

UTAH HEALTHCARE FACILITY DATA SUBMISSION GUIDE

*GENERAL GUIDELINES, FILE FORMATS, RECORD FORMATS AND LAYOUTS, AND
DATA ELEMENT DESCRIPTIONS FOR SUBMITTING AMBULATORY SURGERY,
EMERGENCY ROOM, AND INPATIENT DISCHARGE DATA*

Version 1, January 15, 2016

Utah Health Data Committee

Utah Department of Health

Office of Health Care Statistics

288 North 1460 West

PO Box 144004

Salt Lake City, UT 84114-4004

healthcarestat@utah.gov

Table of Contents

- Introduction and General Guidelines..... 1
 - Effective Dates 1
 - Authority 1
 - Purpose of This Guide 1
 - Administrative Rules 1
 - Multiple Discharges or Billing Claims 1
 - Social Security Numbers 2
 - Required Data Sources and Types 2
 - Ambulatory Surgery Data..... 2
 - Emergency Room Data..... 3
 - Inpatient Discharge Data 3
 - Data Submission Schedule 3
 - Data Transfer 4
 - Secure Transfer Methods..... 4
 - File Descriptions Required 4
 - Data Quality Assurance..... 4
 - Review Prior to Submission 4
 - Edit Checks and Error Corrections 5
 - Reporting Review and Validation..... 5
 - Final Database..... 5
 - Error Rates 5
- Chapter 1 - Ambulatory Surgery Data Requirements..... 6
 - Ambulatory Surgery Record Formats..... 6
 - Ambulatory Surgery Data Record Layout 7
 - Description of Ambulatory Surgery Data Elements..... 9
- Chapter 2 – Emergency Room Data Requirements 28
 - Emergency Data Record Formats 28
 - Emergency Data Record Layouts 30
 - Description of Emergency Data Elements 37
 - Patient’s Header Record – Record Type 1 37

Patient’s Revenue Record – Record Type 2	53
Patient’s Trailing Record – Record Type 3	66
Chapter 3 – Inpatient Data Requirements	94
Inpatient Record Formats	94
Inpatient Data Record Layouts	96
Description of Inpatient Data Elements.....	102
Patient’s Header Record – Record Type 1	102
Patient’s Revenue Record – Record Type 2	117
Patient’s Trailing Record – Record Type 3	130
Appendix	158
Revenue Codes and Units of Service.....	158

List of Tables

Table 1. Submission Schedule.....	3
Table 1.1 Ambulatory Surgery Data Record Layout.....	7
Table 2.1 Emergency Data Header Record Layout – Record Type 1.....	30
Table 2.2 Emergency Data Revenue Record Layout – Record Type 2	31
Table 2.3 Emergency Data Trailing Record Layout – Record Type 3	35
Table 3.1 Inpatient Data Header Record Layout – Record Type 1.....	96
Table 3.2 Inpatient Data Revenue Record Layout – Record Type 2.....	97
Table 3.3 Inpatient Data Trailing Record Layout – Record Type 3.....	100

Introduction and General Guidelines

Effective Dates

This document is effective for inpatient encounters beginning January 1, 2015 and for emergency room and ambulatory surgery encounters beginning October 1, 2015 and supersedes prior guides and manuals.

Authority

Administrative rules R426 and R428 give authority to the Utah Department of Health to collect data on healthcare facility encounters. Healthcare facilities are required to submit data to the Office of Health Care Statistics (OHCS) as described in this document.

Purpose of This Guide

This document defines the types of encounters and data elements that must be reported, specifies the technical requirements for data submission, and outlines the edits to which the data elements may be subjected.

Administrative Rules

General requirements that relate to submission of healthcare facility data can be found in rule R428. An electronic copy of the current version is available upon request from OHCS. Data suppliers are especially encouraged to become familiar with the following sections:

- R428-2-3 Definitions
- R428-2-4 Technical Assistance
- R428-2-6 Editing and Validation
- R428-2-8 Data Disclosure
- R428-2-9 Penalties
- R428-2-10 Exemptions and Extensions
- R428-2-11 Contractor Liability (Use of data intermediaries)
- R428-2-12 Data Supplier Contacts

As used in this document, “encounter” means an inpatient hospital stay, outpatient surgical or diagnostic treatment, or treatment in an emergency room.

Multiple Discharges or Billing Claims

For a patient with multiple discharges, each healthcare facility shall submit a single data record for each discharge.

For a patient with multiple billing claims, each healthcare facility shall consolidate the multiple billings into a single data record for submission after the patient’s discharge.

Social Security Numbers

Each healthcare facility shall collect patient social security number as a required data element and report the patient social security number with the complete healthcare facility data record according to the submission schedule. OHCS has adopted an encryption method for the patient social security number that creates an encrypted control number for linking records.

Required Data Sources and Types

Ambulatory Surgery Data

Healthcare facilities are the source for ambulatory surgery data.

Healthcare facilities shall report ambulatory surgery data records for each outpatient surgical or diagnostic patient treated at its facility. Covered encounters for ambulatory surgery data include surgical and diagnostic procedures that occur in

- Hospital outpatient departments,
- Hospital-affiliated ambulatory surgery centers, and
- Freestanding ambulatory surgery centers.

Surgical procedures performed as emergency treatment to those ill and injured persons who require immediate **unscheduled** surgical care (identified by revenue codes 450-459) are not required to be reported.

Encounters in the following Current Procedural Terminology (CPT-4) surgical procedure code ranges are to be reported as ambulatory surgery data if performed in an operating or procedure room.

DESCRIPTION	CPT- 4 CODE RANGE
Mastectomy¹	19000-19499
Musculoskeletal	20000-29999
Respiratory	30000-32999
Cardiovascular, Mediastinum²	33010-37799 39000-39499 93501-93660
Lymphatic/Hematic	38100-38999
Diaphragm	39501-39599
Digestive System³	40490-49999
Urinary	50010-53899
Male Genital	54000-55899
Female Reproductive	56405-59899
Endocrine/Nervous	60000-64999
Eye	65091-68899
Ear	69000-69979

¹The Mastectomy range has been corrected. This range applies to all data submitted after January 1, 2016 regardless of the date of service.

²The Blood Draw related CPT-4 codes 36000, 36415 and 36600 are to be excluded.

³The HCPCs Level II colorectal cancer screening colonoscopy codes G0104, G0105, G0106, G0120 and G0121 are added to the list for the Digestive System procedures and are required to be reported.

Encounters are to be reported whether or not they were the principal procedure. Any other procedures performed at the same time as the reportable encounters must also be included.

The Ambulatory Surgery Data Record Layout in Chapter 1 (Table 1.1) lists the required ambulatory surgery data elements.

Emergency Room Data

Licensed hospitals and freestanding emergency rooms are the source for emergency room data.

All hospitals shall report emergency room data for all emergency department patient records that indicate the patient was treated in the emergency department.

All records that have a value of “131,” “831,” or “851” in the Type of Bill field and a value in the range 450-459 in at least one of the Revenue Code fields shall be submitted.

The Emergency Data Record Layouts in Chapter 2 (Tables 2.1, 2.2, and 2.3) list the required emergency room data elements.

Inpatient Discharge Data

Licensed hospitals are the source for inpatient discharge data. This includes all types of licensed hospitals.

All hospitals shall report healthcare facility data for each inpatient discharged from its facility.

The Inpatient Data Record Layouts in Chapter 3 (Tables 3.1, 3.2, and 3.3) list the required hospital inpatient discharge data elements.

Data Submission Schedule

The deadline for submitting healthcare facility data is specified in Table 1.

The data to be submitted are based on discharges 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 but should be included with quarterly data when the patient is discharged.

Table 1. Submission Schedule

Person’s Date of Discharge is Between	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

Secure Transfer Methods

Each healthcare facility shall submit healthcare facility data by a secure transmission method or secure e-mail method acceptable to OHCS. OHCS prefers submission of encrypted files by secure e-mail. Encryption programs suggested for use include 7-zip, gpg4win, or PGP.

The Director of OHCS may approve an alternate submission method as long as it meets the needs of the committee. Alternate transfer methods must be approved before the scheduled due date.

Data transfers not in compliance with these specifications will be rejected and must be resubmitted by the scheduled due date by a method that complies with these standards.

File Descriptions Required

For each submission, the healthcare facility shall supply the following descriptive information:

1. Name of data supplier
2. Date of submission as MM/DD/YY
3. Beginning and ending dates of the calendar quarter contained in the transferred file. For example: 4/1/16 - 6/30/16.
4. The total number of records contained in the file.
5. An unduplicated count of the Patients contained in the file.
6. The name, e-mail and telephone number of a contact person for problem solving.

If the file is submitted by e-mail, the descriptive information shall be included in the body of the e-mail. If the file is submitted by another secure transfer method, the descriptive information shall be sent by e-mail to OHCS.

The e-mail address for submitting data is facilitydatasubmission@utah.gov

Questions about this document or requirements should be sent to healthcarestat@utah.gov

The totals indicated must balance with the detail count obtained when processed. If the counts do not agree, the submission may be rejected.

Traditionally, the most common reasons for submission rejection have been:

- total counts do not correspond with the reported totals
- data elements do not conform to edit specifications
- inappropriate or insecure submission of data files

Data Quality Assurance

Review Prior to Submission

In addition to the requirements of R428-2-6, healthcare facilities shall review healthcare facility data files prior to submission to ensure compliance with the requirements of this document.

Edit Checks and Error Corrections

For healthcare facility data, OHCS will perform edit checks for each patient record. The edit checks may identify erroneous or questionable items that require correction or verification by facilities. These edit checks generally consist of checking for agreement with the data requirements, missing items, invalid codes, or items that are inconsistent with other items on the same record. A list of errors or questionable data items discovered will be provided to facilities.

OHCS may also use clinical code editing software to identify records with a high probability of error. Healthcare facilities shall review any identified records from this process and provide comment and correction when applicable.

R428-2-6 gives the requirements for making corrections.

Reporting Review and Validation

OHCS may construct a statistical profile and other tabulations of each facility's submitted and corrected data. This information will be sent to the submitting facility for review, comment, and correction prior to public release. Facilities will review only raw data tabulations of the data they submitted.

R428-2-8(2) and R428-2-8(3) specify the process for healthcare facilities to review and respond to these tabulations.

Final Database

At least once a year and after appropriate reviews, OHCS will create a final database containing all healthcare facility data. The data may be used or released for use within the guidelines provided by the administrative rules governing OHCS operations.

Error Rates

After collection of each full calendar year of data OHCS may calculate the number of records failing any edit checks. OHCS may also calculate the non-reporting rates for any data element. 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 each facility's past rate and a new standard rate for:

1. non-reporting,
2. conformity to the definitions and edit criteria, and
3. clinical code edit errors classified as "true" errors and "highly probable" errors and a new standard rate for improvement.

Chapter 1 - Ambulatory Surgery Data Requirements

Ambulatory Surgery Record Formats

The form of the data submitted to OHCS is intended to minimize the reporting burden.

There is a single record format for each ambulatory surgery encounter. Each encounter should be represented by one and only one record.

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

Number	This is the element number used in the record layout and description.
UB-04 Form	This code indicates the where the corresponding information can be found on the UB-04 Form.
HCFA 1500	This code indicates the where the corresponding information can be found on the HCFA 1500 Form.
Position	The number(s) in this column indicates the starting and ending position of the field in the record.
Width	The number in this column indicates the fixed width of the field.
Description	This includes a name and/or brief description of the element.
Justified	Sometimes the information required is shorter than the field width. This field indicates whether the information should be placed at the end of the field and padded with leading spaces (Right Justified) or whether the information should be placed at the beginning of the field and padded with trailing spaces (Left Justified).

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. Facilities using data sources other than uniform billing should evaluate definitions for agreement with the definitions specified in this document.

Ambulatory Surgery Data Record Layout

The expected Record Length is 354.

Table 1.1 Ambulatory Surgery Data Record Layout

Number	UB-04 Form	HCFA 1500	Position	Width	Description	Justified
AS01	5	25			<u>Facility Identification #</u>	Left
			01-10	10	Federal Tax ID #	
			11-13	3	Federal Tax Sub-ID #	
AS02	3A	26	14-30	17	Patient Control Number (Optional)	Right
AS03	3B	26	31-47	17	Patient Medical Record Number	Right
AS04	60	1A	48-56	9	Patient Social Security Number	Left
AS05	9E	5	57-61	5	Patient ZIP Code	Right
AS06	10	3	62-69	8	Patient Birth Date (date form MMDDCCYY) (Zero fill MM & DD. Valid date.)	Right
AS07	11	3	70	1	Patient Gender (values 'M' or 'F')	N/A
AS08	12	18	71-76	6	Admission Date (date form MMDDYY)	Right
AS09	15		77	1	Point of Origin for Admission or Visit (Values '1' thru '9', 'A' thru 'F' - See Section 2 for code definition)	Right
AS10	17		78-79	2	Patient's Discharge Status	Right
AS11	6	18	80-85	6	Discharge Date (date form MMDDYY)	Right
AS12			86	1	Diagnosis Version Qualifier	Left
AS13	67	21(1)	87-93	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS14	67A	21(2)	94-100	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS15	67B	21(3)	101-107	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS16	67C	21(4)	108-114	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS17	67D	21(5)	115-121	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS18	67E	21(6)	122-128	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS19	67F	21(7)	129-135	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS20	67G	21(8)	136-142	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS21	67H	21(9)	143-149	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
AS22		24D(1)	150-158	9	CPT-4 With Modifiers 1 st or Principle Procedure Code	Left
AS23		24D(2)	159-167	9	Other CPT-4 Procedure Codes	Left
AS24		24D(3)	168-176	9	Other CPT-4 Procedure Codes	Left
AS25		24D(4)	177-185	9	Other CPT-4 Procedure Codes	Left

CHAPTER 1 – Ambulatory Surgery Data Requirements

Number	UB-04 Form	HCFA 1500	Position	Width	Description	Justified
AS26		24D(5)	186-194	9	Other CPT-4 Procedure Codes	Left
AS27		24D(6)	195-203	9	Other CPT-4 Procedure Codes	Left
AS28		24A(1)	204-209	6	Date of CPT-4 or Principal Procedure (Date form MMDDYY. Zero fill MM & DD) (Valid Date)	Right
AS29			210	1	Procedure Coding Method Used (See Section 2 for codes)	N/A
AS30	6	18	211-216	6	Beginning date (MMDDYY)	Right
			217-222	6	Through date (MMDDYY)	Right
AS31	47	28	223-231	9	Total Charges (In the form DDDDDDDCC With no decimal point) D = Dollars / C = Cents	Right
AS32	50A	11c	232-256	25	Primary Payer	Left
AS33	50B	9d	257-281	25	Secondary Payer	Left
AS34	50C		282-306	25	Tertiary Payer	Left
AS35	76	24j	307-318	12	Attending Physician ID (Valid Physician ID)	
AS36	77		319-330	12	Operating Physician ID (Valid Physician ID)	
AS37	4		331-333	3	Type of Bill	
AS38			334-340	7	Patient's Reason for Visit 1	Left
AS39			341-347	7	Patient's Reason for Visit 2	Left
AS40			348-354	7	Patient's Reason for Visit 3	Left

Description of Ambulatory Surgery Data Elements

Number	Description	Position	Width
AS1	Facility Identification Number	1-13	13
	Federal Tax ID#	1-10	10
	Federal Tax Sub-ID#	11-13	3
Definition:	A number that uniquely identifies the facility. The identifier used is the Federal Tax Number or the Federal Tax Number plus the Federal Tax Sub-ID Number. The use of the second component is a facility option. (<i>UB-04 Item Number 5; HCFA-1500 Item Number 25</i>).		
Notes:	This field is left justified with a width of 13 - 10 for the Federal Tax Number and 3 for the Federal Tax Sub-ID Number. The tax number is generally of the form "12-1234567." Whether the Sub-ID Number is used is a facility option. Parent corporations that operate more than one facility or at more than one location will need to use a separate Sub-ID Number or three digit text identification for each facility.		
Edit Check:	This element must be present and valid.		
AS2	Patient Control Number	14-30	17
Definition:	The patient's unique number assigned by the facility to facilitate retrieval of individual case records. (<i>UB-04 Item Number 3A; HCFA-1500 Item Number 26</i>).		
Notes:	The Patient Control Number may be any length up to a maximum of 17 characters. This element is required <u>if</u> the facility needs it to retrieve billing records or medical reports. The field should be right justified.		
Edit Check:	The element must be present for those facilities that indicate they need it to retrieve information for data corrections.		
AS3	Patient Medical Record Number	31-47	17
Definition:	A number that uniquely identifies a patient in a way that allows information to be tracked back to the medical chart. (<i>UB-04 Item Number 3B; HCFA-1500 Item Number 26</i>).		
Notes:	This field is right justified with a length of up to 17 characters.		
Edit Check:	This element must be present.		

Number	Description	Position	Width
AS4	Patient Social Security Number	48-56	9
Definition:	The social security number of the patient receiving care. (HCFA-1500 Box 1A) (UHIN Standard #2). Insured's ID Number. (UB-04 Item Number 60).		
Notes:	This field is to be left justified with spaces to the right to complete the field. The format of The SSN is 123456789 without hyphens. If a patient does not have a social security number, use the following codes: 200 for a patient who has no SSN, 300 for a patient who chooses not to provide his/her SSN.		
Edit Check:	The field is edited for a valid entry.		
AS5	Patient Zip Code	57-61	5
Definition:	The zip code of the patient's residence as given on the billing form. (<i>UB-04 Item Number 9E; HCFA-1500 Item Number 5</i>).		
Notes:	<ol style="list-style-type: none"> 1. This element has a field width of five. 2. <u>Residence</u> zip code must be recorded for each patient. 3. In the case of nine-digit zip codes, only the first five digits should be reported. 4. For persons giving a residence outside the United States, the field should be zero filled. 5. For unknown zip codes(e.g., homeless patients) the field should be left blank. 		
Edit Checks:	<ol style="list-style-type: none"> 1. A valid zip code must be present, unless it meets criteria #5 above 2. Zip codes in the range of 84001 through 84999 are validated against known Utah zip codes. 		

