2017 Utah Healthcare Facility Database

Utah Healthcare Facility Database (2017). Utah Health Data Committee/Office of Health Care Statistics. Utah Department of Health. Salt Lake City, Utah. 2018.

Limited Use Data Sets User Manual

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INTRODUCTION

Utah Healthcare Facility Database

The Utah Health Data Committee is composed of fifteen governor-appointed members and was created by the Utah Health Data Authority Act of 1991. The Committee is staffed by the Office of Health Care Statistics which manages the Utah Healthcare Facility Database.

Utah Administrative Rule requires all Utah licensed hospitals, both general acute care and specialty, and free standing ambulatory surgical centers to provide data on inpatient, emergency department, and ambulatory surgery encounters. The Healthcare Facility Database contains information on patient demographics, admission and discharge, diagnoses, services received, and charges billed for each encounter.

Data submissions by the FASCs are incomplete and caution should be used when trying to perform market level comparisons with these data. Reporting improvements have been made. However, continual efforts will be made over the next few years to further data completeness.

Starting with 2010, the records from University of Utah Health facilities have undergone a dramatic revision. They identified they were previously under-reporting many of their ambulatory surgery procedures, especially GI or eye procedures, which typically might be performed outside of the operating room and in procedure rooms located in their clinics or health centers. For 2016, Huntsman Cancer Institute, Madsen Surgery Center, Moran Eye Center, and University Orthopedic Center are the only University of Utah Health sites reported individually; all other University Hospital & Clinics are reported as one facility (#125).

Selected Ambulatory Surgeries Reported in Utah

The following CPT-4 or ICD-9-CM surgical procedures are reported whether or not they are the principal procedure:

Table 1: Types of Surgical Services Submitted if Performed in Operating or Procedure Rooms

DESCRIPTION	CPT-4 CODES	ICD-9-CM PROCEDURE CODES
Mastectomy	19300-19307	85.0-85.99
Musculoskeletal	20000-29909	76.0-84.99
Respiratory	30000-32999	30.0-34.99
Cardiovascular*	33010-37799, 93501-93660	35.0-39.99
Lymphatic/Hematic	38100-38999	40.0-41.99
Digestive System**	40490-49999, G0104, G0105, G0106, G0120, G0121	42.0-54.99
Urinary	50010-53899	55.0-59.99
Male Genital	54000-55899	60.0-64.99
Female Genital	56405-58999	65.0-71.99
Endocrine/Nervous	60000-64999	01.0-07.99
Eye	65091-68889	08.0-16.99
Ear	69000-69979	18.0-20.99

Nose/Mouth/Pharynx	in Musculoskeletal/Respiratory	21.0-29.99

* 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 2005, HCPCS Level II Colorectal Cancer Screening Colonoscopy codes G0104, G0105, G0106, G0120, & G0121 were added to the list for digestive system procedures and are retained in the database if reported.

Limited Use Data Sets

Separate limited use data sets are created for inpatient, emergency department, and ambulatory surgery encounters. The limited use data sets are designed to provide general health care information to a wide spectrum of users with minimal controls.

The limited use data sets include data on charges and length of stay. Several factors, such as case-mix, severity complexity, payer-mix, market areas, hospital ownership, hospital affiliation, or hospital teaching status, affect the comparability of charge and length of stay across hospitals. Any analysis of charge or length of stay at the hospital level should consider the above factors. More information about hospitals can be found in the "Utah Hospital Characteristics" table at https://opendata.utah.gov/Health/Utah-Hospital-Characteristics/ierb-h3t5.

Data Processing and Quality

Data Submission

The Office of Health Care Statistics maintains and publishes the Utah Healthcare Facility Data Submission Guide on its website. Data suppliers submit all files using specifications in the data submission guide.

System Edits

The data are validated through a process of automated editing and report verification. Each record is subjected to a series of edits that check for validity, consistency, completeness, and conformity with the definitions specified in the Utah Healthcare Facility Data Submission Guide. Files that fail edit checks are returned to the data supplier for correction.

