

- 3 = IV therapy/drug/supply delivery
- 4 = IV therapy/supplies
- 9 = Other IV therapy

27x Item Medical/Surgical supplies and devices - charges for supply items required for patient care.

Subcategory "x"

- 0 = General classification
- 1 = Non-sterile supply
- 2 = Sterile supply
- 3 = Take home supplies
- 4 = Prosthetic/Orthotic devices
- 5 = Pace maker
- 6 = Intra ocular lens
- 7 = Oxygen take home
- 8 = Other implants
- 9 = Other supplies/devices

28x None Oncology - charges for the treatment of tumors and related diseases.

Subcategory "x"

- 0 = General classification
- 1 = Other oncology

29x Item Durable medical equipment (other than rental) - charges for medical equipment that can withstand repeated use.

Subcategory "x"

- 0 = General classification
- 1 = Rental
- 2 = Purchase of new DME
- 3 = Purchase of used DME
- 9 = Other equipment

30x Test Laboratory - charges for the performance of diagnostic and routine clinical laboratory tests.

Subcategory "x"

- 0 = General classification
- 1 = Chemistry
- 2 = Immunology
- 3 = Renal patient
- 4 = Non-routine dialysis
- 5 = Hematology
- 6 = Bacteriology and microbiology
- 7 = Urology
- 9 = Other Laboratory

31x Test Laboratory pathological - charges for diagnostic and routine laboratory tests on tissues and culture.

Subcategory "x"

- 0 = General classification
- 1 = Cytology
- 2 = Histology

CODE UNIT DEFINITION

4 = Biopsy
9 = Other

32x Test Radiology diagnostic - charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Subcategory "x"

0 = General classification
1 = Angiocardiography
2 = Arthrography
3 = Arteriography
4 = Chest X-ray
9 = Other

33x Test Radiology therapeutic - charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Subcategory "x"

0 = General classification
1 = Chemotherapy injected
2 = Chemotherapy oral
3 = Radiation therapy
5 = Chemotherapy IV
9 = Other

34x Test Nuclear medicine - charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Subcategory "x"

0 = General classification
1 = Diagnostic
2 = Therapeutic
9 = Other

35x Scan CT scan - charges for computer topographic scans of the head and other parts of the body.

Subcategory "x"

0 = General classification
1 = Head scan
2 = Body scan
9 = Other CT scans

36x None Operating room services - charges for services provided to patients by specifically trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Subcategory "x"

CODE UNIT DEFINITION

- 0 = General classification
- 1 = Minor surgery
- 2 = Organ transplant other than kidney
- 7 = Kidney transplant
- 9 = Other operating room services

37x None Anesthesia - charges for anesthesia services in the hospital.

Subcategory "x"

- 0 = General classification
- 1 = Anesthesia incident to RAD
- 4 = Acupuncture
- 9 = Other anesthesia

38x Pint Blood

Subcategory "x"

- 0 = General classification
- 1 = Packed red cells
- 2 = Whole blood
- 3 = Plasma
- 4 = Platelets
- 5 = Leukocytes
- 6 = Other components
- 7 = Other derivatives cryoprecipitates
- 9 = Other blood

39x None Blood storage and processing - charges for the storage and processing of whole blood.

Subcategory "x"

- 0 = General classification
- 1 = Blood administration
- 9 = Other blood storage and processing

40x Test Other imaging services

Subcategory "x"

- 0 = General classification
- 1 = Diagnostic mammography
- 2 = Ultrasound
- 3 = Screening mammography
- 9 = Other imaging services

41x Treatment Respiratory services - charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Subcategory "x"

- 0 = General classification
- 2 = Inhalation services
- 3 = Hyper baric oxygen therapy

CODE UNIT DEFINITION

9 = Other respiratory services

42x Treatment Physical therapy - charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Subcategory "x"

- 0 = General classification
- 1 = Visit charge
- 2 = hourly charge
- 3 = Group rate
- 4 = Evaluation or re-evaluation
- 9 = Other physical therapy

43x Treatment Occupational therapy - charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategory "x"

- 0 = General classification
- 1 = Visit charge
- 2 = Hourly charge
- 3 = Group rate
- 4 = Evaluation or re-evaluation
- 9 = Other occupational therapy

44x Treatment Speech language pathology - charges for services provided to persons with impaired functional communications skills.

