ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES

DHHS
ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES

HOSPITAL DISCHARGE DATA SUBMITTAL GUIDE

FEBRUARY 2006

ARKANSAS DEPARTMENT
OF HEALTH AND HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
P O BOX 1437, SLOT H19
LITTLE ROCK, AR 72203-1437

CERTIFICATION

This will certify that the following Rules and Regulations for the Hospital Discharge Data Systems were adopted by the Arkansas Board of Health at a regular session of the Board held in Heber Springs, Arkansas on the 26th day of October, 2006

Executive Officer, Arkansas State Board of Health

The following Rules and Regulations Copy having been filed in my office are herby approved on this
17th day of November, 2006

Governor

TABLE OF CONTENTS

TABLE OF CONTENTS....22
ARKANSAS CODE – “STATE HEALTH DATA CLEARING HOUSE ACT”.... 33
RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM....6
ACT 670....9
INTRODUCTION....15
DATA REPORTING SOURCE....16
CONFIDENTIALITY OF DATA....16
SUBMITTAL SCHEDULE....16
1717DATA ERRORS AND CERTIFICATION....17
ERROR CORRECTION....17
CERTIFICATION AND REVIEW....18
DATA SUBMITTAL SPECIFICATIONS....18
E-MAIL ATTACHMENT SUBMISSIONS....18
DISKETTE SPECIFICATIONS....19
FILE COMPRESSION....20
FILE ENCRYPTION....20
REEL TAPE SPECIFICATIONS....20
MULTI - HOSPITAL SUBMISSION....21
INTERMEDIARIES....21
EDITING INTERMEDIARIES....21
PASS - THRU INTERMEDIARIES....22
22DATA RECORD FORMATS....22
‘UB-92-1450’ RECORD SPECIFICATION....2223
1450-RECORD TYPE 10 - PROVIDER DATA....23
231450-RECORD TYPE 20 - PATIENT DATA....23
]450-RECORD TYPE 27 - HEALTH DEPT. SPECIFIC DATA....24
24DEFINITION OF ELEMENTS (RECORD TYPE 27)....25
1450-RECORD TYPES 30-31 - THIRD PARTY PAYER....26
1450-RECORD TYPE 30 - THIRD PARTY PAYER DATA....26
261450-RECORD TYPE 31 - THIRD PARTY PAYER DATA....27
1450-RECORD TYPE 50 - INPATIENT ACCOMMODATIONS DATA....27
271450-RECORD TYPE 60 - INPATIENT ANCILLARY SERVICES DATA....2828
1450-RECORD TYPE 70 - MEDICAL DATA (SEQUENCE 1)....29
1450-RECORD TYPE 80 - 8N - PHYSICIAN DATA....30
1450-RECORD TYPE 95 - PROVIDER BATCH CONTROL....30
EXCEPTIONS TO 1450 FORMAT....31
'UB-92 1300’ RECORD SPECIFICATION....31
1300 DISCHARGE RECORD....32
USE OF MULTI-PAGE CLAIMS....36
EXCEPTIONS TO 1300 FORMAT....36
DATA DICTIONARY....36
REVENUE CODES AND UNITS OF SERVICE....5959
RESOURCE LIST....7474
RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM....7575
75

ARKANSAS CODE – “STATE HEALTH DATA CLEARING HOUSE ACT”

Arkansas Code Annotated 20-7-301 et seq.

20-7-301. Title.

This subchapter shall be entitled the "State Health Data Clearing House Act."

History. Acts 1995, No. 670, § 1.

20-7-302. Purpose.

The General Assembly finds that as a result of rising health care costs, the shortage of health professionals and health care services in many areas of the state, and the concerns expressed by care providers, consumers, third party payers, and others involved with planning for the provision of health care, there is an urgent need to understand patterns and trends in the availability, use, and costs of these services. Therefore, in order to establish an information base for patients, health professionals, and hospitals, to improve the appropriate and efficient usage of health care services, and to provide for appropriate protection for confidentiality and privacy, the Department of Health shall act as a state health data clearing house for the acquisition and dissemination of data from state agencies and other appropriate sources to carry out the purposes of this subchapter.

History. Acts 1995, No. 670, § 2.

20-7-303. Collection and dissemination of health data.

(a) The Director of the Department of Health shall, with the approval of the State Board of Health, compile and disseminate health data collected by the Department of Health.

(b) The Department of Health, in consultation with advisory groups appointed by the director with representation from hospitals, outpatient surgery centers, health profession licensing boards, and other state agencies, should:

(1)(A) Identify the most practical methods to collect, transmit, and share required health data as described in § 20-7-304;

(B) Utilize, wherever practical, existing administrative databases and modalities of data collection to provide the required data;

(C) Develop standards of accuracy, timeliness, economy, and efficiency for the provision of the data; and

(D) Ensure confidentiality of data by enforcing appropriate rules and regulations.

(2) In order to maximize limited resources and to prevent duplication of effort, the Department of Health may, when appropriate, consider contracting with private entities for the collection of data as set forth in this section subject to the provisions of this subchapter.

(c)(1) All state agencies, including health profession licensing, certification, or registration boards and commissions, which collect, maintain, or distribute health data, including data relating to the Medicaid program, shall make available to the Department of Health such data as are necessary for the Department of Health to carry out its responsibilities as prescribed by this subchapter or such rules and regulations as may be adopted as provided in § 20-7-305.

(2) If health data are already reported to another organization or governmental agency in the same manner, form, and content or in a manner, form, and content acceptable to the department, the director may obtain a copy of such data from said organization or agency, and no duplicative report need be submitted by the organization.

(3) All hospitals and outpatient surgery centers licensed by the state shall submit information in a form and manner as prescribed by rules and regulations by the State Board of Health pursuant to § 20-7-305; however, if the same information is being collected by another state agency, the Department of Health shall obtain such data from the other state agency.

History. Acts 1995, No. 670, § 2.

20-7-304. Release of health data.

The Director of the Department of Health shall be empowered to release data collected pursuant to this subchapter, except that data released shall not include any information which identifies or could be used to identify any individual patient, provider, institution, or health plan except as provided in § 20-7-305.

History. Acts 1995, No. 670, § 2.

20-7-305. State Board of Health to prescribe rules and regulations - Data collected not subject to discovery.

(a)The State Board of Health shall prescribe and enforce such rules and regulations as may be necessary to carry out the purpose of this subchapter, including the manner in which data are collected, maintained, compiled, and disseminated, and including such rules as may be necessary to promote and protect the confidentiality of data reported under this subchapter.

(b) Provided further, that data collected under this subchapter which identifies, or could be used to identify, any individual patient, provider, institution, or health plan shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(c) The Department of Health and Human Services may, only for purposes of research and aggregate statistical reporting, provide data to the Arkansas Center for Health Improvement and the Agency for Healthcare Research and Quality for its Healthcare Cost and Utilization Project. The data shall be treated in a manner consistent with all state and federal privacy requirements, including, without limitation, the federal Health Insurance Portability and Accountability Act of 1996 privacy rule, specifically 45 C.F.R. § 164.512(i). Furthermore, any identifiable data provided, collected, or disseminated under this subsection shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(d) It shall be unlawful for the center to release any patient-identifying information to any nongovernmental third party.

History. Acts 1995, No. 670, § 2.

20-7-306. Reports - Assistance.

(a) The Director of the Department of Health shall prepare and submit a biennial report to the Governor and the House and Senate Interim Committees on Public Health, Welfare, and Labor or appropriate subcommittees thereof.

(b) The Department of Health shall provide assistance to the House and Senate Interim Committees on Public Health, Welfare, and Labor or appropriate subcommittees thereof in the development of information necessary in the examination of health care issues.

History. Acts 1995, No. 670, § 2; 1997, No. 179, § 22.

20-7-307. Penalties.

(a)(1) Any person, firm, corporation, organization, or institution that violates any of the provisions of this subchapter or any rules and regulations promulgated hereunder regarding confidentiality of information shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than one hundred dollars ($100) nor more than five hundred dollars ($500) or by imprisonment not exceeding one (1) month, or both.

(2) Each day of violation shall constitute a separate offense.

(b) Any person, firm, corporation, organization, or institution knowingly violating any of the provisions of this subchapter or any rules and regulations promulgated hereunder shall be guilty of a misdemeanor and, upon a plea of guilty, a plea of nolo contendere, or conviction, shall be punished by a fine of not more than five hundred dollars ($500).

(c)(1) Every person, firm, corporation, organization, or institution that violates any of the rules and regulations adopted by the State Board of Health or that violates any provision of this subchapter may be assessed a civil penalty by the board.

(2) The penalty shall not exceed two hundred fifty dollars ($250) for each violation.

(3) However, no civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1995, No. 670, § 3.
20-7-308. Repealer.

All laws and parts of laws in conflict with this subchapter are hereby repealed, except that nothing herein shall be interpreted to repeal any provision which authorizes the Health Services Agency to gather such data as may be necessary to conduct permit of approval activities.
History. Acts 1995, No. 670, § 6.

RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM

FILED

RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM

97 AUG 21 AM 10: 17

SECTION I. AUTHORITY. The following Rules and Regulations pertaining to the Hospital Discharge Data System are duly adopted and promulgated by the Arkansas Board of Health pursuant to the authority expressly conferred by the State of Arkansas including, without limitation, Act 670 of 1995 (the Act), as amended, the same being A.C.A. 20-7-301 et seq.

BY_____

The Act established the State Health Data Clearing House within the Arkansas Department of Health. The Clearing House is mandated by the Act to acquire and disseminate health care information in order to understand patterns and trends in the availability, use and costs of health care services in the state. Subsection (h) of the Act directs the Arkansas State Board of Health to prescribe and enforce such rules and regulations as may be necessary to carry out the purpose of this Act.

SECTION II. PURPOSE. It is the purpose of these regulations to provide direction about the required collection, submission, management and dissemination of health data.

SECTION III. DEFINITIONS. For the purposes of these Regulations, the following words and phrases when used herein shall be construed as follows:

A. **"Act"** means the State Health Data Clearing House Act 670 of 1995, A.C.A. 20-7-301 et seq.;

B. **"Aggregate data set"** means a compilation of raw data that has been subject to a critical edit check and consists of at least a small cell count. Aggregate data sets shall not include the following data elements: hospital control number; patient control number; attending physician number, or any element which might be used to identify an individual patient;

C. **"Board"** or **"State Board"** means the Arkansas State Board of Health;

D. **"Confidential information"** means that information which the State Board has defined to be confidential in these regulations and procedures;

E. **"Department"** means the Arkansas Department of Health;

F. **"Director"** means the director of the Arkansas Department of Health;

G. **"Hospital"** means any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which is subject to licensure by the Arkansas Department of Health (A.C.A. 20-9-201 et seq.);

H. **"Submit," "submission"** or **"submittal"** means, with respect to data, reports, surveys, statements and documents required to be filed with the Department:

1) delivery to the Arkansas Department of Health, by the close of business on the prescribed filing date, or
2) deposit with the United States Postal Service, postage prepaid, addressed to the Arkansas Department of Health, in sufficient time so that the mailed materials will arrive by the close of business on the prescribed filing date;

I. **"Guide"** means the Hospital Discharge Data Submittal Guide published by the Arkansas Department of Health. This Guide contains technical information relating to data format, media and submittal time frames.

SECTION IV. GENDER AND NUMBER. All terms used in any one gender or number shall be construed to include any other gender or number.

SECTION V. HOSPITAL DISCHARGE DATA SUBMITTAL . Each Arkansas hospital which performs activities meeting the definition of inpatient discharges, as set forth in the Guide, shall submit data to the Department in a manner that complies with the provisions of the Guide for all inpatient hospital discharges occurring on or after January 1, 1996.

SECTION VI. ADDITIONAL DATA REQUIRED TO BE SUBMITTED. In addition to data prescribed for submission in the Guide, the following data must be submitted according to the schedule provided:

Each hospital shall provide a complete and accurate copy of the American Hospital Association's Annual Survey to the Arkansas Department of Health or the Arkansas Hospital Association. The required submission date will be published annually with the distribution of the survey.

SECTION VII. EXTENSION OF TIME. The State Board or the Director shall, upon a showing of good cause and if time permits, extend the time allowed for the performance of any function or duty required by the provisions of the Act or of these regulations and rules. In making any determination with regard to good cause, the Board and the Director shall give due consideration to all relevant facts and circumstances, including such considerations as the complexity of the issues or the existence of extraordinary circumstances or unforeseen events which have led to the request for an extension of time.

The State Board or the Director shall act upon a request for an extension of time within thirty (30) days of receiving the written request by the hospital. Failure to act within thirty (30) days shall be deemed as a grant of the extension.

SECTION VIII. ACCESS TO AGGREGATE REPORTS. All reports generated by the Department from the aggregate data set for a member of the general public are open for public inspection. The Department shall provide copies of these reports, upon request, at a cost of $.25 per page.

The Department shall determine fees to be charged to cover the direct and indirect costs for providing other information requests or special compilations from aggregate data sets. The fee shall include staff time, computer time, copying costs, postage and supplies.

SECTION IX. PENALTIES FOR NON-COMPLIANCE. A.C.A. 20-7-301 et seq. sets forth civil and criminal penalties for non-compliance with provisions of the Act and of rules and regulations adopted by the Arkansas State Board of Health to implement the Act, as follows:

A. Any person, firm, corporation, organization or institution that violates any of the provisions of A.C.A. 20-7-301 et seq., or any rules or regulations promulgated thereunder, regarding confidentiality of information, shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not less than one hundred dollars ($100) nor more than ($500), or by imprisonment not exceeding one month, or both. Each day of violation shall constitute a separate offense.

B. Any person, firm, corporation, organization or institution knowingly violating any of the provisions of A.C.A. 20-7-301 et seq., or any rules or regulations promulgated thereunder, shall be guilty of a misdemeanor and, upon a plea of guilty, a plea of *nolo contendere* or conviction, shall be fined not more than five hundred dollars ($500).

C. Every person, firm, corporation, organization or institution that violates any of the rules or regulations adopted by the Arkansas State Board of Health or that violates any provision of Act 670 may be assessed a civil penalty by the Board. The penalty shall not exceed two hundred fifty dollars ($250) for each violation. No civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure Act, Ark. Code Ann. 25-15-101, *et seq.*

SECTION X. HEARING AND APPEAL. Hearings and appeals will be conducted according to the Adjudication and Rule Making Sections of the Department's Administrative Procedures previously promulgated by the Department, and any revisions thereto.

SECTION XI. MAINTENANCE OF REGULATIONS AND PROCEDURES. All pages of these regulations and rules, and of the Hospital Discharge Data Submittal Guide, issued by the Department are dated at the bottom. As changes occur, replacement pages will be issued. All replacement pages will be dated so that users may be certain they are referring to the most recent information.

SECTION XII. INCORPORATION BY REFERENCE. The following documents are hereby incorporated by reference:

A. The most recent edition of the International Classification of Diseases, Clinical Modifications. Copies are available from the World Health Organization, P.O. Box 5284, Church Street Station, New York, New York 10249.

B. Uniform Hospital Billing Form 1992 (UB92/HCFA-1450). Copies are available from the Office of Public Affairs, Health Care Financing Administration, Humphrey Building, Room 428-H, 200 Independence Avenue S.W., Washington, D.C. 20201.

All incorporated material is available for public review at the central administrative office of the Department.

SECTION XIII. SEVERABILITY. If any provision of these Rules and Regulations or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of these Rules and Regulations which can give effect without the invalid provisions or applications, and to this end the provisions hereto are declared severable.