Hospital Review

Each hospital is given the opportunity to review and validate findings of the edit checks and any public report prior to the release of data or information. Inconsistencies discovered by the facilities are reevaluated or corrected.

Missing Values

When dealing with unknown values, it is important to distinguish between systematic omission by the facility (e.g., for facilities that were granted reporting exemption for particular data elements or which had coding problems that deemed the entire data from the facility unusable) and non-systematic omission (e.g., coding problems, invalid codes, etc.). While systematic omission creates potential bias, non-systematic omission is assumed to occur randomly. The user is advised to examine missing values by facility for each data element to be used. The user is likewise advised to examine the number of observations by facility by quarter to judge if a facility under-reported for a given quarter, which occasionally happens due to data processing problems experienced by a facility.

Patient Confidentiality

The Committee has taken steps to ensure that no individual patient will be identified from the limited use data sets. Patient's age, physician specialty, and payers are grouped. Several data elements are suppressed under specific conditions: 1) ZIP codes with less than 30 visits in a calendar year are suppressed; 2) physician taxonomy is suppressed for hospitals with less than 30 beds; 3) age, sex, and ZIP code are suppressed if the discharge involves substance abuse or HIV infection, as defined by the following Medicare Severity Grouper Diagnosis Related Groups (MS-DRGs):

894—ALCOHOL, DRUG ABUSE OR DEPENDENCE, LEFT AMA

895—ALCOHOL, DRUG ABUSE OR DEPENDENCE WITH REHABILITATION THERAPY

896—ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITH MCC

897—ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITHOUT MCC

969—HIV WITH EXTENSIVE O.R. PROCEDURE WITH MCC

970—HIV WITH EXTENSIVE O.R. PROCEDURE WITHOUT MCC

974—HIV WITH MAJOR RELATED CONDITION WITH MCC

975—HIV WITH MAJOR RELATED CONDITION WITH CC

976—HIV WITH MAJOR RELATED CONDITION WITHOUT CC/MCC

977—HIV WITH OR WITHOUT OTHER RELATED CONDITION

DRG, MS-DRG, APR-DRG, and EAPG Classification

Variables produced by OHCS using 3M grouper software are no longer standard inclusions in the limited use data sets.

Maintenance of the DRG grouper was discontinued in 2007. Previous versions of limited use data sets may have included variables resulting from the DRG grouper to aid comparisons to historical data. However, this grouper cannot be applied to data beginning in 2015 due to the change from ICD-9 to ICD-10 and thus is no is no longer included in the limited use data sets.

Citation

Any statistical reporting or analysis based on the data shall cite the source as the following:

Utah Healthcare Facility Limited Use Data Sets (2017). Utah Health Data Committee/Office of Health Care Statistics. Utah Department of Health. Salt Lake City, Utah. 2018.