Subcategory "x"

- 0 = General classification
- 1 = Visits charges
- 2 = Hourly charge
- 3 = Group rate
- 4 = Evaluation or re-evaluation
- 9 = Other speech language pathology

45x Visit Emergency room - charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Subcategory "x"

- 0 = General classification
- 1 = Other Emergency room

46x Test Pulmonary function - charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Subcategory "x"

- 0 = General classification

<u>CODE</u>	<u>UNIT</u>	<u>DEFINITION</u>
		9 = Other Pulmonary function
47x	Test	Audiology - charges for the detection and management of communication handicaps centering in whole or in part on the hearing function. <u>Subcategory "x"</u> 0 = General classification 1 = Diagnostic 2 = Treatment 9 = Other audiology
48x	Test	Cardiology - charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test. <u>Subcategory "x"</u> 0 = General classification 1 = Cardiac cath lab 2 = Stress test 9 = Other cardiology
49x	None	Ambulatory surgical care - charges for ambulatory surgery which are not covered by other categories. <u>Subcategory "x"</u> 0 = General classification 9 = Other ambulatory surgical care
50x	None	Outpatient services - charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. These charges are incorporated on the inpatient bill of Medicare patients. <u>Subcategory "x"</u> 0 = General classification 9 = Other outpatient services
51x	Visit	Clinic - charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients. <u>Subcategory "x"</u> 0 = General classification 1 = Chronic pain center 2 = Dental clinic 3 = Other clinic
52x	Visit	Free-standing clinic <u>Subcategory "x"</u> 0 = General classification 1 = Rural health-clinic 2 = Rural health-home 3 = Family practice

CODE UNIT DEFINITION

9 = Other free-standing clinic

53x Visit Osteopathic services - charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Subcategory "x"

0 = General classification
1 = Osteopathic therapy
9 = Other osteopathic services

54x Mile Ambulance - charges for ambulance service, usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Subcategory "x"

0 = General classification
1 = Supplies
2 = Medical transport
3 = Heart mobile
4 = Oxygen
5 = Air ambulance
6 = Neonatal ambulance services
9 = Other ambulance

56x Visit Medical social services - charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Subcategory "x"

0 = General classification
1 = Visit charge
2 = Hourly charge
9 = Other medical social services

61x Test MRI - charges for magnetic resonance imaging of the brain and other parts of the body.

Subcategory "x"

0 = General classification
1 = Brain including brainstem
2 = Spinal cord including spine
9 = Other MRI

62x Days Medicare/Surgical supplies - charges for supply items required for patient care. The category is an extension of code 27x for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology.

Subcategory "x"

1 = Supplies incident to radiology

65x Day Hospices service - charges for hospice care services for a terminally ill patient if he elects these services in lieu of other services for the terminal

CODE UNIT DEFINITION

condition.

Subcategory "x"

- 0 = General classification
- 1 = Routine home care
- 2 = Continuous home care
- 5 = Inpatient respite care
- 6 = General non-respite inpatient care
- 7 = Physician services
- 9 = Other hospice

70x None Cast room - charges for services related to the application, maintenance and removal of casts.

Subcategory "x"

- 0 = General classification
- 9 = Other cast room

71x None Recovery room

Subcategory "x"

- 0 = General classification
- 9 = Other recovery room

72x * Labor room and delivery - charges for labor and delivery room services provided by specially trained nursing personnel to patients including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Subcategory "x"

- 0 = General classification
- 1 = Labor
- 2 = Delivery
- 3 = Circumcision
- * 4 = Birthing center (Unit is days)
- 9 = Other labor room and delivery

73x Test EKG/ECG (Electrocardiogram) - charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for diagnosis of heart ailments.