SECTION XIV. REPEAL. All regulations and parts of regulations in conflict herewith are hereby repealed.

CERTIFICATION

This will certify that the foregoing Rules and Regulations for the Hospital Discharge Data System were adopted by the Arkansas Board of Health at a regular session of the Board held in Little Rock, Arkansas, on the 24 day of July, 1997.

Secretary
Arkansas Board of Health

The foregoing Rules and Regulations, copy having been filed in my office, are hereby approved on this 18th day of August, 199___.

Governor

ACT 670

ACT 670 1995
A Bill

State of Arkansas
80th General Assembly
Regular Session, 1995

SENATE BILL 569

By: Senators Bookout, Wilson, Bradford, Scott, Bearden, Edwards, and Ross

For An Act To Be Entitled

"AN ACT TO DESIGNATE THE DEPARTMENT OF HEALTH AS THE STATEWIDE HEALTH DATA CLEARING HOUSE; AND FOR OTHER PURPOSES."

Subtitle

"THE STATE HEALTH DATA CLEARING HOUSE ACT"

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. This act shall be entitled the "State Health Data Clearing House Act."

SECTION 2. Collection and dissemination of health data.

(a) The General Assembly finds that as a result of rising health care costs, the shortage of health professionals and health care services in many areas of the state, and the concerns expressed by care providers, consumers, third-party payers, and others involved with planning for the provision of health care, there is an urgent need to understand patterns and trends in the availability, use, and costs of these services. Therefore, in order to establish an information base for patients, health professionals and hospitals, to improve the appropriate and efficient usage of health care services, and to provide for appropriate protection for confidentiality and privacy, the Department of Health shall act as a state health data clearing house for the acquisition and dissemination of data from state agencies and other appropriate sources to carry out the purposes of this section.

(b) The Department of Health, in consultation with advisory groups *appointed by the Director* with representation from hospitals, outpatient surgery centers, health profession licensing boards and other state agencies, should:

President of the Senate

Speaker of the House

0222951259.jjd580

(1) Identify the most practical methods to collect, transmit, and share required health data *as described in subsection (g)*;

(2) Utilize, wherever practical, existing administrative data bases and modalities of data collection to provide the required data;

(3) Develop standards of accuracy, timeliness, *economy*, and efficiency for the provision of the data;

(4) Ensure confidentiality of data by enforcing appropriate rules and regulations.

(c) In order to maximize limited resources and prevent duplication of effort, the Department of Health may, when appropriate, consider contracting with private entities for the collection of data set forth in this section subject to the provisions of this act.

(d) All state agencies, including health profession licensing, certification or registration boards and commissions, which collect, maintain or distribute health data, including data relating to the Medicaid program, shall make available to the Department of Health such data as are necessary for the Department of Health to carry out its responsibilities as prescribed by this section or such rules and regulations as may be adopted as provided in subsection (h).

(e) If health data are already reported to another organization or governmental agency in the same manner, form, and content or in a manner, form, and content acceptable to the Department, the Director may obtain a copy of such data from said organization or agency; and no duplicative report need be submitted by the organization.

(f) All hospitals and outpatient surgery centers licensed by the state shall submit information in a form and manner as prescribed by rules and regulations by the Arkansas State Board of Health pursuant to subsection (h); however, if the same information is being collected by another state agency, the Department of Health shall obtain such data from the other state agency.

(g) The Director of the Department of Health shall be empowered to release data collected pursuant to this section except that data released shall not include any information which identifies or could be used to identify any individual patient, provider, institution or health plan except as provided in subsection (h).

(h) The Arkansas State Board of Health shall prescribe and enforce such rules and regulations as may be necessary to carry out the purpose of this

President of the Senate

Speaker of the House

section including the manner in which data are collected, maintained, compiled and disseminated and including such rules as may be necessary to promote and protect the confidentiality of data reported under this act; provided further that data collected under this section, which identifies or could be used to identify any individual patient, provider, institution *or health plan*, shall not be subject to discovery pursuant to Arkansas Rules of Civil Procedure or Ark. Code Ann. § 25-19-101, et seq.

(i)(1) The Director of the Department of Health shall, with the approval of the Arkansas State Board of Health, compile and disseminate health data collected by the Department of Health.

(2)(A) The Director of the Department of Health shall prepare and submit a biennial report to the Governor and the Joint Interim Committee on Public Health, Welfare and Labor.

(B) The Department of Health shall provide assistance to the Joint Interim Committee on Public Health, Welfare and Labor in the development of information necessary in the examination of health care issues.

SECTION 3. (a) Any person, firm, corporation, organization or institution that violates any of the provisions of this act or any rules and regulations promulgated thereunder *regarding confidentiality of information* shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not less than one hundred dollars ($100) nor more than five hundred dollars ($500) or by imprisonment not exceeding one month, or both. Each day of violation shall constitute a separate offense.

(b) Any person, firm, corporation, organization or institution knowingly violating any of the provisions of this act or any rules and regulations promulgated thereunder shall be guilty of a misdemeanor and upon a plea of guilty, a plea of nolo contendere or conviction, shall be punished by a fine of not more than five hundred dollars ($500).

(c) Every person, firm, corporation, organization or institution that violates any of the rules and regulations adopted by the Arkansas State Board of Health or that violates any provision of this act may be assessed a civil penalty by the Board. The penalty shall not exceed two hundred fifty dollars ($250) for each violation. However, no civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure

President of the Senate

Act, Ark. Code Ann. §25-15-101, et seq.

SECTION 4. All provisions of this act of a general and permanent nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code Revision Commission shall incorporate the same in the Code.

SECTION 5. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 6. All laws and parts of laws in conflict with this act are hereby repealed, except that nothing herein shall be interpreted to repeal any provision which authorizes the Arkansas State Health Services Agency to gather such data as may be necessary to conduct permit of approval activities.

/s/Bookout et al

President of the Senate

APPROVED 3/17/95 GOVERNOR

ACT 1470

Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

Act 1434 of the Regular Session

State of Arkansas *As Engrossed: S2/28/05 S3/3/05 S3/17/05*
85th General Assembly **A Bill**
Regular Session, 2005 HOUSE BILL 1470

By: Representatives Reep, Ragland

For An Act To Be Entitled

AN ACT TO PRESERVE THE CONFIDENTIALITY OF HEALTH DATA IN ARKANSAS; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO PRESERVE THE CONFIDENTIALITY OF HEALTH DATA IN ARKANSAS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 20-7-305 is amended to read as follows:

20-7-305. State Board of Health to prescribe rules and regulations - Data collected not subject to discovery.

(a) The State Board of Health shall prescribe and enforce such rules and regulations as may be necessary to carry out the purpose of this subchapter, including the manner in which data are collected, maintained, compiled, and disseminated, and including such rules as may be necessary to promote and protect the confidentiality of data reported under this subchapter.

(b) Provided further, that data provided, collected, or disseminated under this subchapter which identifies, or could be used to identify, any individual patient, provider, institution, or health plan shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(c) The Department of Health may, only for purposes of research and aggregate statistical reporting, provide data to the Arkansas Center for Health Improvement and the Agency for Healthcare Research and Quality for its

Healthcare Cost and Utilization Project. The data shall be treated in a manner consistent with all state and federal privacy requirements, including, without limitation, the federal HIPAA Privacy Rule, specifically 45 C.F.R. § 164.512(i). Further, any identifiable data provided, collected, or disseminated under subsection (c) of this section shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(d) It shall be unlawful for the Arkansas Center for Health Improvement to release any patient identifying information to any nongovernmental third party.

/s/ Reep

APPROVED: *3/31/2005*

INTRODUCTION

A statewide Hospital Discharge Data System is one of the most important tools for addressing a broad range of health policy issues. Act 670 of 1995, A.C.A. 20-7-301 et seq. requires all hospitals licensed by the state of Arkansas to report information on inpatient discharges.

In order to simplify the reporting process, the Arkansas Hospital Discharge Data System is based on the HCFA UB-92. Two-thirds of the states in the nation already have hospital discharge data systems; at least two-thirds of those are based on the HCFA UB-92 claim.

In accordance, the Arkansas Department of Health and Human Services is required to collect, analyze and disseminate selected health care data. This guide defines the data that hospitals will submit for the specific purpose of constructing the Hospital Discharge Data System.

The Center for Health Statistics can provide technical consultation and assistance. Initially, such consultation or assistance must necessarily be limited to activities that specifically enable the hospital to submit data that will meet the requirements. For further information, contact Ed Carson, Manager of Hospital Discharge Data System.

Arkansas Department of Health
Center for Health Statistics, Slot H19
P O Box 1437
Little Rock, AR 72203-1437
Ph: (800) 482- 5400 ext. 2368
FAX 661-2544

Ed Carson
john.carson@arkansas.gov
(501) 661-2046

Sue Ellen Peglow
sue.peglow@arkansas.gov
(501) 280-4063

thomas rainer
thomas.rainer@arkansas.gov
(501) 280-4066

Yanzhe Zhao
yanzhe.zhao@arkansas.gov
(501) 661-2853

Katrina Hritz
katrina.hritz@arkansas.gov
501-280-4046

DATA REPORTING SOURCE

All facilities operating and licensed as a hospital in the state of Arkansas by the Arkansas Department of Health, Division of Health Facility Services, will report discharge data to the Arkansas Department of Health for each patient admitted as an inpatient or with at least one full day of stay (overnight). Discharge data means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single inpatient hospital stay. The consolidation of discharge data is a discharge data record. The formats are defined later in this Guide.

For a patient with multiple discharges, submit one discharge data record for each discharge. For a patient with multiple billing claims, consolidate the multiple billings into one discharge data record for submission after the patient's discharge. A discharge data record is submitted for each discharge, not for each bill generated. The discharge data record should be submitted for the reporting period within which the discharge occurs. If a claim will not be submitted to a provider or carrier for collection (e.g., charitable service), a hospital discharge data record should still be submitted to the Department of Health and Human Services, with the normal and customary charges, as if the claim was being submitted. All acute and intensive care discharges or deaths, including newborn discharges or deaths, should be reported.

A hospital may submit discharge data directly to the Arkansas Department of Health and Human Services, or may designate an intermediary, such as a commercial data clearinghouse. Use of an intermediary does not relieve the hospital from its reporting responsibility.

In order to facilitate communication and problem solving, each hospital should designate a person as contact. Please provide the office name, telephone number, job title and name of the person assigned this responsibility.

CONFIDENTIALITY OF DATA

Act 670 of 1995, A.C.A. 20-7-301 et seq. provides for the strictest confidentiality of data and severe penalties for the violation of the Act. Any information collected from hospitals which identifies a patient, provider, institution, or health plan cannot be released without promulgation of rules and regulations by the Arkansas State Board of Health in accordance with Act 670 Section (2)(g) and (h). The Arkansas Department of Health and Human Services will only release data, except as allowed by law that has sufficiently masked these identities.

Since the Department of Health and Human Services needs patient specific information to complete our analyses, we will take every prudent action to ensure the confidentiality and security of the data submitted to us. Procedures include, but are not limited to, physical security and monitoring, access to the files by authorized personnel only, passwords and encryption. Not all measures taken are documented or mentioned in this Guide to further protect our data.

SUBMITTAL SCHEDULE

Discharge data records will be submitted to the Department of Health and Human Services as specified below. The data to be submitted is based on the 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. Deadlines for data submission are 40 days after the end of the quarter for the first through third quarters and 60 days for the fourth quarter.

While most hospitals will be submitting data directly to the Department of Health, some are utilizing third-party intermediaries. When using an intermediary, the reporting deadlines are still to be met. All hospitals will submit data within 30 days to the Department of Health or to the intermediary. See the section on use of INTERMEDIARIES for further details.

SCHEDULE

PERSON'S DATE OF DISCHARGE IS	DISCHARGE DATA MUST BE RECEIVED BY
January 1 through March 31	May 10
April 1 through June 30	August 10
July 1 through September 30	November 10
October 1 through December 31	March 1

REQUEST FOR EXTENSION

All hospitals will submit discharge data in a form consistent with the requirements unless an extension has been granted. Request for extension should be in writing or E-mail and be directed to:

Arkansas Department of Health
Center for Health Statistics, Slot #H19
Hospital Discharge Data Section
P O Box 1437
Little Rock, AR 72203-1437
Phone (501) 661-2046
FAX (501) 661-2544
E-mail: john.carson@arkansas.gov

The Center for Health Statistics will review requests submitted to them for extensions to the reporting schedule requirement. A request for an extension should be submitted at least 10 working days prior to the reporting deadline. Extensions may be granted for a maximum of 20 calendar days. Additional 20-day extensions must be requested separately. Extensions may be granted when the hospital documents that unforeseen difficulties, such as technical problems, prevent compliance.

DATA ERRORS AND CERTIFICATION

Hospitals will review the discharge data records prior to submission for accuracy and completeness. Correction of invalid records and validation of aggregate tabulation are the responsibility of the hospital. All hospitals will certify the data submitted for each quarter in the manner specified.

ERROR CORRECTION

Edits that indicate a high probability of error will be highlighted for review, comment, and correction when applicable. The invalid record will be printed in a simplified format providing record identification, an indication or explanation of the error, and space to record corrections. The error report will be sent by fax or E-mail to the attention of the individual designated to receive the correspondence at the hospital. The corrections made by the hospital are to be returned within seven days of receipt to the Center for Health Statistics.

In the event 1 percent or more of the records for a quarter are indicated as having a high probability of error, the entire submittal may be rejected. A record is in error when one or more required data elements are in error.
Notification of the rejection will accompany the error report and will be sent by fax or e-mail to the attention of the individual designated to receive the

correspondence at the hospital. After correction, the submittal is to be returned within seven days of receipt, to the Center for Health Statistics. In some situations, Hospital Discharge Data System staff will make corrections to the hospital's submissions, based on information obtained from hospital staff and/or internal health department databases. When this is done, notice will be given to the hospital.

DATA SUBMITTAL SPECIFICATIONS

Currently, data must be submitted via encrypted E-mail, diskette or magnetic tape (reel). Alternate modes of transmission may be established by agreement with the Center for Health Statistics. Data submittals not in compliance with media or format specifications will be rejected unless approval is obtained prior to the scheduled due date from the Center for Health Statistics. Data submittal on physical media should be mailed to:

Arkansas Department of Health and Human Services
Center for Health Statistics, Slot H19
Hospital Discharge Data System
P O Box 1437
Little Rock, AR 72203-1437

If you are submitting data for more than one hospital on one media submission, the additional specifications found in the section named **MULTI-HOSPITAL SUBMISSION** must be followed.

E-MAIL ATTACHMENT SUBMISSIONS

The following specifications must be met when submitting data by e-mail attachment via the Internet:

a. Hospitals must use encryption software and passwords provided by the Center for Health Statistics. To receive encryption software and/or passwords, please contact Ed Carson, (501) 661-2046, or by E-mail, john.carson@arkansas.gov.

b. The physical characteristics of the attached file **must** have the following attributes:
   1. Record Length - 192 bytes, Fixed (1450 format)
      1300 bytes, Fixed (300 format)
   2. PC Text File (ASCII), WINZIP file or self-extracting executable file. See FILE COMPRESSION.

c. Each E-mail submission must include a general message that contains the following information:
   1. The description: 'HOSPITAL DISCHARGE DATA' in SUBJECT field
   2. Hospital's name
   3. Date of submittal as MM/DD/YY
   4. Beginning and ending dates of the reporting period (e.g., 1/1/01-3/30/01)
   5. The name and telephone number of the contact person

d. Reference paragraph d. of DISKETTE SUBMISSION for 'filename.extension' naming standard for the attached file.