FILE LAYOUT

Limited Use Data Sets Record Layout

Field Name	Variable
Record_ID	Record ID
Encounter_Type	Encounter Type
Facility_Number	Facility Number
Facility_Name	Facility Name
Age_Group_Num	Patient Age Group Number
Age_Group	Patient Age Group
Patient_Gender	Patient Gender
Admission_Type	Type of Admission
Admission_Source	Source of Admission
ER_Flag	ER Flag
Observation_Stay_Flag	Observation Stay Flag
Quarter	Quarter
Admission_Hour	Admission Hour
LOS_Days	Length of Stay – Days
LOS_Hours	Length of Stay – Hours
Patient_Discharge_Status	Discharge Status
Patient_State	Patient State
Patient_County_FIPS	Patient County FIPS
Patient_ZIP	Patient ZIP Code
Patient_Country	Patient Country
Patient_Marital_Status	Patient Marital Status
Patient_Race_Ethnicity	Patient Race & Ethnicity
ICD_Indicator	ICD Indicator
Admission_Diagnosis_Code	Admission Diagnosis Code
Patient_Reason_For_Visit_1	Patient Reason For Visit 1
Patient_Reason_For_Visit_2	Patient Reason For Visit 2
Patient_Reason_For_Visit_3	Patient Reason For Visit 3
Principal_Diagnosis_Code	Principal Diagnosis Code
Principal_Diagnosis_Code_POA	Principal Diagnosis Code POA
Secondary_Diagnosis_Code_1	Secondary Diagnosis Code 1
Secondary_Diagnosis_Code_POA_1	Secondary Diagnosis Code POA 1
Secondary_Diagnosis_Code_2	Secondary Diagnosis Code 2
Secondary_Diagnosis_Code_POA_2	Secondary Diagnosis Code POA 2
Secondary_Diagnosis_Code_3	Secondary Diagnosis Code 3
Secondary_Diagnosis_Code_POA_3	Secondary Diagnosis Code POA 3
Secondary_Diagnosis_Code_4	Secondary Diagnosis Code 4
Secondary_Diagnosis_Code_POA_4	Secondary Diagnosis Code POA 4

Field Name	Variable
Secondary_Diagnosis_Code_5	Secondary Diagnosis Code 5
Secondary_Diagnosis_Code_POA_5	Secondary Diagnosis Code POA 5
Secondary_Diagnosis_Code_6	Secondary Diagnosis Code 6
Secondary_Diagnosis_Code_POA_6	Secondary Diagnosis Code POA 6
Secondary_Diagnosis_Code_7	Secondary Diagnosis Code 7
Secondary_Diagnosis_Code_POA_7	Secondary Diagnosis Code POA 7
Secondary_Diagnosis_Code_8	Secondary Diagnosis Code 8
Secondary_Diagnosis_Code_POA_8	Secondary Diagnosis Code POA 8
Secondary_Diagnosis_Code_9	Secondary Diagnosis Code 9
Secondary_Diagnosis_Code_POA_9	Secondary Diagnosis Code POA 9
Secondary_Diagnosis_Code_10	Secondary Diagnosis Code 10
Secondary_Diagnosis_Code_POA_10	Secondary Diagnosis Code POA 10
Secondary_Diagnosis_Code_11	Secondary Diagnosis Code 11
Secondary_Diagnosis_Code_POA_11	Secondary Diagnosis Code POA 11
Secondary_Diagnosis_Code_12	Secondary Diagnosis Code 12
Secondary_Diagnosis_Code_POA_12	Secondary Diagnosis Code POA 12
Secondary_Diagnosis_Code_13	Secondary Diagnosis Code 13
Secondary_Diagnosis_Code_POA_13	Secondary Diagnosis Code POA 13
Secondary_Diagnosis_Code_14	Secondary Diagnosis Code 14
Secondary_Diagnosis_Code_POA_14	Secondary Diagnosis Code POA 14
Secondary_Diagnosis_Code_15	Secondary Diagnosis Code 15
Secondary_Diagnosis_Code_POA_15	Secondary Diagnosis Code POA 15
Secondary_Diagnosis_Code_16	Secondary Diagnosis Code 16
Secondary_Diagnosis_Code_POA_16	Secondary Diagnosis Code POA 16
Secondary_Diagnosis_Code_17	Secondary Diagnosis Code 17
Secondary_Diagnosis_Code_POA_17	Secondary Diagnosis Code POA 17
Ext_Cause_Of_Inj_Code_1	External Cause of Injury Code 1
Ext_Cause_Of_Inj_Code_POA_1	External Cause of Injury Code POA 1
Ext_Cause_Of_Inj_Code_2	External Cause of Injury Code 2
Ext_Cause_Of_Inj_Code_POA_2	External Cause of Injury Code POA 2
Ext_Cause_Of_Inj_Code_3	External Cause of Injury Code 3
Ext_Cause_Of_Inj_Code_POA_3	External Cause of Injury Code POA 3
Principal_ICD_Procedure	Principal ICD Procedure
Secondary_ICD_Procedure_1	Secondary ICD Procedure 1
Secondary_ICD_Procedure_2	Secondary ICD Procedure 2
Secondary_ICD_Procedure_3	Secondary ICD Procedure 3
Secondary_ICD_Procedure_4	Secondary ICD Procedure 4
Secondary_ICD_Procedure_5	Secondary ICD Procedure 5
Service_Line	Service Line
HCPCS_Code	HCPCS/CPT Procedure Code
HCPCS_Code_Mod1	HCPCS Code Modifier 1
HCPCS_Code_Mod2	HCPCS Code Modifier 2