Number	Description	Position	Width
AS6	Patient Birth Date	62-69	8
Definition:	Identifies the month, day and year of the patient’s birth. (UB-04 Item Number 10; HCFA-1500 Item Number 3).		
Notes:	<ol style="list-style-type: none"> 1. This is an eight-digit code. It has the Form MMDDCCYY (Month, Day, Century, Year). 2. Month is recorded as a two-digit code ranging from 01 through 12. 3. Day of birth is recorded as a two-digit code ranging from 01 through 31. 4. Year and century of birth is recorded as a four-digit code. If only an age is known, estimate the year of birth. 5. Month and Day should be right justified within its two digits. Any unused space to the left should be zero filled. Example: February 7, 1901 would be recorded as 02071901. 		
Edit Checks:	<ol style="list-style-type: none"> 1. Date of birth must be present and valid. 2. Date of birth cannot be after the procedure date. 3. The age of the patient is checked for consistency with diagnostic codes. Consistency between age and diagnostic codes is determined by the annotations to the ICD-9-CM or ICD-10-CM codes 		
AS7	Patient Gender	70	1
Definition:	The patient’s gender (UB-04 Item Number 11; HCFA-1500 Item Number 3).		
Notes:	<ol style="list-style-type: none"> 1. This is a one-character code. Gender is to be recorded as male, female, or unknown. 2. Patient gender is coded as follows: <ul style="list-style-type: none"> M = Male F = Female U = Unknown 3. Whenever the diagnosis or procedure is gender-specific, the gender code must be consistent with the ICD-9-CM codes indicated. 		
Edit Checks:	<ol style="list-style-type: none"> 1. A valid code (‘M,’ ‘F’ or ‘U’) must be present. 2. The gender of the patient is checked for consistency with diagnosis and procedure codes. Consistency between gender and the indicated codes is determined by the annotations to the ICD-9-CM or ICD-10-CM codes. 		

Number	Description	Position	Width
AS8	Admission Date	71-76	6
Definition:	The date the patient was admitted to the facility for outpatient surgery (<i>UB-04 Item Number 12; HCFA-1500 Item Number 18</i>).		
Notes:	The admission date is to be entered as six digits as month, day, and year. The format is MMDDYY. The month is recorded as two digits ranging from 01 through 12. The day is recorded as two digits ranging from 01 through 31. The year is recorded as two digits ranging from 00 through 99. Each of the three components (month, day, year) must be right justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 2008 is entered as 020708.		
Edit Check:	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” field.		

Number	Description	Position	Width
AS9	Point of Origin for Admission or Visit	77	1
Definition:	A code indicating the point of origin for admission or visit (<i>UB-04 Item Number 15</i>).		
Notes:	This is a single digit code describing the source from which the patient was referred.		
	Point of Origin for Admission or Visit codes 1 through 9 or A through F are valid. The code structure is as follows:		
	1 = Physician Referral		
	The patient was admitted to this facility upon the recommendation of his or her personal physician. (See code 3 if the physician has an HMO affiliation.)		
	2 = Clinic Referral		
	The patient was admitted to this facility upon recommendation of this facility's clinic physician.		
	3 = HMO Referral		
	The patient was admitted to this facility upon the recommendation of a health maintenance organization (HMO) physician.		
	4 = Transfer from a Hospital		
	The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.		
	5 = Transfer from a Skilled Nursing Facility		
	The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.		
	6 = Transfer from Another Healthcare facility		
	The patient was admitted to this facility as a transfer from a healthcare facility other than an acute care facility or skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.		
	7 = Emergency Room		
	The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.		
	8 = Court/Law Enforcement		
	The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.		
	9 = Information Not Available		
	The means by which the patient was admitted to this hospital is not known.		
	A = Transfer from a Critical Access Facility		
	B = Transfer from another HHA Facility		
	C = Readmission to same HHA		
	D = Transfer from Hospital Inpatient in Same Facility		
	E = Transfer from Ambulatory Surgery Center		

Number	Description	Position	Width
	F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program		
Edit Check:	The code must be present and valid.		

Number	Description	Position	Width
AS10	Patient's Discharge Status	78-79	2
Definition:	A code indicating patient status as of the statement covers through date. Generally, indicates the arrangement or event ending a patient's stay in the hospital (<i>UB-04 Item Number 17</i>).		
Notes:	This is a code with a width of two digits. The patient's status is coded as follows:		
	01 = Discharge to home or self care, routine discharge.		
	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 = Discharged/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 the database)		
	40 = Expired at home		
	41 = Expired in a medical facility (e.g., hospital, ASC).		
	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 part 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		
	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/referred to this institution for outpatient services (as per plan of care)		

Number	Description	Position	Width
	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)		
	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 healthcare 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)		
	Blank = Not Reported		

Edit Check: The patient status code must be present and a valid code as defined.

AS11	Discharge Date	80-85	6
------	----------------	-------	---

Definition: The ending date of procedure/service must be present and recorded in six digit format of month day year (MMDDYY) (*UB-04 Item Number 6; HCFA-1500 Item Number 18*).

Number	Description	Position	Width
AS12	Diagnosis Version Qualifier	86	1
Definition:	Indicator to designate which version of ICD was used to report diagnosis codes.		
Notes:	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 Check:	Must be present and valid.		
AS13	Principal Diagnosis Code	87-93	7
Definition:	The condition established, after study, to be chiefly responsible for causing the treatment of the patient (<i>UB-04 Item Number 67; HCFA-1500 Item Number 21-1</i>).		
Notes:	<p>1. Enter the appropriate code that describes the principal diagnosis of the patient. Enter code left justified without decimals. This field is never right filled with zeros.</p> <p>2. Diagnoses are coded according to the International Classification of Diseases, 9th or 10th Revision, Clinical Modification (ICD-9-CM or ICD-10-CM).</p> <p>3. In the ICD-9-CM there are three-digit, four-digit, and five-digit codes. Use of the fourth or fifth digit is <u>not</u> optional. If they are present in the ICD-9-CM, they must be used or the code will be rejected as invalid.</p> <p>4. This element has a field width of 7.</p>		
Edit Checks:	<p>1. A principal diagnosis must be present and valid.</p> <p>2. Whenever the principal diagnosis is gender-specific, the patient gender must be consistent with the ICD-9-CM or ICD-10-CM code. Consistency is determined by the annotations to the ICD-9-CM or ICD-10-CM code.</p> <p>3. Whenever the principal diagnosis is age-specific, the patient age must be consistent with the ICD-9-CM or ICD-10-CM code. Consistency is determined by the annotations to the ICD-9-CM code or ICD-10-CM.</p> <p>4. These fields are never right-filled with zeros</p> <p>5. Screening will be conducted for codes that are not usually used as principal diagnoses. This will be determined by the Medicare Code Edits annotations to the ICD-9-CM or ICD-10-CM code. OHCS should be notified of known, valid exceptions to the Medicare Edits so that unnecessary edit listings will not be sent to the facility for review.</p>		

Number	Description	Position	Width
AS14-AS21	Other Diagnosis Codes		
	AS14	94-100	7
	AS15	101-107	7
	AS16	108-114	7
	AS17	115-121	7
	AS18	122-128	7
	AS19	129-135	7
	AS20	136-142	7
	AS21	143-149	7

Definition: Other diagnoses must be reported only if the diagnoses contribute to the substantiation of total charges. Up to eight other diagnoses can be reported (*UB-04 Item Numbers 67A through 67H; HCFA-1500 Item Numbers 21-2 through 21-6*).

Notes:

1. Enter the appropriate codes that describe the other diagnoses of the patient. Enter codes left justified and without decimals. These fields are never right filled with zeros.
2. *For the UB-04 form*, in the ICD-9-CM there are three-digit, four-digit, and five-digit codes. **Use of the fourth or fifth digit is not optional.** If they are present in the ICD-9-CM, they must be used or the code will be rejected as invalid.
3. These elements each have a field width of 7.

Edit Checks:

1. If other diagnoses are gender-specific, the patient gender must be consistent with the ICD-9-CM or ICD-10-CM. Consistency is determined by the annotations to the ICD-9-CM or ICD-10-CM codes.
2. If other diagnoses are age-specific, the patient age must be consistent with the ICD-9-CM. Consistency is determined by the annotations to the ICD-9-CM or ICD-10-CM codes.
3. Other diagnoses must be valid ICD-9-CM or ICD-10-CM codes.

Number	Description	Position	Width
AS22	CPT-4 with Modifiers 1 st or Principle Procedure Code	150-158	9
Definition:	The Current Procedural Terminology CPT-4 code or principal procedure code is a procedure that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. The principal procedure is usually that procedure most related to the principal diagnosis (<i>HCFA-1500 Item Number 24D(1)</i>).		
Notes:	<p>1. Enter the appropriate code that describes the principal procedure performed. Enter codes left justified without decimals. This field is never right filled with zeros. This element has a field width of 9. The CPT-4 code occupies the first 5 digits and modifiers occupy the last 4 digits, depending on the number of modifiers.</p> <p>2. The HCFA-1500 procedures are coded according to CPT-4. This coding book is revised annually.</p> <p>3. When more than one procedure is reported, the 1st or principle procedure must be designated. In determining which of several procedures is the principal procedure, the following criteria apply:</p> <ul style="list-style-type: none"> a. The 1st or principal procedure is one that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or was necessary to take care of a complication. b. The principal procedure is that procedure most related to the principal diagnosis. <p>4. This data element must be present if other procedures are reported.</p> <p>5. Whenever the principal procedure is gender-specific, the gender that is coded must be consistent with the CPT-4 code indicated.</p> <p>6. For the HCFA-1500, CPT-4 codes are five digits in length with up to two modifiers for each CPT-4 code. Each modifier has two digits with no dashes.</p>		
Edit Checks:	<p>1. The principal procedure code, if gender-specific, must be consistent with the gender of the patient. Gender specific CPT-4 codes (54000-55899, 76870, 76872 for males and 56000-59899, 74710-76949 for females) are checked for consistency.</p> <p>2. The principal procedure must be a valid CPT-4 code.</p> <p>3. Starting with 2005, the Blood Draw related CPT-4 codes 36000, 36415 and 36600 were removed from the inclusion criteria and are not considered Cardiovascular procedures. In addition, the HCPCS Level II Colorectal cancer screening colonoscopy codes G0104, G0105, G0106, G0120 and G0121 were added to the list for the Digestive System procedures and are retained in the database if reported.</p>		

Number	Description	Position	Width
AS23-AS27	Other CPT-4 Procedure Codes		
	AS23	159-167	9
	AS24	168-176	9
	AS25	177-185	9
	AS26	186-194	9
	AS27	195-203	9
Definition:	Additional procedures performed during the principal operative episode which may include diagnostic or exploratory procedures. Up to five other procedures can be reported (<i>HCFA-1500 Item Number 24D(2) though (6)</i>).		
Notes:	<ol style="list-style-type: none"> 1. Enter the appropriate code that describes the other procedures performed. Enter codes left justified without decimals. These fields are never right filled with zeros. These elements have a field width of 9. The CPT-4 code occupies the first 5 digits and modifiers occupy the last 4 digits, depending on the number of modifiers. 2. If more than one procedure is reported, the 1st procedure cannot be blank. 3. Whenever the other procedure is gender-specific, the gender that is coded must be consistent with the CPT-4 code indicated. 4. For the HCFA-1500, CPT-4 codes are five digits in length with up to two modifiers for each CPT-4 code. Each modifier has two digits with no dashes. 		
Edit Checks:	<ol style="list-style-type: none"> 1. Other procedure codes, if gender-specific, must be consistent with the gender of the patient. Gender specific CPT-4 codes (54000-55899, 76870, 76872 for males and 56000-59899, 74710-76949 for females) are checked for consistency. 2. Other procedure codes must be a valid CPT-4 code. 		

Number	Description	Position	Width
AS28	Date of CPT-4 1 st or Principle Procedure	204-209	6
Definition:	The principal procedure date is the year, month and day the principal procedure was performed for the corresponding definitive treatment (<i>HCFA-1500 Item Number 24A(1)</i>).		
Notes:	<ol style="list-style-type: none"> 1. Principal procedure date is a six-digit code. It has the form MMDDYY (Month, Day, Year). 2. Month is recorded as a two-digit code ranging from 01 through 12. 3. Day of procedure is recorded as a two-digit code ranging from 01 through 31. 4. Year of procedure is recorded as a two-digit code ranging from 00 through 99. 5. Each of the three components (Month, Day and Year) should be right justified within its two digits. Any unused space to the left should be zero filled. Example: February 7, 1994 would be recorded as 020794. 		
Edit Checks:	<ol style="list-style-type: none"> 1. Procedure date cannot be before birth date. 2. Procedure date must fall in the three-month range of each data submission quarter. 		
AS29	Procedure Coding Method Used	210	1
Definition:	An indicator that identifies the coding method used for procedure coding.		
Notes:	The default value should be number 4 for CPT-4. If coding method is <u>NOT</u> CPT-4 enter appropriate code from the list: <ol style="list-style-type: none"> 3 = DSM-III-R 4 = CPT-4 5 = HCPCS (HCFA Common Procedure Coding System) 9 = ICD-9-CM 0 = ICD-10-PCS 		
Edit Check:	This field must be consistent with the coding method used to code procedures.		

Number	Description	Position	Width
AS30	Statement Covers Period	211-222	12
	Beginning Date	211-216	6
	Through Date	217-222	6
Definition:	The beginning and ending service dates of the patient's care. The ending date is the discharge date (UB-04 Item Number 6; HCFA-1500 Item Number 18).		
Notes:	<ol style="list-style-type: none"> 1. 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. 2. The months are recorded as two digits ranging from 01 through 12. 3. The days are recorded as two digits ranging from 01 through 31. 4. 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. 5. Any unused space to the left must be zero filled. For example February 7, 2002 through March 1, 2002 is entered as 020702030102. 		
Edit Check:	These dates must be present and be valid.		
AS31	Total Charges	223-231	9
Definition:	Enter total charges for services (total of all charges). Right justified. In the form DDDDDDDCC with no decimal. (UB-04 Item Number 47; HCFA-1500 Item Number 28).		
AS32	Primary Payer Identification	232-256	25
Definition:	Name and, if required by payer, a number identifying the primary payer organization from which the facility might expect some payment for the bill. (UB-04 Item Number 50A; HCFA-1500 Item Number 11c).		
Notes:	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 uniquely identify the organization.		
Edit Check:	The name must be that of a verifiable organization.		

Number	Description	Position	Width
AS33	Secondary Payer Identification	257-281	25
Definition:	Name and, if required by payer, a number identifying the secondary payer organization from which the facility might expect some payment for the bill. (<i>UB-04 Item Number 50B; HCFA-1500 Item Number 9d</i>).		
Notes:	This field is to contain the complete name of the secondary payer organization, if applicable. The name should be spelled out completely when space allows. If a name has more than 25 characters, use abbreviations that uniquely identify the organization.		
Edit Check:	The name must be that of a verifiable organization.		
AS34	Third Payer Identification	282-306	25
Definition:	Name and, if required by payer, a number identifying the tertiary payer organization from which the facility might expect some payment for the bill. (<i>UB-04 Item Number 50C</i>).		
Notes:	This field is to contain the complete name of the tertiary payer organization, if applicable. The name should be spelled out completely when space allows. If a name has more than 25 characters, use abbreviations that uniquely identify the organization.		
Edit Check:	The name must be that of a verifiable organization		

Number	Description	Position	Width
AS35	Attending Physician Id	307-318	12
Definition:	The National Provider ID or Utah Medical License Number of the physician who performed the principal procedure listed on the claim. Only doctors of medicine and doctors of osteopathy are considered physicians. (<i>UB-04 Item Number 76; HCFA-1500 Item Number 24j</i>).		
Notes:	<ol style="list-style-type: none"> 1. The National Provider ID or Utah Medical License Number of the physician who performed the principal procedure listed on the claim. 2. Only the license number should be reported, not the name. 3. Prefixes to the license number (such as T, LT, etc.) must be included. 4. Only the license number of physicians should be reported. 5. If primary responsibility for the patient is in the hands of a non-physician care giver, this field should be blank filled. Examples can include dentist, psychologist, nurse midwife, podiatrist and chiropractor. 6. This element has a field width of 12. 		
Edit Check:	This element must be present and valid.		

Number	Description	Position	Width
AS36	Operating Physician ID	319-330	12
Definition:	The National Provider ID or Utah Medical License number of the operating physician who performed the principal procedure listed on the claim. Only doctors of medicine and doctors of osteopathy are considered physicians (<i>UB-04 Item Number 77</i>).		
Notes:	<ol style="list-style-type: none"> 1. The National Provider ID or Utah Medical License Number of the operating physician who performed the principal procedure listed on the claim. 2. Only the license number should be reported, not the name. 3. Prefixes to the license number (such as T, LT, etc.) must be included. 4. Only the license number of physicians should be reported. 5. If primary responsibility for the patient is in the hands of a non-physician care giver, this field should be zero filled. Examples can include dentist, psychologist, nurse midwife, podiatrist and chiropractor. 6. This element has a field width of 12. 		
Edit Check:	This element must be present and valid.		
AS37	Type of Bill	331-333	3
Definition:	This element is indicative of the type of patient (<i>UB-04 Item Number 4</i>).		
Notes:	This is a three-digit field and is used to separate inpatient from ambulatory surgery records when both patient types are submitted together. This field should always be coded as “131,” “831,” “851” or “999” for ambulatory surgeries.		
Edit Check:	Only bill types “131,” “831,” “851” or “999” should appear on ambulatory records.		