DISKETTE AND CD ROM SPECIFICATIONS

The following specifications must be met when submitting data on PC diskettes:

a. Hospitals will submit no more than two diskettes per quarter

b. The physical characteristics of the diskette **must** have the following attributes:

1. MS-DOS or Windows formatted
2. 3 2" or 5 1/4", double sided high density
3. Record Length - 192 bytes, Fixed (450 format)
   1300 bytes, Fixed (300 format)
4. PC Text File (ASCII), WINZIP file or self-extracting executable file

c. The physical characteristics of the CD Rom must have the following attributes

1. Record Length - 192 bytes, Fixed (1450 format)
   1300 bytes, Fixed (1300 format)
2. PC Text File (ASCII), WINZIP file or self-extracting executable file

Notes: Self-extracting executable file must run on Windows XP or higher operating system.
Source and target of WINZIP or executable file must be ASCII.
ASCII file must have a carriage-return (CR) and line-feed (LF) at the end of each data record.

c. All diskettes and CD Rom's **must** have an external label or accompanying data sheet containing the following information:

1. The description: 'HOSPITAL DISCHARGE DATA'
2. Hospital's name
3. Date of submittal as MM/DD/YY
4. Beginning and ending dates of the reporting period (e.g., 1/1/01-3/30/01)
5. Disk number (i.e., 1 of 1, 1 of 2, 2 of 2)
6. Number of records
7. Record format (1450 or 1300)
8. The name and telephone number of the contact person
9. PC extension, ASCII or ZIP or EXE (see d.4.)
10. If encrypted, the description: 'ENCRYPTED' (see FILE ENCRYPTION).

An example of the diskette label

HOSPITAL DISCHARGE DATA
Hospital: _____
Date: mm/dd/yy Quarter: mmddyy-mmddyy
Disk # of #
Total Record Count: ###### Format: ####
Contact Person:_____ Phone:_____
Extension: _____
ENCRYPTED

d. Use the following 'filename.extension' file naming standard:

1. The first two positions of the filename will be the last two digits of the calendar year;
2. The next three characters will be 'QTR';
3. The last position must be the quarter from one through four that indicates the quarter of the calendar year of the data submitted;
4. The extension will be 'TXT' or 'DAT' for a PC Text file or
   'ZIP' for a file compressed with PKZIP or
   'EXE' for a self-extracting file

Example: 06QTR1.TXT - ASCII data file for the first quarter of 2006

FILE COMPRESSION

WINZIP is the compression utility of choice by the Hospital Discharge Data Section. If a compression utility other that WINZIP is used, the resulting file must be able to be unzipped by the Hospital Discharge Data Section. Please contact an HDDS colleague prior to sending a file compressed with any compression software other than WINZIP.

FILE ENCRYPTION

Cryptext is the freeware, encryption software that the HDDS recommends. An HDDS colleague can be contacted on how to receive this software. Encryption of data files sent as email attachments is required. See item a. under E-Mail attachment submissions. All passwords used with encryption software will be supplied by the HDDS. Please contact an HDDS colleague for the correct password for your hospital.

REEL TAPE SPECIFICATIONS

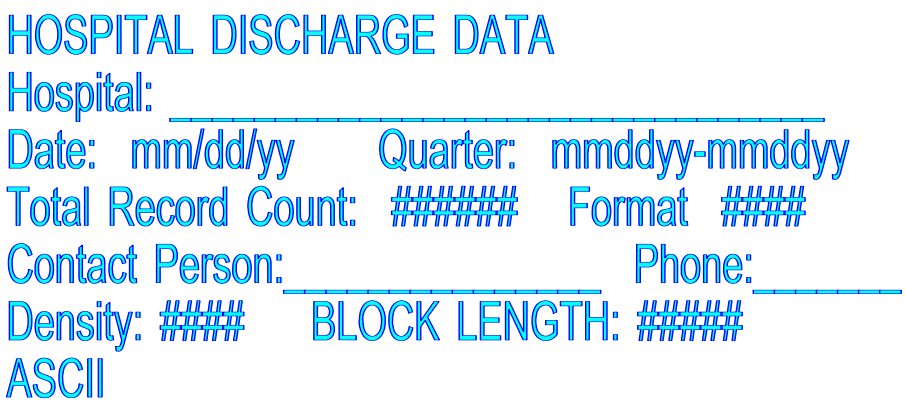
The following specifications must be met when submitting data on magnetic tape:

a. Hospitals will submit no more than one tape per submittal

b. The physical characteristics of the tape media **must** have the following attributes:
   1. Labeling - No label
   2. Density - 1600/6250 BPI, 9 track
   3. Record Length - 192 bytes, Fixed (450 format)
      1300 bytes, Fixed (300 format)
   4. Blocking - Specify block length on the external label
   5. Character Set - ASCII or EBCDIC

c. All tapes **must** have an external label or accompanying data sheet containing the following information:
   1. The description: 'HOSPITAL DISCHARGE DATA'
   2. Hospital's name
   3. Date of submittal as MM/DD/YY
   4. Beginning and ending dates of the reporting period (e.g., 1/1/01-3/30/01)
   5. Number of physical data records
   6. Record format (1450 or 1300)
   7. The name and telephone number of the contact person
   8. Tape Density: 1600/6250 BPI
   9. Blocking - Block length in bytes
   10. 'ASCII' or 'EBCDIC'

An example of the tape label



FILE TRANSFER PROTOCOL

No FTP discharge data submissions are permitted at the present time. FTP and other data submission methods are always under review. If implemented, all Arkansas hospitals will receive notice of the ability to submit discharge data using the new method.

MULTI - HOSPITAL SUBMISSION

Data from more than one hospital may be submitted on one media submission as one file per hospital. Change the following items on your external label or accompanying information sheet:

X If you are not a hospital, replace 'Hospital:' with your company name.

X If you are a hospital or subsidiar2006DHHSDATAGUIDE.docy of a hospital, replace 'Hospital:' with 'Agent:' and your hospital name.

X If multiple files are on the submission, replace 'Total Record Count:' with 'Number of Files:'

X The contact person and phone number should be that of the agent or company, not the hospital.

X If multiple files are placed on diskette, the 'filename.extension' file-naming standard must change. The last two positions of the filename (follows 'QTR' and quarter number) must be the file number provided.

In addition to the above changes, a list of hospitals on the tape must be provided with tax id, number of records, and hospital contact.

INTERMEDIARIES

Third-party intermediaries may be utilized by hospitals for the delivery of data to the Department of Health and Human Services. To better manage data collection, intermediaries must be registered with the Department of Health and Human Services. Additions and deletions to the intermediary's list of hospitals represented must be submitted at least 10 days prior to the Department of Health and Human Services reporting due date. The intermediary must specify hospitals being represented, media, formats, contacts, length of contractual obligation, etc.

EDITING INTERMEDIARIES

The following additional requirements and information apply to intermediaries delivering edited data to the Department of Health and Human Services:

1. The data must not have an error rate greater than 1 percent.

2. Each hospital's data must be submitted in a separate file.
3. Data may be submitted on any approved media - declared at the time of registration.
4. Data may be submitted in any approved data format - declared at the time of registration.

PASS - THRU INTERMEDIARIES

The following additional requirements and information apply to intermediaries delivering unedited data to the Department of Health:

1. The data must not have an error rate greater than 1 percent.
2. Each hospital's data must be submitted in a separate file.

DATA RECORD FORMATS

The accepted data record formats are the UB-92 1450 version 6 format and UB-92 1300 flat file format. Both of these formats have been altered slightly. These alterations are the result of standardizing similar data elements of the two formats. The definition specified for each data element is in general agreement with the definition in the UB-92 Users Manual. Hospitals using data sources other than uniform billing should evaluate definitions for agreement with the definitions specified in this Guide and UB-92 Users Manual. See the EXCEPTIONS section for each format to identify possible changes to your current formats. Each record must be followed by a carriage return/line feed sequence.

'UB-92-1450' RECORD SPECIFICATION

The UB-92 1450 claim 'record' is made up of a series of 192-character physical records. Not all of the physical claim records are used in the Hospital Discharge Data System, such as the Claim Request Data. Records not specified in the Hospital Discharge Data System will be ignored, if included in the submittal. Fields not referenced in the record formats may contain information but will not be processed by computer programs; this also includes fields reserved for national use. The exact record sequence and format of the 1450 is used for the Hospital Discharge Data System, when possible. A complete copy of the patient's 1450 records would satisfy the requirements, with exceptions noted in EXCEPTIONS TO 1450 FORMAT. The physical records for each claim are divided into logical subsets as follows:

Subset 1 - Patient Data - Record Codes 20-29
Subset 2 - Third Party Data - Record Codes 30-39
Subset 3 - Claim Request Data - Record Codes 40-49
Subset 4 - Inpatient Accommodations Data - Record Codes 50-59
Subset 5 - Ancillary Services Data - Record Codes 60-69
Subset 6 - Medical Data - Record Codes 70-79
Subset 7 - Physician Data - Record Codes 80-89

The record layouts that follow will provide the following information:

1. Record Name: The name of the data record
2. Record Type: Code indicating the type of record
3. Record Size: Physical length of record. Constant 192
4. Required Field Annotation: An asterisk '*' denotes the field is required and must contain data if applicable.
5. Field Number: Field number as specified on the UB-92 1450 version 4 file layout. This number is not the Form Locator number found on the UB-92 1450 form.
6. Field Name: Name generally used with the UB-92 1450 Form.
7. Picture: This is the COBOL picture. Pic X is initialized to blanks and Pic 9 is initialized to zeroes. All money and date fields are Pic 9.
8. Field Specification: Indicates how the data field is justified. L = Left justification, and R = Right justification.
9. Position: From = Leftmost position in the record (high order).

Thru = Rightmost position in the record (low order).

10. Form Locator: Number found on the UB-92 Form and associated with the field in that location.

1450-RECORD TYPE 10 - PROVIDER DATA

Only one type '10' record is required per hospital per submittal. Only the first type '10' record and each type '10' record following a type '95' record will be processed, all others will be ignored. This record type will be processed as a header record and a record type '95' will be processed as a trailer record. The records encapsulated between the first type '10' and '95' will be processed using the hospital specified on the type '10' record. It is absolutely imperative that each submission includes at least one type '10' record with correct Federal Tax Number. If the Federal Tax Number is not unique to a facility or cost center, the Federal Tax Sub ID **must** be included.

	FIELD NO.	NAME	PICTURE	SPECIFICATION	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '10'	XX	L	1	2	
*	4	Federal Tax Number or EIN	9(10)	R	8	17	FL05
	5	Federal Tax Sub ID	X()	L	18	21	FL05
*	6	National Provider Identifier	X(13)	L	22	34	
*	7	Medicaid Provider Number	X(13)	L	35	47	
	11	Provider Telephone Number	9(10)	R	87	96	FL01
	12	Provider Name	X(5)	L	97	121	FL01
		Provider Address (Fields 13-16)					FL01
	13	Address	X(5)	L	122	146	
	14	City	X(4)	L	147	160	
	15	State	XX	L	161	162	
	16	ZIP Code	X()	L	163	171	
	17	Provider FAX Number	9(10)	R	172	181	

*An asterisk denotes the field is required and must contain data if applicable.

1450-RECORD TYPE 20 - PATIENT DATA

	FIELD NO.	NAME	PICTURE	SPECIFICATION	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '20'	XX	L	1	2	
*	3	Patient Control Number	X(20)	L	5	24	FL03
		Patient Name (Fields 4-6)					FL12
*	4	Last Name	X(20)	L	25	44	
*	5	First Name	X(9)	L	45	53	
*	6	Middle Initial	X		54	54	
*	7	Patient Sex	X		55	55	FL15
*	8	Patient Birthdate (mmddccyy)	9(8)	R	56	63	FL14
	9	Patient Marital Status	X		64	64	FL16
*	10	Type of Admission	X		65	65	FL19
*	11	Source of Admission	X		66	66	FL20
		Patient Address (Fields 12-16)					FL13
*	12	Address - Line 1	X(18)	L	67	84	
	13	Address - Line 2	X(8)	L	85	102	
*	14	City	X(5)	L	103	117	
*	15	State	XX	L	118	119	
*	16	ZIP Code	X()	L	120	128	
*	17	Admission Date	9(6)	R	129	134	FL17
*	18	Admission Hour	XX	R	135	136	FL18
		Statement Covers Period					FL06
*	19	From (mmddyy)	9(6)	R	137	142	
*	20	Thru (mmddyy)	9(6)	R	143	148	
*	21	Patient Status	99	R	149	150	FL22
	22	Discharge Hour	XX	R	151	152	FL21

23	Payments Received (Patient line)	9(8V99S	R	153	162	FL54
24	Estimated Amt Due(atient line)	9(8)V99S	R	163	172	FL55
* 25	Medical Record Number	X(7)	L	173	189	FL23

NOTE: 'Statement Covers Period From' should be the date of the first medical service related to the hospital stay.
'Statement Covers Period Thru' should be the discharge date.
'Payments Received' and 'Estimated Amt Due' should reflect a single discharge if multiple claims have been submitted.

1450 Y2K-RECORD TYPE 20 - PATIENT DATA

FIELD NO.	NAME	PICTURE	SPECIFICATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '20'	XX	L	1	2	
* 3	Patient Control Number	X(20)	L	5	24	FL03
	Patient Name (Fields 4-6)					FL12
* 4	Last Name	X(20)	L	25	44	
* 5	First Name	X(9)	L	45	53	
* 6	Middle Initial	X		54	54	
* 7	Patient Sex	X		55	55	FL15
* 8	Patient Birthdate(ccyymmdd)	9(8)	R	56	63	FL14
9	Patient Marital Status	X		64	64	FL16
* 10	Type of Admission	X		65	65	FL19
* 11	Source of Admission	X		66	66	FL20
	Patient Address (Fields 12-16)					FL13
* 12	Address - Line 1	X(8)	L	67	84	
13	Address - Line 2	X(8)	L	85	102	
* 14	City	X(5)	L	97	111	
* 15	State	XX	L	112	113	
* 16	ZIP Code	X()	L	114	122	
* 17	Admission Date (ccyymmdd)	9(8)	R	123	130	FL17
* 18	Admission Hour	XX	R	131	132	FL18
	Statement Covers Period					FL06
* 19	From (ccyymmdd)	9(8)	R	133	140	
* 20	Thru (ccyymmdd)	9(8)	R	141	148	
* 21	Patient Status	99	R	149	150	FL22
22	Discharge Hour	XX	R	151	152	FL21
23	Payments Received (Patient line)	9(8)V99S	R	153	162	FL54
24	Estimated Amt Due(atient line)	9(8)V99S	R	163	172	FL55
* 25	Medical Record Number	X(7)	L	173	189	FL23

Date changes made by some hospitals for the year 2000 and following require spacing changes in the type 20 and type 70 records for the 1450 record format. For hospitals using the 1450 record format that began using an eight-digit date format in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 is entered 20010207. Where this change is made, all dates (birth date, admission date, statement from data and statement through date) must use this format. The following position changes in the type 20 record are required:

NOTE: 'Statement Covers Period From' should be the date of the first medical service related to the hospital stay.
'Statement Covers Period Thru' should be the discharge date.
'Payments Received' and 'Estimated Amt Due' should reflect a single discharge if multiple claims have been submitted.

