

UTAH HOSPITAL INPATIENT DISCHARGE DATA SUBMITTAL MANUAL

DATA ELEMENT DESCRIPTIONS AND DEFINITIONS

Version VI, February 2014

(5010/UB-04/ICD-10 Version)

Utah Health Data Committee

Utah Department of Health

Office of Health Care Statistics

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Introduction

Chapter 33a, Title 26, Utah Code Annotated establishes 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 R428-10, 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, 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 rule. Each section that follows 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 request forms.

Data Reporting Source

Licensed hospital facilities are the source for inpatient discharge data. This includes general acute care, critical assess, children's, long term, psychiatric or rehabilitation 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, e-mail address 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. For a patient with multiple discharges, each hospital shall submit a single discharge data record for each discharge. For a patient with multiple billing claims each hospital shall consolidate the multiple billings into a single discharge data record for submission after the patient's discharge. It should be noted that deadlines for data submission are 45 days after the end of each quarter.

Table 1. Submittal Schedule

Person's Date of Discharge is Between	Discharge Data Must Be Received By
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 (following year)

Data Transfer

Each hospital shall submit the reported data elements as encrypted files on compact disc, DVD or send electronically through the Utah Health Information Network or another compatible electronic data interchange network or other secure upload or secure email method. Encryption programs suggested for use would include 7-zip, gpg4win, PGP or Truecrypt. Data transfers not in compliance with these specifications will be rejected unless prior approval is obtained. Rejected submittals will need to conform to the specifications before resubmitting the data. Specifications for other transfer formats must be worked out between the office and the hospital before the scheduled due date.

All CDs or DVDs 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: 4/1/14 - 6/30/14.
- d. The total number of records contained in the file.
- e. An unduplicated count of the Patients contained in the file.
- f. The name, Email and telephone number of a contact person for problem solving.

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 may be rejected.

Preferred method of submittal would be for each hospital or hospital system to work out a secure upload or secure email process between their system and the office staff.

Otherwise, data submittal may be mailed to the following address, but only after encryption methods are applied:

Utah Department of Health
Office of Health Care Statistics
Attn: Hospital Discharge Database Manager
288 North 1460 West
P. O. Box 144004
Salt Lake City, Utah 84114-4004
Telephone: 801-538-6700
johnmorgan@utah.gov

The office will provide reasons when it rejects a data transfer. The most likely reasons are:

- total counts do not correspond with previously reported totals
- data elements do not conform to edit specifications
- receipt of insecure/unencrypted data files

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-04) will fit the record formats and would satisfy the requirements.

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 23 services. It is possible that a patient may have more revenue services than the 23 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, 12, 13, 14 and 37 in Table 2; 1 and 2 in Table 3; and 1 and 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 15, 16, 17, 18, 19 and 20 in Table 2; and 1 and 2 in Table 4. 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 23

revenue services. The last revenue entry must contain code "0001" 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 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36 in Table 2; 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 in Table 3; and 1 and 2 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.

Table 2 and Table 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-04) User's 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 (hospital name)

Patient

2. Patient control number
3. Patient's medical record number
4. Patient Social Security Number
5. Patient name
6. Patient's address, city, state, zip
7. Patient's date of birth
8. Patient's gender

Service

9. Admission date
10. Type of admission/visit
11. Point of origin for admission or visit
12. Patient's discharge status
13. Statement covers period
14. Condition codes (do not resuscitate, homeless, ED admit)

Charge

15. Service line
16. Revenue codes
17. HCPCS Procedure codes including modifiers
18. Unit or basis for measurement code
19. Service units/days
20. Total charges by revenue code

Payer

21. Payer's identification
22. Patient's relationship to insured

Diagnosis and Treatment

23. Diagnosis version qualifier
24. Principal diagnosis with present on admission
25. Other diagnosis codes with present on admission
26. Admitting diagnosis code
27. Patient's reason for visit codes
28. External cause of injury codes (E-code) with present on admission
29. Principal ICD procedure code
30. Other ICD procedure codes
31. Date of principal procedure

Physician

32. Attending provider primary ID
33. Operating physician primary ID
34. Other operating physician primary ID
35. Rendering physician primary ID
36. Referring provider primary ID

Other

37. Type of bill

Table 3. “As Available” (Level 2) Hospital Inpatient Discharge Data Elements

DATA ELEMENT NAME

Patient

1. Patient marital status
2. Patient race and ethnicity

Employer

3. Employer name

Charge

4. Prior payments
5. Estimated amount due

Payer

6. Insured names
7. Certificate/Social Security Number/HealthInsurance Claim/Identification Number
8. Insured group names

Physician

9. Attending provider secondary ID
10. Attending provider specialty information
11. Operating physician secondary ID
12. Operating physician specialty information
13. Other operating physician secondary ID
14. Other operating physician specialty information
15. Rendering physician secondary ID
16. Rendering physician specialty information
17. Referring provider secondary ID
18. Referring provider specialty information
19. Resident ID
20. Resident ID Type

Data Elements Layout and Description

Table 4. Utah Hospital Inpatient Discharge Data Base Record Layout

Record Layout for UB04/5010 Format (Record Length=976)

HEADER RECORD – RECORD TYPE 1 FIELD NAME	CLASS	WIDTH	POSITION
Unique patient control number	N	9	1-9
Record type	N	1	10-10
Provider identifier (Hospital)	A	100	11-110
Patient social security number	A	13	111-123
Patient control number	A	20	124-143
Type of bill	A	4	144-147
Patient name	A	31	148-178
Patient's address	A	84	179-262
Patient date of birth	N	8	263-270
Patient's gender	A	1	271-271
Patient's marital status	A	1	272-272
Date of admission	N	6	273-278
Type of admission/ visit	N	1	279-279
Point of origin for admission or visit	A	1	280-280
Patient's discharge status	A	2	281-282
Statement covers period	N	12	283-294
Patient's medical record number	A	24	295-318
Patient's race	A/N	1	319-319
Condition codes (ED Admit, DNR, homeless)	A	22	320-341
Patient's ethnicity	A/N	1	342-342

REVENUE RECORD – RECORD TYPE 2: FIELD NAME	CLASS	WIDTH	POSITION
Unique patient control number	N	9	1-9
Record type	N	1	10-10
Service line 1	N	6	11-16
Revenue code 1	A	4	17-20
HCPCS code including modifiers 1	A	14	21-34
Unit or basis for measurement code 1	A	2	35-36
Service units/days 1	N	7	37-43
Total charges by revenue code 1	N	10	44-53
Service line 2	N	6	54-59
Revenue code 2	A	4	60-63
HCPCS code including modifiers 2	A	14	64-77
Unit or basis for measurement code 2	A	2	78-79
Service units/days 2	N	7	80-86
Total charges by revenue code 2	N	10	87-96
Service line 3	N	6	97-102
Revenue code 3	A	4	103-106
HCPCS code including modifiers 3	A	14	107-120
Unit or basis for measurement code 3	A	2	121-122

REVENUE RECORD – RECORD TYPE 2: FIELD NAME	CLASS	WIDTH	POSITION
Service units/days 3	N	7	123-129
Total charges by revenue code 3	N	10	130-139
Service line 4	N	6	140-145
Revenue code 4	A	4	146-149
HCPCS code including modifiers 4	A	14	150-163
Unit or basis for measurement code 4	A	2	164-165
Service units/days 4	N	7	166-172
Total charges by revenue code 4	N	10	173-182
Service line 5	N	6	183-188
Revenue code 5	A	4	189-192
HCPCS code including modifiers 5	A	14	193-206
Unit or basis for measurement code 5	A	2	207-208
Service units/days 5	N	7	209-215
Total charges by revenue code 5	N	10	216-225
Service line 6	N	6	226-231
Revenue code 6	A	4	232-235
HCPCS code including modifiers 6	A	14	236-249
Unit or basis for measurement code 6	A	2	250-251
Service units/days 6	N	7	252-258
Total charges by revenue code 6	N	10	259-268
Service line 7	N	6	269-274
Revenue code 7	A	4	275-278
HCPCS code including modifiers 7	A	14	279-292
Unit or basis for measurement code 7	A	2	293-294
Service units/days 7	N	7	295-301
Total charges by revenue code 7	N	10	302-311
Service line 8	N	6	312-317
Revenue code 8	A	4	318-321
HCPCS code including modifiers 8	A	14	322-335
Unit or basis for measurement code 8	A	2	336-337
Service units/days 8	N	7	338-344
Total charges by revenue code 8	N	10	345-354
Service line 9	N	6	355-360
Revenue code 9	A	4	361-364
HCPCS code including modifiers 9	A	14	365-378
Unit or basis for measurement code 9	A	2	379-380
Service units/days 9	N	7	381-387
Total charges by revenue code 9	N	10	388-397
Service line 10	N	6	398-403
Revenue code 10	A	4	404-407
HCPCS code including modifiers 10	A	14	408-421
Unit or basis for measurement code 10	A	2	422-423
Service units/days 10	N	7	424-430
Total charges by revenue code 10	N	10	431-440
Service line 11	N	6	441-446
Revenue code 11	A	4	447-450
HCPCS code including modifiers 11	A	14	451-464
Unit or basis for measurement code 11	A	2	465-466