Number	Description	Position	Width
AS38	Patient's Reason for Visit 1	334-340	7
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.		
Notes:	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 width.		
Edit Check:	If patient's reason for visit is present it must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.		
AS39	Patient's Reason for Visit 2	341-347	7
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.		
Notes:	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 width.		
Edit Check:	If patient's reason for visit is present it must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.		

Number	Description	Position	Width
AS40	Patient's Reason for Visit 3	348-354	7
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.		
Notes:	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 width.		
Edit Check:	If patient's reason for visit is present it must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.		

Chapter 2 – Emergency Room Data Requirements

Emergency Data Record Formats

The form of the data submitted to OHCS is intended to minimize the reporting burden.

Three record formats are required for each emergency room encounter. All three formats must be written to the file in sequence 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 record types are defined as:

1. Patient’s header record: The “Record type” field of this record must be set to “1” to indicate 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 and will contain the reportable revenue information for the patient’s care. The “Record type” field must be set to “2” to indicate the patient’s revenue record is being processed.
Each revenue record accommodates from 1 to 23 revenue services. If a patient has more than 23 revenue services, multiple revenue records should be written until all revenue services have been included. 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 the patient’s record has ended. The “Record type” field must be set to “3” for this record. There must be one and only one type “3” record per discharge.

The column headings used in the Data Records Layout and Description sections are as follows:

Number	This is the element number used in the record layout and description.
Level	Indicates the level of requirement for collection and reporting 1 = Facilities shall collect and report these data elements 2 = Facilities shall report these data elements if the data is included in the patient record
Field Name	This the element name used in the record layout and descriptions. The name “filler” is used to indicate areas in the record that may contain information but will not be processed by computer programs.
Class	The letter in this column indicates the field’s attribute A = Alphanumeric N = Numeric

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

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. Facilities using data sources other than uniform billing should evaluate definitions for agreement with the definitions specified in this document.

Emergency Data Record Layouts

The expected Record Length is 976. Space filler can be used to equalize the record length for each record type. For example, the header record (type 1) uses only 355 characters. Space filler can be added to the end of the record until position 976 is reached.

Table 2.1 Emergency Data Header Record Layout – Record Type 1

Number	Level	Field Name	Class	Width	Position
ER001	1	Unique patient control number	N	9	1-9
ER002	1	Record type	N	1	10-10
ER101	1	Encounter Type	A	5	11-15
ER102	1	Provider identifier (Hospital)	A	100	16-115
ER103	1	Patient social security number	A	13	116-128
ER104	1	Patient control number	A	20	129-148
ER105	1	Type of bill	A	4	149-152
ER106	1	Patient name	A	31	153-183
ER107	1	Patient's street address	A	43	184-226
ER108	1	Patient's city name	A	25	227-251
ER109	1	Patient's state or province	A	2	252-253
ER110	1	Patient's ZIP code	A	11	254-264
ER111	1	Patient's country code	A	3	265-267
ER112	1	Patient date of birth	N	8	268-275
ER113	1	Patient's gender	A	1	276-276
ER114	2	Patient's marital status	A	1	277-277
ER115	1	Date of admission	N	6	278-283
ER116	1	Admission Hour	N	4	284-287
ER117	1	Type of admission/ visit	N	1	288-288
ER118	1	Point of origin for admission or visit	A	1	289-289
ER119	1	Discharge Hour	N	4	290-293
ER120	1	Patient's discharge status	A	2	294-295
ER121	1	Statement covers period	N	12	296-307
ER122	1	Patient's medical record number	A	24	308-331
ER123	2	Patient's race	A/N	1	332-332
ER124	2	Condition codes (ER Admit, DNR, homeless)	A	22	333-354
ER125	2	Patient's ethnicity	A/N	1	355-355
ER126	2	Optional Filler	A/N	621	356-976

Table 2.2 Emergency Data Revenue Record Layout – Record Type 2

Number	Level	Field Name	Class	Width	Position
ER001	1	Unique patient control number	N	9	1-9
ER002	1	Record type	N	1	10-10
ER201A	1	Service line 1	N	6	11-16
ER201B	1	Revenue code 1	A	4	17-20
ER201C	1	HCPCS code including modifiers 1	A	14	21-34
ER201D	1	Unit or basis for measurement code 1	A	2	35-36
ER201E	1	Service units/days 1	N	7	37-43
ER201F	1	Total charges by revenue code 1	N	10	44-53
ER202A	1	Service line 2	N	6	54-59
ER202B	1	Revenue code 2	A	4	60-63
ER202C	1	HCPCS code including modifiers 2	A	14	64-77
ER202D	1	Unit or basis for measurement code 2	A	2	78-79
ER202E	1	Service units/days 2	N	7	80-86
ER202F	1	Total charges by revenue code 2	N	10	87-96
ER203A	1	Service line 3	N	6	97-102
ER203B	1	Revenue code 3	A	4	103-106
ER203C	1	HCPCS code including modifiers 3	A	14	107-120
ER203D	1	Unit or basis for measurement code 3	A	2	121-122
ER203E	1	Service units/days 3	N	7	123-129
ER203F	1	Total charges by revenue code 3	N	10	130-139
ER204A	1	Service line 4	N	6	140-145
ER204B	1	Revenue code 4	A	4	146-149
ER204C	1	HCPCS code including modifiers 4	A	14	150-163
ER204D	1	Unit or basis for measurement code 4	A	2	164-165
ER204D	1	Service units/days 4	N	7	166-172
ER204F	1	Total charges by revenue code 4	N	10	173-182
ER205A	1	Service line 5	N	6	183-188
ER205B	1	Revenue code 5	A	4	189-192
ER205C	1	HCPCS code including modifiers 5	A	14	193-206
ER205D	1	Unit or basis for measurement code 5	A	2	207-208
ER205E	1	Service units/days 5	N	7	209-215
ER205F	1	Total charges by revenue code 5	N	10	216-225
ER206A	1	Service line 6	N	6	226-231
ER206B	1	Revenue code 6	A	4	232-235
ER206C	1	HCPCS code including modifiers 6	A	14	236-249
ER206D	1	Unit or basis for measurement code 6	A	2	250-251
ER206E	1	Service units/days 6	N	7	252-258
ER206F	1	Total charges by revenue code 6	N	10	259-268
ER207A	1	Service line 7	N	6	269-274

CHAPTER 2 – Emergency Room Data Requirements

Number	Level	Field Name	Class	Width	Position
ER207B	1	Revenue code 7	A	4	275-278
ER207C	1	HCPCS code including modifiers 7	A	14	279-292
ER207D	1	Unit or basis for measurement code 7	A	2	293-294
ER207E	1	Service units/days 7	N	7	295-301
ER207F	1	Total charges by revenue code 7	N	10	302-311
ER208A	1	Service line 8	N	6	312-317
ER208B	1	Revenue code 8	A	4	318-321
ER208C	1	HCPCS code including modifiers 8	A	14	322-335
ER208D	1	Unit or basis for measurement code 8	A	2	336-337
ER208E	1	Service units/days 8	N	7	338-344
ER208F	1	Total charges by revenue code 8	N	10	345-354
ER209A	1	Service line 9	N	6	355-360
ER209B	1	Revenue code 9	A	4	361-364
ER209C	1	HCPCS code including modifiers 9	A	14	365-378
ER209D	1	Unit or basis for measurement code 9	A	2	379-380
ER209E	1	Service units/days 9	N	7	381-387
ER209F	1	Total charges by revenue code 9	N	10	388-397
ER210A	1	Service line 10	N	6	398-403
ER210B	1	Revenue code 10	A	4	404-407
ER210C	1	HCPCS code including modifiers 10	A	14	408-421
ER210D	1	Unit or basis for measurement code 10	A	2	422-423
ER210E	1	Service units/days 10	N	7	424-430
ER210F	1	Total charges by revenue code 10	N	10	431-440
ER211A	1	Service line 11	N	6	441-446
ER211B	1	Revenue code 11	A	4	447-450
ER211C	1	HCPCS code including modifiers 11	A	14	451-464
ER211D	1	Unit or basis for measurement code 11	A	2	465-466
ER211E	1	Service units/days 11	N	7	467-473
ER211F	1	Total charges by revenue code 11	N	10	474-483
ER212A	1	Service line 12	N	6	484-489
ER212B	1	Revenue code 12	A	4	490-493
ER212C	1	HCPCS code including modifiers 12	A	14	494-507
ER212D	1	Unit or basis for measurement code 12	A	2	508-509
ER212E	1	Service units/days 12	N	7	510-516
ER212F	1	Total charges by revenue code 12	N	10	517-526
ER213A	1	Service line 13	N	6	527-532
ER213B	1	Revenue code 13	A	4	533-536
ER213C	1	HCPCS code including modifiers 13	A	14	537-550
ER213D	1	Unit or basis for measurement code 13	A	2	551-552
ER213E	1	Service units/days 13	N	7	553-559

Number	Level	Field Name	Class	Width	Position
ER213F	1	Total charges by revenue code 13	N	10	560-569
ER214A	1	Service line 14	N	6	570-575
ER214B	1	Revenue code 14	A	4	576-579
ER214C	1	HCPCS code including modifiers 14	A	14	580-593
ER214D	1	Unit or basis for measurement code 14	A	2	594-595
ER214E	1	Service units/days 14	N	7	596-602
ER214F	1	Total charges by revenue code 14	N	10	603-612
ER215A	1	Service line 15	N	6	613-618
ER215B	1	Revenue code 15	A	4	619-622
ER215C	1	HCPCS code including modifiers 15	A	14	623-636
ER215D	1	Unit or basis for measurement code 15	A	2	637-638
ER215E	1	Service units/days 15	N	7	639-645
ER215F	1	Total charges by revenue code 15	N	10	646-655
ER216A	1	Service line 16	N	6	656-661
ER216B	1	Revenue code 16	A	4	662-665
ER216C	1	HCPCS code including modifiers 16	A	14	666-679
ER216D	1	Unit or basis for measurement code 16	A	2	680-681
ER216E	1	Service units/days 16	N	7	682-688
ER216F	1	Total charges by revenue code 16	N	10	689-698
ER217A	1	Service line 17	N	6	699-704
ER217B	1	Revenue code 17	A	4	705-708
ER217C	1	HCPCS code including modifiers 17	A	14	709-722
ER217D	1	Unit or basis for measurement code 17	A	2	723-724
ER217E	1	Service units/days 17	N	7	725-731
ER217F	1	Total charges by revenue code 17	N	10	732-741
ER218A	1	Service line 18	N	6	742-747
ER218B	1	Revenue code 18	A	4	748-751
ER218C	1	HCPCS code including modifiers 18	A	14	752-765
ER218D	1	Unit or basis for measurement code 18	A	2	766-767
ER218E	1	Service units/days 18	N	7	768-774
ER218F	1	Total charges by revenue code 18	N	10	775-784
ER219A	1	Service line 19	N	6	785-790
ER219B	1	Revenue code 19	A	4	791-794
ER219C	1	HCPCS code including modifiers 19	A	14	795-808
ER219D	1	Unit or basis for measurement code 19	A	2	809-810
ER219E	1	Service units/days 19	N	7	811-817
ER219F	1	Total charges by revenue code 19	N	10	818-827
ER220A	1	Service line 20	N	6	828-833
ER220B	1	Revenue code 20	A	4	834-837
ER220C	1	HCPCS code including modifiers 20	A	14	838-851

CHAPTER 2 – Emergency Room Data Requirements

Number	Level	Field Name	Class	Width	Position
ER220D	1	Unit or basis for measurement code 20	A	2	852-853
ER220E	1	Service units/days 20	N	7	854-860
ER220F	1	Total charges by revenue code 20	N	10	861-870
ER221A	1	Service line 21	N	6	871-876
ER221B	1	Revenue code 21	A	4	877-880
ER221C	1	HCPCS code including modifiers 21	A	14	881-894
ER221D	1	Unit or basis for measurement code 21	A	2	895-896
ER221E	1	Service units/days 21	N	7	897-903
ER221F	1	Total charges by revenue code 21	N	10	904-913
ER222A	1	Service line 22	N	6	914-919
ER222B	1	Revenue code 22	A	4	920-923
ER222C	1	HCPCS code including modifiers 22	A	14	924-937
ER222D	1	Unit or basis for measurement code 22	A	2	938-939
ER222E	1	Service units/days 22	N	7	940-946
ER222F	1	Total charges by revenue code 22	N	10	947-956
ER223A	1	Revenue code 23 (0001 if last page)	A	4	957-960
ER224	1	Page ___ of ___ 23	A	6	961-966
ER225	1	Total overall charges 23	N	10	967-976

Table 2.3 Emergency Data Trailing Record Layout – Record Type 3

Number	Level	Field Name	Class	Width	Position
ER001	1	Unique patient control number	N	9	1-9
ER002	1	Record type	N	1	10-10
ER301	1	Primary payer identification	A	25	11-35
ER302	2	Estimated amount due	N	10	36-45
ER303	2	Prior payment	N	10	46-55
ER304	1	Secondary payer identification	A	25	56-80
ER305	2	Estimated amount due	N	10	81-90
ER306	2	Prior payment	N	10	91-100
ER307	1	Tertiary payer identification	A	25	101-125
ER308	2	Estimated amount due	N	10	126-135
ER309	2	Prior payment	N	10	136-145
ER310	2	Insured's name - Primary	A	25	146-170
ER311	1	Patient's relationship - Primary	N	2	171-172
ER312	2	Insured's unique ID - Primary	A	20	173-192
ER313	2	Insured group name - Primary	A	20	193-212
ER314	2	Insured's name - Secondary	A	25	213-237
ER315	1	Patient's relationship - Secondary	N	2	238-239
ER316	2	Insured's unique ID – Secondary	A	20	240-259
ER317	2	Insured group name – Secondary	A	20	260-279
ER318	2	Insured's name – Tertiary	A	25	280-304
ER319	1	Patient's relationship – Tertiary	N	2	305-306
ER320	2	Insured's unique ID – Tertiary	A	20	307-326
ER321	2	Insured group name – Tertiary	A	20	327-346
ER322	2	Employer name – Primary	A	24	347-370
ER323	2	Employer name – Secondary	A	24	371-394
ER324	1	Diagnosis version qualifier	A	1	395-395
ER325	1	Principal diagnosis code with POA	A	8	396-403
ER326	1	Secondary diagnosis code with POA 1	A	8	404-411
ER327	1	Secondary diagnosis code with POA 2	A	8	412-419
ER328	1	Secondary diagnosis code with POA 3	A	8	420-427
ER329	1	Secondary diagnosis code with POA 4	A	8	428-435
ER330	1	Secondary diagnosis code with POA 5	A	8	436-443
ER331	1	Secondary diagnosis code with POA 6	A	8	444-451
ER332	1	Secondary diagnosis code with POA 7	A	8	452-459
ER333	1	Secondary diagnosis code with POA 8	A	8	460-467
ER334	1	Secondary diagnosis code with POA 9	A	8	468-475
ER335	1	Secondary diagnosis code with POA 10	A	8	476-483
ER336	1	Secondary diagnosis code with POA 11	A	8	484-491
ER337	1	Secondary diagnosis code with POA 12	A	8	492-499

Number	Level	Field Name	Class	Width	Position
ER338	1	Secondary diagnosis code with POA 13	A	8	500-507
ER339	1	Secondary diagnosis code with POA 14	A	8	508-515
ER340	1	Secondary diagnosis code with POA 15	A	8	516-523
ER341	1	Secondary diagnosis code with POA 16	A	8	524-531
ER342	1	Secondary diagnosis code with POA 17	A	8	532-539
ER343	2	Admitting diagnosis code	A	7	540-546
ER344	2	Patient's reason for visit 1	A	7	547-553
ER345	2	Patient's reason for visit 2	A	7	554-560
ER346	2	Patient's reason for visit 3	A	7	561-567
ER347	1	Ext cause of Inj code with POA 1	A	8	568-575
ER348	1	Ext cause of Inj code with POA 2	A	8	576-583
ER349	1	Ext cause of Inj code with POA 3	A	8	584-591
ER350	1	Filler	A	1	592-592
ER351	1	Principal ICD procedure	A	7	593-599
ER352	1	Date of principal procedure	N	6	600-605
ER353	1	Secondary ICD procedure 1	A	7	606-612
ER354	1	Date of principal/secondary procedure	N	6	613-618
ER355	1	Secondary ICD procedure 2	A	7	619-625
ER356	1	Date of principal/secondary procedure	N	6	626-631
ER357	1	Secondary ICD procedure 3	A	7	632-638
ER358	1	Date of principal/secondary procedure	N	6	639-644
ER359	1	Secondary ICD procedure 4	A	7	645-651
ER360	1	Date of principal/secondary procedure	N	6	652-657
ER361	1	Secondary ICD procedure 5	A	7	658-664
ER362	1	Date of principal/secondary procedure	N	6	665-670
ER363	1	Attending provider ID - NPI/QUAL/ID	A	26	671-696
ER364	2	Attending provider taxonomy code	A	10	697-706
ER365	1	Operating physician ID - NPI/QUAL/ID	A	26	707-732
ER366	2	Operating physician taxonomy code	A	10	733-742
ER367	1	Other operating physician ID - NPI/QUAL/ID	A	26	743-768
ER368	2	Other operating physician taxonomy code	A	10	769-778
ER369	1	Rendering physician ID - NPI/QUAL/ID	A	26	779-804
ER370	2	Rendering physician taxonomy code	A	10	805-814
ER371	1	Referring provider ID - NPI/QUAL/ID	A	26	815-840
ER372	2	Referring provider taxonomy code	A	10	841-850
ER373	2	Resident ID - NPI/QUAL/ID	A	26	851-876
ER374	2	Resident ID type	A	1	877-877
ER375	2	Optional Filler	A/N	99	878-976

Description of Emergency Data Elements

Patient's Header Record – Record Type 1

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

Number	Field Name	Class	Position	Width
ER001	Unique Patient Control Number	N	1-9	9

Level: Required

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

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

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

ER002	Record Type	N	10	1
-------	-------------	---	----	---

Level: Required

Definition: The record format type indicator.