Subcategory "x"

- 0 = General classification
- 1 = Holter monitor
- 2 = Telemetry
- 9 = Other EKG/ECG

74x Test EEG (Electroencephalogram) - charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory "x"

- 0 = General classification

<u>CODE</u>	<u>UNIT</u>	<u>DEFINITION</u>
		9 = Other EEG
75x	Test	Gastrointestinal services - procedure room charges for endoscopic procedures not performed in the operating room.
		<u>Subcategory "x"</u>
		0 = General classification
		9 = Other gastro intestinal
76x	None	Treatment or observation room - charges for minor procedures performed in the OR or other room.
		<u>Subcategory "x"</u>
		0 = General classification
		9 = Other treatment room

<u>CODE</u>	<u>UNIT</u>	<u>DEFINITION</u>
79x	None	Lithotripsy - charges for the use of lithotripsy in the treatment of kidney stones. <u>Subcategory "x"</u> 0 = General classification 9 = Other lithotripsy
80x	Session	Inpatient renal dialysis - a waste removal process preformed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis). <u>Subcategory "x"</u> 0 = General classification 1 = Inpatient hemodialysis 2 = Inpatient peritoneal 3 = Inpatient continuous ambulatory peritoneal dialysis 4 = Inpatient continuous cycling peritoneal dialysis 9 = Other inpatient dialysis
81x	None	Organ acquisition - the acquisition of a kidney, liver or heart for use in transplantation. <u>Subcategory "x"</u> 0 = General classification 1 = Living donor - kidney 2 = Cadaver donor - kidney 3 = Unknown donor - kidney 4 = Other kidney acquisition 5 = Cadaver donor - heart 6 = Other heart acquisition 7 = Donor - liver 9 = Other organ acquisition
88x	Session	Miscellaneous dialysis - charges for dialysis services not identified elsewhere. <u>Subcategory "x"</u> 0 = General classification 1 = Ultra filtration 9 = Other miscellaneous dialysis
89x	None	Other donor bank - charges for the acquisition, storage and preservation of all human organs, excluding kidneys. <u>Subcategory "x"</u> 0 = General classification 1 = Bone 2 = Organ other than kidney 3 = Skin 9 = Other donor bank
90x	Visit	Psychiatric or psychological treatments <u>Subcategory "x"</u>

CODE UNIT DEFINITION

- 0 = General classification
- 1 = Electroshock treatment
- 2 = Milieu therapy
- 3 = Play therapy
- 9 = Other

91x Visit Psychiatric or psychological services - charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

Subcategory "x"

- 0 = General classification
- 1 = Rehabilitation
- 2 = Day care
- 3 = Night care
- 4 = Individual therapy
- 5 = Group therapy
- 6 = Family therapy
- 7 = Biofeedback
- 8 = Testing
- 9 = Other

92x Test Other diagnostic services

Subcategory "x"

- 0 = General classification
- 1 = Peripheral vascular lab.
- 2 = Electromyelgram
- 3 = Pap smear
- 4 = Allergy test
- 5 = Pregnancy test
- 9 = Other diagnostic service

94x Visit Other therapeutic services - charges for other therapeutic services not otherwise categorized.

Subcategory "x"

- 0 = General classification
- 1 = Recreational therapy
- 2 = Education or training
- 3 = Cardiac rehabilitation
- 4 = Drug rehabilitation
- 5 = Alcohol rehabilitation
- 6 = Air fluid support beds
- 9 = Other therapeutic services

96x None Professional fees - charges for medical professionals that the hospitals or third party payers require to be separately identified on the billing form.

Subcategory "x"

- 0 = General classification
- 1 = Psychiatric
- 2 = Ophthalmology
- 3 = MD Anesthesiologist

CODE UNIT DEFINITION

- 4 = CRNA Anesthetist
- 9 = Other professional fees

97x None Professional fees continued.

Subcategory "x"

- 1 = Laboratory
- 2 = Radiology - Diagnostic
- 3 = Radiology - Therapeutic
- 4 = Radiology - Nuclear Medicine
- 5 = Operating room
- 6 = Respiratory therapy
- 7 = Physical therapy
- 8 = Occupational therapy
- 9 = Speech pathology

98x None Professional fees continued.