REVENUE RECORD – RECORD TYPE 2: FIELD NAME	CLASS	WIDTH	POSITION
Service units/days 11	N	7	467-473
Total charges by revenue code 11	N	10	474-483
Service line 12	N	6	484-489
Revenue code 12	A	4	490-493
HCPCS code including modifiers 12	A	14	494-507
Unit or basis for measurement code 12	A	2	508-509
Service units/days 12	N	7	510-516
Total charges by revenue code 12	N	10	517-526
Service line 13	N	6	527-532
Revenue code 13	A	4	533-536
HCPCS code including modifiers 13	A	14	537-550
Unit or basis for measurement code 13	A	2	551-552
Service units/days 13	N	7	553-559
Total charges by revenue code 13	N	10	560-569
Service line 14	N	6	570-575
Revenue code 14	A	4	576-579
HCPCS code including modifiers 14	A	14	580-593
Unit or basis for measurement code 14	A	2	594-595
Service units/days 14	N	7	596-602
Total charges by revenue code 14	N	10	603-612
Service line 15	N	6	613-618
Revenue code 15	A	4	619-622
HCPCS code including modifiers 15	A	14	623-636
Unit or basis for measurement code 15	A	2	637-638
Service units/days 15	N	7	639-645
Total charges by revenue code 15	N	10	646-655
Service line 16	N	6	656-661
Revenue code 16	A	4	662-665
HCPCS code including modifiers 16	A	14	666-679
Unit or basis for measurement code 16	A	2	680-681
Service units/days 16	N	7	682-688
Total charges by revenue code 16	N	10	689-698
Service line 17	N	6	699-704
Revenue code 17	A	4	705-708
HCPCS code including modifiers 17	A	14	709-722
Unit or basis for measurement code 17	A	2	723-724
Service units/days 17	N	7	725-731
Total charges by revenue code 17	N	10	732-741
Service line 18	N	6	742-747
Revenue code 18	A	4	748-751
HCPCS code including modifiers 18	A	14	752-765
Unit or basis for measurement code 18	A	2	766-767
Service units/days 18	N	7	768-774
Total charges by revenue code 18	N	10	775-784
Service line 19	N	6	785-790
Revenue code 19	A	4	791-794
HCPCS code including modifiers 19	A	14	795-808
Unit or basis for measurement code 19	A	2	809-810

REVENUE RECORD – RECORD TYPE 2: FIELD NAME	CLASS	WIDTH	POSITION
Service units/days 19	N	7	811-817
Total charges by revenue code 19	N	10	818-827
Service line 20	N	6	828-833
Revenue code 20	A	4	834-837
HCPCS code including modifiers 20	A	14	838-851
Unit or basis for measurement code 20	A	2	852-853
Service units/days 20	N	7	854-860
Total charges by revenue code 20	N	10	861-870
Service line 21	N	6	871-876
Revenue code 21	A	4	877-880
HCPCS code including modifiers 21	A	14	881-894
Unit or basis for measurement code 21	A	2	895-896
Service units/days 21	N	7	897-903
Total charges by revenue code 21	N	10	904-913
Service line 22	N	6	914-919
Revenue code 22	A	4	920-923
HCPCS code including modifiers 22	A	14	924-937
Unit or basis for measurement code 22	A	2	938-939
Service units/days 22	N	7	940-946
Total charges by revenue code 22	N	10	947-956
Revenue code 23 (0001 if last page)	A	4	957-960
Page ___ of ___ 23	A	6	961-966
Total overall charges 23	N	10	967-976

TRAILING RECORD – RECORD TYPE 3: FIELD NAME	CLASS	WIDTH	POSITION
Unique patient control number	N	9	1-9
Record type	N	1	10-10
Primary payer identification	A	25	11-35
Estimated amount due	N	10	36-45
Prior payment	N	10	46-55
Secondary payer identification	A	25	56-80
Estimated amount due	N	10	81-90
Prior payment	N	10	91-100
Tertiary payer identification	A	25	101-125
Estimated amount due	N	10	126-135
Prior payment	N	10	136-145
Insured's name - Primary	A	25	146-170
Patient's relationship - Primary	N	2	171-172
Insured's unique ID - Primary	A	20	173-192
Insured group name - Primary	A	20	193-212
Insured's name - Secondary	A	25	213-237
Patient's relationship - Secondary	N	2	238-239
Insured's unique ID - Secondary	A	20	240-259
Insured group name - Secondary	A	20	260-279
Insured's name - Tertiary	A	25	280-304

TRAILING RECORD – RECORD TYPE 3:			
FIELD NAME	CLASS	WIDTH	POSITION
Patient's relationship - Tertiary	N	2	305-306
Insured's unique ID - Tertiary	A	20	307-326
Insured group name - Tertiary	A	20	327-346
Employer name - Primary	A	24	347-370
Employer name - Secondary	A	24	371-394
Diagnosis version qualifier	A	1	395-395
Principal diagnosis code with POA	A	8	396-403
Secondary diagnosis code with POA 1	A	8	404-411
Secondary diagnosis code with POA 2	A	8	412-419
Secondary diagnosis code with POA 3	A	8	420-427
Secondary diagnosis code with POA 4	A	8	428-435
Secondary diagnosis code with POA 5	A	8	436-443
Secondary diagnosis code with POA 6	A	8	444-451
Secondary diagnosis code with POA 7	A	8	452-459
Secondary diagnosis code with POA 8	A	8	460-467
Secondary diagnosis code with POA 9	A	8	468-475
Secondary diagnosis code with POA 10	A	8	476-483
Secondary diagnosis code with POA 11	A	8	484-491
Secondary diagnosis code with POA 12	A	8	492-499
Secondary diagnosis code with POA 13	A	8	500-507
Secondary diagnosis code with POA 14	A	8	508-515
Secondary diagnosis code with POA 15	A	8	516-523
Secondary diagnosis code with POA 16	A	8	524-531
Secondary diagnosis code with POA 17	A	8	532-539
Admitting diagnosis code	A	7	540-546
Patient's reason for visit 1	A	7	547-553
Patient's reason for visit 2	A	7	554-560
Patient's reason for visit 3	A	7	561-567
Ext cause of inj code (E-code) with POA 1	A	8	568-575
Ext cause of Inj code (E-code) with POA 2	A	8	576-583
Ext cause of Inj code (E-code) with POA 3	A	8	584-591
Filler	A	1	592-592
Principal ICD procedure	A	7	593-599
Date of principal procedure	N	6	600-605
Secondary ICD procedure 1	A	7	606-612
Date of principal procedure	N	6	613-618
Secondary ICD procedure 2	A	7	619-625
Date of principal procedure	N	6	626-631
Secondary ICD procedure 3	A	7	632-638
Date of principal procedure	N	6	639-644
Secondary ICD procedure 4	A	7	645-651
Date of principal procedure	N	6	652-657
Secondary ICD procedure 5	A	7	658-664
Date of principal procedure	N	6	665-670
Attending provider ID - NPI/QUAL/ID	A	26	671-696
Attending provider taxonomy code	A	10	697-706
Operating physician ID - NPI/QUAL/ID	A	26	707-732
Operating physician taxonomy code	A	10	733-742

TRAILING RECORD – RECORD TYPE 3:			
FIELD NAME	CLASS	WIDTH	POSITION
Other operating physician ID - NPI/QUAL/ID	A	26	743-768
Other operating physician taxonomy code	A	10	769-778
Rendering physician ID - NPI/QUAL/ID	A	26	779-804
Rendering physician taxonomy code	A	10	805-814
Referring provider ID - NPI/QUAL/ID	A	26	815-840
Referring provider taxonomy code	A	10	841-850
Resident ID - NPI/QUAL/ID	A	26	851-876
Resident ID type	A	1	877-877

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

Field Name	Class	Position	Length
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 (Hospital Name)	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 same 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.

Field Name	Class	Position	Length
Patient Social Security Number	A	111-123	13

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 with no SSN,

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

Edit: The field is edited for valid entry

Patient Control Number	A	124-143	20
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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 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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Type of Bill	A	144-147	4

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. Enter the four digit code that identifies the specific type of bill and frequency of submission.

General Comments: 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:

First position is a leading 0.

Second position indicates type of facility:

1=Hospital

4=Christian Science (Hospital)

8=Special Facility (used for Critical Access Hospitals which are usually 0851)

Third position indicates billing classification:

1=Inpatient (Including Medicare Part A);

2=Inpatient (Medicare Part B only).

5=Critical Assess Hospital only

Fourth position indicates the frequency and ranges from 0 – 8 and are defined as:

0=Non-payment/Zero Claim

1=Admit through discharge Claim

7=Replacement of prior claim

Edit: When the field is present the following must apply except for Critical Access Hospitals:

the first digit must be a 1 or 4;

the second digit must be within the range 1 – 2;

the third digit must be within the range 0 – 1, 7

Patient Level Identifier (Patient Name)	A	148-178	31
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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, Dr. should not be recorded. Record hyphenated names with the hyphen as in Smith-Jones, Rebecca. To record a 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	A	179-262	84

Data Reporting Level: Required

Definition: The address including postal zip code or postal zip code only of 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 for (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 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 XXXXX-YYYY where the X's are the five digit zip code and the Y's are the zip code extension. The zip code must be followed by space filler to the end of the field. If the address exceeds 84 characters in length, abbreviate parts of the address so that the zip code can occupy the last five (5) positions e.g., 84120 in columns 258-262.