Field Name	Variable
Total_Charge_Header	Total Charges
ER_Charges	Emergency Room Charges
Facility_Charges	Facility Charges
Professional_Charges	Professional Charges
Attending_Taxonomy_Code	Attending Taxonomy Code
Operating_Taxonomy_Code	Operating Taxonomy Code
Other_1_Taxonomy_Code	Other Provider 1 Taxonomy Code
Other_2_Taxonomy_Code	Other Provider 2 Taxonomy Code
Other_3_Taxonomy_Code	Other Provider 3 Taxonomy Code
Other_4_Taxonomy_Code	Other Provider 4 Taxonomy Code
Payer_Raw_Primary	Raw Primary Payer String
Payer_Typology_Primary	Primary Payer Typology

DESCRIPTION OF DATA ELEMENTS

General Elements

Record ID

A unique number for each visit, which is also unique across all years of available data.

Encounter Type

The ED limited use dataset includes the combined data on all ED outpatient visits and ED inpatient admissions. An Encounter Type field with values of 'o' and 'i' was added to the record layout starting in 1999. Values changed in 2015. Beginning in the 2015 ED limited use dataset, 'E' indicates an ED outpatient visit and 'I' indicates an ED inpatient admission. Caution should be used when comparing this data with years prior to 1999 as they only included ED outpatient visits.

A = Ambulatory Surgery
E = Emergency Department
I = Inpatient

Facility Number

OHCS assigned identifier for the facility from which patient was discharged. More information about facilities can be found in the "Utah Hospital Characteristics" table at https://opendata.utah.gov/Health/Utah-Hospital-Characteristics/ierb-h3t5.

Quarter

Quarter from which the data was collected. This field in conjunction with Facility Name/Numbers is useful for data quality control. The combination of facility and quarter represent units of data collected.

Service Line

Count of services. Service lines represent revenue lines and the associated procedures and charges. Header data repeats while service line data changes with each new line. Currently only applies to ambulatory surgery records. That is, inpatient and ED encounters only consist of a single record line, while ambulatory surgery encounters can consist of multiple lines with incrementing service line values.

Patient Demographics

Patient Age Group

Age of patient at date of release.

0	=	1 - 28 days
1	=	29 -365 days
2	=	1-4 years
3	=	5-9
4	=	10-14
5	=	15-17
6	=	18-19
7	=	20-24
8	=	25-29
9	=	30-34
10	=	35-39
11	=	40-44
12	=	45-49
13	=	50-54
14	=	55-59
15	=	60-64
16	=	65-69
17	=	70-74
18	=	75-79
19	=	80-84
20	=	85-89
21	=	90 +
99	=	Suppressed

Patient Gender

M	=	Male
F	=	Female
U	=	Unknown
S	=	Suppressed

Patient Geography

Patient Zip Code

This field changed in 2015 and no longer includes county or state values as a means of suppression. If less than 30 encounters occurred for a ZIP code, the ZIP code value was set to “SUPPRESSED”.