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

Edit Check: The number must be present, and there can only be one record with record type equal 1 for each Unique Patient Control Number.

Number	Field Name	Class	Position	Length
ER101	Encounter Type	A	11-15	5
Level:	Required			
Definition:	Patient encounter type, indicating whether the record is for an inpatient, emergency, or ambulatory surgery encounter.			
Notes:	The first character represents the encounter type.			
	A = Ambulatory surgery			
	E = Emergency department			
	I = Inpatient			
	The remaining four characters should be filled with zeros (0). For example, an emergency department encounter would be coded as E0000.			
Edit Check:	The number must be present.			
ER102	Provider Identifier (Hospital Name)	A	16-115	100
	Provider name		16-40	25
	Line 2 Filler		41-65	25
	Line 3 Filler		66-90	25
	Line 4 Filler		91-115	25
Level:	Required			
Definition:	The name of the hospital submitting the record.			
Notes:	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 Check:	The name must be present and match a name in a coding table.			

Number	Field Name	Class	Position	Length
ER103	Patient Social Security Number	A	116-128	13
Level:	Required			
Definition:	The social security number of the patient receiving care			
Notes:	<p>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:</p> <p>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.</p>			
Edit Check:	The field is edited for valid entry			
ER104	Patient Control Number	A	129-148	20
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.			
Notes:	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 Check:	The number must be present and should be unique within a hospital.			

Number	Field Name	Class	Position	Length
ER105	Type of Bill	A	149-152	4
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.			
Notes:	<p>The Department requires the submission of all emergency department patient records that indicate the patient was treated in the emergency department. All records that have a value of “131,” “831,” or “851” in the Type of Bill field and a value in the range of 450-459 in at least one of the Revenue Code fields should be submitted.</p> <p>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:</p> <p>First position is a leading 0.</p> <p>Second position indicates type of facility:</p> <ul style="list-style-type: none"> 1 = Hospital 4 = Christian Science Hospital 8 = Special Facility (used for Critical Access Hospitals which are usually 0851) <p>Third position indicates billing classification:</p> <ul style="list-style-type: none"> 1 = Inpatient (Including Medicare Part A) 2 = Inpatient (Medicare Part B only) 3 = Outpatient 5 = Critical Assess Hospital only <p>Fourth position indicates the frequency and ranges from 0 – 8 and are defined as:</p> <ul style="list-style-type: none"> 0 = Non-payment/Zero Claim 1 = Admit through discharge Claim 7 = Replacement of prior claim 			
Edit Check:	<p>When the field is present the following must apply except for Critical Access Hospitals:</p> <ul style="list-style-type: none"> The first digit must be a 1 or 4; The second digit must be within the range 1 – 3; The third digit must be within the range 0 – 1, 7 			

Number	Field Name	Class	Position	Length
ER106	Patient Name	A	153-183	31
Level:	Required			
Definition:	The name of the patient in last, first, and middle initial order.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from first name.			
ER107	Patient's street address	A	184-226	43
Level:	Required			
Definition:	The patient's street address.			
Notes:	Street address is preferred. However, if street address is unavailable, mailing address will be acceptable. The address must be followed by space filler to the end of the field.			
Edit Check:	This field is edited for the presence of a valid entry.			
ER108	Patient's city name	A	227-251	25
Level:	Required			
Definition:	The patient's city name.			
Notes:	Should coincide with the street address provided in the previous field. The city name must be followed by space filler to the end of the field.			
Edit Check:	This field is edited for the presence of a valid entry.			

Number	Field Name	Class	Position	Length
ER109	Patient's state or province	A	252-253	2
Level:	Required			
Definition:	The patient's state or province.			
Notes:	The state or province code must be the standard post office abbreviations. International addresses may or may not have this value.			
Edit Check:	This field is edited for the presence of a valid state or province code.			
ER110	Patient's ZIP code	A	254-264	11
Level:	Required			
Definition:	The patient's ZIP code.			
Notes:	ZIP+4 is optional but desired. If a ZIP+4 (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. Additionally, this field may use non-US codes as needed and available. The ZIP code must be followed by space filler to the end of the field.			
Edit Check:	This field is edited for the presence of a valid ZIP code.			
ER111	Patient's country code	A	265-267	3
Level:	Required			
Definition:	The patient's country code.			
Notes:	Code US for United States. The country code must be followed by space filler to the end of the field.			
Edit Check:	This field is edited for the presence of a valid country code or abbreviation.			

Number	Field Name	Class	Position	Length
ER112	Patient's Date of Birth	N	268-275	8
Level:	Required			
Definition:	The date of birth of the patient in month, day, year order.			
Notes:	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 Check:	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.			
ER113	Patient's Gender	A	276	1
Level:	Required			
Definition:	The gender of the patient as recorded at date of admission or start of care.			
Notes:	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 Check:	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.			

Number	Field Name	Class	Position	Length
ER114	Patient's Marital Status	A	277	1
Level:	As Available			
Definition:	The marital status of the patient at date of admission, or start of care.			
Notes:	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 Check:	This field is edited for a valid entry.			
ER115	Date of Admission	N	278-283	6
Level:	Required			
Definition:	The date the patient was admitted to the hospital.			
Notes:	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 Check:	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.			

Number	Field Name	Class	Position	Length
ER116	Admission Hour	N	284-287	4
Level:	Required			
Definition:	The hour and minute the patient was admitted to the hospital.			
Notes:	The admission hour is to be entered expressed as military time in HHMM format.			
Edit Check:	Admission hour and minute must be present and a valid time code.			
ER117	Type of Admission/Visit	N	288	1
Level:	Required			
Definition:	A code indicating the priority of the admission.			
Notes:	This is a one digit code ranging from 1 through 5 or maybe a 9. The code structure is as follows:			
	1 = Emergency			
	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.			
	2 = Urgent			
	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.			
	3 = Elective			
	The patient's condition permits adequate time to schedule the availability of a suitable accommodation. An elective admission can be delayed without substantial risk to the health of the individual.			
	4 = Newborn			
	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			
	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 Check:	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.			

Number	Field Name	Class	Position	Length
ER118	Point of Origin for Admission or Visit	A	289	1
Level:	Required			
Definition:	A code indicating the point of origin for the admission or visit.			
Notes:	<p>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:</p> <p>CODE STRUCTURE FOR EMERGENCY (1), URGENT (2), ELECTIVE (3), OR TRAUMA CENTER (5)</p> <p>1 = Non-Healthcare facility Point of Origin The patient was admitted to this facility includes patients coming from home or workplace.</p> <p>2 = Clinic or Physician’s Office The patient was admitted to this facility upon recommendation of another clinic or physician office.</p> <p>3 = (reserved for assignment by the NUBC)</p> <p>4 = Transfer from a hospital (Different Facility) 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).</p> <p>5 = Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.</p> <p>6 = Transfer from another healthcare facility The patient was admitted to this facility as a transfer from another type of healthcare facility not defined elsewhere on this list.</p> <p>7 = (Discontinued, for Emergency Room admission use Condition Code P7)</p> <p>8 = Court/Law enforcement 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.</p> <p>9 = Information not available The means by which the patient was admitted to this facility is not known.</p> <p>D = Transfer from one distinct unit of the hospital to another distinct unit of the hospital.</p>			

Number	Field Name	Class	Position	Length
--------	------------	-------	----------	--------

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

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

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

A baby born inside this hospital.

6 = Born Outside this Hospital

A baby born outside this hospital.

9 = Information not available.

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

ER119	Discharge Hour	N	290-293	4
-------	----------------	---	---------	---

Level: Required

Definition: The hour and minute the patient was discharged from the hospital.

Notes: The discharge hour is to be entered expressed as military time in HHMM format.

Edit Check: Discharge hour and minute must be present and a valid time code.

Number	Field Name	Class	Position	Length
ER120	Patient's Discharge Status	A	294-295	2
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.			
Notes:	<p>This is a code with a length of two. 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:</p> <p>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'.</p> <p>02 = Discharge/transferred to another short-term general hospital.</p> <p>03 = Discharge/transferred to skilled nursing facility</p> <p>04 = Discharge/transferred to an intermediate care facility</p> <p>05 = Discharged/transferred to a designated cancer center or children's hospital.</p> <p>06 = Discharge/transferred to home under care of organized home health service organization.</p> <p>07 = Left against medical advice or discontinued care</p> <p>08 = Discharge/transferred to home under care of a home IV provider</p> <p>09 = Unknown</p> <p>20 = Expired</p> <p>21 = Discharged/transferred to Court/Law Enforcement</p> <p>30 = Still patient (will be excluded from database)</p> <p>40 = Expired at home</p> <p>41 = Expired in a medical facility, i.e. hospital, skilled nursing facility, intermediate care facility, or free standing hospice.</p> <p>42 = Expired – place unknown</p> <p>43 = Discharged/transferred to federal facility</p> <p>50 = Discharged/transferred to hospice - home</p> <p>51 = Discharged/transferred to hospice - medical facility</p> <p>61 = Discharged/transferred within institution to hospital based Medicare swing bed</p> <p>62 = Discharged/transferred to another rehab facility including distinct units in hospital</p> <p>63 = Discharged/transferred to a long term care hospital</p> <p>64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare</p> <p>65 = Discharged/transferred to a psychiatric hospital or psychiatric unit of a hospital</p> <p>66 = Discharged/transferred to a Critical Access Hospital</p> <p>69 = Discharge/transferred to a designated disaster alternative care site (valid 10/2013)</p> <p>70 = Discharged/transferred/referred to another type of health care institution not defined elsewhere in this code list</p>			

Number	Field Name	Class	Position	Length
	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)			
	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 healthcare 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 Check:	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.			

Number	Field Name	Class	Position	Length
ER121	Statement Covers Period	N	296-307	12
	Beginning Date	N	296-301	6
	Through Date	N	302-307	6

Level: Required

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

Notes: 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 Check: 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.

ER122	Patient’s Medical/Health Record Number	A	308-331	24
-------	--	---	---------	----

Level: Required

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

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

Edit Check: The field must be present.

Number	Field Name	Class	Position	Length
ER123	Patient's Race	A/N	332	1
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.			
Notes:	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 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 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 A person having origins in any of the black racial groups of Africa.			
	4 = White A person having origins in any of the original Caucasian peoples of Europe, North Africa, or the Middle East.			
	5 = Other Any possible options not covered in the above categories.			
	6 = Unknown A person who chooses not to answer the question.			
	7 = Native Hawaiian or Other Pacific Islander 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 The hospital made no effort to obtain the information.			

Number	Field Name	Class	Position	Length
ER124	Condition Codes (ER Admit, DNR, Homeless)	A	333-354	22
Level:	As available			
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.			
Notes:	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 Check:	This field is required. The P7 value is needed to replace the previous code 7 from the Source of Admission.			
ER125	Patient's Ethnicity	A/N	355	1
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.			
Notes:	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			
	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			
	A person who is not classified in 1.			
	6 = Unknown			
	A person who chooses not to respond to the inquiry.			
	Blank Space			
	The hospital made no effort to obtain the information.			
Edit Check:	If the data field contains an entry it must be a valid code combination.			

Patient’s Revenue Record – Record Type 2

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 code “0001” to indicate the sum of all revenue services, see “Revenue Codes and Units of Service” in the Appendix for the complete list of revenue codes and definitions.

Number	Field Name	Class	Position	Width
ER001	Unique Patient Control Number	N	1-9	9

Level: Required

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

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

Edit Check: 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.

ER002	Record Type	N	10	1
-------	-------------	---	----	---

Level: Required

Definition: The record type indicator.

Notes: This field must equal 2 for a revenue record.

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

Number	Field Name	Class	Position	Length
ER201A	Service Line 1	N	11-16	6
Level:	Required			
Definition:	The service line number for each row.			
Notes:	This field must start with 1 for the first revenue record.			
Edit Check:	The number must be present in each revenue service and is incremental.			
ER201B	Revenue Code 1	A	17-20	4
Level:	Required			
Definition:	A four digit code which identifies a specific accommodation, ancillary service, or billing calculation.			
Notes:	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 Check:	This field must be present and contain a valid revenue code as defined in "Revenue Codes and Units of Service" in the Appendix.			
ER201C	HCPCS Code including Modifiers 1	A	21-34	14
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.			
ER201D	Unit or Basis for Measurement Code 1	A	35-36	2
Level:	Required if the revenue code needs units, see "Revenue Codes and Units of Service" in the Appendix.			
Definition:	Indicator of whether the service Units/Days below is a Unit = 'UN' or a Day = 'DA'.			

Number	Field Name	Class	Position	Length
ER201E	Service Units/Days 1	N	37-43	7
Level:	Required if the revenue code needs units, see “Revenue Codes and Units of Service” in the Appendix.			
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.			
Notes:	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” in the Appendix defines the appropriate units for each revenue codes.			
Edit Check:	The units of service must be present for those revenue services which require a unit, see “Revenue Codes and Units of Service” in the Appendix.			
ER201F	Total Charges by Revenue Code 1	N	44-53	10
Level:	Required			
Definition:	Total dollars and cents amount charged for the related revenue service entered.			
Notes:	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, 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 Check:	This field must be present and contain a value greater than 0 when revenue code field is greater than 0.			
ER202A	Service Line 2	N	54-59	6
Level:	Required			
Definition:	The service line number for each row.			
Notes:	This field must start with 2 for the second revenue record.			
Edit Check:	The number must be present in each revenue service and is incremental.			

Number	Field Name	Class	Position	Length
ER202B	Revenue Code 2	A	60-60	4
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.			
Notes:	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 Check:	This field must be present and contain a valid revenue code as defined in "Revenue Codes and Units of Service" in the Appendix. 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.			
ER202C	HCPCS Code Including Modifiers 2	A	64-77	14
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.			
ER202D	Unit or Basis for Measurement Code 2	A	78-79	2
Level:	Required if the revenue code needs units, see "Revenue Codes and Units of Service" in the Appendix.			
Definition:	Indicator of whether the service Units/Days below is a Unit = 'UN' or a Day = 'DA'.			

Number	Field Name	Class	Position	Length
ER202E	Service Units/Days 2	N	80-86	7
Level:	Required if the revenue code needs units, see “Revenue Codes and Units of Service” in the Appendix.			
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.			
Notes:	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 Check:	The units of service must be present for those revenue services which require a unit.			

ER202F	Total Charges by Revenue Code 2	N	87-96	10
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.			
Notes:	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, 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 Check:	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.			

Note: Each subsequent revenue record should follow the same directions as for the previous record, with all integers incremented accordingly.

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER203A	Service Line 3	N	97-102	6
ER203B	Revenue Code 3	A	103-106	4
ER203C	HCPCS Code Including Modifiers 3	A	107-120	14
ER203D	Units or Basis for Measurement Code 3	A	121-122	2
ER203E	Service Units/Days 3	N	123-129	7
ER203F	Total Charges by Revenue Code 3	N	130-139	10
ER204A	Service Line 4	N	140-145	6
ER204B	Revenue Code4	A	146-149	4
ER204C	HCPCS Code Including Modifiers 4	A	150-163	14
ER204D	Units or Basis for Measurement Code 4	A	164-165	2
ER204E	Service Units/Days 4	N	166-172	7
ER204F	Total Charges by Revenue Code 4	N	173-182	10
ER205A	Service Line 5	N	183-188	6
ER205B	Revenue Code 5	A	189-192	4
ER205C	HCPCS Code Including Modifiers 5	A	193-206	14
ER205D	Units or Basis for Measurement Code 5	A	207-208	2
ER205E	Service Units/Days 5	N	209-215	7
ER205F	Total Charges by Revenue Code 5	N	216-225	10

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER206A	Service Line 6	N	226-231	6
ER206B	Revenue Code 6	A	232-235	4
ER206C	HCPCS Code Including Modifiers 6	A	236-249	14
ER206D	Units or Basis for Measurement Code 6	A	250-25	12
ER206E	Service Units/Days 6	N	252-258	7
ER206F	Total Charges by Revenue Code 6	N	259-268	10
ER207A	Service Line 7	N	269-274	6
ER207B	Revenue Code 7	A	275-278	4
ER207C	HCPCS Code Including Modifiers 7	A	279-292	14
ER207D	Units or Basis for Measurement Code 7	A	293-294	2
ER207E	Service Units/Days 7	N	295-301	7
ER207F	Total Charges by Revenue Code 7	N	302-311	10
ER208A	Service Line 8	N	312-317	6
ER208B	Revenue Code 8	A	318-321	4
ER208C	HCPCS Code Including Modifiers 8	A	322-335	14
ER208D	Units or Basis for Measurement Code 8	A	336-337	2
ER208E	Service Units/Days 8	N	338-344	7
ER208F	Total Charges by Revenue Code 8	N	345-354	10

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER209A	Service Line 9	N	355-360	6
ER209B	Revenue Code 9	A	361-364	4
ER209C	HCPCS Code Including Modifiers 9	A	365-378	14
ER209D	Units or Basis for Measurement Code 9	A	379-380	2
ER209E	Service Units/Days 9	N	381-387	7
ER209F	Total Charges by Revenue Code 9	N	388-397	10
ER210A	Service Line 10	N	398-403	6
ER210B	Revenue Code 10	A	404-407	4
ER210C	HCPCS Code Including Modifiers 10	A	408-421	14
ER210D	Units or Basis for Measurement Code 10	A	422-423	2
ER210E	Service Units/Days 10	N	424-430	7
ER210F	Total Charges by Revenue Code 10	N	431-440	10
ER211A	Service Line 11	N	441-446	6
ER211B	Revenue Code 11	A	447-450	4
ER211C	HCPCS Code Including Modifiers 11	A	451-464	14
ER211D	Units or Basis for Measurement Code 11	A	465-466	2
ER211E	Service Units/Days 11	N	467-473	7
ER211F	Total Charges by Revenue Code 11	N	474-483	10