Edit: This field is edited for the presence of a valid zip code. The city, if provided, is used to classify into counties if the zip code is invalid or missing.

Patient's Date of Birth	N	263-270	8
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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 an 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 2099. 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 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	271	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	272	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

W = Widowed

P = Life Partner

Space = Not present in patient's record.

Edit: This field is edited for a valid entry.

Date of Admission	N	273-278	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 with its two digits. Any unused space to the left must be zero filled. For example, February 7, 2002 is entered 020702.

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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Type of Admission/Visit	N	279	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 5 or maybe 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 Admission below. Generally, the child is born within the facility.

5 = Trauma Center

Definition: Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.

9 = Information not available

Edit: The field must be present and be a valid code 1 through 5 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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Point of Origin for Admission or Visit	A	280	1

Data Reporting Level: Required

Definition: A code indicating the point of origin for the admission or visit.

General Comments: This is a single digit code whose meaning is dependent of the code entered for Type of Admission. For Type of Admission codes 1, 2, 3 or 5 Source of Admission codes 1 through 9 and D through F are valid. For Type of Admission code 4 (newborn) Source of Admission codes 5 and 6 are valid, and have different meanings than when Type of Admission is a 1, 2, 3, or 5. The code structure is as follows:

CODE STRUCTURE FOR EMERGENCY (1), URGENT (2), ELECTIVE (3), OR TRAUMA CENTER (5)

1 = Non-Health Care Facility Point of Origin

Definition: The patient was admitted to this facility includes patients coming from home or workplace.

2 = Clinic or Physician's Office

Definition: The patient was admitted to this facility upon recommendation of another clinic or physician office.

3 = (reserved for assignment by the NUBC)

4 = Transfer from a hospital (Different Facility)

Definition: The patient was admitted to the facility as a transfer from an acute care facility where he or she was an inpatient or outpatient. Excludes transfers from hospital inpatient in the same facility (see code D).

5 = Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)

Definition: The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

6 = Transfer from another health care facility

Definition: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere on this list.

7 = (Discontinued, for Emergency Room admission use Condition Code P7)

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. Includes transfers from incarceration facilities.

9 = Information not available

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

D = Transfer from one distinct unit of the hospital to another distinct unit of the hospital.

Definition: The patient was admitted to the hospital as a transfer from another distinct unit within the hospital to hospital inpatient within this hospital resulting in a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, or a swing bed located in an acute hospital.

E = Transfer from Ambulatory Surgery Center

Field Name **Class** **Position** **Length**

Definition: The patient was admitted to the facility as a transfer from an ambulatory surgery center.

F = Transfer from Hospice and is under a Hospice Plan of Care or Program

Definition: The patient was admitted to the facility as a transfer from a hospice.

CODE OF STRUCTURE FOR NEWBORN (4)

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

5 = Born Inside this Hospital

Definition: A baby born inside this hospital.

6 = Born Outside this Hospital

Definition: A baby born outside this hospital.

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>
Patient's Discharge Status	A	281-282	2

Data Reporting Level: Required

Definition: A code indicating patient status as of the statement covers through date. Generally, 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 = Discharge to home or self-care, routine discharge. If a patient is discharged from an inpatient program to an outpatient program, code the case as '01'.
- 02 = Discharge/transferred to another short-term general hospital.
- 03 = Discharge/transferred to skilled nursing facility
- 04 = Discharge/transferred to an intermediate care facility
- 05 = Discharged/transferred to a designated cancer center or children's hospital.
- 06 = Discharge/transferred to home under care of organized home health service organization.
- 07 = Left against medical advice or discontinued care
- 08 = Discharge/transferred to home under care of a home IV provider
- 09 = Unknown
- 20 = Expired
- 21 = Discharged/transferred to Court/Law Enforcement
- 30 = Still patient (will be excluded from database)
- 40 = Expired at home
- 41 = Expired in a medical facility, i.e. hospital, skilled nursing facility, intermediate care facility, or free standing hospice.
- 42 = Expired – place unknown
- 43 = Discharged/transferred to federal facility
- 50 = Discharged/transferred to hospice - home
- 51 = Discharged/transferred to hospice - medical facility
- 61 = Discharged/transferred within institution to hospital based Medicare swing bed
- 62 = Discharged/transferred to another rehab facility including distinct units in hospital
- 63 = Discharged/transferred to a long term care hospital
- 64 = Discharged/transferred to a nursing facility certified under medicaid but not certified under medicare
- 65 = Discharged/transferred to a psychiatric hospital or psychiatric unit of a hospital
- 66 = Discharged/transferred to a Critical Access Hospital
- 69 = Discharge/transferred to a designated disaster alternative care site (valid 10/2013)
- 70 = Discharged/transferred/referred to another type of health care institution not defined elsewhere in this code list
- 71 = Discharged/transferred/referred to another institution for outpatient (as per plan of care)
- 72 = Discharged/transferred to this institution for outpatient services (as per plan of care)
- 81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission (valid 10/2013)
- 82 = Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (valid 10/2013)

Field Name	Class	Position	Length
83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (valid 10/2013)			
84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (valid 10/2013)			
85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (valid 10/2013)			
86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (valid 10/2013)			
87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (valid 10/2013)			
88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (valid 10/2013)			
89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (valid 10/2013)			
90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (valid 10/2013)			
91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (valid 10/2013)			
92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (valid 10/2013)			
93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (valid 10/2013)			
94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (valid 10/2013)			
95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (valid 10/2013)			

Edit: 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.

Field Name	Class	Position	Length
Statement Covers Period	N	283-294	12
Beginning Date	N	283-288	6
Through Date	N	289-294	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 dates should be at least one day.

Patient's Medical/Health Record Number	A	295-318	24
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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.

Field Name	Class	Position	Length
Patient's Race	A/N	319	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 judgment.

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

Definition: A person having origins in any of the original oriental peoples of the Far East, Southeast Asia, or the Indian Subcontinent. This area includes, for example, China, India, Japan, Korea, and the Philippine Islands.

3 = Black or African American

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.

7 = Native Hawaiian or Other Pacific Islander

Definition: A person having origins in Hawaii or other Pacific Islands such as Guam, Tonga, Samoa, Fiji, the Marshalls or other Pacific Islands. This also includes Indigenous Australians and Maori, the natives of New Zealand.

Blank Space

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

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Condition Codes (ED Admit, DNR, Homeless)	A	320-341	22

Data Reporting Level: Required

Definition: Condition codes identify provisions and certain circumstances, such as billing for denial or medical appropriateness, with a particular bill. This field is to be left justified with spaces to the right to complete the field.

General Comments: The values below are the only ones required at this time. Other values would be accepted if on the patient record but will be ignored at processing.

17 = Homeless or ZIP code unknown

P1 = Do Not Resuscitate (DNR) order was written at the time of or within the first 24 hours of the patient's admission to the hospital and is clearly documented in the patient's medical record

P7 = Admit from Emergency Room

Edit: This field is required. The P7 value is needed to replace the previous code 7 from the Source of Admission.

Patient's Ethnicity	A/N	342	1
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Data Reporting Level: As available

Definition: This item gives the ethnicity 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 judgment.

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 = Hispanic origin

Definition: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

2 = Not of Hispanic origin

Definition: A person who is not classified in 1.

6 = Unknown

Definition: A person who chooses not to respond to the inquiry.

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 combination.

Patient's Revenue Record – Record Type 2

Introduction

Each of the revenue records may contain from 1 to 23 revenue services. If a patient has more than 23 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 record is needed it must have at least two revenue entries. The first entry records the service provided. The second entry would have revenue codes “0001” 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

Field Name	Class	Position	Length
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.

Service Line 1	N	11-16	6
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Data Reporting Level: Required

Definition: The service line number for each row. .

General Comments: This field must start with 1 for the first revenue record.

Edit: The number must be present in each revenue service and is incremental.

Field Name	Class	Position	Length
Revenue Code 1	A	17-20	4

Data Reporting Level: Required

Definition: A four 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 in the first of 23 possible in the record. The second or last entry will be "0001" 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.

HCPCS Code including Modifiers 1	A	21-34	14
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Data Reporting Level: As available

Definition: HCPCS/Rates/HIPPS Code: Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. In addition report up to 4 HCPCS modifiers when a modifier clarifies or improves the reporting accuracy.

Unit or Basis for Measurement Code 1	A	35-36	2
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Data Reporting Level: Required if the revenue code needs units, see Revenue Codes and Units of Service section below.

Definition: Indicator of whether the service Units/Days below is a Unit='UN' or a Day='DA'.