Helpful Hint: A quick way to identify the city associated with a zip code is to use the United States Postal Service website. (https://tools.usps.com/go/ZipLookupAction!input.action)

Patient County

FIPS code for the county of residence (https://www.census.gov/geo/reference/codes/cou.html). This field is derived from the patient's ZIP code using the Federal Department of Housing and Urban Development's Zip-County ratios (https://www.huduser.gov/portal/datasets/usps_crosswalk.html). If a ZIP crossed a county boundary, all encounters in the Zip were assigned to the county with the higher proportion of the population.

Local Health Districts

Counties can be grouped into Local Health Districts (LHD). LHDs are subject to change. Please refer to the Utah Department of Health website for more detail.
(https://ibis.health.utah.gov/about/LocalHealth.html)

Patient Marital Status

S	=	Single
M	=	Married
X	=	Legally Separated
D	=	Divorced
W	=	Widowed
P	=	Life Partner
U	=	Unknown
Blank	=	Not reported

Patient Race & Ethnicity

W	=	White, non-Hispanic origin
WH	=	White, Hispanic origin
NW	=	Non-white, Hispanic origin
NH	=	Non-white, non-Hispanic origin
UK	=	Unknown
Blank	=	Not reported

Admission and Discharge

Type of Admission

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 = Unknown

Blank = Not reported

Source of Admission/Point of Origin for Non-Newborns (Type of Admission Other Than 4)

0 = Newborns

1 = Non-health care facility: The patient was admitted to this facility includes patients coming from home or workplace.

2 = Clinic or Physician's Office: The patient was admitted to this facility upon recommendation of another clinic or physician office.

3 = (Reserved for assignment by the NUBC)

4 = Transfer from a hospital: 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 or intermediate care facility: The patient was admitted to this facility as a transfer from a skilled nursing facility or intermediate care facility where he or she was an inpatient.

6 = Transfer from another health care facility: The patient was admitted to this facility as a transfer from a health care facility not defined elsewhere on this list.

7 = (Discontinued. 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. Includes transfers from incarceration facilities.

9 = Information not available: The means by which the patient was admitted to this hospital is not known.

A = Transfer from a critical access hospital

B = Transfer from another HHA

C = Readmission to same HHA

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

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 Enrolled in a Hospice Program: The patient was admitted to the facility as a transfer from a hospice.

Source of Admission/Point of Origin for Newborns (Type of Admission = 4)

0 = Non-Newborns
1 = Normal delivery: a baby delivered without complications
2 = Premature delivery: a baby delivered with time or weight factors qualifying it for premature status
3 = Sick baby: a baby delivered with medical complications, other than those relating to premature status
4 = Extramural birth: a baby born in non-sterile environment
5 = Born inside this hospital
6 = Born outside this hospital
9 = Information not available
Blank = Not reported

Admission Hour

The hour during which the patient arrived at the Emergency Department (using the 24-hour clock format). *Only applies to outpatient ED encounters.*

Length of Stay—Days

Total days stayed in hospital from the date of admission to the date of discharge. *Only applies to inpatient encounters.*

Blank = Not calculable

Length of Stay—Hours

Total hour stayed in hospital from the date of admission to the date of discharge. *Only applies to outpatient emergency encounters.*

Blank = Not calculable

ER Flag

Flag indicating whether an encounter included services billed under an emergency room-related NUBC revenue code: 045X.

1 = Included services billed under 045X
0 = Did not include services billed under 045X
Blank = Not calculable

Observation Stay Flag

Flag indicating whether an encounter included services billed under an observation stay-related NUBC revenue code: 076X.

1 = Included services billed under 076X
0 = Did not include services billed under 076X

Blank = Not calculable

Discharge Status

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
08 = Discharged/transferred to home under care of a home IV provider
20 = Expired
21 = Discharged/transferred to Court/Law enforcement
40 = Expired at home
41 = Expired in a medical facility; i.e. hospital, skilled nursing facility, intermediate care facility, or free standing h
42 = Expired - place unknown
43 = Discharged 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 facility
66 = Discharged/transferred to a Critical Access Hospital
69 = Discharge/transferred to a designated disaster alternative care site
70 = Discharged/transferred/referred to another 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)
81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission
82 = Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospita
83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute ca
84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hos
85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospit
86 = Discharged/transferred to home under care of organized home health service organization with a planned a
87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmis
89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospita
90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units
91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hos
92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a
93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inp
94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readm

95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with
09 = Unknown
Blank = Not reported

Diagnosis Codes

ICD Indicator

Indicates whether ICD-9 or ICD-10 codes are used in ICD diagnosis and procedure code fields.