1450-RECORD TYPE 27 - HEALTH DEPT. SPECIFIC DATA

FIELD NO.	NAME	PICTURE	SPECIFICATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '27'	XX	L	1		
* 2	Sequence '01'	99	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
* 4	Type of Bill	X(3)	L	25	27	FL04

5	Patient Social Security Number	9(10)	R	28	37	FL60
6	Patient Race	X		38	38	
7	Patient Ethnicity	X		39	39	
8	Birth Weight	9999	R	40	43	
9	Total Charges	9(8)V99S	R	44	53	
10	Estimated Collection rate	999	R	54	56	
11	Charitable / Donation rate	999	R	57	59	
12	APGAR Score	9999	R	60	63	

DEFINITION OF ELEMENTS (RECORD TYPE 27)

Type of Bill
A code indicating the specific type of bill (inpatient, outpatient, etc.).
This three-digit code requires one digit each, in the following sequence:
1. Type of facility
2. Bill classification, and
3. Frequency

All positions must be fully coded. See UB-92 guidelines for codes and definitions. In most situations, the discharge should be coded as '111'.

Patient Social Security Number The Social Security Number of the patient receiving inpatient care.
If the patient is a newborn, use the mother's SSN.
If a patient does not have a social security number, fill with zeroes.

Patient Race
This item gives the race of the patient. Use the following codes:

1 = American Indian or Alaskan Native	
2 = Asian or Pacific Islander	
3 = Black	
4 = White	
5 = Other	Any possible options not covered in the above categories
6 = Unknown	A person who chooses not to answer the question
Blank Space	The hospital made no effort to obtain the information

****
Patients may self identify themselves as Hispanic or the admissions registration person may identify the patient as Hispanic. However, Hispanic is not a correct race classification for our data gathering purposes. Hispanic is considered to be an ethnicity group. Hispanic patients should be registered as Hispanic for the ethnicity field and white for the race field unless the patient self identifies as being of a race other than white. Other should not be used for the race field for Hispanic patients.
****

Patient Ethnicity
This item gives the ethnicity of the patient. Use the following codes:

1 = Hispanic origin	
2 = Not of Hispanic origin	
6 = Unknown	A person who chooses not to respond to the inquiry
Blank Space = The hospital made no effort to obtain the information	

Birth Weight
Birth weight in grams for a newborn. Zero fillif unknown.

Total Charges
Total of charges for this inpatient occurrence.

Estimated Collection Rate
Collection rate (percentage) expected from all sources for this inpatient occurrence.
This percentage could be the result of bad debt, contracted amounts or rates with insurance carriers, etc.

Charitable / Donation Rate

This item identifies the inpatient discharge fully or partially as charitable or a donation of services. (This should not be confused with a bad debt.)

Use the following rates:

100	fully charitable / donation
1 - 99	partially charitable, expecting some reimbursement of expenses, estimate the percentage of total charges that will be charitable
0	not charitable, expect collection of all or some of the charges, or does not apply

APGAR Score

APGAR score for a newborn. Zero fillif unknown or does not apply.

1450-RECORD TYPES 30-31 - THIRD PARTY PAYER

The use of these record types for the Hospital Discharge Data System (HDDS) is the same as the UB-92 claim. When reporting for HDDS, records may need to be consolidated and amounts accumulated by payer. Below are specifications and an example as taken from UB-92.

One third party payer record packet (record types 30-3N) must appear in the bill record for each payer involved in the bill. Each third party payer packet must contain a record type 30. However, each record type 30 may or may not have an associated record type 3l, depending on the specific third party payer data required by the particular payer.

Example: Medicare is primary, and the secondary payer requires the insured's address.

	Record Type Code	Sequence Number
Medicare	30	01
Secondary Payer	30	02
Secondary Payer	31	02

Because the sequence number of the type 31 record for the secondary payer matches the sequence number of the secondary payer's type 30 record, it serves as a matching criterion for the specific third party payer record packet.

Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

1450-RECORD TYPE 30 - THIRD PARTY PAYER DATA

FIELD NO.	NAME	PICTURE	SPECIFICATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '30'	XX	L	1	2	
* 2	Sequence Number	99	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
* 4	Source of Payment Code	X		25	25	FL50
5-6	PayerIdentification	X(9)	L	26	34	FL51
7	Certificate/SocSecNumber/ Health Insurance Claim/ Identification Number	X(9)	L	35 54	53 79	FL60
10	Insurance Group Number	X(7)	L	80	96	FL62
11	Insured Group Name	X(4)	L	97	110	FL61

	Insured's Name (Fields 12-14)					FL58
12	Last Name	X(0)	L	111	130	
13	First Name	X()	L	131	139	
14	Middle Initial	X		140	140	
15	Insured Sex	X		141	141	
18	Patient Relationship to Insured	99	R	144	145	FL59
19	Employment Status Code	9		146	146	FL64
25	Payments Received	9(8)V99S	R	173	182	FL54
26	Estimated Amount Due	9(8)V99SR	183	192	FL55	

NOTE: 'Payments Received' and 'Estimated Amount Due' should reflect a single discharge per payer if multiple claims have been submitted.

1450-RECORD TYPE 31 - THIRD PARTY PAYER DATA

FIELD NO.	NAME	PICTURE	SPECIFI-CATION	POSITION FROM	POSITION THRU	FROM LOCATOR
* 1	Record Type '31'	XX	L	1	2	
* 2	Sequence Number	99	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
	Insured's Address (Fields 4-8)					
4	Address - Line 1	X(8)	L	25	42	
5	Address - Line 2	X(8)	L	43	60	
6	City	X(5)	L	61	75	
7	State	XX	L	76	77	
8	ZIP Code	X()	L	78	86	
9	Employer Name	X(4)	L	87	110	FL65
	Employer Location (Fields 10 - 13)					FL66
10	Employer Address	X(8)	L	111	128	
11	Employer City	X(5)	L	129	143	
12	Employer State	XX	L	144	145	
13	Employer ZIP Code	X()	R	146	154	

1450-RECORD TYPE 50 -INPATIENT ACCOMMODATIONS DATA

The sequence number for record type 50 can go from 01 to 99, each such physical record containing four accommodations, thus making provision for reporting up to 396 accommodations on a single claim. Accommodation revenue codes: 100through21X.

FIELD NO.	NAME	PICTURE	SPECIFI-CATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '50'	XX	L	1	2	
* 2	Sequence Number	99	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
	Accommodations (occurs 4 times)					
	Accommodations - 1	X(2)		25	66	
* 4	Revenue Code	9(4)	R	25	28	FL42
5	Accommodations Rate	9(7)V99	R	29	37	FL44
* 6	Accommodations Days	9(4)	R	38	41	FL46
* 7	Total Charges by Revenue Code	9(8)V99S	R	42	51	FL47
8	Noncovered Charges by Revenue Code	9(8)99S	R	52	61	FL48
	Accommodations - 2	X(2)		67	108	
* 9	Revenue Code	9(4)	R	67	70	FL42
10	Accommodations Rate	9(7)V99	R	71	79	FL44
* 11	Accommodations Days	9(4)	R	80	83	FL46
* 12	Total Charges by Revenue Code	9(8)V99S	R	84	93	FL47
13	Noncovered Charges by Revenue Code	9(8V99S	R	94	103	FL48

		Accommodations - 3	X (42)		109	150	
*	14	Revenue Code	9(4)	R	109	112	FL42
	15	Accommodations Rate	9(7) V99	R	113	121	FL44
*	16	Accommodations Days	9(4)	R	122	125	FL46
*	17	Total Charges by Revenue Code	9(8)V99S	R	126	135	FL47
	18	Noncovered Charges by Revenue Code	9(8)V99S	R	136	145	FL48
		Accommodations - 4	X(42)		151	192	
*	19	Revenue Code	9(4)	R	151	154	FL42
	20	Accommodations Rate	9(7)V99	R	155	163	FL44
*	21	Accommodations Days	9(4)	R	164	167	FL46
*	22	Total Charges by Revenue Code	9(8)V99S	R	168	177	FL47
	23	Noncovered Charges by Revenue Code	9(8)V99S	R	178	187	FL48

1450-RECORD TYPE 60 - INPATIENT ANCILLARY SERVICES DATA

The sequence number for record type 60 can go from 0l to 99, each such physical record containing up to three inpatient ancillary service codes, thus making provision for reporting up to 297 inpatient ancillary services on a single claim. Payer and related information revenue codes: codes 001 - 099. Inpatient ancillary services revenue codes: codes 220 - 99x.

FIELD NO.	NAME	PICTURE	SPECIFICATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '60'	XX	L	1	2	
* 2	Sequence Number	99	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
	Inpatient Ancillaries (occurs 3 times)					
	Inpatient Ancillaries - 1	X(56)		25	80	
* 4	Revenue Code	9(4)	R	25	28	FL42
5	HCPCS / Procedure Code	X(5)	L	29	34	
6	Modifier 1 (HCPCS & CPT-4)	X(2)	L	34	35	
7	Modifier 2 (HCPCS & CPT-4)	X(2)	L	36	37	
* 8	Units of Service	9(7)	R	38	44	FL46
* 9	Total Charges by Revenue Code	9(8)V99S	R	45	54	FL47
10	Noncovered Charges by Revenue Code	9(8)V99S	R	55	64	FL48
	Inpatient Ancillaries - 2	X(56)		81	136	
* 11	Revenue Code	9(4)	R	81	84	FL42
12	HCPCS / Procedure Code	X(5)	L	85	89	
13	Modifier 1 (HCPCS & CPT-4)	X(2)	L	90	91	
14	Modifier 2 (HCPCS & CPT-4)	X(2)	L	92	93	
* 15	Units of Service	9(7)	R	94	100	FL46
* 16	Total Charges by Revenue Code	9(8)V99S	R	101	110	FL47
17	Noncovered Charges by Revenue Code	9(8)V99S	R	111	120	FL48
	Inpatient Ancillaries - 3	X(56)		137	192	
* 18	Revenue Code	9(4)	R	137	140	FL42
19	HCPCS / Procedure Code	X(5)	L	141	145	
20	Modifier 1 (HCPCS & CPT-4)	X(2)	L	146	147	
21	Modifier 2 (HCPCS & CPT-4)	X(2)	L	148	149	
* 22	Units of Service	9(7)	R	150	156	FL46
* 23	Total Charges by Revenue Code	9(8)V99S	R	157	166	FL47
24	Noncovered Charges by Revenue Code	9(8)V99S	R	167	176	FL48

Note: Identical revenue codes should be combined and their charges added together for reporting purposes.

1450-RECORD TYPE 70 - MEDICAL DATA (SEQUENCE 1)

FIELD NO.	NAME	PICTURE	SPECIFI-CATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '70'	XX	L	1	2	
* 2	Sequence '01'	XX	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
* 4	Principal Diagnosis Code	X(6)	L	25	30	FL67
* 5	Other Diagnosis Code - 1	X(6)	L	31	36	FL68
* 6	Other Diagnosis Code - 2	X(6)	L	37	42	FL68
* 7	Other Diagnosis Code - 3	X(6)	L	43	48	FL68
* 8	Other Diagnosis Code - 4	X(6)	L	49	54	FL68
* 9	Other Diagnosis Code - 5	X(6)	L	55	60	FL68
* 10	Other Diagnosis Code - 6	X(6)	L	61	66	FL68
* 11	Other Diagnosis Code - 7	X(6)	L	67	72	FL68
* 12	Other Diagnosis Code - 8	X(6)	L	73	78	FL68
* 13	Principal Procedure Code	X(7)	L	79	85	FL80
* 14	Principal Procedure Date(mmddyy)	9(6)	R	86	91	FL80
* 15	Other Procedure Code - 1	X(7)	L	92	98	FL81
* 16	Other Procedure Date - 1 (mmddyy)	9(6)	R	99	104	FL81
* 17	Other Procedure Code - 2	X(7)	L	105	111	FL81
* 18	Other Procedure Date - 2 (mmddyy)	9(6)	R	112	117	FL81
* 19	Other Procedure Code - 3	X(7)	L	118	124	FL81
* 20	Other Procedure Date - 3 (mmddyy)	9(6)	R	125	130	FL81
* 21	Other Procedure Code - 4	X(7)	L	131	137	FL81
* 22	Other Procedure Date - 4 (mmddyy)	9(6)	R	138	143	FL81
* 23	Other Procedure Code - 5	X(7)	L	144	150	FL81
* 24	Other Procedure Date - 5 (mmddyy)	9(6)	R	151	156	FL81
* 25	Admitting Diagnosis Code	X(6)	L	157	162	FL76
* 26	External Cause of Injury(E-Code)	X(6)	L	163	168	FL77
* 27	Procedure Coding Method Used	9	R	169	169	FL79

1450 Y2K-RECORD TYPE 70 - MEDICAL DATA (SEQUENCE 1)

Date changes made by some hospitals for the year 2000 and following require spacing changes in the type 20 and the type 70 records for the 1450 record format. For hospitals using the 1450 record format that began using an eight-digit date format in 2000, the date must be given as CCYYMMDD. In this case, February 7,2001 is entered 20010207. Where this change is made, all dates (birth date, admission date, statement from data, statement through date and procedure dates) must use this format. The following position changes in the type 70 record are required:

FIELD NO.	NAME	PICTURE	SPECIFI-CATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '70'	XX	L	1	2	
* 2	Sequence '01'	XX	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
* 4	Principal Diagnosis Code	X(6)	L	25	30	FL67
* 5	Other Diagnosis Code - 1	X(6)	L	31	36	FL68
* 6	Other Diagnosis Code - 2	X(6)	L	37	42	FL68
* 7	Other Diagnosis Code - 3	X(6)	L	43	48	FL68
* 8	Other Diagnosis Code - 4	X(6)	L	49	54	FL68
* 9	Other Diagnosis Code - 5	X(6)	L	55	60	FL68
* 10	Other Diagnosis Code - 6	X(6)	L	61	66	FL68
* 11	Other Diagnosis Code - 7	X(6)	L	67	72	FL68
* 12	Other Diagnosis Code - 8	X(6)	L	73	78	FL68
* 13	Principal Procedure Code	X(7)	L	79	85	FL80
* 14	Principal Procedure Date (ccyymmdd)	9(8)	R	86	93	FL80
* 15	Other Procedure Code - 1	X(7)	L	94	100	FL81
* 16	Other Procedure Date - 1 (ccyymmdd)	9(8)	R	101	108	FL81
* 17	Other Procedure Code - 2	X(7)	L	109	115	FL81
* 18	Other Procedure Date - 2 (ccyymmdd)	9(8)	R	116	123	FL81
* 19	Other Procedure Code - 3	X(7)	L	124	130	FL81
* 20	Other Procedure Date - 3 (ccyymmdd)	9(8)	R	131	138	FL81
* 21	Other Procedure Code - 4	X(7)	L	139	145	FL81
* 22	Other Procedure Date - 4 (ccyymmdd)	9(8)	R	146	153	FL81
* 23	Other Procedure Code - 5	X(7)	L	154	160	FL81
* 24	Other Procedure Date - 5 (ccyymmdd)	9(8)	R	161	168	FL81
* 25	Admitting Diagnosis Code	X(6)	L	169	174	FL76

* 26	External Cause of Injury(E-Code)	X(6)	L	175	180	FL77
* 27	Procedure Coding Method Used	9	R	181	181	FL79

FOR BOTH 1450 AND 1450 Y2K

ICD-9-CM is required for diagnosis coding. Do not report the decimal in the code. The ICD-9-CM diagnosis codes are assigned a COBOL picture of X. Format the actual code in one of four general ways, as follows:

If you report 99999, it translates to 999.99.
If you report V9999, it translates to V99.99.
If you report E9999, it translates to E999.9.
If you report M99999, it translates to M9999/9.