Service Units/Days 1	N	37-43	7
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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 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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Total Charges by Revenue Code 1	N	44-53	10

Data Reporting Level: Required

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

General Comments: The total allows for an 8 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.

Service Line 2	N	54-59	6
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Data Reporting Level: Required

Definition: The service line number for each row. .

General Comments: This field must start with 2 for the second revenue record.

Edit: The number must be present in each revenue service and is incremental.

Revenue Code 2	A	60-60	4
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Data Reporting Level: Required

Definition: A four 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 an entry representing the sum of all revenue services. If the patient has only one service such as room and board it is entered in the first of 23 possible in the record. The second or last entry will be "0001" 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. If the patient received only one revenue service this field must contain "0001" to indicate that the associated Total Charge by Revenue Code field contains the sum of the revenue charges.

HCPCS Code Including Modifiers 2	A	64-77	14
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Data Reporting Level: As available

Definition: HCPCS/Rates/HIPPS Code: Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. In addition report up to 4 HCPCS modifiers when a modifier clarifies or improves the reporting accuracy.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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Unit or Basis for Measurement Code 2	A	78-79	2
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Data Reporting Level: Required if the revenue code needs units, see Revenue Codes and Units of Service section below.

Definition: Indicator of whether the service Units/Days below is a Unit='UN' or a Day='DA'.

Service Units/Days 2	N	80-86	7
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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 service 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 service are adjusted to a common base for comparison.

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

Total Charges by Revenue Code 2	N	87-96	10
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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 an 8 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 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 "0001" then the entry must equal the sum of all other Total Charges by Revenue Code entries.

Service Line 3	N	97-102	6
Revenue Code 3	A	103-106	4
HCPCS Code Including Modifiers 3	A	107-120	14
Units or Basis for Measurement Code 3	A	121-122	2
Service Units/Days 3	N	123-129	7
Total Charges by Revenue Code 3	N	130-139	10

Field Name	Class	Position	Length
Service Line 4	N	140-145	6
Revenue Code4	A	146-149	4
HCPCS Code Including Modifiers 4	A	150-163	14
Units or Basis for Measurement Code 4	A	164-165	2
Service Units/Days 4	N	166-172	7
Total Charges by Revenue Code 4	N	173-182	10
Service Line 5	N	183-188	6
Revenue Code 5	A	189-192	4
HCPCS Code Including Modifiers 5	A	193-206	14
Units or Basis for Measurement Code 5	A	207-208	2
Service Units/Days 5	N	209-215	7
Total Charges by Revenue Code 5	N	216-225	10
Service Line 6	N	226-231	6
Revenue Code 6	A	232-235	4
HCPCS Code Including Modifiers 6	A	236-249	14
Units or Basis for Measurement Code 6	A	250-25	12
Service Units/Days 6	N	252-258	7
Total Charges by Revenue Code 6	N	259-268	10
Service Line 7	N	269-274	6
Revenue Code 7	A	275-278	4
HCPCS Code Including Modifiers 7	A	279-292	14
Units or Basis for Measurement Code 7	A	293-294	2
Service Units/Days 7	N	295-301	7
Total Charges by Revenue Code 7	N	302-311	10
Service Line 8	N	312-317	6
Revenue Code 8	A	318-321	4
HCPCS Code Including Modifiers 8	A	322-335	14
Units or Basis for Measurement Code 8	A	336-337	2
Service Units/Days 8	N	338-344	7
Total Charges by Revenue Code 8	N	345-354	10
Service Line 9	N	355-360	6
Revenue Code 9	A	361-364	4
HCPCS Code Including Modifiers 9	A	365-378	14
Units or Basis for Measurement Code 9	A	379-380	2
Service Units/Days 9	N	381-387	7
Total Charges by Revenue Code 9	N	388-397	10

Field Name	Class	Position	Length
Service Line 10	N	398-403	6
Revenue Code 10	A	404-407	4
HCPCS Code Including Modifiers 10	A	408-421	14
Units or Basis for Measurement Code 10	A	422-423	2
Service Units/Days 10	N	424-430	7
Total Charges by Revenue Code 10	N	431-440	10
Service Line 11	N	441-446	6
Revenue Code 11	A	447-450	4
HCPCS Code Including Modifiers 11	A	451-464	14
Units or Basis for Measurement Code 11	A	465-466	2
Service Units/Days 11	N	467-473	7
Total Charges by Revenue Code 11	N	474-483	10
Service Line 12	N	484-489	6
Revenue Code 12	A	490-493	4
HCPCS Code Including Modifiers 12	A	494-507	14
Units or Basis for Measurement Code 12	A	508-509	2
Service Units/Days 12	N	510-516	7
Total Charges by Revenue Code 12	N	517-526	10
Service Line 13	N	527-532	6
Revenue Code 13	A	533-536	4
HCPCS Code Including Modifiers 13	A	537-550	14
Units or Basis for Measurement Code 13	A	551-552	2
Service Units/Days 13	N	553-559	7
Total Charges by Revenue Code 13	N	560-569	10
Service Line 14	N	570-575	6
Revenue Code 14	A	576-579	4
HCPCS Code Including Modifiers 14	A	580-593	14
Units or Basis for Measurement Code 14	A	594-595	2
Service Units/Days 14	N	596-602	7
Total Charges by Revenue Code 14	N	603-612	10
Service Line 15	N	613-618	6
Revenue Code 15	A	619-622	4
HCPCS Code Including Modifiers 15	A	623-636	14
Units or Basis for Measurement Code 15	A	637-638	2
Service Units/Days 15	N	639-645	7
Total Charges by Revenue Code 15	N	646-655	10

Field Name	Class	Position	Length
Service Line 16	N	656-661	6
Revenue Code 16	A	662-665	4
HCPCS Code Including Modifiers 16	A	666-679	14
Units or Basis for Measurement Code 16	A	680-681	2
Service Units/Days 16	N	682-688	7
Total Charges by Revenue Code 16	N	689-698	10
Service Line 17	N	699-704	6
Revenue Code 17	A	705-708	4
HCPCS Code Including Modifiers 17	A	709-722	14
Units or Basis for Measurement Code 17	A	723-724	2
Service Units/Days 17	N	725-731	7
Total Charges by Revenue Code 17	N	732-741	10
Service Line 18	N	742-747	6
Revenue Code 18	A	748-751	4
HCPCS Code Including Modifiers 18	A	752-765	14
Units or Basis for Measurement Code 18	A	766-767	2
Service Units/Days 18	N	768-774	7
Total Charges by Revenue Code 18	N	775-784	10
Service Line 19	N	785-790	6
Revenue Code 19	A	791-794	4
HCPCS Code Including Modifiers 19	A	795-808	14
Units or Basis for Measurement Code 19	A	809-810	2
Service Units/Days 19	N	811-817	7
Total Charges by Revenue Code 19	N	818-827	10
Service Line 20	N	828-833	6
Revenue Code 20	A	834-837	4
HCPCS Code Including Modifiers 20	A	838-851	14
Units or Basis for Measurement Code 20	A	852-853	2
Service Units/Days 20	N	854-860	7
Total Charges by Revenue Code 20	N	861-870	10
Service Line 21	N	871-876	6
Revenue Code 21	A	877-880	4
HCPCS Code Including Modifiers 21	A	881-894	14
Units or Basis for Measurement Code 21	A	895-896	2
Service Units/Days 21	N	897-903	7
Total Charges by Revenue Code 21	N	904-913	10

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Service Line 22	N	914-919	6
Revenue Code 22	A	920-923	4
HCPCS Code Including Modifiers 22	A	924-937	14
Units or Basis for Measurement Code 22	A	938-939	2
Service Units/Days 22	N	940-946	7
Total Charges by Revenue Code 22	N	947-956	10
<hr/>			
Revenue Code 23 (0001 if last page)	A	957-960	4

Data Reporting Level: Required

Definition: A four digit code which identifies the accompanying overall total charge.

General Comments: This is reserved for the entry representing the sum of all revenue services.

This last entry will be "0001" indicating the entry represents the sum of all total charges.

This field should only be populated for the last page or record if multiple records are generated. If only one record is generated then this would be populated.

Edit: This field must be present and contain "0001" for the last record reported.

Page __ of __ 23	A	961-966	6
Current Page/Record Number	A	961-963	3
Total Pages/Records	A	964-966	3

Data Reporting Level: Required

Definition: Current Page Number or current record number and Total Pages or total record number. Total Pages should equal the total variable number of revenue record '2' records generated. If the current page number equals the total pages, i.e. the last page then 0001 revenue code should be reported along with overall total charge below.

Edit: These dual fields must be present and contain a counting value equal to '1' if only one revenue record is generated. If multiple records are generated should be '1' and '2' followed by '2' and '2', etc.

Total Overall Charges 23	N	967-976	10
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Data Reporting Level: Required

Definition: Total dollars and cents amount charged for all the revenue services entered.

General Comments: The total allows for a 8 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 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 "0001" then the entry must equal the sum of all other Total Charges by Revenue Code entries.

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 non-applicable. The source of the codes and definitions are the National Uniform Billing Committee's published manual.