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER212A	Service Line 12	N	484-489	6
ER212B	Revenue Code 12	A	490-493	4
ER212C	HCPCS Code Including Modifiers 12	A	494-507	14
ER212D	Units or Basis for Measurement Code 12	A	508-509	2
ER212E	Service Units/Days 12	N	510-516	7
ER212F	Total Charges by Revenue Code 12	N	517-526	10
ER213A	Service Line 13	N	527-532	6
ER213B	Revenue Code 13	A	533-536	4
ER213C	HCPCS Code Including Modifiers 13	A	537-550	14
ER213D	Units or Basis for Measurement Code 13	A	551-552	2
ER213E	Service Units/Days 13	N	553-559	7
ER213F	Total Charges by Revenue Code 13	N	560-569	10
ER214A	Service Line 14	N	570-575	6
ER214B	Revenue Code 14	A	576-579	4
ER214C	HCPCS Code Including Modifiers 14	A	580-593	14
ER214D	Units or Basis for Measurement Code 14	A	594-595	2
ER214E	Service Units/Days 14	N	596-602	7
ER214F	Total Charges by Revenue Code 14	N	603-612	10

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER215A	Service Line 15	N	613-618	6
ER215B	Revenue Code 15	A	619-622	4
ER215C	HCPCS Code Including Modifiers 15	A	623-636	14
ER215D	Units or Basis for Measurement Code 15	A	637-638	2
ER215E	Service Units/Days 15	N	639-645	7
ER215F	Total Charges by Revenue Code 15	N	646-655	10
ER216A	Service Line 16	N	656-661	6
ER216B	Revenue Code 16	A	662-665	4
ER216C	HCPCS Code Including Modifiers 16	A	666-679	14
ER216D	Units or Basis for Measurement Code 16	A	680-681	2
ER216E	Service Units/Days 16	N	682-688	7
ER216F	Total Charges by Revenue Code 16	N	689-698	10
ER217A	Service Line 17	N	699-704	6
ER217B	Revenue Code 17	A	705-708	4
ER217C	HCPCS Code Including Modifiers 17	A	709-722	14
ER217D	Units or Basis for Measurement Code 17	A	723-724	2
ER217E	Service Units/Days 17	N	725-731	7
ER217F	Total Charges by Revenue Code 17	N	732-741	10

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER218A	Service Line 18	N	742-747	6
ER218B	Revenue Code 18	A	748-751	4
ER218C	HCPCS Code Including Modifiers 18	A	752-765	14
ER218D	Units or Basis for Measurement Code 18	A	766-767	2
ER218E	Service Units/Days 18	N	768-774	7
ER218F	Total Charges by Revenue Code 18	N	775-784	10
ER219A	Service Line 19	N	785-790	6
ER219B	Revenue Code 19	A	791-794	4
ER219C	HCPCS Code Including Modifiers 19	A	795-808	14
ER219D	Units or Basis for Measurement Code 19	A	809-810	2
ER219E	Service Units/Days 19	N	811-817	7
ER219F	Total Charges by Revenue Code 19	N	818-827	10
ER220A	Service Line 20	N	828-833	6
ER220B	Revenue Code 20	A	834-837	4
ER220C	HCPCS Code Including Modifiers 20	A	838-851	14
ER220D	Units or Basis for Measurement Code 20	A	852-853	2
ER220E	Service Units/Days 20	N	854-860	7
ER220F	Total Charges by Revenue Code 20	N	861-870	10

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER221A	Service Line 21	N	871-876	6
ER221B	Revenue Code 21	A	877-880	4
ER221C	HCPCS Code Including Modifiers 21	A	881-894	14
ER221D	Units or Basis for Measurement Code 21	A	895-896	2
ER221E	Service Units/Days 21	N	897-903	7
ER221F	Total Charges by Revenue Code 21	N	904-913	10
ER222A	Service Line 22	N	914-919	6
ER222B	Revenue Code 22	A	920-923	4
ER222C	HCPCS Code Including Modifiers 22	A	924-937	14
ER222D	Units or Basis for Measurement Code 22	A	938-939	2
ER222E	Service Units/Days 22	N	940-946	7
ER222F	Total Charges by Revenue Code 22	N	947-956	10
ER223A	Revenue Code 23 (0001 if last page)	A	957-960	4

Level: Required

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

Notes: 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, this would be populated.

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

Number	Field Name	Class	Position	Length
ER224	Page __ of __ 23	A	961-966	6
	Current Page/Record Number	A	961-963	3
	Total Pages/Records	A	964-966	3

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 Check: 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.

ER225	Total Overall Charges 23	N	967-976	10
-------	--------------------------	---	---------	----

Level: Required

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

Notes: 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, 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 Check: 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.

Patient's Trailing Record – Record Type 3

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.

Number	Field Name	Class	Position	Width
ER001	Unique Patient Control Number	N	1-9	9

Level: Required

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

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

Edit Check: 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.

ER002	Record Type	N	10	1
-------	-------------	---	----	---

Level: Required

Definition: The record type indicator.

Notes: This field must equal 3 to indicate the end of the patient's discharge data record.

Edit Check: 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.

Number	Field Name	Class	Position	Length
<u>1st of three Payers</u>				
ER301	Primary Payer Identification	A	11-35	25
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.			
Notes:	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 Check:	The name must be that of a veritable organization.			
ER302	Estimated Amount Due	N	36-45	10
Level:	As Available			
Definition:	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
Notes:	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, 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 Check:	None			

Number	Field Name	Class	Position	Length
ER303	Prior Payment	N	46-55	10
Level:	As Available			
Definition:	The amount the hospital has received toward the payment prior to the billing date from the indicated payer.			
Notes:	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, 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 Check:	None			

2nd of three Payers

ER304	Secondary Payer Identification	A	56-80	25
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.			
Notes:	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 Check:	The name must be that of a veritable organization.			

Number	Field Name	Class	Position	Length
ER305	Estimated Amount Due	N	81-90	10
Level:	As Available			
Definition:	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
Notes:	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, 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 Check:	None			

ER306	Prior Payment	N	91-100	10
-------	---------------	---	--------	----

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.

Notes: 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, 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 Check: None

3rd of three Payers

ER307	Tertiary Payer Identification	A	101-125	25
-------	-------------------------------	---	---------	----

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.

Notes: 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 Check: The name must be that of a veritable organization.

Number	Field Name	Class	Position	Length
ER308	Estimated Amount Due	N	126-135	10
Level:	As Available			
Definition:	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
Notes:	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, 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 Check:	None			

ER309	Prior Payment	N	136-145	10
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.			
Notes:	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, 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 Check:	None			

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

Number	Field Name	Class	Position	Length
<u>1st of three Insured Persons</u>				
ER310	Insured's Name—Primary	A	146-170	25
Level:	As Available			
Definition:	The name of the individual in whose name the insurance is carried.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from the first name.			

Number	Field Name	Class	Position	Length
ER311	Patient's Relationship—Primary	N	171-172	2
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.			
Notes:	<p>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:</p> <p>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 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 Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage 23 = Sponsored Dependent 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 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 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</p>			

Number	Field Name	Class	Position	Length
	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 Patient is claiming insurance as a result of injury covered by insured 43 = Child where insured has no financial responsibility 53 = Life Partner Edit Check: A code must be present and valid if Insured's Name is entered.			
ER312	Insured's Unique ID—Primary	A	173-192	20
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 Check:	None			
ER313	Insured Group Name—Primary	A	193-212	20
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.			
Notes:	Enter the complete name of the group or plan name. If the name exceeds 16 characters, truncate the excess.			
Edit Check:	None			

Number	Field Name	Class	Position	Length
<u>2nd of three Insured Persons</u>				
ER314	Insured's Name—Secondary	A	213-237	25
Level:	As Available			
Definition:	The name of the individual in whose name the insurance is carried.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from first name.			

Number	Field Name	Class	Position	Length
ER315	Patient's Relationship—Secondary	N	238-239	2
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.			
Notes:	<p>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:</p> <p>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 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 Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage 23 = Sponsored Dependent 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 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 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</p>			

Number	Field Name	Class	Position	Length
	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 Patient is claiming insurance as a result of injury covered by insured 43 = Child where insured has no financial responsibility 53 = Life Partner Edit Check: A code must be present and valid if Insured's Name is entered.			
ER316	Insured's Unique ID—Secondary	A	240-259	20
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.			
Notes:	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 Check:	None			
ER317	Insured Group Name—Secondary	A	260-279	20
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.			
Notes:	Enter the complete name of the group of plan name. If the name exceeds 16 characters, truncate the excess.			
Edit Check:	None			

Number	Field Name	Class	Position	Length
<u>3rd of three Insured Persons</u>				
ER318	Insured's Name—Tertiary	A	280-304	25
Level:	As Available			
Definition:	The name of the individual in whose name the insurance is carried.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from first name.			

Number	Field Name	Class	Position	Length
ER319	Patient's Relationship—Tertiary	N	305-306	2
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.			
Notes:	<p>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:</p> <p>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 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 Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage 23 = Sponsored Dependent 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 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 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</p>			

Number	Field Name	Class	Position	Length
	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 Patient is claiming insurance as a result of injury covered by insured 43 = Child where insured has no financial responsibility 53 = Life Partner Edit Check: The code must be present and a valid number.			
ER320	Insured's Unique ID—Tertiary	A	307-326	20
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.			
Notes:	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 Check:	None			
ER321	Insured Group Name—Tertiary	A	327-346	20
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.			
Notes:	Enter the complete name of the group or plan name. If the name exceeds 16 characters, truncate the excess.			
Edit Check:	None			

Number	Field Name	Class	Position	Length
ER322	Employer Name—Primary	A	347-370	24
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.			
Notes:	Enter the full and complete name of the employer providing health care coverage.			
Edit Check:	None			
ER323	Employer Name—Secondary	A	371-394	24
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.			
Notes:	Enter the full and complete name of the employer providing health care coverage.			
Edit Check:	None			
ER324	Diagnosis Version Qualifier	A	395-395	1
Level:	Required			
Definition:	Indicator to designate which version of ICD was used to report diagnosis codes.			
Notes:	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 Check:	Must be present and valid.			

Number	Field Name	Class	Position	Length
ER325	Principal Diagnosis Code with POA	A	396-403	8
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.			
Notes:	<p>This field is to contain the appropriate ICD-9-CM or ICD-10-CM code without a decimal followed by POA in position 8. POA is only required on inpatient records. Position 8 should be populated with “E” or “1” for ER and AS records. 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 width. An “E” code should not be recorded as the principal diagnosis.</p> <p>POA coding:</p> <p>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.</p>			
Edit Check:	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.

Number	Field Name	Class	Position	Length
ER326	Secondary Diagnosis Code with POA (1 st of 17)	A	404-411	8
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.			
Notes:	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. POA is only required on inpatient records. Position 8 should be populated with “E” or “1” for ER and AS records. 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 width. 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 Check:	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.			
ER327	Secondary Diagnosis Code with POA (2 nd of 17)	A	412-419	8
ER328	Secondary Diagnosis Code with POA (3 rd of 17)	A	420-427	8
ER329	Secondary Diagnosis Code with POA (4 th of 17)	A	428-435	8
ER330	Secondary Diagnosis Code with POA (5 th of 17)	A	436-443	8
ER331	Secondary Diagnosis Code with POA (6 th of 17)	A	444-451	8
ER332	Secondary Diagnosis Code with POA (7 th of 17)	A	452-459	8

CHAPTER 2 – Emergency Room Data Requirements

Number	Field Name	Class	Position	Length
ER333	Secondary Diagnosis Code with POA (8 th of 17)	A	460-467	8
ER334	Secondary Diagnosis Code with POA (9 th of 17)	A	468-475	8
ER335	Secondary Diagnosis Code with POA (10 th of 17)	A	476-483	8
ER336	Secondary Diagnosis Code with POA (11 th of 17)	A	484-491	8
ER337	Secondary Diagnosis Code with POA (12 th of 17)	A	492-499	8
ER338	Secondary Diagnosis Code with POA (13 th of 17)	A	500-507	8
ER339	Secondary Diagnosis Code with POA (14 th of 17)	A	508-515	8
ER340	Secondary Diagnosis Code with POA (15 th of 17)	A	516-523	8
ER341	Secondary Diagnosis Code with POA (16 th of 17)	A	524-531	8
ER342	Secondary Diagnosis Code with POA (17 th of 17)	A	532-539	8

Number	Field Name	Class	Position	Length
ER343	Admitting Diagnosis Code	A	540-546	7
Level:	Required for inpatient only.			
Definition:	This field is only applicable to inpatient records. Blank fill for ER and AS. 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.			
Notes:	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 width. An "E" code should not be recorded as the admitting diagnosis.			
Edit Check:	If admitting diagnosis is present it must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.			
ER344	Patient's Reason for Visit 1	A	547-553	7
Level:	Required for AS, ER 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.			
Notes:	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 <u>NOT</u> 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 width.			
Edit Check:	If patient's reason for visit is present it must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.			

Number	Field Name	Class	Position	Length
ER345	Patient's Reason for Visit 2	A	554-560	7
ER346	Patient's Reason for Visit 3	A	561-567	7
ER347	External Cause of Injury Code with POA 1	A	568-575	8
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. POA is only required on inpatient records. Position 8 should be populated with "E" or "1" for ER and AS records.			
Notes:	Hospitals are encouraged to complete this field whenever there is a diagnosis of an injury, poisoning, or adverse effect. The priorities for recording an external cause of injury 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 width.			
	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 Check:	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.			
ER348	External Cause of Injury Code with POA 2	A	576-583	8
ER349	External Cause of Injury Code with POA 3	A	584-591	8
ER350	Filler	A	592	1

Note: Six procedures (one principal and five others) are accommodated in the record. All procedures entered must be coded using the same ICD method.

Number	Field Name	Class	Position	Length
ER351	Principal ICD Procedure	A	593-599	7
Level:	Required for inpatient only			
Definition:	ICD-9-CM or ICD-10-PCS codes are only applicable to inpatient records. Blank fill for ER and AS. 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.			
Notes:	The coding method used should be ICD-9-CM or ICD-10-PCS. Entries must include all digits available. 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 Check:	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.			
ER352	Date of Principal Procedure	N	600-605	6
Notes:	Entries must be in MMDDYY format			
ER353	Secondary ICD Procedure 1	A	606-612	7
Level:	Required for inpatient only			
Definition:	ICD-9-CM or ICD-10-PCS codes are only applicable to inpatient records. Blank fill for ER and AS. 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.			
Notes:	Procedures that make for accurate DRG Categorization must be included. The coding method used should be ICD-9-CM or ICD-10-PCS. Entries must include all digits available. 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 Check:	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.			

Number	Field Name	Class	Position	Length
--------	------------	-------	----------	--------

Note: The record provides space to record up to five secondary procedures and dates. When a secondary procedure field is filled, the date should be the date of the secondary procedure. The date of the secondary procedure may be different that the date of the primary procedure.

ER354	Date of Principal/Secondary Procedure 1	N	613-618	6
-------	---	---	---------	---

ER355	Secondary ICD Procedure 2	A	619-625	7
-------	---------------------------	---	---------	---

ER356	Date of Principal/Secondary Procedure 2	N	626-631	6
-------	---	---	---------	---

ER357	Secondary ICD Procedure 3	A	632-638	7
-------	---------------------------	---	---------	---

ER358	Date of Principal/Secondary Procedure 3	N	639-644	6
-------	---	---	---------	---

ER359	Secondary ICD Procedure 4	A	645-651	7
-------	---------------------------	---	---------	---

ER360	Date of Principal/Secondary Procedure 4	N	652-657	6
-------	---	---	---------	---

ER361	Secondary ICD Procedure 5	A	658-664	7
-------	---------------------------	---	---------	---

ER362	Date of Principal/Secondary Procedure 5	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.

Number	Field Name	Class	Position	Length
ER363	Attending Provider ID – NPI/QUAL/ID	A	671-696	26
Level:	Required			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
ER364	Attending Provider Taxonomy Code	A	697-706	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Length
ER365	Operating Physician ID – NPI/QUAL/ID	A	707-732	26
Level:	As Available			
Definition:	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.			
Notes:	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			
Edit Check:	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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.			
ER366	Operating Physician Taxonomy Code	A	733-742	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Length
ER367	Other Operating Physician ID – NPI/QUAL/ID	A	743-768	26
Level:	As Available			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
ER368	Other Operating Physician Taxonomy Code	A	769-778	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Length
ER369	Rendering Physician ID – NPI/QUAL/ID	A	779-804	26
Level:	Required			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
ER370	Rendering Physician Taxonomy Code	A	805-814	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Length
ER371	Referring Provider ID – NPI/QUAL/ID	A	815-840	26
Level:	Required			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
ER372	Referring Provider Taxonomy Code	A	841-850	10
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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Length
ER373	Resident ID – NPI/QUAL/ID	A	851-876	26
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.			
Notes:	If there were no residents involved, 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:			
	OB = State License Number			
	1G = Provider UPIN Number			
	G2 = Provider Commercial Number			
	LU = Location Number			
Edit Check:	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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.			
ER374	Resident ID Type	A	877	1
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			
Notes:	If there were no residents involved in patient care this field may be space filled.			
Edit Check:	If Resident ID is completed, this field must be completed with 'F' or 'U'.			

Chapter 3 – Inpatient Data Requirements

Inpatient Record Formats

The form of the data submitted to OHCS is intended to minimize the reporting burden.