Subcategory "x"

- 1 = Emergency room
- 2 = Outpatient services
- 3 = Clinic
- 4 = Medical social services
- 5 = EKG
- 6 = EEG
- 7 = Hospital visit
- 8 = Consultation
- 9 = Private duty nurse

99x None Patient convenience items - charges for items that are generally considered by the third party payer to be strictly convenience items and, as such, are not covered.

Subcategory "x"

- 0 = General classification
- 1 = Cafeteria/guest tray
- 2 = Private linen service
- 3 = Telephone/Telegraph
- 4 = TV/Radio
- 5 = Nonpatient room rentals
- 6 = Late discharge charge
- 7 = Admission kits
- 8 = Beauty shop/barber
- 9 = Other patient convenience items

**PATIENT'S TRAILING RECORD
RECORD TYPE 3**

INTRODUCTION

The trailing record completes the individual patient's discharge 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 discharged patient must have one and 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 discharged 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 hospitals transferred batch of records, and equal the number entered in corresponding field in the Patient's Header Record.

Record Type	N	10	1
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Data Reporting Level: Required

Definition: The record type indicator.

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

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

1st of three Payers

Payer's Identification	A	11-35	25
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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 as completely as space allows. If a name has

- 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 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
- 20 = Life Partner

Definition: Self-explanatory

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

Certificate/Social Security A 234-249 16
Number/Health Insurance Claim
/Identification Number

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.

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 250-265 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.

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

Edit: None

3rd of three Insured persons

Insured's Name A 266-289 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 last and first names allow one space between first name and the middle initial. No space should be left between a prefix and name as in MacBeth, VonSchmidt, McEnroe. Titles such as Sir, Msgr, Dr. should not be recorded in this data field. Record hyphenated names with the hyphen as in Smith-Jones, Rebecca. To record 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.

Patient's Relationship to A 290-291 2
Insured

Data Reporting Level: Required

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

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 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

20 = Life Partner

Definition: Self-explanatory

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

Certificate/Social Security A 292-307 16
Number/Health Insurance Claim
/Identification Number

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.

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 308-323 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

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

there are three, four, and five digit codes plus "V" and "E" codes. Use of the fourth, fifth, "V" and "E" is NOT optional, but must be entered when present in the code. For example a five-digits 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.

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

 Other Diagnosis Code (1st of 8) A 454-459 6

Data Reporting Level: Required

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

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. Use of the fourth, fifth, "V" and "E" is NOT optional, but must be entered when present in the code. For example a five-digits 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: 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.

Other Diagnosis Code (2nd of 8) A 460-465 6

Other Diagnosis Code (3rd of 8) A 466-471 6

Other Diagnosis Code (4th of 8) A 472-477 6

Other Diagnosis Code (5th of 8) A 478-483 6

Other Diagnosis Code (6th of 8) A 484-489 6

Other Diagnosis Code (7th of 8) A 490-495 6

Other Diagnosis Code (8th of 8) A 496-501 6

External Cause of Injury Code (E-code) A 502-507 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 for recording an E-code in 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 508 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. If coding method is NOT ICD-9 enter 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.

Note: 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 Procedure Coding Method Used field must indicate the coding method.

Principal Procedure Code A 509-514 6

Data Reporting Level: Required

Definition: The code that identifies the principal procedure performed during the hospital stay covered by this discharge 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. If some other coding method is used 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

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 without a decimal.

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

```
-----
Other Procedure Code           A           515-520           6
(1st of 5 others)
```

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 discharge 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 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 without 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.

```
-----
Other Procedure Code (2nd of 5)  A           521-526           6
-----
```

```
Other Procedure Code (3rd of 5)  A           527-532           6
-----
```

```
Other Procedure Code (4th of 5)  A           533-538           6
-----
```

```
Other Procedure Code (5th of 5)  A           539-544           6
-----
```

Note: The record provides space to record three physician ID numbers. One for attending physician and two for other physicians.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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Attending physician's license number A		545-556	12
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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.