To determine the location of the decimal position and the potential number of decimal positions it is necessary only to examine the high order (left most) position of the field.

1450-RECORD TYPE 80 - 8N - PHYSICIAN DATA

FIELD NO.	NAME	PICTURE	SPECIFI-CATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '80'	XX	L	1	2	
* 2	Sequence	99	R	3	4	
* 3	Patient Control Number	X(20)	L	5	24	FL03
* 4	Physician Number Qualifying Code	X(2)	L	25	26	
* 5	Attending Physician Number	X(16)	L	27	42	FL82
* 6	Operating Physician Number	X(16)	L	43	58	
* 7	Other Physician Number	X(16)	L	59	74	FL83
* 8	Other Physician Number	X(16)	L	75	90	FL83
9	Attending Physician Name	X(25)	L	91	115	
10	Operating Physician Name	X(25)	L	116	140	
11	Other Physician Name	X(25)	L	141	165	
12	Other Physician Name	X(25)	L	166	190	

Physician Name is to be broken down as follows:

Last Name	Positions	1-16
First Name	Positions	17-24
Middle Initial	Position	25

Physician Number Qualifying Codes:

UP = Universal Physician Identification Number (UPIN)- Alpha and 5 digits
FI = Federal Taxpayer's Identification Number
SL = State License Number - Alpha and 4 digits
SP = Specialty License Number
NI = National Provider Identifier (NPI) – 10 digit number

1450-RECORD TYPE 95 - PROVIDER BATCH CONTROL

Only one type ‘95’ is allowed per hospital per submittal. The Federal Tax Number must match the type ‘10’ record. This record type will be processed as a trailer record and a record type ‘10’ will be processed as a header record. The records encapsulated between the first type ‘10’ and ‘95’ will be processed using the hospital specified on the type ‘10’ record.

FIELD NO.	NAME	PICTURE	SPECIFI-CATION	POSITION FROM	POSITION THRU	FORM LOCATOR
* 1	Record Type '95'	XX	L	1	2	
* 2	Federal Tax Number (EIN)	9(10)	R	3	12	FL05
	Federal Tax Sub ID	X(4)	L	13	16	FL05
* 6	Number of Claims	9(6)	R	25	30	

Note: Federal Tax Sub ID **must** be the same as specified on the type '10' record. 'Number of Claims' should be the number of discharges in the batch (number of type '20' records).

EXCEPTIONS TO 1450 FORMAT

In general, the submittal is identical to the current UB-92 1450 version 6 format used. The differences are minor but nevertheless important. The most notable difference is the requirement for one discharge record for one patient, as opposed to the possibility of multiple claim records for one patient. For discharges with multiple claim records, they should be consolidated into a single discharge, accumulating amounts where necessary (e.g., amounts by Payer).

Only one type '10' is required per hospital per submittal. Only the first type '10' record and each type '10' record following a type '95' record will be processed, all others will be ignored. A record type '10' will be processed as a header record and a record type '95' will be processed as a trailer record. The records encapsulated between the first type '10' and '95' will be processed using the hospital specified on the type '10' record.

In record type '20', 'Statement Covers Period Thru' should be the discharge date.

In record type '95', Federal Tax Sub ID is a new field and must be the same as specified on the type '10' record.

'Number of Claims' in record type '95' should be the number of discharges in the batch, the number of type '20' records.

Record type '27' is not a record type used in the UB-92 claim. It contains data that may come from other record types, such as 'Type of Bill,' or may be computable, such as 'Total Charges,' or should be found in your current databases, 'Patient Social Security Number,' for example.

UB-92 1300 RECORD SPECIFICATION

The UB-92 1300 flat file contains one record per discharge, except in the case of multi-page claims. However, the standard 1300 format does not contain some fields that are found on the 1450 format. To make the 1450 and 1300 compatible, only those elements we deemed necessary for effective analysis have been included in an enhanced version of the 1300; these exceptions are documented in EXCEPTIONS TO 1300 FORMAT. Variations of the 1300 from other states have been examined and their usage of free space incorporated, standardizing whenever possible.

The record layouts that follow will provide the following information:

1. Record Name: The name of the data record
2. Record Size: Physical length of record. Constant 1300
3. Required Field Annotation:
   An asterisk '*' denotes the field is a required field and must contain data if applicable.
4. Field Number: Sequentially assigned field number. This is not the Form Locator.
5. Field Name: Name generally used with the UB-92 1450 Form.
6. Picture: This is the COBOL picture. Pic X is initialized to blanks and Pic 9 is initialized to zeroes. All money and date fields are Pic 9.
7. Field Specification: Indicates how the data field is justified. L = Left justification, and R = Right justification.
8. Position: From = Leftmost position in the record (high order).
   Thru = Rightmost position in the record (low order).

9. Form Locator: Number found on the UB-92 Form and associated with the field in that location.

1300 DISCHARGE RECORD

Only one record per patient discharge is allowed except for multi-page claims. The last entry in the series of Revenue Code/Total Charges fields **must** be the Total Charge (0001) Revenue Code and the Charge Amount **must** be the total of all previous entries. Any remaining revenue and charge fields **must** be blank or zero filled. **No** zero or space filled fields should precede the 0001 entry.

FIELD NO.	NAME	SPECIFI-PICTURE	POSITION CATION	FORM FROM	THRU	LOCATOR
* 1	Patient Control Number	X(20)	L	1	20	FL03
* 2	Type of Bill	X(3)	L	21	23	FL04
* 3	Federal Tax Number (EIN)	9(10)	R	24	33	FL05
* 4	Statement Covers Period: FROM	9(8)	R	34	41	FL06
* 5	Statement Covers Period: TO	9(8)	R	42	49	FL06
* 6	Patient Address Zip Code	X(9)	L	50	58	FL13
* 7	Patient Date of Birth	9(8)	R	59	66	FL14
* 8	Patient Sex	X		67	67	FL15
* 9	Admission Date	9(8)	R	68	75	FL17
* 10	Admission Hour	X(2)	L	76	77	FL18
* 11	Type of Admission	X		78	78	FL19
* 12	Source of Admission	X		79	79	FL20
* 13	Patient Status	9(2)	L	80	81	FL22
* 14	Medical Record Number	X(17)	L	82	98	FL23
* 15	Revenue Code Line 1	9999	R	99	102	FL42
* 16	Total Charges by Revenue 1	S9(8)V99	R	103	112	FL47
* 17	Revenue Code Line 2	9999	R	113	116	FL42
* 18	Total Charges by Revenue 2	S9(8)V99	R	117	126	FL47
* 19	Revenue Code Line 3	9999	R	127	130	FL42
* 20	Total Charges by Revenue 3	S9(8)V99	R	131	140	FL47
* 21	Revenue Code Line 4	9999	R	141	144	FL42
* 22	Total Charges by Revenue 4	S9(8)V99	R	145	154	FL47
* 23	Revenue Code Line 5	9999	R	155	158	FL42
* 24	Total Charges by Revenue 5	S9(8)V99	R	159	168	FL47
* 25	Revenue Code Line 6	9999	R	169	172	FL42
* 26	Total Charges by Revenue 6	S9(8)V99	R	173	182	FL47
* 27	Revenue Code Line 7	9999	R	183	186	FL42
* 28	Total Charges by Revenue 7	S9(8)V99	R	187	196	FL47
* 29	Revenue Code Line 8	9999	R	197	200	FL42
* 30	Total Charges by Revenue 8	S9(8)V99	R	201	210	FL47
* 31	Revenue Code Line 9	9999	R	211	214	FL42
* 32	Total Charges by Revenue 9	S9(8)V99	R	215	224	FL47
* 33	Revenue Code Line 10	9999	R	225	228	FL4
* 34	Total Charges by Revenue 10	S9(8)V99	R	229	238	FL47
* 35	Revenue Code Line 11	9999	R	239	242	FL42
* 36	Total Charges by Revenue 11	S9(8)V99	R	243	252	FL47
* 37	Revenue Code Line 12	9999	R	253	256	FL42

* 38	Total Charges by Revenue 12	S9(8)V99	R	257	266	FL47
* 39	Revenue Code Line 13	9999	R	267	270	FL42
* 40	Total Charges by Revenue 13	S9(8)V99	R	271	280	FL47
* 41	Revenue Code Line 14	9999	R	281	284	FL42
* 42	Total Charges by Revenue 14	S9(8)V99	R	285	294	FL47
* 43	Revenue Code Line 15	9999	R	295	298	FL42
* 44	Total Charges by Revenue 15	S9(8)V99	R	299	308	FL47
* 45	Revenue Code Line 16	9999	R	309	312	FL42
* 46	Total Charges by Revenue 16	S9(8)V99	R	313	322	FL47
* 47	Revenue Code Line 17	9999	R	323	326	FL42
* 48	Total Charges by Revenue 17	S9(8)V99	R	327	336	FL47
* 49	Revenue Code Line 18	9999	R	337	340	FL42
* 50	Total Charges by Revenue 18	S9(8)V99	R	341	350	FL47
* 51	Revenue Code Line 19	9999	R	351	354	FL42
* 52	Total Charges by Revenue 19	S9(8)V99	R	355	364	FL47
* 53	Revenue Code Line 20	9999	R	365	368	FL42
* 54	Total Charges by Revenue 20	S9(8)V99	R	369	378	FL47
* 55	Revenue Code Line 21	9999	R	379	382	FL42
* 56	Total Charges by Revenue 21	S9(8)V99	R	383	392	FL47
* 57	Revenue Code Line 22	9999	R	393	396	FL42
* 58	Total Charges by Revenue 22	S9(8)V99	R	397	406	FL47
* 59	Revenue Code Line 23	9999	R	407	410	FL42
* 60	Total Charges by Revenue 23	S9(8)V99	R	411	420	FL47
61	Filler	X(25)		421	445	
62	Payer Identification (1st Payer)	X(13)	L	446	458	FL51
63	Patient’s Relationship to Insured	9(2)	R	459	460	FL59
64	Certificate/SocSecNumber/ Health Insurance Claim/ Identification Number	X(19)	L	461	479	FL60
65	Insurance Group Number	X(20)	L	480	499	FL62
66	Employment Status Code	X		500	500	FL64
67	Employer Name	X(24)	L	501	524	FL65
68	Employer Zip Code	X(9)	L	525	533	FL66
* 69	Principal Diagnosis Code	X(6)	L	534	539	FL67
* 70	Other Diagnosis Code 1	X(6)	L	540	545	FL68
* 71	Other Diagnosis Code 2	X(6)	L	546	551	FL69
* 72	Other Diagnosis Code 3	X(6)	L	552	557	FL70
* 73	Other Diagnosis Code 4	X(6)	L	558	563	FL71
* 74	Other Diagnosis Code 5	X(6)	L	564	569	FL72
* 75	Other Diagnosis Code 6	X(6)	L	570	575	FL73
* 76	Other Diagnosis Code 7	X(6)	L	576	581	FL74
* 77	Other Diagnosis Code 8	X(6)	L	582	587	FL75
* 78	Admitting Diagnosis	X(6)	L	588	593	FL76
* 79	External Cause of Injury (E-Code)	X(6)	L	594	599	FL77
* 80	Principal Procedure Code	X(7)	L	600	606	FL80
* 81	Principal Procedure Date	9(6)	R	607	612	FL80

* 82	Other Procedure 1: Code	X(7)	L	613	619	FL81
* 83	Other Procedure 1: Date	9(6)	R	620	625	FL81
* 84	Other Procedure 2: Code	X(7)	L	626	632	
* 85	Other Procedure 2: Date	9(6)	R	633	638	
* 86	Other Procedure 3: Code	X(7)	L	639	645	
* 87	Other Procedure 3: Date	9(6)	R	646	651	
* 88	Other Procedure 4: Code	X(7)	L	652	658	
* 89	Other Procedure 4: Date	9(6)	R	659	664	
* 90	Other Procedure 5: Code	X(7)	L	665	671	
* 91	Other Procedure 5: Date	9(6)	R	672	677	
* 92	Attending Physician Number	X(22)	L	678	699	FL82
* 93	Other Physician Number	X(22)	L	700	721	FL83
* 94	Other Physician Number	X(22)	L	722	743	FL84
* 95	Physician Number Qualifying Code	X(2)	L	744	745	
96	Century Flag Patient’s DOB 0 = Birth Year > 1900 1 = Birth Year < 1900	9		746	746	
* 97	Units of Service Line 1	9(7)	R	747	753	FL46
98	Date of Service Line 1	9(6)	R	754	759	FL45
* 99	Units of Service Line 2	9(7)	R	760	766	FL46
100	Date of Service Line 2	9(6)	R	767	772	FL45
* 101	Units of Service Line 3	9(7)	R	773	779	FL46
102	Date of Service Line 3	9(6)	R	780	785	FL45
* 103	Units of Service Line 4	9(7)	R	786	792	FL46
104	Date of Service Line 4	9(6)	R	793	798	FL45
* 105	Units of Service Line 5	9(7)	R	799	805	FL46
106	Date of Service Line 5	9(6)	R	806	811	FL45
* 107	Units of Service Line 6	9(7)	R	812	818	FL46
108	Date of Service Line 6	9(6)	R	819	824	FL45
* 109	Units of Service Line 7	9(7)	R	825	831	FL46
110	Date of Service Line 7	9(6)	R	832	837	FL45
* 111	Units of Service Line 8	9(7)	R	838	844	FL46
112	Date of Service Line 8	9(6)	R	845	850	FL45
* 113	Units of Service Line 9	9(7)	R	851	857	FL46
114	Date of Service Line 9	9(6)	R	858	863	FL45
* 115	Units of Service Line 10	9(7)	R	864	870	FL46
116	Date of Service Line 10	9(6)	R	871	876	FL45
* 117	Units of Service Line 11	9(7)	R	877	883	FL46
118	Date of Service Line 11	9(6)	R	884	889	FL45
* 119	Units of Service Line 12	9(7)	R	890	896	FL46
120	Date of Service Line 12	9(6)	R	897	902	FL45
* 121	Units of Service Line 13	9(7)	R	903	909	FL46
122	Date of Service Line 13	9(6)	R	910	915	FL45
* 123	Units of Service Line 14	9(7)	R	916	922	FL46
124	Date of Service Line 14	9(6)	R	923	928	FL45
* 125	Units of Service Line 15	9(7)	R	929	935	FL46