Three record formats are required for each emergency room encounter. All three formats must be written to the file in sequence 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 record types are defined as:

1. Patient’s header record: 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 and will contain the reportable revenue information for the patient’s care. The “Record type” field must be set to “2” to indicate the patient’s revenue record is being processed.
Each revenue record accommodates from 1 to 23 revenue services. If a patient has more than 23 revenue services, multiple revenue records should be written until all revenue services have been included. 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 the patient’s record has ended. The “Record type” field must be set to “3” for this record. There must be one and only one type “3” record per discharge.

The column headings used in the Data Records Layout and Description sections are as follows:

Number	This is the element number used in the record layout and description.
Level	Indicates the level of requirement for collection and reporting 1 = Facilities shall collect and report these data elements 2 = Facilities shall report these data elements if the data is included in the patient record
Field Name	This the element name used in the record layout and descriptions. The name “filler” is used to indicate areas in the record that may contain information but will not be processed by computer programs.
Class	The letter in this column indicates the field’s attribute A = Alphanumeric N = Numeric

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

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. Facilities using data sources other than uniform billing should evaluate definitions for agreement with the definitions specified in this document.

Inpatient Data Record Layouts

The expected Record Length is 976. Space filler can be used to equalize the record length for each record type. For example, the header record (type 1) uses only 342 characters. Space filler can be added to the end of the record until position 976 is reached.

Table 3.1 Inpatient Data Header Record Layout – Record Type 1

Number	Level	Field Name	Class	Width	Position
IP001	1	Unique patient control number	N	9	1-9
IP002	1	Record type	N	1	10-10
IP102	1	Provider identifier (Hospital)	A	100	11-110
IP103	1	Patient social security number	A	13	111-123
IP104	1	Patient control number	A	20	124-143
IP105	1	Type of bill	A	4	144-147
IP106	1	Patient name	A	31	148-178
IP107	1	Patient's address	A	84	179-262
IP112	1	Patient date of birth	N	8	263-270
IP113	1	Patient's gender	A	1	271-271
IP114	2	Patient's marital status	A	1	272-272
IP115	1	Date of admission	N	6	273-278
IP117	1	Type of admission/ visit	N	1	279-279
IP118	1	Point of origin for admission or visit	A	1	280-280
IP120	1	Patient's discharge status	A	2	281-282
IP121	1	Statement covers period	N	12	283-294
IP122	1	Patient's medical record number	A	24	295-318
IP123	2	Patient's race	A/N	1	319-319
IP124	2	Condition codes (ER Admit, DNR, homeless)	A	22	320-341
IP125	2	Patient's ethnicity	A/N	1	342-342

Table 3.2 Inpatient Data Revenue Record Layout – Record Type 2

Number	Level	Field Name	Class	Width	Position
IP001	1	Unique patient control number	N	9	1-9
IP002	1	Record type	N	1	10-10
IP201A	1	Service line 1	N	6	11-16
IP201B	1	Revenue code 1	A	4	17-20
IP201C	1	HCPCS code including modifiers 1	A	14	21-34
IP201D	1	Unit or basis for measurement code 1	A	2	35-36
IP201E	1	Service units/days 1	N	7	37-43
IP201F	1	Total charges by revenue code 1	N	10	44-53
IP202A	1	Service line 2	N	6	54-59
IP202B	1	Revenue code 2	A	4	60-63
IP202C	1	HCPCS code including modifiers 2	A	14	64-77
IP202D	1	Unit or basis for measurement code 2	A	2	78-79
IP202E	1	Service units/days 2	N	7	80-86
IP202F	1	Total charges by revenue code 2	N	10	87-96
IP203A	1	Service line 3	N	6	97-102
IP203B	1	Revenue code 3	A	4	103-106
IP203C	1	HCPCS code including modifiers 3	A	14	107-120
IP203D	1	Unit or basis for measurement code 3	A	2	121-122
IP203E	1	Service units/days 3	N	7	123-129
IP203F	1	Total charges by revenue code 3	N	10	130-139
IP204A	1	Service line 4	N	6	140-145
IP204B	1	Revenue code 4	A	4	146-149
IP204C	1	HCPCS code including modifiers 4	A	14	150-163
IP204D	1	Unit or basis for measurement code 4	A	2	164-165
IP204E	1	Service units/days 4	N	7	166-172
IP204F	1	Total charges by revenue code 4	N	10	173-182
IP205A	1	Service line 5	N	6	183-188
IP205B	1	Revenue code 5	A	4	189-192
IP205C	1	HCPCS code including modifiers 5	A	14	193-206
IP205D	1	Unit or basis for measurement code 5	A	2	207-208
IP205E	1	Service units/days 5	N	7	209-215
IP205F	1	Total charges by revenue code 5	N	10	216-225
IP206A	1	Service line 6	N	6	226-231
IP206B	1	Revenue code 6	A	4	232-235
IP206C	1	HCPCS code including modifiers 6	A	14	236-249
IP206D	1	Unit or basis for measurement code 6	A	2	250-251
IP206E	1	Service units/days 6	N	7	252-258
IP206F	1	Total charges by revenue code 6	N	10	259-268
IP207A	1	Service line 7	N	6	269-274
IP207B	1	Revenue code 7	A	4	275-278
IP207C	1	HCPCS code including modifiers 7	A	14	279-292
IP207D	1	Unit or basis for measurement code 7	A	2	293-294
IP207E	1	Service units/days 7	N	7	295-301
IP207F	1	Total charges by revenue code 7	N	10	302-311
IP208A	1	Service line 8	N	6	312-317

CHAPTER 3 – Inpatient Data Requirements

Number	Level	Field Name	Class	Width	Position
IP208B	1	Revenue code 8	A	4	318-321
IP208C	1	HCPCS code including modifiers 8	A	14	322-335
IP208D	1	Unit or basis for measurement code 8	A	2	336-337
IP208E	1	Service units/days 8	N	7	338-344
IP208F	1	Total charges by revenue code 8	N	10	345-354
IP209A	1	Service line 9	N	6	355-360
IP209B	1	Revenue code 9	A	4	361-364
IP209C	1	HCPCS code including modifiers 9	A	14	365-378
IP209D	1	Unit or basis for measurement code 9	A	2	379-380
IP209E	1	Service units/days 9	N	7	381-387
IP209F	1	Total charges by revenue code 9	N	10	388-397
IP210A	1	Service line 10	N	6	398-403
IP210B	1	Revenue code 10	A	4	404-407
IP210C	1	HCPCS code including modifiers 10	A	14	408-421
IP210D	1	Unit or basis for measurement code 10	A	2	422-423
IP210E	1	Service units/days 10	N	7	424-430
IP210F	1	Total charges by revenue code 10	N	10	431-440
IP211A	1	Service line 11	N	6	441-446
IP211B	1	Revenue code 11	A	4	447-450
IP211C	1	HCPCS code including modifiers 11	A	14	451-464
IP211D	1	Unit or basis for measurement code 11	A	2	465-466
IP211E	1	Service units/days 11	N	7	467-473
IP211F	1	Total charges by revenue code 11	N	10	474-483
IP212A	1	Service line 12	N	6	484-489
IP212B	1	Revenue code 12	A	4	490-493
IP212C	1	HCPCS code including modifiers 12	A	14	494-507
IP212D	1	Unit or basis for measurement code 12	A	2	508-509
IP212E	1	Service units/days 12	N	7	510-516
IP212F	1	Total charges by revenue code 12	N	10	517-526
IP213A	1	Service line 13	N	6	527-532
IP213B	1	Revenue code 13	A	4	533-536
IP213C	1	HCPCS code including modifiers 13	A	14	537-550
IP213D	1	Unit or basis for measurement code 13	A	2	551-552
IP213E	1	Service units/days 13	N	7	553-559
IP213F	1	Total charges by revenue code 13	N	10	560-569
IP214A	1	Service line 14	N	6	570-575
IP214B	1	Revenue code 14	A	4	576-579
IP214C	1	HCPCS code including modifiers 14	A	14	580-593
IP214D	1	Unit or basis for measurement code 14	A	2	594-595
IP214E	1	Service units/days 14	N	7	596-602
IP214F	1	Total charges by revenue code 14	N	10	603-612
IP215A	1	Service line 15	N	6	613-618
IP215B	1	Revenue code 15	A	4	619-622
IP215C	1	HCPCS code including modifiers 15	A	14	623-636
IP215D	1	Unit or basis for measurement code 15	A	2	637-638
IP215E	1	Service units/days 15	N	7	639-645
IP215F	1	Total charges by revenue code 15	N	10	646-655

CHAPTER 3 – Inpatient Data Requirements

Number	Level	Field Name	Class	Width	Position
IP216A	1	Service line 16	N	6	656-661
IP216B	1	Revenue code 16	A	4	662-665
IP216C	1	HCPCS code including modifiers 16	A	14	666-679
IP216D	1	Unit or basis for measurement code 16	A	2	680-681
IP216E	1	Service units/days 16	N	7	682-688
IP216F	1	Total charges by revenue code 16	N	10	689-698
IP217A	1	Service line 17	N	6	699-704
IP217B	1	Revenue code 17	A	4	705-708
IP217C	1	HCPCS code including modifiers 17	A	14	709-722
IP217D	1	Unit or basis for measurement code 17	A	2	723-724
IP217E	1	Service units/days 17	N	7	725-731
IP217F	1	Total charges by revenue code 17	N	10	732-741
IP218A	1	Service line 18	N	6	742-747
IP218B	1	Revenue code 18	A	4	748-751
IP218C	1	HCPCS code including modifiers 18	A	14	752-765
IP218D	1	Unit or basis for measurement code 18	A	2	766-767
IP218E	1	Service units/days 18	N	7	768-774
IP218F	1	Total charges by revenue code 18	N	10	775-784
IP219A	1	Service line 19	N	6	785-790
IP219B	1	Revenue code 19	A	4	791-794
IP219C	1	HCPCS code including modifiers 19	A	14	795-808
IP219D	1	Unit or basis for measurement code 19	A	2	809-810
IP219E	1	Service units/days 19	N	7	811-817
IP219F	1	Total charges by revenue code 19	N	10	818-827
IP220A	1	Service line 20	N	6	828-833
IP220B	1	Revenue code 20	A	4	834-837
IP220C	1	HCPCS code including modifiers 20	A	14	838-851
IP220D	1	Unit or basis for measurement code 20	A	2	852-853
IP220E	1	Service units/days 20	N	7	854-860
IP220F	1	Total charges by revenue code 20	N	10	861-870
IP221A	1	Service line 21	N	6	871-876
IP221B	1	Revenue code 21	A	4	877-880
IP221C	1	HCPCS code including modifiers 21	A	14	881-894
IP221D	1	Unit or basis for measurement code 21	A	2	895-896
IP221E	1	Service units/days 21	N	7	897-903
IP221F	1	Total charges by revenue code 21	N	10	904-913
IP222A	1	Service line 22	N	6	914-919
IP222B	1	Revenue code 22	A	4	920-923
IP222C	1	HCPCS code including modifiers 22	A	14	924-937
IP222D	1	Unit or basis for measurement code 22	A	2	938-939
IP222E	1	Service units/days 22	N	7	940-946
IP222F	1	Total charges by revenue code 22	N	10	947-956
IP223A	1	Revenue code 23 (0001 if last page)	A	4	957-960
IP224	1	Page ___ of ___ 23	A	6	961-966
IP225	1	Total overall charges 23	N	10	967-976

Table 3.3 Inpatient Data Trailing Record Layout – Record Type 3

Number	Level	Field Name	Class	Width	Position
IP001	1	Unique patient control number	N	9	1-9
IP002	1	Record type	N	1	10-10
IP301	1	Primary payer identification	A	25	11-35
IP302	2	Estimated amount due	N	10	36-45
IP303	2	Prior payment	N	10	46-55
IP304	1	Secondary payer identification	A	25	56-80
IP305	2	Estimated amount due	N	10	81-90
IP306	2	Prior payment	N	10	91-100
IP307	1	Tertiary payer identification	A	25	101-125
IP308	2	Estimated amount due	N	10	126-135
IP309	2	Prior payment	N	10	136-145
IP310	2	Insured's name - Primary	A	25	146-170
IP311	1	Patient's relationship - Primary	N	2	171-172
IP312	2	Insured's unique ID - Primary	A	20	173-192
IP313	2	Insured group name - Primary	A	20	193-212
IP314	2	Insured's name - Secondary	A	25	213-237
IP315	1	Patient's relationship - Secondary	N	2	238-239
IP316	2	Insured's unique ID - Secondary	A	20	240-259
IP317	2	Insured group name - Secondary	A	20	260-279
IP318	2	Insured's name - Tertiary	A	25	280-304
IP319	1	Patient's relationship - Tertiary	N	2	305-306
IP320	2	Insured's unique ID - Tertiary	A	20	307-326
IP321	2	Insured group name - Tertiary	A	20	327-346
IP322	2	Employer name - Primary	A	24	347-370
IP323	2	Employer name - Secondary	A	24	371-394
IP324	1	Diagnosis version qualifier	A	1	395-395
IP325	1	Principal diagnosis code with POA	A	8	396-403
IP326	1	Secondary diagnosis code with POA 1	A	8	404-411
IP327	1	Secondary diagnosis code with POA 2	A	8	412-419
IP328	1	Secondary diagnosis code with POA 3	A	8	420-427
IP329	1	Secondary diagnosis code with POA 4	A	8	428-435
IP330	1	Secondary diagnosis code with POA 5	A	8	436-443
IP331	1	Secondary diagnosis code with POA 6	A	8	444-451
IP332	1	Secondary diagnosis code with POA 7	A	8	452-459
IP333	1	Secondary diagnosis code with POA 8	A	8	460-467
IP334	1	Secondary diagnosis code with POA 9	A	8	468-475
IP335	1	Secondary diagnosis code with POA 10	A	8	476-483
IP336	1	Secondary diagnosis code with POA 11	A	8	484-491
IP337	1	Secondary diagnosis code with POA 12	A	8	492-499
IP338	1	Secondary diagnosis code with POA 13	A	8	500-507
IP339	1	Secondary diagnosis code with POA 14	A	8	508-515
IP340	1	Secondary diagnosis code with POA 15	A	8	516-523
IP341	1	Secondary diagnosis code with POA 16	A	8	524-531
IP342	1	Secondary diagnosis code with POA 17	A	8	532-539
IP343	1	Admitting diagnosis code	A	7	540-546

Number	Level	Field Name	Class	Width	Position
IP344	1	Patient's reason for visit 1	A	7	547-553
IP345	1	Patient's reason for visit 2	A	7	554-560
IP346	1	Patient's reason for visit 3	A	7	561-567
IP347	1	Ext cause of inj code (E-code) with POA 1	A	8	568-575
IP348	1	Ext cause of Inj code (E-code) with POA 2	A	8	576-583
IP349	1	Ext cause of Inj code (E-code) with POA 3	A	8	584-591
IP350	1	Filler	A	1	592-592
IP351	1	Principal ICD procedure	A	7	593-599
IP352	1	Date of principal procedure	N	6	600-605
IP353	1	Secondary ICD procedure 1	A	7	606-612
IP354	1	Date of principal/secondary procedure	N	6	613-618
IP355	1	Secondary ICD procedure 2	A	7	619-625
IP356	1	Date of principal/secondary procedure	N	6	626-631
IP357	1	Secondary ICD procedure 3	A	7	632-638
IP358	1	Date of principal/secondary procedure	N	6	639-644
IP359	1	Secondary ICD procedure 4	A	7	645-651
IP360	1	Date of principal/secondary procedure	N	6	652-657
IP361	1	Secondary ICD procedure 5	A	7	658-664
IP362	1	Date of principal/secondary procedure	N	6	665-670
IP363	1	Attending provider ID - NPI/QUAL/ID	A	26	671-696
IP364	2	Attending provider taxonomy code	A	10	697-706
IP365	1	Operating physician ID - NPI/QUAL/ID	A	26	707-732
IP366	2	Operating physician taxonomy code	A	10	733-742
IP367	1	Other operating physician ID - NPI/QUAL/ID	A	26	743-768
IP368	2	Other operating physician taxonomy code	A	10	769-778
IP369	1	Rendering physician ID - NPI/QUAL/ID	A	26	779-804
IP370	2	Rendering physician taxonomy code	A	10	805-814
IP371	1	Referring provider ID - NPI/QUAL/ID	A	26	815-840
IP372	2	Referring provider taxonomy code	A	10	841-850
IP373	2	Resident ID - NPI/QUAL/ID	A	26	851-876
IP374	2	Resident ID type	A	1	877-877

Description of Inpatient Data Elements

Patient's Header Record – Record Type 1

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

Number	Field Name	Class	Position	Width
IP001	Unique Patient Control Number	N	1-9	9
Level:	Required			
Definition:	A unique identification number assigned by the hospital to each discharged patient's record.			
Notes:	The only use of this number is to ensure that the three types of records are processed as one record.			
Edit Check:	The number must be present in each record and be unique within the batch of hospital records processed.			
IP002	Record Type	N	10	1
Level:	Required			
Definition:	The record format type indicator.			
Notes:	This field must equal 1 indicating that the record is a Patient's Header Records.			
Edit Check:	The number must be present, and there can only be one record with record type equal 1 for each Unique Patient Control Number.			

Number	Field Name	Class	Position	Width
IP102	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	

Level: Required

Definition: The name of the hospital submitting the record.

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

IP103	Patient Social Security Number	A	111-123	13
-------	--------------------------------	---	---------	----

Level: Required

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

Notes: 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 Check: The field is edited for valid entry

Number	Field Name	Class	Position	Width
IP104	Patient Control Number	A	124-143	20
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.			
Notes:	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 Check:	The number must be present and should be unique within a hospital.			

Number	Field Name	Class	Position	Width
IP105	Type of Bill	A	144-147	4

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.

Notes: 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 Check: 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

Number	Field Name	Class	Position	Width
IP106	Patient Name	A	148-178	31
Level:	Required			
Definition:	The name of the patient in last, first, and middle initial order.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from first name.			
IP107	Patient's Address	A	179-262	84
Level:	Required			
Definition:	The address including postal zip code or postal zip code only of patient, as defined by the payer organization.			
Notes:	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 Check:	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.			