Revenue Code: A four digit code which identifies a specific accommodation, ancillary service, or billing calculation. The first three digits of the four digit code indicate major category, the fourth 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>
0001	None	Total Overall Charges
002x	None	Health Insurance – Prospective Payment System – This revenue code is used to denote that a HIPPS rate code is being reported. <u>Subcategory "x"</u> 2 = Skilled Nursing Facility-PPS 3 = Home Health-PPS 4 = Inpatient rehab facility –PPS
010x	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
011x	Days	Room and Board (Private One Bed) - routine service charges incurred for accommodations in a private room (1 bed). <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
012x	Days	Room and Board (Semi-Private Two Beds) - routine service charges incurred for accommodations in a semi-private room with two 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

013x Days Room and Board (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

014x Days Room and Board (Deluxe Private) - 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

015x Days Room and Board (Ward) - 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

016x Days Room and Board (Other) - any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Subcategory "x"

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

017x Days Nursery - charges for nursing care to newborn and premature infants in nurseries.

Subcategory "x"

- 0 = General classification
- 1 = Newborn nursery
- 2 = Continuing care
- 3 = Intermediate care
- 4 = Intensive Care
- 5 = Neonatal ICU
- 9 = Other nursery

018x 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

019x Days Subacute Care – accommodation charges for subacute care to inpatients in hospitals or skilled nursing facilities.

Subcategory "x"

- 0 = General classification
- 1 = Skilled care
- 2 = Comprehensive care
- 3 = Complex care
- 4 = Intensive care
- 9 = Other subacute care

020x 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

021x 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

022x 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

023x 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

024x 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

025x 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

026x 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
- 3 = IV therapy/drug/supply delivery
- 4 = IV therapy/supplies
- 9 = Other IV therapy

027x 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

028x None Oncology - charges for the treatment of tumors and related diseases.

Subcategory "x"

- 0 = General classification
- 1 = Other oncology

029x 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
- 4 = Supplies/drugs for DME
- 9 = Other equipment

030x 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 (home)
- 4 = Non-routine dialysis
- 5 = Hematology
- 6 = Bacteriology and microbiology
- 7 = Urology
- 9 = Other Laboratory

031x Test Laboratory Pathological - charges for diagnostic and routine laboratory tests on tissues and culture.

Subcategory "x"

- 0 = General classification
- 1 = Cytology
- 2 = Histology
- 4 = Biopsy
- 9 = Other laboratory pathology

032x Test Radiology Diagnostic - charges for diagnostic radiology services provided for the examination and care of patients. This includes: taking, processing, examining and interpreting radiographs and fluorographs.

Subcategory "x"

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

033x Test Radiology Therapeutic - charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. This 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 radiology therapeutic

034x 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
- 3 = Diagnostic radiopharmaceuticals
- 4 = Therapeutic radiopharmaceuticals

- 9 = Other nuclear medicine
- 035x 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
- 036x 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"
 0 = General classification
 1 = Minor surgery
 2 = Organ transplant other than kidney
 7 = Kidney transplant
 9 = Other operating room services
- 037x None Anesthesia - charges for anesthesia services in the hospital.
- Subcategory "x"
 0 = General classification
 1 = Anesthesia incident to RAD
 2 = Anesthesia incident to other DX services
 4 = Acupuncture
 9 = Other anesthesia
- 038x Pint Blood
- Subcategory "x"
 0 = General classification
 1 = Packed red cells
 2 = Whole blood
 3 = Plasma
 4 = Platelets
 5 = Leukocytes
 6 = Other blood components
 7 = Other derivatives cryoprecipitates
 9 = Other blood
- 039x None Blood Storage and Processing - charges for the storage and processing of whole blood.
- Subcategory "x"
 0 = General classification
 1 = Blood administration
 2 = Processing and storage
 9 = Other blood handling
- 040x Test Other Imaging Services – charges for specialty imaging services for body structures.
- Subcategory "x"

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

041x 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 = Hyperbaric oxygen therapy
- 9 = Other respiratory services

042x 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

043x 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

044x 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

045x 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

046x 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

9 = Other Pulmonary function

047x Test Audiology - charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Subcategory "x"

0 = General classification

1 = Diagnostic

2 = Treatment

9 = Other audiology

048x 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.

Subcategory "x"

0 = General classification

1 = Cardiac cath lab

2 = Stress test

3 = Echocardiology

9 = Other cardiology

049x None Ambulatory Surgical Care - charges for ambulatory surgery which are not covered by other categories.

Subcategory "x"

0 = General classification

9 = Other ambulatory surgical care

050x 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.

Subcategory "x"

0 = General classification

9 = Other outpatient services

051x Visit Clinic - charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Subcategory "x"

0 = General classification

1 = Chronic pain center

2 = Dental clinic

- 3 = Psychiatric clinic
- 4 = OB-GYN clinic
- 5 = Pediatric clinic
- 6 = Urgent care clinic
- 7 = Family practice clinic
- 9 = Other clinic

052x Visit Free-standing Clinic

Subcategory "x"

- 0 = General classification
- 1 = Rural health-clinic
- 2 = Rural health-home
- 3 = Family practice
- 4 = SNF/covered
- 5 = SNF/uncovered
- 6 = Urgent care clinic
- 7 = Visiting nurse
- 8 = Other site/scene of accident
- 9 = Other free-standing clinic

053x 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

054x 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
- 7 = Pharmacy
- 8 = EKG transmission
- 9 = Other ambulance

056x Visit Home Health (HH) Medical Social Services – HH 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

- 057x Visit Home Health (HH) Aide - HH charges for personnel (aides) that are primarily responsible for the personal care of the patient.
- Subcategory "x"
 0 = General classification
 1 = Visit charge
 2 = Hourly charge
 9 = Other HH - aide
- 058x Visit Home Health (HH) Other Visits – HH charges for visits other than physical therapy, occupational therapy or speech therapy, requiring specific identification.
- Subcategory "x"
 0 = General classification
 1 = Visit charge
 2 = Hourly charge
 3 = Assessment
 9 = Other HH visit
- 059x Visit Home Health (HH) Units of Service – HH charges for services billed according to the units of service provided.
- Subcategory "x"
 0 = General classification
- 060x Visit Home Health (HH) Oxygen – HH charges for oxygen equipment, supplies or contents, excluding purchased equipment.
- Subcategory "x"
 0 = General classification
 1 = Oxygen supply content
 2 = Oxygen supply < 1 LPM
 3 = Oxygen supply > 4 LPM
 4 = Oxygen port addon
 9 = Other HH oxygen
- 061x Test Magnetic Resonance Technology (MRT) – Charges for magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA).
- Subcategory "x"
 0 = General classification
 1 = MRI Brain including brainstem
 2 = MRI Spinal cord including spine
 4 = MRI other
 5 = MRA head and neck
 6 = MRA lower extremities
 8 = MRA other
 9 = Other MRT
- 062x Item Medicare/Surgical Supplies (extension of 027x) - charges for supply items required for patient care. The category is an extension of code 027x for reporting additional breakdown where needed. Subcategory code 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcategory code 2 is for providers that cannot bill supplies used for other diagnostic procedures.

Subcategory "x"

- 1 = Supplies incident to radiology
- 2 = Supplies incident to other DX services
- 3 = Surgical dressings
- 4 = FDA investigational devices

063x Unit Pharmacy (extension of 025x) - charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist The category is an extension of code 025x for reporting additional breakdown where needed.

Subcategory "x"

- 1 = Single source drug
- 2 = Multiple source drug
- 3 = Restrictive prescription
- 4 = EPO < 10,000 Units
- 5 = EPO >= 10,000 Units
- 6 = Detailed coding drug
- 7 = Self administrable drugs

064x Hour Home IV Therapy Services - charge for intravenous therapy services performed in the patient's residence. For Home IV providers enter the HCPCS code for all equipment, and all types of covered therapy.

Subcategory "x"

- 0 = General classification
- 1 = Non-routine nursing, central line
- 2 = IV site care, central line
- 3 = IV start, peripheral line
- 4 = Non-routine nursing, peripheral line
- 5 = Training patient/caregiver, central line
- 6 = Training disabled patient, central line
- 7 = Training patient/caregiver, peripheral line
- 8 = Training disabled patient, peripheral line
- 9 = Other home IV therapy services

065x 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 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

066x Hour Respite Care - charges for non-hospice respite care.