	126	Date of Service Line 15	9(6)	R	936	941	FL45
*	127	Units of Service Line 16	9(7)	R	942	948	FL46
	128	Date of Service Line 16	9(6)	R	949	954	FL45
*	129	Units of Service Line 17	9(7)	R	955	961	FL46
	130	Date of Service Line 17	9(6)	R	962	967	FL45
*	131	Units of Service Line 18	9(7)	R	968	974	FL46
	132	Date of Service Line 18	9(6)	R	975	980	FL45
*	133	Units of Service Line 19	9(7)	R	981	987	FL46
	134	Date of Service Line 19	9(6)	R	988	993	FL45
*	135	Units of Service Line 20	9(7)	R	994	1000	FL46
	136	Date of Service Line 20	9(6)	R	1001	1006	FL45
*	137	Units of Service Line 21	9(7)	R	1007	1013	FL46
	138	Date of Service Line 21	9(6)	R	1014	1019	FL45
*	139	Units of Service Line 22	9(7)	R	1020	1026	FL46
	140	Date of Service Line 22	9(6)	R	1027	1032	FL45
*	141	Units of Service Line 23	9(7)	R	1033	1039	FL46
	142	Date of Service Line 23	9(6)	R	1040	1045	FL45
*	143	Operating Physician Number	X(22)	L	1046	1067	
		Filler	X(3)		1068	1070	
	144	Payer Identification (2nd Payer)	X(13)	L	1071	1083	FL51
	145	Patient’s Relationship to Insured	9(2)	L	1084	1085	FL59
	146	Certificate/SocSecNumber/ Health Insurance Claim/ Identification Number	X(19)	L	1086	1104	FL60
	147	Insurance Group Number	X(20)	L	1105	1124	FL62
*	148	Patient's Name	X(25)	L	1125	1149	FL12
	149	Payer Identification (3rd Payer)	X(13)	L	1150	1162	FL51
	150	Patient’s Relationship to Insured	9(2)	L	1163	1164	FL59
	151	Certificate/SocSecNumber/ Health Insurance Claim/ Identification Number	X(19)	L	1165	1183	FL60
	152	Insurance Group Number	X(20)	L	1184	1203	FL62
*	153	Birth Weight (In Grams)	9(4)	R	1204	1207	
*	154	APGAR Score	9(4)	R	1208	1211	
*	155	Patient Race	X		1212	1212	
*	156	Source of Payment Code (1st)	X(2)	L	1213	1214	FL50
*	157	Source of Payment Code (2nd)	X(2)	L	1215	1216	FL50
*	158	Source of Payment Code (3rd)	X(2)	L	1217	1218	FL50
*	159	Medicaid Provider Number	X(12)	L	1219	1230	FL51
*	160	National Provider Identifier	X(12)	L	1231	1242	FL51
*	161	Patient’s Social Security Number	9(9)	R	1243	1251	FL60
	162	Filler	X(12)		1252	1263	
	163	Federal Tax Sub Id	X(4)	L	1264	1267	FL05
*	164	Patient Address - City	X(15)	L	1268	1282	FL13
*	165	Patient Address - State	X(2)	L	1283	1284	FL13

* 166 Patient Address - Street X(16) L 1285 1300 FL13

USE OF MULTI-PAGE CLAIMS

All data except revenue code and charge fields should be duplicated on successive records. All available revenue and charge fields should be completely filled before using additional records. The '0001' revenue code should be the last entry on the last record for a multi-page claim and its charge should be equal to the total charge for all pages.

EXCEPTIONS TO 1300 FORMAT

With the inclusion of the 1300 format as an accepted data format, the standard 1300 required the addition of data elements not found on the 1300 format but found on the 1450 format. Formats used by other states have been reviewed in an attempt to use standard data layouts. Their usage of free space has been incorporated whenever possible.

The following fields are the additional data elements:

Field Number	Field Name	Form Locator
10	Admission Hour	FL18
14	Medical Record Number	FL23
78	Admitting Diagnosis	FL76
95	Physician Number Qualifying Code	
143	Operating Physician Number	
148	Patient's Name	FL12
164	Patient Address - City	FL13
165	Patient Address - State	FL13
166	Patient Address - Street	FL13

DATA DICTIONARY

The definition specified for each data element is in general agreement with the definition in the UB-92 Users Manual. Hospitals using existing UB-92 record formats should reference the sections, EXCEPTIONS TO 1450 FORMAT and EXCEPTIONS TO 1300 FORMAT, for differences from the established UB-92 record formats. Hospitals using data sources other than uniform billing should evaluate their definitions for agreement with the definitions specified in this Guide and the UB-92 Users Manual.

The dictionary format that follows will provide the following information:

1. Data Element: The name of the data element
2. Char Type: Character type for the data element
   N = numeric
   A = alphanumeric
3. Char Length: Character length of data element. For fields with an implied decimal point, the first number is the total length, the second number is the length after the implied decimal point (e.g., '9, 2' represents the COBOL picture clause 9(7)V99).
4. Data Reporting Level: Reporting requirement for the data element
   Required = must be reported
   As available = must be present, if captured in your database
5. Definition: A definition of the data element
6. General Comments: These comments help to further define or explain the data Comments: elements and give permissible values for code and type data elements
7. Edit: Minimal edits that will be performed on the data element; these edits should be performed by the hospital prior to

submission.

Accommodations Days N 4

Data Reporting Level: Required (1450 only)
Definition: A numeric count of accommodations days in accordance with payer instructions. Includes UB-92 revenue codes 10X through 21X.
General Comments: This field should be a numeric value greater than zero.
Edit: The total number of days between admission date and discharge date must be within +/- 2 days of Accommodations Days.

Accommodations Rate N 9,2

Data Reporting Level: Required
Definition: Per-diem rate for related UB-92 accommodations revenue codes.
General Comments: The rate should be right justified with leading zeroes. There is an implied decimal place 2 positions from the right.
Edit: If present, rate must be greater than zero.

Admission Date N 6 or 8 1450
N 8 1300

Data Reporting Level: Required
Definition: The date the patient was admitted to the hospital.
General Comments: The admission date is to be entered as month, day, and year. The format is MMDDYY for 1450 record and MMDDCCYY for 1300 record. The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging from 01-31. The year is recorded as two digits ranging from 00 -99. Each of the three components (month, day, year) must be right justified within its two digits. The 1300 record also contains a two digit century. Any unused space to the left must be zero filled. For example February 7, 1992 is entered as 020792 (1450) or 02071992 (1300).

For hospitals using the 1450 record format that began using a different date format in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 is entered 20010207. Where this change is made, all dates must use this format.
Edit: Admission date must be present and a valid date. The date cannot be before date of birth or be after ending date in Statement Covers Period.

Admission Hour A 2

Data Reporting Level: Required
Definition: The hour during which the patient was admitted for inpatient care.
General Comments: Military time should be used to represent the hour of admission. If admitted between midnight and noon, use the values from 00 to 11; if admitted between noon and 11:59 pm, use the values from 12 to 23.
Edit: Valid numeric value for the hour of admission or blank.

Admitting Diagnosis Code A 6

Data Reporting Level: Required
Definition: The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.
General Comments: This field is to contain the appropriate ICD-9-CM code without a decimal. In the ICD-9-CM codebook there are three, four and five digit codes plus 'V' and 'E' codes. Use of the fourth, fifth, 'V' and 'E' is not optional, but must be entered when present in the code.

For example, a five-digit code is entered as '12345"; a 'V' code is entered as 'V270.' All entries are to be left justified with spaces to the right to complete the field length. An 'E' code should not be recorded as the principal diagnosis.

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

APGAR Score N 4

Data Reporting Level: Required
Definition: APGAR Score for a newborn. Zero fill if not a newborn.
General Comments: Right justify the field with zeroes to the left to complete the field.
Edit: If present, must be numeric.

Attending Physician Name A 25

Data Reporting Level: As available
Definition: Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
General Comments: Entered in the order of last name, first name and middle initial. Last name in positions 1-16, first name in positions 17-24 and initial in position 25.
Edit: None

Attending Physician Number A 16 1450
A 22 1300

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

Birth Weight N 4

Data Reporting Level: Required
Definition: Birth weight in grams for a newborn. Zero fill if not a newborn.
General Comments: Right justify the field with zeroes to the left to complete the field.
Edit: Must be numeric.

Certificate/Social Security Number/ Health Insurance Claim/ Identification Number A 19

Data Reporting Level: Required
Definition: Insured's unique identification number assigned by the payer organization. Medicare purposes, enter the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.

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

Edit: None

Charitable / Donation Rate N 3

Data Reporting Level: As available
Definition: This item identifies the 'claim' fully or partially as charitable or a donation of services. (This should not be confused with a bad debt.)
General Comments: Use the following percentage rates:

100	Fully charitable / donation
1 - 99	Partially charitable, expecting some reimbursement of expenses, estimate the percentage of total charges that will be charitable
0	Not charitable, expect collection of all or some of the charges

Edit: If present, must be a valid numeric value.

Date of Service N 6

Data Reporting Level: As available
Definition: Date the service indicated by the related revenue code was performed or provided.
General Comments: None
Edit: If present, must be a valid date.

Discharge Hour A 2

Data Reporting Level: As available
Definition: Hour that the patient was discharged from inpatient care.
General Comments: Military time should be used to represent the hour of discharge. If discharged between midnight and noon, use the values from 00 to 11; if discharged between noon and 11:59 pm, use the values from 12 to 23.
Edit: Valid numeric value for the hour of discharge or blank.

Employer Location A 44

Data Reporting Level: As available
Definition: The specific location represented by the address of the employer of the individual identified by the second of two entries in employment information data field
General Comments: This is to be the full and complete address of the employer of the individual.
Edit: None

Employer Name A 24

Data Reporting Level: As available
Definition: The name of the employer that might or does provide health care coverage for the individual identified by the first of two entries in the employment information data fields.
General Comments: Enter the full and complete name of the employer providing health care coverage.
Edit: None

Employer ZIP Code A 9

Data Reporting Level: As available
Definition: The ZIP Code of the employer of the individual identified by the first of two entries in the employment information data fields.
General Comments: None

Edit: None

Employment Status Code A 1

Data Reporting Level: As available
Definition: A code used to define the employment status of the individual identified in the first of two employment information data fields
General Comments: This field contains the employment status of the person described in the first of two employment information data fields. The codes to be used are as follows:

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

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

Estimated Amount Due N 8, 2

Data Reporting Level: As available
Definition: The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).
General Comments: The format of this estimate is dollars and cents. The dollar amount can be a maximum of 6 digits with 2 additional digits for cents (no decimal is entered). If the amount has no cents then the last 2 digits must be zeros. For example, an estimate of $500 is entered as 50000; an estimate of $50.55 is entered as 5055. The entry is right justified within the field.
Edit: None

Estimated Amount Due (Patient) A 8, 2

Data Reporting Level: As available
Definition: The amount estimated by the hospital to be due from the patient (estimated responsibility less prior payments).
General Comments: The format of this estimate is dollars and cents. The dollar amount can be a maximum of 6 digits with 2 additional digits for cents (no decimal is entered). If the amount has no cents then the last 2 digits must be zero. For example, an estimate of $500 is entered as 50000 and an estimate of $50.55 is entered as 5055. The entry is right justified within the field.
Edit: None

Estimated Collection Rate N 3

Data Reporting Level: As available
Definition: Collection rate (percentage) expected from all sources for this inpatient occurrence. This percentage could be the result of bad debt, contracted amounts or rates with insurance carriers, etc.
General Comments: The value could be for the specific patient or could be the hospital's percentage of collections against charges. The hospital collection rate should also include capitated rates against normal charges.

Edit: Numeric value; range 0 to 100

External Cause of Injury Code (E-code) A 6

Data Reporting Level: Required
Definition: The ICD-9-CM code for the external cause of injury, poisoning or adverse effect.
General Comments: Hospitals are to complete this field whenever there is a diagnosis of an injury, poisoning or adverse effect. The priorities for recording an E-code are:

1) Principal diagnosis of an injury or poisoning
2) Other diagnosis of an injury
3) Other diagnosis with an external cause

All entries are to be left justified without a decimal.
Edit: Must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

Federal Tax Number (EIN) N 10

Data Reporting Level: Required
Definition: The number assigned to the provider by the Federal government for tax report purposes, also known as a tax identification number (TIN) or employer identification number (EIN).
General Comments: None

Edit: None

Federal Tax Sub ID A 4

Data Reporting Level: Required when Federal Tax Number is not unique.
Definition: Four-position modifier to Federal Tax ID.
General Comments: Used by providers to identify their affiliated subsidiaries when the Federal Tax Number does not distinguish between separate facilities or cost centers.
Edit: None

HCPCS / Procedure Code A 5

Data Reporting Level: As available
Definition: Procedure codes reported in record types identify services so that appropriate payment can be made. HCFA Common Procedural Coding System (HCPCS) code is required for many specific types of outpatient services and a few inpatient services. May include up to two modifiers.
General Comments: None
Edit: None

Insured Address A 62

Data Reporting Level: As available
Definition: Insured's current mailing address. Address Line 1. Address Line 2. City. State. Zip.
General Comments: None
Edit: None

Insured Group Name A 14

Data Reporting Level: As available
Definition: Name of the group or plan through which the insurance is provided to the Insured’s Name listed in the first Insured’s Name field.
General Comments: Enter the complete name of the group or plan name. If the

name exceeds 16 characters, truncate the excess.
Edit: None

Insurance Group Number A 17 1450
A 20 1300

Data Reporting Level: As available
Definition: The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered
General Comments: None
Edit: None

Insured's Name A 30

Data Reporting Field: As available
Definition: The name of the individual in whose name the insurance is carried.
General Comments: Enter the name of the insured individual in last name, first name, middle initial order. Titles such as Sir, Mr. or Dr. should not be recorded in this data field. Record hyphenated names with the hyphen as in Smith-Jones. To record suffix of a name, write the last name, leave a space then write the suffix, for example, Snyder III or Addams Jr.
Edit: None

Insured's Sex A 1

Data Reporting Level: As available.
Definition: A code indicating the sex of the insured.
General Comments: This is a one-character code. The sex is to be reported as male, female or unknown using the following coding:
M = Male
F = Female
U = Unknown
Edit: If present, the code must be valid.

Medicaid Provider Number A 13 1450
A 12 1300
Data Reporting Level: Required.
Definition: The number assigned to the provider by Medicaid.
General Comments: None
Edit: Will be verified against Department of Health databases.

Medical Record Number A 17

Data Reporting Level: Required
Definition: Number assigned to patient by hospital or other provider to assist in retrieval of medical records
General Comments: This number is assigned by the hospital for each patient.
Edit: None

Medicare Provider Number (See **National Provider Identifier**)

Modifier A 2

Data Reporting Level: As available.
Definition: Two-position codes serving as modifier to HCPCS procedure.
General Comments: None
Edit: None

National Provider Identifier A 13 1450

	A	12	1300

Data Reporting Level: Required
Definition: The National Provider Identifier (NPI) is a ten-position identifier issued by Medicare.
General Comments: Beginning January 1, 1997, the Medicare Provider Number is the NPI. On April 1, 1997, only the NPI will be accepted by Medicare.
Edit: Will be verified against Department of Health databases obtained from Medicare.

Non-Covered Charges by Revenue Code N 10, 2

Data Reporting Level: As available.
Definition: Charges pertaining to the related UB-92 revenue code that are not covered by the primary payer as determined by the provider.
General Comments: The total allows for an 8-digit dollar amount followed by 2 digits for cents (no decimal point). All entries are right justified. If the charge has no cents, then the last two digits must be zero. For example, a charge of $500.00 is entered as 50000; a charge of $37.50 is entered as 3750.
Edit: This field must be present and contain a value greater than 0 when revenue code field is greater than 0.

Number of Claims N 6

Data Reporting Level: Required (1450 only)
Definition: The number of discharge submitted by a hospital for this submitted. Used to verify a complete submittal, no losses of data.
General Comments: None.
Edit: Must be the total number of discharges for the hospital in the batch (type '20' records).

Operating Physician Name A 25

Data Reporting Level: As available.
Definition: Name used by the provider to identify the operating physician in the provider records.
General Comments: Entered in the order of last name, first name and middle initial. Last name in positions 1-16, first name in positions 17-24 and initial in position 25.
Edit: None

Operating Physician Number	A	16	1450
	A	22	1300

Data Reporting Level: Required.
Definition: Number used by the provider to identify the operating physician in the provider records.
General Comments: Must be left justified in the field.
Edit: This field must contain a valid license or assigned number according to 'Physician Number Qualifying Code.'