Number	Field Name	Class	Position	Width
IP112	Patient's Date of Birth	N	263-270	8
Level:	Required			
Definition:	The date of birth of the patient in month, day, year order.			
Notes:	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 Check:	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.			
IP113	Patient's Gender	A	271	1
Level:	Required			
Definition:	The gender of the patient as recorded at date of admission or start of care.			
Notes:	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 Check:	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.			

Number	Field Name	Class	Position	Width
IP114	Patient's Marital Status	A	272	1
Level:	As Available			
Definition:	The marital status of the patient at date of admission, or start of care.			
Notes:	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 Check:	This field is edited for a valid entry.			
IP115	Date of Admission	N	273-278	6
Level:	Required			
Definition:	The date the patient was admitted to the hospital for inpatient care.			
Notes:	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 Check:	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.			

Number	Field Name	Class	Position	Width
IP117	Type of Admission/Visit	N	279	1
Level:	Required			
Definition:	A code indicating the priority of the admission.			
Notes:	This is a one digit code ranging from 1 through 5 or maybe a 9. The code structure is as follows:			
	1 = Emergency			
	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.			
	2 = Urgent			
	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.			
	3 = Elective			
	The patient's condition permits adequate time to schedule the availability of a suitable accommodation. An elective admission can be delayed without substantial risk to the health of the individual.			
	4 = Newborn			
	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			
	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 Check:	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.			

Number	Field Name	Class	Position	Width
IP118	Point of Origin for Admission or Visit	A	280	1
Level:	Required			
Definition:	A code indicating the point of origin for the admission or visit.			
Notes:	<p>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:</p> <p>CODE STRUCTURE FOR EMERGENCY (1), URGENT (2), ELECTIVE (3), OR TRAUMA CENTER (5)</p> <p>1 = Non-Healthcare facility Point of Origin The patient was admitted to this facility includes patients coming from home or workplace.</p> <p>2 = Clinic or Physician’s Office The patient was admitted to this facility upon recommendation of another clinic or physician office.</p> <p>3 = (reserved for assignment by the NUBC)</p> <p>4 = Transfer from a hospital (Different Facility) 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).</p> <p>5 = Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.</p> <p>6 = Transfer from another healthcare facility The patient was admitted to this facility as a transfer from another type of healthcare facility not defined elsewhere on this list.</p> <p>7 = (Discontinued, for Emergency Room admission use Condition Code P7)</p> <p>8 = Court/Law enforcement 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.</p> <p>9 = Information not available The means by which the patient was admitted to this facility is not known.</p> <p>D = Transfer from one distinct unit of the hospital to another distinct unit of the hospital.</p>			

Number	Field Name	Class	Position	Width
	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			
	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			
	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			
	A baby born inside this hospital.			
6	Born Outside this Hospital			
	A baby born outside this hospital.			
9	Information not available.			
Edit Check:	The code must be present and valid and agree with the Type of Admission code entered.			

Number	Field Name	Class	Position	Width
IP120	Patient's Discharge Status	A	281-282	2
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.			
Notes:	<p>This is a code with a length of two. 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:</p> <p>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'.</p> <p>02 = Discharge/transferred to another short-term general hospital.</p> <p>03 = Discharge/transferred to skilled nursing facility</p> <p>04 = Discharge/transferred to an intermediate care facility</p> <p>05 = Discharged/transferred to a designated cancer center or children's hospital.</p> <p>06 = Discharge/transferred to home under care of organized home health service organization.</p> <p>07 = Left against medical advice or discontinued care</p> <p>08 = Discharge/transferred to home under care of a home IV provider</p> <p>09 = Unknown</p> <p>20 = Expired</p> <p>21 = Discharged/transferred to Court/Law Enforcement</p> <p>30 = Still patient (will be excluded from database)</p> <p>40 = Expired at home</p> <p>41 = Expired in a medical facility, i.e. hospital, skilled nursing facility, intermediate care facility, or free standing hospice.</p> <p>42 = Expired – place unknown</p> <p>43 = Discharged/transferred to federal facility</p> <p>50 = Discharged/transferred to hospice - home</p> <p>51 = Discharged/transferred to hospice - medical facility</p> <p>61 = Discharged/transferred within institution to hospital based Medicare swing bed</p> <p>62 = Discharged/transferred to another rehab facility including distinct units in hospital</p> <p>63 = Discharged/transferred to a long term care hospital</p> <p>64 = Discharged/transferred to a nursing facility certified under medicaid but not certified under medicare</p> <p>65 = Discharged/transferred to a psychiatric hospital or psychiatric unit of a hospital</p> <p>66 = Discharged/transferred to a Critical Access Hospital</p> <p>69 = Discharge/transferred to a designated disaster alternative care site (valid 10/2013)</p> <p>70 = Discharged/transferred/referred to another type of health care institution not defined elsewhere in this code list</p>			

Number	Field Name	Class	Position	Width
	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)			
	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 healthcare 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 Check:	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.			

Number	Field Name	Class	Position	Width
IP121	Statement Covers Period	N	283-294	12
	Beginning Date	N	283-288	
	6 Through Date	N		
	289-294	6		

Level: Required

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

Notes: 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 Check: 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.

IP122	Patient's Medical/Health Record Number	A	295-318	24
-------	--	---	---------	----

Level: Required

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

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

Edit Check: The field must be present.

Number	Field Name	Class	Position	Width
IP123	Patient's Race	A/N	319	1
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.			
Notes:	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 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 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 A person having origins in any of the black racial groups of Africa.			
	4 = White A person having origins in any of the original Caucasian peoples of Europe, North Africa, or the Middle East.			
	5 = Other Any possible options not covered in the above categories.			
	6 = Unknown A person who chooses not to answer the question.			
	7 = Native Hawaiian or Other Pacific Islander 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 The hospital made no effort to obtain the information.			

Number	Field Name	Class	Position	Width
IP124	Condition Codes (ER Admit, DNR, Homeless)	A	320-341	22
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.			
Notes:	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 Check:	This field is required. The P7 value is needed to replace the previous code 7 from the Source of Admission.			
IP125	Patient's Ethnicity	A/N	342	1
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.			
Notes:	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 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 A person who is not classified in 1.			
	6 = Unknown A person who chooses not to respond to the inquiry.			
	Blank Space The hospital made no effort to obtain the information.			
Edit Check:	If the data field contains an entry it must be a valid code combination.			

Patient's Revenue Record – Record Type 2

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 code “0001” to indicate the sum of all revenue services, see “Revenue Codes and Units of Service” in the Appendix for the complete list of revenue codes and definitions.

Number	Field Name	Class	Position	Width
IP001	Unique Patient Control Number	N	1-9	9
Level:	Required			
Definition:	A unique identification number assigned by the hospital to each discharged patient's record.			
Notes:	Its use is to ensure that the three types of formats are processed as one record.			
Edit Check:	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.			
IP002	Record Type	N	10	1
Level:	Required			
Definition:	The record type indicator.			
Notes:	This field must equal 2 for a revenue record.			
Edit Check:	The number must be present in each record and equal 2.			

Number	Field Name	Class	Position	Width
IP201A	Service Line 1	N	11-16	6
Level:	Required			
Definition:	The service line number for each row.			
Notes:	This field must start with 1 for the first revenue record.			
Edit Check:	The number must be present in each revenue service and is incremental.			
IP201B	Revenue Code 1	A	17-20	4
Level:	Required			
Definition:	A four digit code which identifies a specific accommodation, ancillary service, or billing calculation.			
Notes:	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 Check:	This field must be present and contain a valid revenue code as defined in "Revenue Codes and Units of Service" in the Appendix.			
IP201C	HCPCS Code including Modifiers 1	A	21-34	14
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.			
IP201D	Unit or Basis for Measurement Code 1	A	35-36	2
Level:	Required if the revenue code needs units, see "Revenue Codes and Units of Service" in the Appendix.			
Definition:	Indicator of whether the service Units/Days below is a Unit = 'UN' or a Day = 'DA'.			

Number	Field Name	Class	Position	Width
IP201E	Service Units/Days 1	N	37-43	7
Level:	Required if the revenue code needs units, see “Revenue Codes and Units of Service” in the Appendix.			
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.			
Notes:	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” in the Appendix defines the appropriate units for each revenue codes.			
Edit Check:	The units of service must be present for those revenue services which require a unit, see “Revenue Codes and Units of Service” in the Appendix.			
IP201F	Total Charges by Revenue Code 1	N	44-53	10
Level:	Required			
Definition:	Total dollars and cents amount charged for the related revenue service entered.			
Notes:	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, 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 Check:	This field must be present and contain a value greater than 0 when revenue code field is greater than 0.			
IP202A	Service Line 2	N	54-59	6
Level:	Required			
Definition:	The service line number for each row.			
Notes:	This field must start with 2 for the second revenue record.			
Edit Check:	The number must be present in each revenue service and is incremental.			

Number	Field Name	Class	Position	Width
IP202B	Revenue Code 2	A	60-60	4
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.			
Notes:	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 Check:	This field must be present and contain a valid revenue code as defined in "Revenue Codes and Units of Service" in the Appendix . 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.			
IP202C	HCPCS Code Including Modifiers 2	A	64-77	14
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.			
IP202D	Unit or Basis for Measurement Code 2	A	78-79	2
Level:	Required if the revenue code needs units, see "Revenue Codes and Units of Service" in the Appendix.			
Definition:	Indicator of whether the service Units/Days below is a Unit = 'UN' or a Day = 'DA'.			

Number	Field Name	Class	Position	Width
IP202E	Service Units/Days 2	N	80-86	7
Level:	Required if the revenue code needs units, see “Revenue Codes and Units of Service” in the Appendix.			
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.			
Notes:	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 Check:	The units of service must be present for those revenue services which require a unit.			

IP202F	Total Charges by Revenue Code 2	N	87-96	10
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.			
Notes:	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, 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 Check:	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.			

Note: Each subsequent revenue record should follow the same directions as for the previous record, with all integers incremented accordingly.

CHAPTER 3 – Inpatient Data Requirements

Number	Field Name	Class	Position	Width
IP203A	Service Line 3	N	97-102	6
IP203B	Revenue Code 3	A	103-106	4
IP203C	HCPCS Code Including Modifiers 3	A	107-120	14
IP203D	Units or Basis for Measurement Code 3	A	121-122	2
IP203E	Service Units/Days 3	N	123-129	7
IP203F	Total Charges by Revenue Code 3	N	130-139	10
IP204A	Service Line 4	N	140-145	6
IP204B	Revenue Code4	A	146-149	4
IP204C	HCPCS Code Including Modifiers 4	A	150-163	14
IP204D	Units or Basis for Measurement Code 4	A	164-165	2
IP204E	Service Units/Days 4	N	166-172	7
IP204F	Total Charges by Revenue Code 4	N	173-182	10
IP205A	Service Line 5	N	183-188	6
IP205B	Revenue Code 5	A	189-192	4
IP205C	HCPCS Code Including Modifiers 5	A	193-206	14
IP205D	Units or Basis for Measurement Code 5	A	207-208	2
IP205E	Service Units/Days 5	N	209-215	7
IP205F	Total Charges by Revenue Code 5	N	216-225	10

CHAPTER 3 – Inpatient Data Requirements

Number	Field Name	Class	Position	Width
IP206A	Service Line 6	N	226-231	6
IP206B	Revenue Code 6	A	232-235	4
IP206C	HCPCS Code Including Modifiers 6	A	236-249	14
IP206D	Units or Basis for Measurement Code 6	A	250-25	12
IP206E	Service Units/Days 6	N	252-258	7
IP206F	Total Charges by Revenue Code 6	N	259-268	10
IP207A	Service Line 7	N	269-274	6
IP207B	Revenue Code 7	A	275-278	4
IP207C	HCPCS Code Including Modifiers 7	A	279-292	14
IP207D	Units or Basis for Measurement Code 7	A	293-294	2
IP207E	Service Units/Days 7	N	295-301	7
IP207F	Total Charges by Revenue Code 7	N	302-311	10
IP208A	Service Line 8	N	312-317	6
IP208B	Revenue Code 8	A	318-321	4
IP208C	HCPCS Code Including Modifiers 8	A	322-335	14
IP208D	Units or Basis for Measurement Code 8	A	336-337	2
IP208E	Service Units/Days 8	N	338-344	7
IP208F	Total Charges by Revenue Code 8	N	345-354	10

CHAPTER 3 – Inpatient Data Requirements

Number	Field Name	Class	Position	Width
IP209A	Service Line 9	N	355-360	6
IP209B	Revenue Code 9	A	361-364	4
IP209C	HCPCS Code Including Modifiers 9	A	365-378	14
IP209D	Units or Basis for Measurement Code 9	A	379-380	2
IP209E	Service Units/Days 9	N	381-387	7
IP209F	Total Charges by Revenue Code 9	N	388-397	10
IP210A	Service Line 10	N	398-403	6
IP210B	Revenue Code 10	A	404-407	4
IP210C	HCPCS Code Including Modifiers 10	A	408-421	14
IP210D	Units or Basis for Measurement Code 10	A	422-423	2
IP210E	Service Units/Days 10	N	424-430	7
IP210F	Total Charges by Revenue Code 10	N	431-440	10
IP211A	Service Line 11	N	441-446	6
IP211B	Revenue Code 11	A	447-450	4
IP211C	HCPCS Code Including Modifiers 11	A	451-464	14
IP211D	Units or Basis for Measurement Code 11	A	465-466	2
IP211E	Service Units/Days 11	N	467-473	7
IP211F	Total Charges by Revenue Code 11	N	474-483	10

CHAPTER 3 – Inpatient Data Requirements

Number	Field Name	Class	Position	Width
IP212A	Service Line 12	N	484-489	6
IP212B	Revenue Code 12	A	490-493	4
IP212C	HCPCS Code Including Modifiers 12	A	494-507	14
IP212D	Units or Basis for Measurement Code 12	A	508-509	2
IP212E	Service Units/Days 12	N	510-516	7
IP212F	Total Charges by Revenue Code 12	N	517-526	10
IP213A	Service Line 13	N	527-532	6
IP213B	Revenue Code 13	A	533-536	4
IP213C	HCPCS Code Including Modifiers 13	A	537-550	14
IP213D	Units or Basis for Measurement Code 13	A	551-552	2
IP213E	Service Units/Days 13	N	553-559	7
IP213F	Total Charges by Revenue Code 13	N	560-569	10
IP214A	Service Line 14	N	570-575	6
IP214B	Revenue Code 14	A	576-579	4
IP214C	HCPCS Code Including Modifiers 14	A	580-593	14
IP214D	Units or Basis for Measurement Code 14	A	594-595	2
IP214E	Service Units/Days 14	N	596-602	7
IP214F	Total Charges by Revenue Code 14	N	603-612	10

CHAPTER 3 – Inpatient Data Requirements

Number	Field Name	Class	Position	Width
IP215A	Service Line 15	N	613-618	6
IP215B	Revenue Code 15	A	619-622	4
IP215C	HCPCS Code Including Modifiers 15	A	623-636	14
IP215D	Units or Basis for Measurement Code 15	A	637-638	2
IP215E	Service Units/Days 15	N	639-645	7
IP215F	Total Charges by Revenue Code 15	N	646-655	10
IP216A	Service Line 16	N	656-661	6
IP216B	Revenue Code 16	A	662-665	4
IP216C	HCPCS Code Including Modifiers 16	A	666-679	14
IP216D	Units or Basis for Measurement Code 16	A	680-681	2
IP216E	Service Units/Days 16	N	682-688	7
IP216F	Total Charges by Revenue Code 16	N	689-698	10
IP217A	Service Line 17	N	699-704	6
IP217B	Revenue Code 17	A	705-708	4
IP217C	HCPCS Code Including Modifiers 17	A	709-722	14
IP217D	Units or Basis for Measurement Code 17	A	723-724	2
IP217E	Service Units/Days 17	N	725-731	7
IP217F	Total Charges by Revenue Code 17	N	732-741	10

CHAPTER 3 – Inpatient Data Requirements

Number	Field Name	Class	Position	Width
IP218A	Service Line 18	N	742-747	6
IP218B	Revenue Code 18	A	748-751	4
IP218C	HCPCS Code Including Modifiers 18	A	752-765	14
IP218D	Units or Basis for Measurement Code 18	A	766-767	2
IP218E	Service Units/Days 18	N	768-774	7
IP218F	Total Charges by Revenue Code 18	N	775-784	10
IP219A	Service Line 19	N	785-790	6
IP219B	Revenue Code 19	A	791-794	4
IP219C	HCPCS Code Including Modifiers 19	A	795-808	14
IP219D	Units or Basis for Measurement Code 19	A	809-810	2
IP219E	Service Units/Days 19	N	811-817	7
IP219F	Total Charges by Revenue Code 19	N	818-827	10
IP220A	Service Line 20	N	828-833	6
IP220B	Revenue Code 20	A	834-837	4
IP220C	HCPCS Code Including Modifiers 20	A	838-851	14
IP220D	Units or Basis for Measurement Code 20	A	852-853	2
IP220E	Service Units/Days 20	N	854-860	7
IP220F	Total Charges by Revenue Code 20	N	861-870	10

Number	Field Name	Class	Position	Width
IP221A	Service Line 21	N	871-876	6
IP221B	Revenue Code 21	A	877-880	4
IP221C	HCPCS Code Including Modifiers 21	A	881-894	14
IP221D	Units or Basis for Measurement Code 21	A	895-896	2
IP221E	Service Units/Days 21	N	897-903	7
IP221F	Total Charges by Revenue Code 21	N	904-913	10
IP222A	Service Line 22	N	914-919	6
IP222B	Revenue Code 22	A	920-923	4
IP222C	HCPCS Code Including Modifiers 22	A	924-937	14
IP222D	Units or Basis for Measurement Code 22	A	938-939	2
IP222E	Service Units/Days 22	N	940-946	7
IP222F	Total Charges by Revenue Code 22	N	947-956	10
IP223A	Revenue Code 23 (0001 if last page)	A	957-960	4

Level: Required

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

Notes: 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, this would be populated.