Other physician's license number (1 of 2)	A	557-568	12
---	---	---------	----

Data Reporting Level: Required

Description: This is the license number of a physician other than the attending physician as defined by the payer organization.

General Comments: If there were no other physicians reported then this field may be space filled. The physician must be coded as a unique individual using his/her Utah State license number. 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.

Other physician's license number (2 of 2)	A	569-580	12
---	---	---------	----

Data Reporting Level: Required

Definition: This is the license number of a physician other than the attending physician as defined by the payer organization.

General Comments: If there were no reported then this field may be space filled. The physician must be coded as a unique individual using his/her Utah State license number. 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 or be blank.

Resident ID	A	581-592	12
-------------	---	---------	----

Data Reporting Level: As available

Definition: If a resident provided care the ID number should be entered in this field. The data if entered must be entered in the following manner. The facility id for first and second year residents. The UPIN number for all other residents.

General Comments: If there were no residents involve in patient care then this field may be space filled.

Edit: None

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Resident ID Type	A	593-593	1
<u>Data Reporting Level</u> : As available			
<u>Definition</u> : If a resident provided care the following should be entered in this field.			
F - Facility id number for 1-2 year residents			
U - UPIN number for all other residents			

General Comments: If there were no residents involve in patient care then this field may be space filled.

Edit: None

CLINICAL CODE EDITOR

INTRODUCTION

Clinical code editing (CCE) will be applied to a sample of each hospital's discharge records. The edit process checks for potential problems in a record related to highly improbable clinical situations, which in most cases, prove to be in error. The CCE will flag records when any of 25 conditions are detected. Table 5 summarizes the conditions which may result in the record failing the edit process and requiring a correction or explanation from the hospital.

TABLE 5
CLINICAL CONDITIONS FLAGGED AS POSSIBLE ERRORS
BY CLINICAL CODE EDIT

1. Procedure unlikely with diagnosis
2. O.R. Procedures coded are not usually performed for principal diagnosis
3. Principal diagnosis suggests surgery but no O.R. surgery performed
4. Symptom code as principal diagnosis
5. Clinically unreasonable length-of-stay (high or low)
6. Questionable admission
7. Age conflict
8. Sex conflict
9. E-Code as principal diagnosis
10. Manifestation code as principal diagnosis
11. Non-specific principal diagnosis
12. Open biopsy check
13. Unacceptable principal diagnosis
14. Non-specific O.R. procedure
15. Duplicate of principal diagnosis
16. Bilateral procedure
17. Invalid diagnosis or procedure code
18. Invalid 4th or 5th digit
19. Duplicate code
20. Evaluate as principal diagnosis
21. Requires secondary diagnosis
22. Diagnosis conflict
23. Procedure conflict
24. Maternal/Newborn code conflict
25. Invalid or unknown age

DISCUSSION

Procedure unlikely with diagnosis

The CCE identifies surgical procedures for which no related diagnosis, either principal or secondary, is recorded. An example of this problem is a coronary artery bypass performed on a patient whose claim does not contain a diagnosis of heart disease. Two probable causes of this problem include omission of a related secondary diagnosis, or an improperly coded diagnosis or procedure.

O.R. Procedures coded are not usually performed for principal diagnosis

When all the O.R. procedures performed are unrelated to the principal diagnosis, the CCE reports this condition. Although such an occurrence isn't necessarily an error, it is unusual enough to warrant a review of the principal diagnosis, secondary diagnosis, and all procedures on the claim. Likely causes of this condition include: 1) a coding error in principal diagnosis, 2) coding one of the secondary diagnoses as principal diagnosis, 3) mis-coding of one of the procedures.

Principal diagnosis suggests surgery but no O.R. surgery performed

There are some diagnoses for which patients are seldom admitted to the hospital without having surgery performed. Examples of such diagnoses are: acute appendicitis, carpal tunnel syndrome, senile cataract. The CCE identifies diagnoses normally associated with surgery. If a patient has one of these diagnoses as a principal diagnosis but no surgical procedures were performed, the CCE identifies the condition. While such an occurrence is not necessarily an error, it is unusual enough to warrant a review of the claim to check if a surgical procedure was performed but not coded.