Other Diagnosis Code A 6

Data Reporting Level: Required
Definition: ICD-9-CM codes describing other diagnoses corresponding to additional conditions that co-exist at the time of admission or develop subsequently, and which have an effect on the treatment received or the length of stay.
General Comments: The first of eight additional diagnoses. This field must contain the appropriate ICD-9-CM code without a decimal. In the ICD-9-CM codebook there are three, four, and five digit codes, plus 'V' and

'E' codes. Use of the fourth, fifth, 'V,' and 'E' is not optional, but must be entered when present in the code. For example, a five-digit code is entered as '12345', a 'V' code is entered as 'V270.' All entries are to be left justified with spaces to the right to complete the field length. An 'E' code should not be recorded as the principal diagnosis.

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

Other Physician Name	A	25	

Data Reporting Field: As available
Definition: This is the name of a physician other than the attending physician as defined by the payer organization.
General Comments: Entered in the order of last name, first name and middle initial. Last name in positions 1-16, first name in positions 17-24 and initial in position 25.
Edit: None

Other Physician Number	A	16	1450
	A	22	1300

Data Reporting Field: Required
Definition: This is the license number of a physician other than the attending physician as defined by the payer organization.
General Comments: Must be left justified in the field.
Edit: This field must contain a valid license or assigned number according to 'Physician Number Qualifying Code.

Other Procedure Code	A	7	

Data Reporting Level: Required
Definition: The code that identifies the other procedures performed during the patient's hospital stay covered by this discharge record. This may include diagnostic or exploratory procedures.
General Comments: Procedures that make for accurate DRG Categorization must be included. The coding method used must agree with the coding method used for the principal procedure. Entries must include all digits. In the ICD-9-CM there are three-digit procedure codes and four-digit codes, use of the fourth digit is NOT optional. It must be present. Enter the code left justified, without a decimal.
Edit: If this field is present, there must be a principal procedure entered. Codes entered must be valid. When a procedure is gender-specific, the gender code entered in the record must be consistent.

Other Procedure Date	N	6	

Data Reporting Level: Required
Definition: Date that the procedure indicated by the related procedure code was performed
General Comments: None
Edit: Must be a valid date.

Patient Address	A	62	1450
- Street	A	16	1300
- City	A	15	1300
- State	A	2	1300
- ZIP Code	A	9	1300

Data Reporting Level: Required
Definition: The address including postal zip code of the patient, as defined by the payer organization. (Address line 1 & 2, City, State, & ZIP

Code).

General Comments: The order of the complete address if provided should be street number, apartment number, city, state and zip code, left justified with spaces to the right to complete the field. The state must be the standard post office abbreviations (AR for Arkansas). If the nine digit zip code is used, it must be entered in the form XXXXXYYYY where X's are the five digit zip code and the Y's are the zip code extension. If Street Address is not provided, the nine digit postal ZIP code is required for a valid address.

Edit: This field is edited for the presence of an address with a valid and complete postal ZIP code.

Patient Control Number A 20

Data Reporting Level; Required

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

General Comments: This number should not be the same as the Medical Record Number. This number will be used for reference in correspondence, problem solving or edit corrections.

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

Patient's Date of Birth N 8

Data Reporting Level: Required

Definition: The date of birth of the patient in month day year order; year is 4 digits.

General Comments: The date of birth must be present and recorded in an eight-digit format of month day year (MMDDYYYY). The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging form 01-31. The year is recorded as four digits ranging from 1800-2100. Each of the first two components (month, day) 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.'

For hospitals using the 1450 record format that began using a different date in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 format is entered 20010207. Where this change is made, all dates must use this format.

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

Patient's Ethnicity (1450 only) A 1

Data Reporting Level: Required

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

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

1 = Hispanic origin

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

2 = Not of Hispanic Origin

Definition: A person who is not classified in 1.

6 = Unknown
Definition: A person who chooses not to respond to the inquiry

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

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

Patient's Marital Status A 1

Data Reporting Level: As available
Definition: The marital status of the patient at date of admission, or start of care.
General Comments: The marital status of the patient is to be reported as a one character code whenever the information is recorded in the patient's hospital record. The following codes apply:

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

Edit: This field is edited for a valid entry.

Patient Name A 31 1450
A 25 1300

Data Reporting Level: Required
Definition: The name of the patient in last, first and middle initial order.
General Comments: Titles such as Sir, Msgr., Dr. should not be recorded. Record hyphenated names with the hyphen, as in Smith-Jones. To record a suffix of a name, write the last name, leave a space, then write the suffix, for example: Snyder III or Addams Jr.
Edit: The name will be edited for the presence of the last name and the first name.

Patient's Race (1450 only) A 1 1450

Data Reporting Level: Required
Definition: This item gives the race of the patient.
General Comments: The patient may choose not to provide the information. If the patient chooses not to answer, the hospital should enter the code for unknown. If the hospital fails to request the information, the field should be space filled.

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

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

3 = Black
Definition: A person having origins in any of the black racial groups of Africa

4 = White
Definition: A person having origins in any of the

original Caucasian peoples of Europe, North Africa or the Middle East.

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

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

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

Patient's Race/Ethnicity(1300 only) A 1 1300

Data Reporting Level: Required
Definition: This item gives the race of the patient.
General Comments: The patient may choose not to provide the information. If the patient chooses not to answer, the hospital should enter the code for unknown. If the hospital fails to request the information, the field should be space filled.

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

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

2 = Other
Definition: Any possible options not covered in the other categories.

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

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

5 = Hispanic origin - White
Definition: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, and whose race is white.

6 = Hispanic origin - Black
Definition: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, and whose race is black.

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

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

Patient's Relationship to Insured N 2

Data Reporting Level: As available
Definition: A code indicating the relationship, such as patient, spouse, child, etc., of the patient to the identified insured person listed in the first of three Insured's Name fields.
General Comments: Enter the 2 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
Definition: Self-explanatory
04 = Grandparent
Definition: Self-explanatory
05 = Grandchild
Definition: Self-explanatory
07 = Niece or Nephew
Definition: Self-explanatory
10 = Foster Child
Definition: Self-explanatory
15 = Ward of the Court
Definition: Patient is ward of the insured as a result of a court order
17 = Step Child
Definition: Self-explanatory
18 = Patient is named insured
Definition: Self-explanatory
19 = Natural child/insured financially responsible
Definition: Self-explanatory
20 = Employee
Definition: The patient is employed by the named insured.
21 = Unknown
Definition: The patient's relationship to the named insured is unknown
22 = Handicapped Dependent
Definition: Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage
23 = Sponsored Dependent
Definition: Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.
24 = Minor Dependent of a Minor Dependent
Definition: Code is used where patient is a minor and a dependent of another minor who in turn is a dependent, although not a child of the insured.
29 = Significant Other
32 = Mother
33 = Father
Definition: Self-explanatory
36 = Emancipated Minor
39 = Organ Donor
Definition: Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.
40 = Cadaver Donor
Definition: Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.
41 = Injured Plaintiff
Definition: Patient is claiming insurance as a result of injury covered by insured.

43 = Natural child/insured does not have financial responsibility
Definition: Self-explanatory
53 = Life Partner
G8 = Other Relationship

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

Patient's Sex A 1

Data Reporting Level: Required
Definition: The gender of the patient as recorded at date of admission.
General Comments: This is a one-character code. The sex is to be reported as male, female or unknown using the following coding:
M = Male
F = Female
U = Unknown
Edit: A valid code must be present. The gender of the patient is checked for consistency with diagnosis and procedure codes. The edit is to identify gender diagnosis conflicts and invalid or unknown gender.

Patient Social Security Number N 10 1450
N 9 1300

Data Reporting Level: As Available
Definition: The social security number of the patient receiving inpatient care.
General Comments: For 1450 submissions, this field is to be right justified, with zeroes to the left to complete the field. The format of SSN is 0123456789 without hyphens. For 1300 submissions, the SSN should fill the field. If the patient is a newborn, use the mother's SSN. If a patient does not have a social security number, fill with zeroes.
Edit: The field is edited for a valid entry.

Patient's Status N 2

Data Reporting Level: Required
Definition: A code indicating patient status at the time of the discharge. It is the arrangement or event ending a patient's stay in the hospital.
General Comments: This is a two-character code. This should be the status at the time of discharge, the last 'Patient Status'; this would invalidate any patient's stay codes of 30-39. The patient's status is coded as follows:

01 = Discharged to Home or Self Care (Routine Discharge)- Includes discharges to home; jail or law enforcement; home on oxygen if DME only; any other DME only; home IV care; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated

02 = Discharged/transferred to a Short-Term General Hospital for Inpatient Care

03 = Discharge/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care- Indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities see 04 and 64.

04 = Discharge/transferred to an Intermediate Care Facility (ICF) - Typically defined at the state lever for specifically designated intermediate care facilities. Used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.

05 = Discharge/transferred to another Type of Health Care

Institution not Defined Elsewhere in this Code List if a patient is discharged from an inpatient program to a residential program, code it as '05'.

06 = Discharge/transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care

07 = Left Against Medical Advice or Discontinued Care

09 = Admitted as an Inpatient to this Hospital-Use only with Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

20 = Expired

30= Still a Patient in the Hospital- ***not a valid code

40= Expired at home- hospice claims only

41= Expired in a Medical Facility-hospital, skilled nursing facility, intermediate care facility, or freestanding hospice (hospice claims only)

42= Expired - Place Unknown (hospice claims only)

43= Discharge/transferred to a Federal Health Care Facility e.g. Department of Defense hospital, a VA hospital, or a VA nursing facility

50= Hospice – Home

51= Hospice - Medical Facility

61= Discharged/transferred to a hospital based (Medicare approved) swing bed- For Medicare discharges, use for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.

62= Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital

63= Discharged/transferred to a Long Term Care Hospital (LTCH)

64= Discharged/transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare

65= Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a hospital

66= Discharged/transferred to a critical Access Hospital (CAH)

Edit: The patient status code must be present and a valid code as defined. A patient status code of 30 is not a valid code.

*In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier, such as observation following outpatient surgery, which results in admission.

Payer Identification	A	9	1450
	A	13	1300

Data Reporting Level: As available
Definition: An identifier of the primary payer organization from which the hospital might expect some payment for the bill. The sub-identification is of the specific office within the insurance carrier designated as responsible for this claim.
General Comments: This can be a unique identifier used solely by the hospital.
Edit: None

Payments Received N 8, 2

Data Reporting Level: As available
Definition: The amount the hospital has received toward payment of a bill prior to the billing date from an indicated payer.
General Comments: The format of this payment is dollar and cents. The dollar amount can be a maximum of 6 digits with 2 additional digits for cents (no decimal is entered). If the amount has no cents, then the last 2 digits must be zeros. For example, an estimate of $500 is entered as 50000 and a payment of $50.00 is entered as 5000. The entry is right justified within the field.
Edit: None

Payments Received (Patient)	N	8, 2

Data Reporting Level: As available
Definition: The amount the hospital has received from the patient toward payment of a bill prior to the billing date.
General Comments: The format of this payment is dollar and cents. The dollar amount can be a maximum of 6 digits with 2 additional digits for cents (no decimal is entered). If the amount has no cents, then the last 2 digits must be zeros. For example, an estimate of $500 is entered as 50000 and a payment of $50.00 is entered as 5000. The entry is right justified within the field.
Edit: None

Physician Number Qualifying Code	A	2

Data Reporting Level: Required
Definition: The type of Physician Number being submitted. Applies to all Physician Numbers for a single hospital discharge.
General Comments: Use one of the following codes:

UP = UPIN
FI = Federal Taxpayer ID Number
SL = State License ID Number
SP = Specialty License Number
XX = National Provider Identifier

If the UPIN coding is used, the following may be used for physicians without assigned UPINs:

INT000 for each intern
RES000 for each resident
PHS000 for Public Health Service physicians
VAD000 for Department of Veterans Affairs physicians
RET000 for retired physicians
SLF000 for providers to report that the patient is self-referred
OTH000 for all other unspecified entities without UPINs

Edit: Must be a valid code or spaces. Spaces will be assumed to be UPIN.

Principal Diagnosis Code A 6

Data Reporting Level: Required
Definition: The principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the patient for care. An ICD-9-CM code describes the principal disease.
General Comments: This field is to contain the appropriate ICD-9-CM code without a decimal. In the ICD-9-CM codebook there are three, four, and five digit codes plus 'V' and 'E' codes. Use of the fourth, fifth, 'V' and 'E' is not optional, but must be entered when present in the code. For example, a five-digit code is entered as '12345'; a 'V' code is entered as 'V270'. All entries are to be left justified with spaces to the right to complete the field length. An 'E' code should not be recorded as the principal diagnosis.
Edit: A principal diagnosis must be present and valid. When the principal diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

Principal Procedure Code A 7

Data Reporting Level: Required
Definition: The code that identifies the principal procedure performed during the hospital stay covered by this discharge data record. The principal procedure is one that is performed for definitive treatment rather than for diagnostic or exploratory purposes, or is necessary as a result of complications. The principal procedure is that procedure most related to the principal diagnosis.
General Comments: The coding method used should be ICD-9. If some other coding method is used, Procedure Coding Method Used field must NOT be 9, but must indicate the code for all digits and decimal. In the ICD-9-CM, there are three-digit procedure codes and four-digit procedure codes; use of the fourth-digit is NOT optional. It must be present. Enter the code left justified without a decimal
Edit: This field must be present if other procedures are reported and be a valid code. When a procedure is sex-specific, the sex code entered in the record must be consistent.

Principal Procedure Date N 6
Data Reporting Level: Required
Definition: The date on which the principal procedure described on the bill was performed.
General Comments: None
Edit: Must be a valid date falling between admission and discharge dates.

Procedure Coding Method Used N 1

Data Report Level: Required (1450 only) if procedure coding is NOT ICD-9-CM
Definition: An indicator that identifies the coding method used for procedure coding.
General Comments: The default value is 9 for ICD-9. If coding

method is NOT ICD-9,enter appropriate code from the list:
4 = CPT - 4
5 = HCPCS (HCFA Common Procedure Coding System)
9 = ICD - 9 - CM

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

Provider Address A 50

Data Reporting Level: Required
Definition: Complete mailing address to which the provider correspondence is to be sent for the correction and acknowledgment of discharge data. Street address or box number, city, state and ZIP code are required.
General Comments: None
Edit: All address fields must be present.

Provider FAX Number N 10

Data Reporting Level: As available
Definition: FAX number for provider.
General Comments: Fax number to be used for transmission of correction documents and acknowledgment of discharge data. If a FAX number does not exist, fill with zeroes.
Edit: Must be numeric data.

Provider Name A 25

Data Reporting Level: Required
Definition: The name of the hospital submitting the record.
General Comments: The hospital's name is entered in the first 25 character positions and must be the name as it is licensed by the Department of Health.
Edit: The name must be present and match a name in a coding table.

Provider Telephone Number N 10

Data Reporting Level: Required
Definition: Telephone number, including area code, at which the provider wishes to be contacted for correction and acknowledgment of discharge data.
General Comments: None
Edit: Must be present and numeric, cannot be all zeroes.