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

Number	Field Name	Class	Position	Width
IP224	Page __ of __ 23	A	961-966	6
	Current Page/Record Number	A	961-963	3
	Total Pages/Records	A	964-966	3

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 Check: 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, they should be '1' and '2' followed by '2' and '2', etc.

IP225	Total Overall Charges 23	N	967-976	10
-------	--------------------------	---	---------	----

Level: Required

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

Notes: 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, 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 Check: 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.

Patient's Trailing Record – Record Type 3

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.

Number	Field Name	Class	Position	Width
--------	------------	-------	----------	-------

IP001	Unique Patient Control Number	N	1-9	9
-------	-------------------------------	---	-----	---

Level: Required

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

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

Edit Check: 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.

IP002	Record Type	N	10	1
-------	-------------	---	----	---

Level: Required

Definition: The record type indicator.

Notes: This field must equal 3 to indicate the end of the patient's discharge data record.

Edit Check: 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.

Number	Field Name	Class	Position	Width
<u>1st of three Payers</u>				
IP301	Primary Payer Identification	A	11-35	25
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.			
Notes:	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 Check:	The name must be that of a veritable organization.			
IP302	Estimated Amount Due	N	36-45	10
Level:	As Available			
Definition:	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
Notes:	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, 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 Check:	None			

Number	Field Name	Class	Position	Width
IP303	Prior Payment	N	46-55	10
Level:	As Available			
Definition:	The amount the hospital has received toward the payment prior to the billing date from the indicated payer.			
Notes:	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, 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 Check:	None			

2nd of three Payers

IP304	Secondary Payer Identification	A	56-80	25
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.			
Notes:	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 Check:	The name must be that of a veritable organization.			

Number	Field Name	Class	Position	Width
IP305	Estimated Amount Due	N	81-90	10
Level:	As Available			
Definition:	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
Notes:	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, 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 Check:	None			
IP306	Prior Payment	N	91-100	10
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.			
Notes:	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, 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 Check:	None			

Number	Field Name	Class	Position	Width
<u>3rd of three Payers</u>				
IP307	Tertiary Payer Identification	A	101-125	25
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.			
Notes:	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 Check:	The name must be that of a veritable organization.			
IP308	Estimated Amount Due	N	126-135	10
Level:	As Available			
Definition:	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
Notes:	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, 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 Check:	None			

Number	Field Name	Class	Position	Width
IP309	Prior Payment	N	136-145	10
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.			
Notes:	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, 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 Check:	None			

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

1st of three Insured Persons

IP310	Insured's Name—Primary	A	146-170	25
Level:	As Available			
Definition:	The name of the individual in whose name the insurance is carried.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from the first name.			

Number	Field Name	Class	Position	Width
IP311	Patient's Relationship—Primary	N	171-172	2
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.			
Notes:	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			
	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			
	Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage			
	23 = Sponsored Dependent			
	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			
	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			
	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			

Number	Field Name	Class	Position	Width
--------	------------	-------	----------	-------

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

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

43 = Child where insured has no financial responsibility

53 = Life Partner

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

IP312	Insured's Unique ID—Primary	A	173-192	20
-------	-----------------------------	---	---------	----

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 Check: None

IP313	Insured Group Name—Primary	A	193-212	20
-------	----------------------------	---	---------	----

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.

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

Edit Check: None

Number	Field Name	Class	Position	Width
<u>2nd of three Insured Persons</u>				
IP314	Insured's Name—Secondary	A	213-237	25
Level:	As Available			
Definition:	The name of the individual in whose name the insurance is carried.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from first name.			

Number	Field Name	Class	Position	Width
IP315	Patient's Relationship—Secondary	N	238-239	2
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.			
Notes:	<p>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:</p> <p>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 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 Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage 23 = Sponsored Dependent 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 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 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</p>			

Number	Field Name	Class	Position	Width
--------	------------	-------	----------	-------

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

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

43 = Child where insured has no financial responsibility

53 = Life Partner

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

IP316	Insured's Unique ID—Secondary	A	240-259	20
-------	-------------------------------	---	---------	----

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.

Notes: 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 Check: None

IP317	Insured Group Name—Secondary	A	260-279	20
-------	------------------------------	---	---------	----

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.

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

Edit Check: None

Number	Field Name	Class	Position	Width
<u>3rd of three Insured Persons</u>				
IP318	Insured's Name—Tertiary	A	280-304	25
Level:	As Available			
Definition:	The name of the individual in whose name the insurance is carried.			
Notes:	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 Check:	The name will be edited for the presence of the space and comma separating the last name from first name.			

Number	Field Name	Class	Position	Width
IP319	Patient's Relationship—Tertiary	N	305-306	2
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.			
Notes:	<p>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:</p> <p>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 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 Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage 23 = Sponsored Dependent 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 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 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</p>			

Number	Field Name	Class	Position	Width
--------	------------	-------	----------	-------

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

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

43 = Child where insured has no financial responsibility

53 = Life Partner

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

IP320	Insured's Unique ID—Tertiary	A	307-326	20
-------	------------------------------	---	---------	----

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.

Notes: 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 Check: None

IP321	Insured Group Name—Tertiary	A	327-346	20
-------	-----------------------------	---	---------	----

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.

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

Edit Check: None

Number	Field Name	Class	Position	Width
IP322	Employer Name—Primary	A	347-370	24
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.			
Notes:	Enter the full and complete name of the employer providing health care coverage.			
Edit Check:	None			
IP323	Employer Name—Secondary	A	371-394	24
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.			
Notes:	Enter the full and complete name of the employer providing health care coverage.			
Edit Check:	None			
IP324	Diagnosis Version Qualifier	A	395-395	1
Level:	Required			
Definition:	Indicator to designate which version of ICD was used to report diagnosis codes.			
Notes:	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 Check:	Must be present and valid.			

Number	Field Name	Class	Position	Width
IP325	Principal Diagnosis Code with POA	A	396-403	8
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.			
Notes:	<p>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 width. An “E” code should not be recorded as the principal diagnosis.</p> <p>POA coding:</p> <p>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.</p>			
Edit Check:	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.

Number	Field Name	Class	Position	Width
IP326	Secondary Diagnosis Code with POA (1 st of 17)	A	404-411	8
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.			
Notes:	<p>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 width. An “E” code should not be recorded as the principal diagnosis.</p> <p>POA coding:</p> <p>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.</p>			
Edit Check:	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.			
IP327	Secondary Diagnosis Code with POA (2 nd of 17)	A	412-419	8
IP328	Secondary Diagnosis Code with POA (3 rd of 17)	A	420-427	8
IP329	Secondary Diagnosis Code with POA (4 th of 17)	A	428-435	8
IP330	Secondary Diagnosis Code with POA (5 th of 17)	A	436-443	8
IP331	Secondary Diagnosis Code with POA (6 th of 17)	A	444-451	8

Number	Field Name	Class	Position	Width
IP332	Secondary Diagnosis Code with POA (7 th of 17)	A	452-459	8
IP333	Secondary Diagnosis Code with POA (8 th of 17)	A	460-467	8
IP334	Secondary Diagnosis Code with POA (9 th of 17)	A	468-475	8
IP335	Secondary Diagnosis Code with POA (10 th of 17)	A	476-483	8
IP336	Secondary Diagnosis Code with POA (11 th of 17)	A	484-491	8
IP337	Secondary Diagnosis Code with POA (12 th of 17)	A	492-499	8
IP338	Secondary Diagnosis Code with POA (13 th of 17)	A	500-507	8
IP339	Secondary Diagnosis Code with POA (14 th of 17)	A	508-515	8
IP340	Secondary Diagnosis Code with POA (15 th of 17)	A	516-523	8
IP341	Secondary Diagnosis Code with POA (16 th of 17)	A	524-531	8
IP342	Secondary Diagnosis Code with POA (17 th of 17)	A	532-539	8

Number	Field Name	Class	Position	Width
IP343	Admitting Diagnosis Code	A	540-546	7
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.			
Notes:	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 width. An “E” code should not be recorded as the admitting diagnosis.			
Edit Check:	If admitting diagnosis is present it must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.			
IP344	Patient’s Reason for Visit 1	A	547-553	7
Level:	Required for AS, ER 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.			
Notes:	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 <u>NOT</u> 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 width.			
Edit Check:	If patient’s reason for visit is present it must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.			
IP345	Patient’s Reason for Visit 2	A	554-560	7

Number	Field Name	Class	Position	Width
IP346	Patient's Reason for Visit 3	A	561-567	7
IP347	External Cause of Injury Code (E-code) with POA 1 8		A	568-575
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.			
Notes:	<p>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 width.</p> <p>POA coding:</p> <p>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.</p>			
Edit Check:	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.			
IP348	External Cause of Injury Code (E-code) with POA 2 8		A	576-583
IP349	External Cause of Injury Code (E-code) with POA 3 8		A	584-591
IP350	Filler	A	592	1

Note: Six procedures (one principal and five others) are accommodated in the record. All procedures entered must be coded using the same ICD method.

Number	Field Name	Class	Position	Width
IP351	Principal ICD Procedure	A	593-599	7
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.			
Notes:	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 Check:	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.			
IP352	Date of Principal Procedure (MMDDYY)	N	600-605	6
IP353	Secondary ICD Procedure 1	A	606-612	7
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.			
Notes:	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 Check:	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.			
Note: The record provides space to record up to five secondary procedures and dates. When a secondary procedure field is filled, the date should be the date of the secondary procedure. The date of the secondary procedure may be different that the date of the primary procedure.				

Number	Field Name	Class	Position	Width
IP354	Date of Principal/Secondary Procedure 1	N	613-618	6
IP355	Secondary ICD Procedure 2	A	619-625	7
IP356	Date of Principal/Secondary Procedure 2	N	626-631	6
IP357	Secondary ICD Procedure 3	A	632-638	7
IP358	Date of Principal/Secondary Procedure 3	N	639-644	6
IP359	Secondary ICD Procedure 4	A	645-651	7
IP360	Date of Principal/Secondary Procedure 4	N	652-657	6
IP361	Secondary ICD Procedure 5	A	658-664	7
IP362	Date of Principal/Secondary Procedure 5	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.

Number	Field Name	Class	Position	Width
IP363	Attending Provider ID – NPI/QUAL/ID	A	671-696	26
Level:	Required			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
IP364	Attending Provider Taxonomy Code	A	697-706	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Width
IP365	Operating Physician ID – NPI/QUAL/ID	A	707-732	26
Level:	Required			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
IP366	Operating Physician Taxonomy Code	A	733-742	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Width
IP367	Other Operating Physician ID – NPI/QUAL/ID	A	743-768	26
Level:	Required			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
IP368	Other Operating Physician Taxonomy Code	A	769-778	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Width
IP369	Rendering Physician ID – NPI/QUAL/ID	A	779-804	26
Level:	Required			
Definition:	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.			
Notes:	<p>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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
IP370	Rendering Physician Taxonomy Code	A	805-814	10
Level:	As Available			
Definition:	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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Width
IP371	Referring Provider ID – NPI/QUAL/ID	A	815-840	26
Level:	Required			
Definition:	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.			
Notes:	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			
Edit Check:	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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.			
IP372	Referring Provider Taxonomy Code	A	841-850	10
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.			
Notes:	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 Check:	If not available, this field may be space filled.			

Number	Field Name	Class	Position	Width
IP373	Resident ID – NPI/QUAL/ID	A	851-876	26
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.			
Notes:	<p>If there were no residents involved, 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.</p> <p>The secondary identification qualifiers must be selected from the following list:</p> <p>OB = State License Number 1G = Provider UPIN Number G2 = Provider Commercial Number LU = Location Number</p>			
Edit Check:	<p>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 + OB + 97-266855-1205 = 12345678900B97-266855-1205.</p>			
IP374	Resident ID Type	A	877	1
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			
Notes:	If there were no residents involved in patient care, this field may be space filled.			
Edit Check:	If Resident ID is completed, this field must be completed with 'F' or 'U'.			

Appendix

Revenue Codes and Units of Service

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.

Code	Unit	Definition
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

Code	Unit	Definition
		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.
		<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
013x	Days	Room and Board (Three and Four Beds) - routine service charges incurred for accommodations with three and four beds.
		<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
014x	Days	Room and Board (Deluxe Private) - deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.
		<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
015x	Days	Room and Board (Ward) - routine service charge for accommodations with five or more beds.
		<u>Subcategory "x"</u>

Code	Unit	Definition
		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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 0 = General classification 1 = Skilled care 2 = Comprehensive care 3 = Complex care 4 = Intensive care

Code	Unit	Definition
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		0 = General classification
		1 = Nursery
		2 = OB
		3 = ICU
		4 = CCU
		5 = Hospice
		9 = Other

Code	Unit	Definition
024x	None	All Inclusive Ancillary - a flat rate charge incurred on either a daily basis or total stay basis for ancillary services only. <u>Subcategory "x"</u> 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. <u>Subcategory "x"</u> 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. <u>Subcategory "x"</u> 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. <u>Subcategory "x"</u> 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. <u>Subcategory "x"</u> 0 = General classification

Code	Unit	Definition
		1 = Other oncology
029x	Item	Durable Medical Equipment (other than rental) -charges for medical equipment that can withstand repeated use.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.

Code	Unit	Definition
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 0 = General classification 1 = Anesthesia incident to RAD 2 = Anesthesia incident to other DX services 4 = Acupuncture 9 = Other anesthesia
038x	Pint	Blood
		<u>Subcategory "x"</u>

Code	Unit	Definition
		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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 0 = General classification 1 = Visit charge 2 = hourly charge 3 = Group rate 4 = Evaluation or re-evaluation

Code	Unit	Definition
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>

Code	Unit	Definition
		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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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.
		<u>Subcategory "x"</u> 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
		<u>Subcategory "x"</u> 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.

Code	Unit	Definition
		<u>Subcategory “x”</u> 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.
		<u>Subcategory “x”</u> 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.
		<u>Subcategory “x”</u> 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.
		<u>Subcategory “x”</u> 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.
		<u>Subcategory “x”</u> 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.

Code	Unit	Definition
		<u>Subcategory “x”</u> 0 = General classification
060x	Visit	Home Health (HH) Oxygen – HH charges for oxygen equipment, supplies or contents, excluding purchased equipment.
		<u>Subcategory “x”</u> 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).
		<u>Subcategory “x”</u> 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.
		<u>Subcategory “x”</u> 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.
		<u>Subcategory “x”</u> 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

Code	Unit	Definition
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		0 = General classification
		1 = Hospital owned
		2 = Contracted
		9 = Other special residence charge
068x	*	Trauma Response – charges representing the activation of the trauma team.
		<u>Subcategory "x"</u>
		0 = General classification

Code	Unit	Definition
		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.
		<u>Subcategory "x"</u>
		0 = General classification
		9 = Other cast room
071x	None	Recovery Room
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		0 = General classification
		9 = Other EEG
075x	Test	Gastrointestinal Services - procedure room charges for endoscopic procedures not performed in the operating room.
		<u>Subcategory "x"</u>

Code	Unit	Definition
		0 = General classification
076x	None	Specialty Services - charges for patients requiring treatment room services or patients placed under observation.
		<u>Subcategory "x"</u>
		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).
		<u>Subcategory "x"</u>
		0 = General classification
		1 = Vaccine administration
078x	None	Telemedicine – facility charges related to the use of telemedicine services.
		<u>Subcategory "x"</u>
		0 = General classification
079x	None	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) - charges related to Extra-Corporeal Shock Wave Therapy (ESWT).
		<u>Subcategory "x"</u>
		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).
		<u>Subcategory "x"</u>
		0 = General classification
		1 = Inpatient hemodialysis
		2 = Inpatient peritoneal
		3 = Inpatient continuous ambulatory peritoneal dialysis
		4 = Inpatient continuous cycling peritoneal dialysis
		9 = Other inpatient dialysis
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.
		<u>Subcategory "x"</u>
		0 = General classification
		1 = Living donor
		2 = Cadaver donor
		3 = Unknown donor
		4 = Unsuccessful Organ search

Code	Unit	Definition
		9 = Other organ acquisition
086x	None	Magneto Encephalography - charges for operation of specialized medical equipment to measure the magnetic fields generated by brain activity.
		<u>Subcategory "x"</u>
		0 = General classification
		1 = MEG
088x	None	Miscellaneous Dialysis - charges for dialysis services not identified elsewhere.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		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.
		<u>Subcategory "x"</u>
		0 = General classification
		1 = Peripheral vascular lab.

Code	Unit	Definition
		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. <u>Subcategory “x”</u> 1 = Half day 2 = Full day
094x	Visit	Other Therapeutic Services - charges for other therapeutic services not otherwise categorized. <u>Subcategory “x”</u> 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. <u>Subcategory “x”</u> 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. <u>Subcategory “x”</u> 0 = General classification 1 = Psychiatric 2 = Ophthalmology 3 = MD Anesthesiologist 4 = CRNA Anesthetist 9 = Other professional fee
097x	None	Professional Fees (extension of 096x)

Code	Unit	Definition
		<u>Subcategory “x”</u>
		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)
		<u>Subcategory “x”</u>
		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.
		<u>Subcategory “x”</u>
		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.
		<u>Subcategory “x”</u>
		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

Code	Unit	Definition
		under other therapeutic service revenue codes (042x, 043x, 044x, 091x, 094x, 095x) or services such as anesthesia or clinic (0374, 0511).
		<u>Subcategory “x”</u>
		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).
		<u>Subcategory “x”</u>
		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