Symptom code as principal diagnosis

A symptom code should not be used as a principal diagnosis unless a more specific code is not available. An example of a symptom code is chest pain.

Clinically unreasonable length-of-stay (high or low)

From a clinical perspective, it is highly improbable that patients with certain diagnoses and procedures could legitimately have length-of-stays less than or greater than a specific number of days. Such clinically unreasonable high and low length-of-stays are identified by the CCE for specific diagnoses and procedures.

Questionable admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital; for example, benign hypertension.

Age conflict

The CCE detects inconsistencies between a patient's age and any diagnosis on the patient's claim. Examples of such conflicts are: a 5-year-old patient with benign prostatic hypertrophy, or a 78-year-old delivery. In such cases either the diagnosis or the age is presumed to be incorrect.

Sex conflict

The CCE detects inconsistencies between a patient's sex and any diagnosis or procedure on the patient's record. Examples of such conflicts are: a male patient with cervical cancer, or a male patient with a hysterectomy. In such cases either the patient's diagnosis, procedure or sex is incorrect.

E-Code as principal diagnosis

E-codes describe the circumstances that caused an injury, not the nature of the injury. An E-code should not be used as a principal diagnosis.

Manifestation code as principal diagnosis

Manifestation codes describe the manifestation of an underlying disease, not the disease itself. A manifestation code should not be used as a principal diagnosis.

Non-specific principal diagnosis

A set of diagnosis codes, particularly those described as "not otherwise specified," are identified by the CCE as non-specific diagnoses. Although these codes are valid according to the ICD-9-CM coding scheme, more precise codes should be used for the principal diagnosis.

Open biopsy check

Biopsies can be performed surgically, (a body cavity is entered surgically), percutaneously, or through an endoscope. In general, for most organ systems, open biopsies are performed infrequently. There are explicit ICD-9-CM codes for open and non-open biopsies. Since the distinction made by the different biopsy codes is not applied uniformly, the CCE identifies all biopsies that are coded as open biopsies. Using the non-open biopsy code will generally result in assignment of the patient to a less costly DRG.

Unacceptable principal diagnosis

Selected "V" codes describe a circumstance which influences an individual's health status but is not a current illness or injury. These V codes are considered unacceptable as principal diagnosis. For example, a family history of ischemic heart disease (V173) would be an unacceptable principal diagnosis.

Non-specific O.R. procedure

A set of O.R. procedure codes, particularly those described as "not otherwise specified," are identified by the CCE as non-specific. Although these codes are valid according the ICD-9-CM coding scheme, more specific codes should be used.

Duplicate of principal diagnosis

Whenever a secondary diagnosis is coded the same as the principal diagnosis, the secondary diagnosis is identified by the CCE as a duplicate of the principal diagnosis.

Bilateral procedure

Certain codes do not accurately reflect procedures performed in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes show a bilateral procedure when they could be procedures performed on a single joint (i.e., duplicate procedure).

Invalid diagnosis or procedure code

The CCE checks each diagnosis and procedure code entered in the record against a table of valid ICD-9-CM codes. If a code is not found in the table the record is flagged as in error.

Invalid 4th or 5th digit

The CCE identifies any diagnosis or procedure code that requires a 4th or 5th digit. The code entered may have the 4th or 5th digit missing or not be valid for the code in question.

Duplicate code

When the CCE detects the same ICD-9-CM diagnosis or procedure code more than once in a record, the record is flagged as a possible error.

Evaluate as principal diagnosis

When a disease or condition is a symptom of, or the result of, some other underlying disease and is recorded as the principal diagnosis, the CCE will identify when there is a more specific secondary diagnosis that should be evaluated as principal.

Requires secondary diagnosis

There are a few "V" codes which when used as the principal diagnosis in a record, require a secondary diagnosis. The CCE will check these codes for the presence of a secondary diagnosis.

Diagnosis conflict edit

The CCE identifies when two or more diagnoses conflict with one another from a clinical perspective.