Subcategory "x"

- 0 = General classification
- 1 = Hourly charge nursing
- 2 = Hourly charge aide/homemaker/companion

- 3 = Daily respite charge
9 = Other respite care
- 067x * Outpatient Special Residence Charges – residence arrangements for patients requiring continuous outpatient care.
- Subcategory "x"
0 = General classification
1 = Hospital owned
2 = Contracted
9 = Other special residence charge
- 068x * Trauma Response – charges representing the activation of the trauma team.
- Subcategory "x"
0 = General classification
1 = Level I Trauma
2 = Level II Trauma
3 = Level III trauma
4 = Level IV trauma
9 = Other trauma response
- 070x None Cast Room - charges for services related to the application, maintenance and removal of casts.
- Subcategory "x"
0 = General classification
9 = Other cast room
071x None Recovery Room
- Subcategory "x"
0 = General classification
9 = Other recovery room
- 072x * 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
- 073x 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

- 074x 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
9 = Other EEG
- 075x Test Gastrointestinal Services - procedure room charges for endoscopic procedures not performed in the operating room.
- Subcategory "x"
0 = General classification
- 076x None Specialty Services - charges for patients requiring treatment room services or patients placed under observation.
- Subcategory "x"
0 = General classification
1 = Treatment room
2 = Observation hours
9 = Other specialty services
- 077x None Preventive Care Services – revenue code used to capture preventive care services established by payers (e.g. vaccination).
- Subcategory "x"
0 = General classification
1 = Vaccine administration
- 078x None Telemedicine – facility charges related to the use of telemedicine services.
- Subcategory "x"
0 = General classification
- 079x None Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) - charges related to Extra-Corporeal Shock Wave Therapy (ESWT).
- Subcategory "x"
0 = General classification
- 080x Session Inpatient Renal Dialysis - a waste removal process performed 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).
- Subcategory "x"
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
- 081x None Acquisition of Body Components - the acquisition and storage costs of body tissue,

bone marrow, organs and other body components not otherwise identified used for transplantation.

Subcategory "x"

- 0 = General classification
- 1 = Living donor
- 2 = Cadaver donor
- 3 = Unknown donor
- 4 = Unsuccessful Organ search
- 9 = Other organ acquisition

086x None Magneto Encephalography - charges for operation of specialized medical equipment to measure the magnetic fields generated by brain activity.

Subcategory "x"

- 0 = General classification
- 1 = MEG

088x None Miscellaneous Dialysis - charges for dialysis services not identified elsewhere.

Subcategory "x"

- 0 = General classification
- 1 = Ultra filtration
- 2 = Home dialysis
- 9 = Other miscellaneous dialysis

090x Visit Behavior Health Treatment/Services – charges for prevention, intervention, and treatment services in the area of mental health, substance abuse, developmental disabilities, and sexuality. Behavior health care services are individualized, holistic, and culturally competent and may include on-going care and support and non-traditional services.

Subcategory "x"

- 0 = General classification
- 1 = Electroshock treatment
- 2 = Milieu therapy
- 3 = Play therapy
- 4 = Activity therapy
- 5 = Intensive outpatient services-psychiatric
- 6 = Intensive outpatient services-chemical dependency
- 7 = Community behavioral health program (day treatment)

091x Visit Behavior Health Treatment/Services – extension of 090x.

Subcategory "x"

- 1 = Rehabilitation
- 2 = Partial hospitalization – less intensive
- 3 = Partial hospitalization – intensive
- 4 = Individual therapy
- 5 = Group therapy
- 6 = Family therapy
- 7 = Biofeedback
- 8 = Testing
- 9 = Other behavior health treatments

- 092x Test Other Diagnostic Services – charges for various diagnostic services specific to common screenings for disease, illness or medical condition.
- Subcategory "x"
 0 = General classification
 1 = Peripheral vascular lab.
 2 = Electromyogram
 3 = Pap smear
 4 = Allergy test
 5 = Pregnancy test
 9 = Other diagnostic service
- 093x Hour Medical Rehabilitation Day Program – medical rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy, and speech therapy.
- Subcategory "x"
 1 = Half day
 2 = Full day
- 094x 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 = Complex medical equipment - routine
 7 = Complex medical equipment – ancillary
 8 = Pulmonary rehabilitation
 9 = Other therapeutic services
- 095x Visit Other Therapeutic Services – extension of 094x.
- Subcategory "x"
 0 = Athletic training
 1 = Kinesiotherapy
- 096x None Professional Fees (also see 097x and 098x) - charges for medical professionals that the institutional healthcare provider along with the third-party payer require the professional fee component to be billed on the billing form. The professional fee component is separately identified by this revenue code. Generally used by Critical Access Hospitals (CAH) which bill both the technical and professional service components on the billing form.
- Subcategory "x"
 0 = General classification
 1 = Psychiatric
 2 = Ophthalmology
 3 = MD Anesthesiologist
 4 = CRNA Anesthetist
 9 = Other professional fee

- 097x None Professional Fees (extension of 096x)
- 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
- 098x None Professional Fees (extension of 096x and 097x)
- 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
- 099x 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/Telecom
 - 4 = TV/Radio
 - 5 = Non-patient room rentals
 - 6 = Late discharge
 - 7 = Admission kits
 - 8 = Beauty shop/barber
 - 9 = Other patient convenience items
- 100x None Behavior Health Accommodations - charges for routine accommodations at specific behavior health facilities.
- Subcategory "x"
- 0 = General classification
 - 1 = Residential treatment - psychiatric
 - 2 = Residential treatment – chemical dependency
 - 3 = Supervised living
 - 4 = Halfway house
 - 5 = Group home
- 210x None Alternative Therapy Services - charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042x, 043x, 044x, 091x, 094x, 095x)

or services such as anesthesia or clinic (0374, 0511).

Subcategory "x"

0 = General classification

1 = Acupuncture

2 = Acupressure

3 = Massage

4 = Reflexology

5 = Biofeedback

6 = Hypnosis

9 = Other alternative therapy services

310x None Adult Care - charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with activities of daily living (ADL).

Subcategory "x"

1 = Adult day care, medical and social - hourly

2 = Adult day care, social - hourly

3 = Adult day care, medical and social - daily

4 = Adult day care, social - daily

5 = Adult foster care - daily

9 = Other adult care

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

Field Name	Class	Position	Length
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, and equal the number entered in the 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.

	<u>1st of three Payers</u>		
Primary Payer 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 as completely as space allows. If a name has more than 25 characters, use abbreviations that can be used uniquely to identify the organization.

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

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Estimated Amount Due	N	36-45	10

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 eight 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.

Edit: None

Prior Payment	N	46-55	10
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Data Reporting Level: As Available

Definition: The amount the hospital has received toward the payment 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 eight 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.

Edit: None

	<u>2nd of three Payers</u>		
Secondary Payer Identification	A	56-80	25

Data Reporting Level: Required if patient has more than one payer

Definition: Name, and if required by payer, a number identifying the secondary 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 secondary payer organization. The name should be spelled out completely when space allows. If a 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 veritable organization.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Estimated Amount Due	N	81-90	10

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 eight 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.

Edit: None

Prior Payment	N	91-100	10
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Data Reporting Level: As Available

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

General Comments: The format of this estimate is dollars and cents. The dollar amount can be a maximum of eight digits with two 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.

Edit: None

	<u>3rd of three Payers</u>		
Tertiary Payer Identification	A	101-125	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 a 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 veritable organization.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Estimated Amount Due	N	126-135	10

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 eight 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.

Edit: None

Prior Payment	N	136-145	10
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Data Reporting Level: As Available

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

General Comments: The format of this estimate is dollars and cents. The dollar amount can be a maximum of eight 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.

Edit: None

Note: The record accommodates from one to three insured individuals and the associated information.

1st of three Insured Persons

Insured's Name—Primary	A	146-170	25
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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 middle initial. No space should be left between a prefix and a 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: Synder 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 the first name.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Patient's Relationship—Primary	N	171-172	2

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 first 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 = Spouse

04 = Grandfather or Grandmother

05 = Grandson or Granddaughter

07 = Niece or Nephew

09 = Unknown/Other Relationship

10 = Foster Child

15 = Ward of the Court

Definition: This patient is a ward of the insured as a result of a court order.

17 = Stepson or Stepdaughter

18 = Self/Patient is the named insured

19 = Child where insured has financial responsibility

20 = Employee

21 = Unknown

22 = Handicapped Dependent

Definition: Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage

23 = Sponsored Dependent

Definition: Individual not normally covered by insurance coverage but coverage has been specifically arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.

24 = 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.

29 = Significant Other

32 = Mother

33 = Father

36 = Emancipated Minor

39 = Organ Donor

Definition: Code is used in cases where bill is submitted for care given to organ donor where such care is paid for by the receiving patient's insurance coverage

40 = 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

41 = Injured Plaintiff

Definition: Patient is claiming insurance as a result of injury covered by insured

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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43 = Child where insured has no financial responsibility

53 = Life Partner

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

Insured's Unique ID—Primary	A	173-192	20
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Data Reporting Level: As Available

Definition: The insured's unique identification number assigned. The payer's 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—Primary	A	193-212	20
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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.

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

Edit: None

2nd of three Insured Persons

Insured's Name—Secondary	A	213-237	25
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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 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.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Patient's Relationship—Secondary	N	238-239	2

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 first 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 = Spouse

04 = Grandfather or Grandmother

05 = Grandson or Granddaughter

07 = Niece or Nephew

09 = Unknown/Other Relationship

10 = Foster Child

15 = Ward of the Court

Definition: This patient is a ward of the insured as a result of a court order.

17 = Stepson or Stepdaughter

18 = Self/Patient is the named insured

19 = Child where insured has financial responsibility

20 = Employee

21 = Unknown

22 = Handicapped Dependent

Definition: Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage

23 = Sponsored Dependent

Definition: Individual not normally covered by insurance coverage but coverage has been specifically arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.