9	=	ICD-9-CM
10	=	ICD-10-CM/PCS

ICD Diagnosis Codes

ICD-9-CM or ICD-10-CM code. Refer to *International Classification of Diseases, Clinical Modification* for description. There is an implied decimal point which is standard for a diagnosis code but has been stripped out of the data. External Cause of Injury might also be found in this field.

Blank	=	Not reported

Reason for Visit

The diagnosis code describing the patient's reason for visit at the time of outpatient registration.

Present on Admission Codes (POA)

Diagnosis was present on inpatient admission. POA is associated with Principal Diagnosis Code.

Y	=	Present at time of inpatient admission
N	=	Not present at time of inpatient admission
U	=	Unknown
W	=	Clinically undetermined
1, E	=	Exempt from POA reporting
Blank	=	Not reported

External Cause of Injury Code (E-Code)

Supplementary classification of External Causes of Injury and Poisoning. Refer to *International Classification of Diseases, Clinical Modification* for description. There is an implied decimal point which is part of ICD code but has been stripped out of data.

Blank	=	Not reported

Procedure Codes

ICD Procedure Codes

ICD-9-CM or ICD-10-PCS code. Refer to *International Classification of Diseases, Clinical Modification* for description. There is an implied decimal point which is part of ICD code but has been removed.

Blank = Not reported

HCPCS/CPT Procedure Codes and Modifiers

The five characters of the HCPCS code, followed by optional numeric or character modifiers. Refer to Centers for Medicare & Medicaid Services (HCPCS) and American Medical Association's Current Procedure Terminology (CPT) for descriptions.

Blank = Not reported

Charges and Payers

Facility Charges

For inpatient encounters, this is the sum of charges with NUBC revenue codes 010x-095x (with 2 implied decimal digits).

Blank = Not reported

Emergency Room Charges

For encounters involving the emergency room, this is the sum of charges for the encounter with NUBC revenue code: 045X.

Blank = Not reported

Professional Charges

For inpatient encounters, this is the sum of charges with NUBC revenue codes 096x-098x for the discharge (with 2 decimal digits).

CHARGE NOTE: Total charge is reported by hospitals. Facility and professional charges are calculated from individual revenue charges. Due to various reasons (adjusting total charges without making corresponding adjustment in specific revenue charge), the sum of facility and professional charges are not necessarily equal to total charges.

Blank = Not reported

Total Charge Header

Total amount charged for the visit (with 2 decimal digits). The total charges are calculated on the header rather than the service line, thus total charge repeats for each service line.

Blank = Not reported

Raw Payer String

Payer name as a raw text string submitted by the facility. This element may be useful for developing or validating payer typology logic.

Suppressed = Suppressed

Payer Typology

This value set is adapted from the Public Health Data Standards Consortium's (PHDSC) Users Guide for Source of Payment Typology 7.0. (http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion7FinalJune27_2016.pdf)

1 = Medicare
2 = Medicaid
3 = Other Government

4 = Department of Corrections
5 = Private Health Insurance
6 = Blue Cross/Blue Shield
7 = Managed Care, Unspecified
8 = Self-Pay, No Charge, Charity, Refusal, Research/Donor, or No Payment
9 = Workers Compensation, Foreign National, Disability, Long-Term Care, Auto Insurance, or Legal Liability
Blank = Unknown

Providers

Provider Taxonomy

Provider specialty using National Uniform Claim Committee (NUCC) coding standard.

Suppressed	=	Suppressed