Procedure conflict edit

The CCE identifies when two or more procedures conflict with one another from a clinical perspective.

Maternal and fetal/newborn edit

A maternal diagnosis code and a fetal/newborn diagnosis code should not appear on the same discharge record. When the CCE detects a maternal diagnosis code and a fetal/newborn diagnosis code together the record is flagged as in error.

Invalid or unknown age

CCE allows entry of patient age from 0 through 124 years. Any other entry is considered an error.

EDITING, VALIDATION AND ERRORS

EDITING AND VALIDATION

Hospitals shall review the discharge 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:

- a. **AGREEMENT WITH DATA DEFINITION:** The submitted discharge data is edited for consistency and conformity against the standards specified in this manual. Any record containing fields that fail to agree with the definition or edit criteria specified will be return to the hospital, in a simplified format.
- b. **CLINICAL CODE EDIT:** Records will be edited for clinical accuracy and quality when possible. The minimum clinical edit procedure will consist of a selective sample of hospital discharge records. A clinical code editor will be applied to all diagnosis, procedure, and patient specific codes to determine the validity of clinical hospital discharge data. Records failing the clinical edit will be returned, in a simplified format, for correction when the data is in error. Edits that indicate a high probability of error will be highlighted for review, comment, and correction when applicable.

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

- a. **VALIDATION OF HOSPITAL DATA BY PROVIDERS:**
Any record failing to pass an edit check will be returned to the hospital for correction or comment. The errored record 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 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
Office of Health Care Statistics
Attention: Information Analyst
288 North 1460 West
P.O. Box 144004
Salt Lake City, Utah 84114-4004

- 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 submitted directly. 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 the committee shall conclude that the tabulations are correct and suitable for release.

ERROR RATES

After collection of each full calendar year of data the office may calculate the number of discharge data records failing an edit checks. The office may also calculate the non-reporting rates for both level 1 and level 2 data elements. Based on these calculations the committee 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 AND FORM

INTRODUCTION

Hospitals may request an exemption, extension, or waiver to requirements established by the Utah Health Data Committee (UHDC). A "Request For Exemption, Extension, or Waiver Form," see following page, may be completed and submitted to:

Office of Health Care Statistics
288 North 1460 West
P.O. Box 144004
Salt Lake City, Utah 84114-4004
Telephone number: (801) 538-7048

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 7). 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;

- Consolidation of discharge data if a hospital lacks automated files or the storage of automated discharge data records is demonstrated to impose unreasonable costs. (An alternative might be to submit multiple records such as interim UB-82 claim records or a paper copy);

- 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).

- Submission media if a hospital can demonstrate that their system cannot produce the required format or that a different format is shown to be more cost-effective. Alternative formats might be a paper copy of the UB-82 claims record or a consistent alternate electronic format that the office can process.

The Office of Health Care Statistics and the UHDC 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 the UHDC determines that the burden on a hospital outweighs the public purpose, the UHDC 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 30 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 Office of Health Care Statistics, Utah Department of Health at the above address.

REQUEST FOR EXEMPTION, EXTENSION, OR WAIVER FORM

To: Health Data Committee
Utah Department of Health
Office of Health Care Statistics
288 North 1460 West
P.O. Box 144004
Salt Lake City, Utah 84114-4004

Telephone: 1-538-7048

Requester:

Name: _____
Address: _____
Contact Person: _____
Telephone: _____

Complete each section of this form. If more space is needed attach additional pages using the indicated format.

This request is for: (Select one)
 Exemption, Extension, Waiver

If this request is granted, what is the time period covered?

Starting Date: __/__/__ Ending date __/__/__.
(Maximums: Exemption 1 year, Extension 30 calendar days, Waiver 1 year.)

Describe the relief sought. Include a reference to the specific requirement (i.e., submittal schedule, data consolidation, etc.).

Provide justification for granting this request:

Facts: _____

Reasons: _____

Legal Authority: _____

What alternative do you propose to meet the requirement? _____

Other germane comments: _____

Health Data Committee: Approve Disapprove Date: __/__/__