24 = 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.

29 = Significant Other

32 = Mother

33 = Father

36 = Emancipated Minor

39 = Organ Donor

Definition: Code is used in cases where bill is submitted for care given to organ donor where such care is paid for by the receiving patient's insurance coverage

40 = 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

41 = Injured Plaintiff

Definition: Patient is claiming insurance as a result of injury covered by insured

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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43 = Child where insured has no financial responsibility

53 = Life Partner

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

Insured's Unique ID—Secondary	A	240-259	20
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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—Secondary	A	260-279	20
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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—Tertiary	A	280-304	25
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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 the first name and 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, write the suffix followed by a comma, and 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>
Patient's Relationship—Tertiary	N	305-306	2

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 = Spouse

04 = Grandfather or Grandmother

05 = Grandson or Granddaughter

07 = Niece or Nephew

09 = Unknown/Other Relationship

10 = Foster Child

15 = Ward of the Court

Definition: This patient is a ward of the insured as a result of a court order.

17 = Stepson or Stepdaughter

18 = Self/Patient is the named insured

19 = Child where insured has financial responsibility

20 = Employee

21 = Unknown

22 = Handicapped Dependent

Definition: Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage

23 = Sponsored Dependent

Definition: Individual not normally covered by insurance coverage but coverage has been specifically arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.

24 = 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.

29 = Significant Other

32 = Mother

33 = Father

36 = Emancipated Minor

39 = Organ Donor

Definition: Code is used in cases where bill is submitted for care given to organ donor where such care is paid for by the receiving patient's insurance coverage

40 = 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

41 = Injured Plaintiff

Definition: Patient is claiming insurance as a result of injury covered by insured

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
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43 = Child where insured has no financial responsibility

53 = Life Partner

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

Insured's Unique ID—Tertiary	A	307-326	20
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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—Tertiary	A	327-346	20
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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

Employer Name—Primary	A	347-370	24
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Data Reporting Level: As Available

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

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

Edit: None

Employer Name—Secondary	A	371-394	24
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Data Reporting Level: As Available

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

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

Edit: None

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Diagnosis Version Qualifier	A	395-395	1

Data Reporting Level: Required

Definition: Indicator to designate which version of ICD was used to report diagnosis codes.

General Comments: Should be initially hard coded to 9 for every record prior to ICD-10.

9 Ninth revision of ICD

0 Tenth revision of ICD

Edit: Must be present and valid.

Principal Diagnosis Code with POA	A	396-403	8
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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 or ICD-10-CM code describes the principal diagnosis.

General Comments: This field is to contain the appropriate ICD-9-CM or ICD-10-CM code without a decimal followed by POA in position 8. 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-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.

POA coding: Y=Present at time of inpatient admission, N=Not present at time of inpatient admission, U=Unknown, W=Clinically undetermined, E or 1=Exempt from POA reporting.

Edit: A principal diagnosis must be present and valid and must contain a corresponding Present on Admission indicator coded appropriately. 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 seventeen additional diagnoses when present in the patient record.

Field Name	Class	Position	Length
Secondary Diagnosis Code with POA (1 st of 17)	A	404-411	8

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 seventeen additional diagnoses. This field is to contain the appropriate ICD-9-CM or ICD-10 code without a decimal followed by POA in position 8. 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-digit code is entered as “12345”, a “V” code 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. POA coding: Y=Present at time of inpatient admission, N=Not present at time of inpatient admission, U=Unknown, W=Clinically undetermined, E or I=Exempt from POA reporting.

Edit: If other diagnoses are present they must be valid and must contain a corresponding Present on Admission indicator coded appropriately. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

Secondary Diagnosis Code with POA (2 nd of 17)	A	412-419	8
Secondary Diagnosis Code with POA (3 rd of 17)	A	420-427	8
Secondary Diagnosis Code with POA (4 th of 17)	A	428-435	8
Secondary Diagnosis Code with POA (5 th of 17)	A	436-443	8
Secondary Diagnosis Code with POA (6 th of 17)	A	444-451	8
Secondary Diagnosis Code with POA (7 th of 17)	A	452-459	8
Secondary Diagnosis Code with POA (8 th of 17)	A	460-467	8
Secondary Diagnosis Code with POA (9 th of 17)	A	468-475	8
Secondary Diagnosis Code with POA (10 th of 17)	A	476-483	8
Secondary Diagnosis Code with POA (11 th of 17)	A	484-491	8
Secondary Diagnosis Code with POA (12 th of 17)	A	492-499	8
Secondary Diagnosis Code with POA (13 th of 17)	A	500-507	8
Secondary Diagnosis Code with POA (14 th of 17)	A	508-515	8

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Secondary Diagnosis Code with POA (15 th of 17)	A	516-523	8
Secondary Diagnosis Code with POA (16 th of 17)	A	524-531	8
Secondary Diagnosis Code with POA (17 th of 17)	A	532-539	8
Admitting Diagnosis Code	A	540-546	7

Data Reporting Level: Required

Definition: The ICD-9-CM or ICD-10-CM diagnosis provided by the physician at the time of admission which describes the patient's condition upon admission to the hospital. Since the Admitting Diagnosis is formulated before all tests and examinations are complete, it may be stated in the form of a problem or symptom and it may differ from any of the final diagnoses recorded in the medical record.

General Comments: This field is to contain the appropriate ICD-9-CM or ICD-10-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-digit code is entered as "12345", a "V" code 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 admitting diagnosis.

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

Patient's Reason for Visit 1	A	547-553	7
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Data Reporting Level: Required for AS, ED Only

Definition: The diagnosis describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one diagnosis code describing the patient's primary reason for seeking care.

General Comments: This field is to contain the appropriate ICD-9-CM or ICD-10-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-digit code is entered as "12345", a "V" code entered as "V270". All entries are to be left justified with spaces to the right to complete the field length.

Edit: If patient's reason for visit is present they must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

Patient's Reason for Visit 2	A	554-560	7
Patient's Reason for Visit 3	A	561-567	7

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
External Cause of Injury Code (E-code) with POA 1	A	568-575	8

Data Reporting Level: Required

Definition: The ICD-9-CM or ICD-10-CM code followed by POA in position 8 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 and 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 with spaces to the right to complete the field length. POA coding: Y=Present at time of inpatient admission, N=Not present at time of inpatient admission, U=Unknown, W=Clinically undetermined, E or 1=Exempt from POA reporting.

Edit: If other diagnoses are present they must be valid and must contain a corresponding Present on Admission indicator coded appropriately. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

External Cause of Injury Code (E-code) with POA 2	A	576-583	8
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External Cause of Injury Code (E-code) with POA 3	A	584-591	8
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Filler	A	592	1
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Note: Six procedures (one principal and five others) are accommodated in the record. All procedures entered must be coded using the same ICD method.

Principal ICD Procedure	A	593-599	7
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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-CM or ICD-10-CM. 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.

Date of Principal Procedure (MMDDYY)	N	600-605	6
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Field Name	Class	Position	Length
Secondary ICD Procedure 1	A	606-612	7

Data Reporting Level: Required

Definition: The code that identifies the first of five 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 of the principal procedure. Entries must include all digits and decimal. In the ICD-9-CM there are three-digit codes and four-digit 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.

Date of Principal Procedure or Secondary 1 if different	N	613-618	6
Secondary ICD Procedure 2	A	619-625	7
Date of Principal Procedure or Secondary 2 if different	N	626-631	6
Secondary ICD Procedure 3	A	632-638	7
Date of Principal Procedure or Secondary 3 if different	N	639-644	6
Secondary ICD Procedure 4	A	645-651	7
Date of Principal Procedure or Secondary 4 if different	N	652-657	6
Secondary ICD Procedure 5	A	658-664	7
Date of Principal Procedure or Secondary 5 if different	N	665-670	6

Note: The record provides space to record up to five physician/provider ID numbers: the attending provider, operating physician, other operating physician, rendering physician and referring provider.

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Attending Provider ID – NPI/QUAL/ID	A	671-696	26
<p><u>Data Reporting Level:</u> Required</p> <p><u>Definition:</u> This is a composite field containing the license number(s) of the individual health care provider who has overall responsibility for the patient’s medical care and treatment.</p> <p><u>General Comments:</u> 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 unique NPI and secondary license number. This field is to be left justified with spaces to the right to complete the field. The secondary identification qualifiers must be selected from the following list: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number, LU=Location Number</p> <p><u>Edit:</u> This field must contain a valid national provider number. If available, a secondary ID such as the Utah State license number should be submitted as well preceded by its respective qualifier ‘OB’. Examples: 1234567890+’1G’+G12345=’12345678901GG12345 ‘. 1234567890+’0B’+97-266855-1205=’12345678900B97-266855-1205’.</p>			
Attending Provider Taxonomy Code	A	697-706	10
<p><u>Data Reporting Level:</u> As Available</p> <p><u>Definition:</u> This field contains the Health Care Provider Taxonomy Code of the individual health care provider who has overall responsibility for the patient’s medical care and treatment.</p> <p><u>General Comments:</u> This code set is copyrighted by the AMA on behalf of the National Uniform Claim Committee (NUCC). The current version is Version 14.0, 1/1/2014. If a newer version or update is released then those changes will be acceptable for submission.</p> <p><u>Edit:</u> If not available, this field may be space filled.</p>			
Operating Physician ID – NPI/QUAL/ID	A	707-732	26
<p><u>Data Reporting Level:</u> Required</p> <p><u>Definition:</u> This is a composite field containing the license number(s) of a physician other than the attending physician with primary responsibility for performing the principal procedure.</p> <p><u>General Comments:</u> 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 unique NPI and secondary license number. This field is to be left justified with spaces to the right to complete the field. The secondary identification qualifiers must be selected from the following list: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number, LU=Location Number</p> <p><u>Edit:</u> This field must contain a valid national provider number. If available, a secondary ID such as the Utah State license number should be submitted as well preceded by its respective qualifier ‘OB’. Examples: 1234567890+’1G’+G12345=’12345678901GG12345 ‘. 1234567890+’0B’+97-266855-1205=’12345678900B97-266855-1205’.</p>			

Field Name	Class	Position	Length
Operating Physician Taxonomy Code	A	733-742	10
<p><u>Data Reporting Level:</u> As Available</p> <p><u>Definition:</u> This field contains the Health Care Provider Taxonomy Code of a physician other than the attending physician with primary responsibility for performing the principal procedure.</p> <p><u>General Comments:</u> This code set is copyrighted by the AMA on behalf of the National Uniform Claim Committee (NUCC). The current version is Version 14.0, 1/1/2014. If a newer version or update is released then those changes will be acceptable for submission.</p> <p><u>Edit:</u> If not available, this field may be space filled.</p>			
Other Operating Physician ID – NPI/QUAL/ID	A	743-768	26
<p><u>Data Reporting Level:</u> Required</p> <p><u>Definition:</u> This is a composite field containing the license number(s) of a physician other than the attending physician or operating physician with primary responsibility for performing secondary procedures.</p> <p><u>General Comments:</u> 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 unique NPI and secondary license number. This field is to be left justified with spaces to the right to complete the field. The secondary identification qualifiers must be selected from the following list: OB=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number, LU=Location Number</p> <p><u>Edit:</u> This field must contain a valid national provider number. If available, a secondary ID such as the Utah State license number should be submitted as well preceded by its respective qualifier 'OB'. Examples: 1234567890+'1G'+G12345='12345678901GG12345'. 1234567890+'0B'+97-266855-1205='12345678900B97-266855-1205'.</p>			
Other Operating Physician Taxonomy Code	A	769-778	10
<p><u>Data Reporting Level:</u> As Available</p> <p><u>Definition:</u> This field contains the Health Care Provider Taxonomy Code of a physician other than the attending physician or operating physician with primary responsibility for performing secondary procedures.</p> <p><u>General Comments:</u> This code set is copyrighted by the AMA on behalf of the National Uniform Claim Committee (NUCC). The current version is Version 14.0, 1/1/2014. If a newer version or update is released then those changes will be acceptable for submission.</p> <p><u>Edit:</u> If not available, this field may be space filled.</p>			

<u>Field Name</u>	<u>Class</u>	<u>Position</u>	<u>Length</u>
Rendering Physician ID – NPI/QUAL/ID	A	779-804	26
<p><u>Data Reporting Level:</u> Required</p> <p><u>Definition:</u> This is a composite field containing the license number(s) of a physician other than the attending physician or operating physicians which provided the services or treated the patient.</p> <p><u>General Comments:</u> 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 unique NPI and secondary license number. This field is to be left justified with spaces to the right to complete the field. The secondary identification qualifiers must be selected from the following list: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number, LU=Location Number</p> <p><u>Edit:</u> This field must contain a valid national provider number. If available, a secondary ID such as the Utah State license number should be submitted as well preceded by its respective qualifier ‘OB’. Examples: 1234567890+’1G’+G12345=’12345678901GG12345 ’. 1234567890+’0B’+97-266855-1205=’12345678900B97-266855-1205’.</p>			
Rendering Physician Taxonomy Code	A	805-814	10
<p><u>Data Reporting Level:</u> As Available</p> <p><u>Definition:</u> This field contains the Health Care Provider Taxonomy Code of a physician other than the attending physician or operating physicians which provided the services or treated the patient.</p> <p><u>General Comments:</u> This code set is copyrighted by the AMA on behalf of the National Uniform Claim Committee (NUCC). The current version is Version 14.0, 1/1/2014. If a newer version or update is released then those changes will be acceptable for submission.</p> <p><u>Edit:</u> If not available, this field may be space filled.</p>			
Referring Provider ID – NPI/QUAL/ID	A	815-840	26
<p><u>Data Reporting Level:</u> Required</p> <p><u>Definition:</u> This is a composite field containing the license number(s) of a provider which referred the patient to this facility or a specialist for assistance, examination or treatment.</p> <p><u>General Comments:</u> 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 unique NPI and secondary license number. This field is to be left justified with spaces to the right to complete the field. The secondary identification qualifiers must be selected from the following list: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number, LU=Location Number</p> <p><u>Edit:</u> This field must contain a valid national provider number. If available, a secondary ID such as the Utah State license number should be submitted as well preceded by its respective qualifier ‘OB’. Examples: 1234567890+’1G’+G12345=’12345678901GG12345 ’. 1234567890+’0B’+97-266855-1205=’12345678900B97-266855-1205’.</p>			

Field Name	Class	Position	Length
Referring Provider Taxonomy Code	A	841-850	10

Data Reporting Level: As Available

Definition: This field contains the Health Care Provider Taxonomy Code of a provider which referred the patient to this facility or a specialist for assistance, examination or treatment.

General Comments: This code set is copyrighted by the AMA on behalf of the National Uniform Claim Committee (NUCC). The current version is Version 14.0, 1/1/2014. If a newer version or update is released then those changes will be acceptable for submission.

Edit: If not available, this field may be space filled.

Resident ID – NPI/QUAL/ID	A	851-876	26
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Data Reporting Level: As Available

Definition: If a resident provided care, this is a composite field containing the license number(s) of the facility or the resident providing the care. The data if entered must be entered in the following manner: the facility NPI for first and second year residents, the unique NPI and secondary license number for all other residents.

General Comments: If there were no residents involved, then this field may be space filled. If available, the physician must be coded as a unique individual using his/her unique NPI and secondary license number. This field is to be left justified with spaces to the right to complete the field. The secondary identification qualifiers must be selected from the following list: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number, LU=Location Number

Edit: This field must contain a valid national provider number. If available, a secondary ID such as the Utah State license number should be submitted as well preceded by its respective qualifier '0B'. Examples: 1234567890+'1G'+G12345='12345678901GG12345 ' . 1234567890+'0B'+97-266855-1205='12345678900B97-266855-1205'.

Resident ID Type	A	877	1
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Data Reporting Level: As Available

Definition: If a resident provided care, the following should be entered in this field:

F—Facility ID number for 1-2 year residents

U—NPI/QUAL/ID number for all other residents

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

Edit: If Resident ID is completed this field must be completed with 'F' or 'U'.

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 improbably 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 the principal diagnosis, 3) miscoding 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, 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 a principal diagnosis. For example, a family history of ischemic heart disease (V173) would be an unacceptable principal diagnosis.

Bilateral procedure

Certain codes do not accurately reflect procedures performed in one admission on two or more different bilateral joints of 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 an 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 an 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:

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 returned to the hospital, in a simplified format.

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

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 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 mailing or e-mail. The corrected records are to be returned by first class U.S. certified mail addressed as follows:

Utah Department of Health
Office of Health Care Statistics
Attention: Hospital Discharge Database Manager
288 North 1460 West
P.O. Box 144004
Salt Lake City, Utah 84114-4004

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 tabulations to the office with their comments and corrections within 35 days of the date of mailing or e-mail. 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 any 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

Introduction

Hospitals may request an exemption, extension, or waiver to requirements established by the Utah Health Data Committee (HDC).

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-04 claim records);

Reporting of a specific data element if a hospital can document a substantive difference, which 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 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.

How to Submit a Request for Exemption, Extension, or Waiver

Please send a letter by mail or e-mail requesting the exemption, extension or waiver to:

Utah Department of Health
Office of Health Care Statistics
Attention: Compliance Officer
288 North 1460 West
P.O. Box 144004
Salt Lake City, Utah 84104-4004
Telephone: (801) 538-7048

E-mail: healthcarestat@utah.gov

Please include the following information in your request letter.

1. Requester's Name, Address, Contact Person, and Telephone Number
2. Indicate if you are requesting an exemption, extension or waiver and the time period (starting and ending date) to be covered by your request. (Maximums: Exemption 1 year, Extension 30 calendar days, Waiver 1 year.)
3. Describe the relief sought, including a reference to the specific requirement (i.e., submittal schedule, data consolidation, etc.).
4. Provide justification for granting this request, including the facts, reasons, and legal authority for granting your request.
5. Outline the alternative approach or timeline that you propose to meet the requirement.