Record Type N 2

Data Reporting Level: Required (1450 only)
Definition: The record format type indicator.
General Comments: This field is used to specify each type of record. Use the following numbers:

Record Name	Record Type Code
Processor Data	01
Reserved for National Assignment	02-04
Local Use	05-09
Provider Data	10
Reserved for National Assignment	11-14
Local Use	15-19
Patient Data	20
Noninsured Employment Information	21
Unassigned State Form Locators	22
Reserved for National Assignment	23-24
Local Use	25-29

Third Party Payer Data	30-31
Reserved for National Assignment	32-33
Authorization	34
Local Use	35-39
Claim Data TAN-Occurrence	40
Claim Data Condition-Value	41
Reserved for National Assignment	42-44
Local Use	45-49
IP Accommodations Data	50
Reserved for National Assignment	51-54
Local Use	55-59
IP Ancillary Services Data	60
Outpatient Procedures	61
Reserved for National Assignment	62-64
Local Use	65-69
Medical Data	70
Plan of Treatment and Patient Information	71
Specific Services and Treatments	72
Plan of Treatment/Medical Update Narrative	73
Patient Information	74
Reserved for National Assignment	75-78
Local Use	79
Physician Data	80
Pacemaker Registry Record	81
Reserved for National Assignment	82-84
Local Use	85-89
Claim Control Screen	90
Remarks (Overflow from RT 90)	91
Reserved for National Assignment	92-94
Provider Batch Control	95
Local Use	96-98
File Control	99

Edit: The number must be present and valid.

Revenue Code N 4

Data Reporting Level: Required
Definition: A four-digit code that identifies a specific accommodation, ancillary service or billing calculation.
General Comments: For every patient there must be at least one revenue service entered. There may be an entry representing the sum of all revenue services; this entry would have a revenue code of '0001.' If the summed entry ('0001') is one of the entries, the revenue amount associated must equal 'TOTAL CHARGE' found on record type 27.
Edit: This field must be present and contain a valid revenue code as defined in Revenue Codes and Units of Service section.

Sequence Number N 2

Data Reporting Level: Required (1450 only)
Definition: Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 21-2n do not have a sequence number greater than 01. Records 01, 10, 90, 91, 95 and 99 do not have sequence numbers. The sequence numbers for record types 30, 31, 34, 80 and 81 are used as matching criteria to determine which type 30, type 31, type 34, type 80 and/or type 81 records are associated, like sequence numbers indicating the records are associated.

General Comments: None
Edit: Must be valid sequence number for record type.

Source of Admission A 1

Data Reporting Level: Required
Definition: A code indicating the source of the admission.
General Comments: This is a single-digit code whose meaning depends on the code entered for Type of Admission. For Type of Admission codes 1, 2 or 3, Source of Admission codes 1 - 9 are valid. For Type of Admission code 4 (newborn), Source of Admission codes 1 - 4 are valid, and have different meanings than when Type of Admission is a 1, 2 or 3. The code structure is as follows:

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

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

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

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

4 = Transfer from a Hospital
Definition: The patient was admitted to this facility as a transfer from an acute care facility where he/she was an inpatient

5 = Transfer from a Skilled Nursing Facility
Definition: The patient was admitted to this facility as a transfer from a skilled nursing facility where he/she was an inpatient.

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

7 = Emergency Room
Definition: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.

8 = Court/Law Enforcement
Definition: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.

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

D – Inpatient transfers within the same facility
Definition: The patient was transferred from a separate unit of a hospital to another unit of the same hospital which results in separate claim to the payers

CODE STRUCTURE FOR NEWBORN (4)
If Type of Admission is a 4, the following codes apply:

1 = Normal delivery
Definition: A baby delivered without complications.

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

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

4 = Extramural birth
Definition: A baby born in a non-sterile environment.
9 = Information not available.

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

Source of Payment Code (1450 only)	A	1	1450

Data Reporting Level: Required
Definition: A code indicating source of payment associated with this payer record.
General Comments: Valid codes are:

A = Self Pay
B = Worker's Compensation
C = Medicare
D = Medicaid
E = Other Federal Programs
F = Commercial Insurance
G = Blue Cross/Blue Shield, Medi-Pak, Medi-Pak Plus
H = CHAMPUS
I = Other
J = County or State (ex:state or county employees)
L = Managed Assistance
N = Division of Health Services
Q = HMO/Managed Care
S = Self Insured
Z = Medically Indigent/Free

Edit: Code must be present and valid

Source of Payment Code (1300 only)	A	1	1300

Data Reporting Level: Required
Definition: A code indicating source of payment associated with this payer record.
General Comments: Valid codes are:

P = Self Pay
W = Worker's Compensation
M = Medicare
D = Medicaid
V = Other Federal Programs
I = Commercial Insurance
B = Blue Cross/Blue Shield, Medi-Pak, Medi-Pak Plus
C = CHAMPUS
O = Other
E = County or State (ex: state or county employees)
L = Managed Assistance
N = Division of Health Services
H = HMO/Managed Care
S = Self Insured
Z = Medically Indigent/Free

Edit: Code must be present and valid.

Statement Covers Period From	N	6	1450
	N	8	1300

Data Reporting Level: Required
Definition: The date of the first medical service relating to this patient=s stay in the hospital.
General Comments: The format is MMDDYY for 1450 record and MMDDCCYY for 1300 record. The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging from 01-31. The year is recorded

as two digits ranging from 00 -99. Each of the three components (month, day, year) must be right justified within its two digits. The 1300 record also contains a two-digit century. Any unused space to the left must be zero filled. For example February 7, 1992 is entered as 020792 (1450) or 02071992 (1300).

For hospitals using the 1450 record format that began using a different date format in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 is entered 20010207. Where this change is made, all dates must use this format.

Edit: This date must be present and be valid.

Statement Covers Period To	N	6	1450
(Discharge Date)	N	8	1300

Data Reporting Level: Required

Definition: The discharge date of the patient in the hospital or the ending date of a hospital stay longer than 24 hours.

General Comments: The format is MMDDYY for 1450 record and MMDDCCYY for 1300 record. The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging from 01-31. The year is recorded as two digits ranging from 00 -99. Each of the three components (month, day, year) must be right justified within its two digits. The 1300 record also contains a two-digit century. Any unused space to the left must be zero filled. For example February 7, 1992 is entered as 020792 (1450) or 02071992 (1300).

For hospitals using the 1450 record format that began using a different date format in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 is entered 20010207. Where this change is made all dates must use this format.

Edit: This date must be present and be valid.

Total Charges	N	10, 2

Data Reporting Level: Required

Definition: Total of charges for this inpatient hospital stay.

General Comments: The total allows for an 8-digit dollar amount followed by 2 digits for cents (no decimal point). All entries are right justified. If the charge has no cent then the last two digits must be zero. For example, a charge of $500.00 is entered as 50000 and a charge of $37.50 is entered as 3750.

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

Total Charges by Revenue Code	N	10, 2

Data Reporting Level: Required

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

General Comments: The total allows for an 8-digit dollar amount followed by 2 digits for cents (no decimal point). All entries are right justified. If the charge has no cents, then the last two digits must be zero. For example, a charge of $500.00 is entered as 50000 and a charge of $37.50 is entered as 3750.

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

Type of Admission	A	1

Data Reporting Level: Required

Definition: A code indicating priority of the admission.

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

1 = Emergency
Definition: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.

2 = Urgent
Definition: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.

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

4 = Newborn
Definition: Use of this code necessitates the use of special Source of Admission codes; see Source of Admission. Generally, the child is born within the facility.

9 = Information not available
Definition: Information was not collected or was not available.

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

Type of Bill A 3

Data Reporting Level: Required

Definition: A code indicating the specific type of bill (inpatient, outpatient, etc.). This three digit code requires 1 digit each, in the following sequence:
1. Type of facility
2. Bill classification, and
3. Frequency

General Comments: All positions must be fully coded. See UB-92 guidelines for codes and definitions. This code indicates the specific type of inpatient billing.

Edit: None

Units Of Service N 7

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

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

General Comments: This number qualifies the revenue service. The presence of this code ensures that charges per revenue service are adjusted to a common base for comparison. Revenue Codes and Units of Service section (Appendix B) defines the appropriate units for each revenue code.

Edit: The units of service must be present for those revenue services that require a unit; see Revenue Codes and Units of Service section.

REVENUE CODES AND UNITS OF SERVICE

This section defines acceptable revenue codes representing services provided to a patient, and the unit of measure associated with each revenue service. Any codes not assigned are assumed to be non-applicable unless found in the National Uniform Billing Committee's published manual or addenda to this manual.

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

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

DATA ELEMENT DESCRIPTION

CODE	UNIT	DEFINITION
001	None	Total charges
01x to 06x	Reserved for National Assignment	
07x to 09x	Reserved for State Use	
10x	Days	All inclusive rate - a flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.
	Subcategory 'x' 0 = All inclusive room and board plus ancillary 1 = All inclusive room and board	
11x	Days	Room and board - private medical or general routine services for single bed rooms
	Subcategory 'x' 0 = General Classification 1 = Medical/surgical/GYN 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice 6 = Detoxification 7 = Oncology 8 = Rehabilitation 9 = Other	
12x	Days	Room and board - semi-private (two beds) medical or general - routine service charges incurred for accommodations with two beds
	Subcategory 'x' 0 = General classification 1 = Medical/Surgical/GYN 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice	

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

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

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

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

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

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

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

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

Subcategory 'x'
0 = General classification
4 = Sterile environment
7 = Self care
9 = Other

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

nurseries

Subcategory 'x'
0 = General classification
1 = Newborn - Level I
2 = Newborn - Level II
3 = Newborn - Level III
4 = Newborn - Level IV
9 = Other

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

Subcategory 'x'
0 = General classification
1 = Reserved
2 = Patient convenience
3 = Therapeutic leave
4 = ICF/MR (any reason)
5 = Nursing home (for hospitalization)
9 = Other leave of absence

19x Not Assigned

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

Subcategory 'x'
0 = General classification
1 = Surgical
2 = Medical
3 = Pediatric
4 = Psychiatric
6 = Intermediate ICU
7 = Burn care
8 = Trauma
9 = Other intensive care

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

Subcategory 'x'
0 = General classification
1 = Myocardial infarction
2 = Pulmonary care
3 = Heart transplant
4 = Intermediate ICU
9 = Other coronary care

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

Subcategory 'x'
0 = General classification
1 = Admission charge
2 = Technical support charge
3 = U. R. service charge
4 = Late discharge, medically necessary

9 = Other special charges

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

Subcategory 'x'
0 = General classification
1 = Nursery
2 = OB
3 = ICU (includes transitional care)
4 = CCU (includes transitional care)
5 = Hospice
9 = Other

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

Subcategory 'x'
0 = General classification
9 = Other inclusive ancillary

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

Subcategory 'x'
0 = General classification
1 = Generic drug
2 = Non-generic drug
3 = Take home drug
4 = Drugs incident to other diagnostic services
5 = Drugs incident to radiology
6 = Experimental drug
7 = Non-prescription
8 = IV solutions
9 = Other pharmacy

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

Subcategory 'x'
0 = General classification
1 = Infusion pump
2 = IV therapy/pharmacy service
3 = IV therapy/drug/supply/delivery
4 = IV therapy/supplies
9 = Other IV therapy

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

Subcategory 'x'
0 = General classification
1 = Non-sterile supply
2 = Sterile supply
3 = Take home supplies
4 = Prosthetic/orthotic devices
5 = Pace maker
6 = Intraocular lens
7 = Oxygen take home
8 = Other implants
9 = Other supplies/devices

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

Subcategory 'x'
0 = General classification
9 = Other oncology

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

Subcategory 'x'
0 = General classification
1 = Rental
2 = Purchase of new DME
3 = Purchase of used DME
4 = Supplies\drugs for DME effectiveness (HHA's only)
9 = Other equipment

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

Subcategory 'x'
0 = General classification
1 = Chemistry
2 = Immunology
3 = Renal patient (home)
4 = Non-routine dialysis
5 = Hematology
6 = Bacteriology and microbiology
7 = Urology
9 = Other laboratory

31x Test Laboratory pathological - charges for diagnostic and routine lab tests on tissue and culture

Subcategory 'x'
0 = General classification
1 = Cytology
2 = Histology
4 = Biopsy
9 = Other

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

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

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

Subcategory 'x'
0 = General classification
1 = Chemotherapy injected
2 = Chemotherapy oral

3 = Radiation therapy
5 = Chemotherapy IV
9 = Other

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

Subcategory 'x'
0 = General classification
1 = Diagnostic
2 = Therapeutic
9 = Other

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

Subcategory 'x'
0 = General classification
1 = Head scan
2 = Body scan
9 = Other CT scan

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

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

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

Subcategory 'x'
0 = General classification
1 = Anesthesia incident to RAD
2 = Anesthesia incident to other diagnostic services
4 = Acupuncture
9 = Other anesthesia

38x Pint — Blood storage and processing - charges for the storage and processing of whole blood

Subcategory 'x'
0 = General classification
1 = Blood administration
2 = Whole blood
3 = Plasma
4 = Platelets
5 = Leucocytes
6 = Other components
7 = Other derivatives (cryoprecipitates)
9 = Other blood storage and processing

39x Blood storage and processing - charges for the storage and processing of whole blood

Subcategory 'x'
0 = General classification
1 = Blood administration
9 = Other blood storage & processing

40x Test Other imaging services

Subcategory 'x'
0 = General classification
1 = Diagnostic mammography
2 = Ultrasound
3 = Screening mammography
9 = Other imaging services

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

Subcategory 'x'
0 = General classification
2 = Inhalation services
3 = Hyper baric oxygen therapy
9 = Other respiratory services

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

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

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

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

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

Subcategory 'x'
0 = General classification
1 = Visit charge
2 = Hourly charge
3 = Group rate
4 = Evaluation or re-evaluation
9 = Other speech language pathology

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

Subcategory 'x'
0 = General classification
1 = EMTALA emergency medical screening services

2 = ER beyond EMTALA screening
6 = Urgent care
9 = Other emergency room

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

Subcategory 'x'
0 = General classification
9 = Other pulmonary function

47x Test Audiology - charges for the detection and management of communication handicaps centering in whole or in part on the hearing function

Subcategory 'x'
0 = General classification
1 = Diagnostic
2 = Treatment
9 = Other audiology

48x Test Cardiology - charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization and exercise stress test.

Subcategory 'x'
0 = General classification
1 = Cardiac cath lab
2 = Stress test
9 = Other cardiology

49x None Ambulatory surgical care - charges for ambulatory surgery that are not covered by other categories

Subcategory 'x'
0 = General classification
9 = Other ambulatory surgical care

50x None Outpatient service- charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. These charges are incorporated on the inpatient bill of Medicare patients.

Subcategory 'x'
0 = General classification
9 = Other outpatient services

51x Visit Clinic - charges for providing diagnostic, preventive, curative, rehabilitative and education services on a scheduled basis to an ambulatory patient

Subcategory 'x'
0 = General classification
1 = Chronic pain center
2 = Dental clinic
3 = Psychiatric clinic
4 = OB-GYN clinic
5 = Pediatric clinic
6 = Urgent care clinic
7 = Family practice
9 = Other clinic

52x Free Standing — Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory 'x'
0 = General classification
1 = Rural health - clinic
2 = Rural health - home
3 = Family practice clinic
6 = Urgent care clinic
9 = Other free standing clinic

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

Subcategory 'x'
0 = General classification
1 = Osteopathic therapy
9 = Other osteopathic services

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

Subcategory 'x'
0 = General classification
1 = Supplies
2 = Medical transport
3 = Heart mobile
4 = Oxygen
5 = Air ambulance
6 = Neonatal ambulance services
7 = Pharmacy
8 = Telephone transmission EKG
9 = Other ambulance

55x Skilled Nursing — Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory 'x'
0 = General classification
1 = Visit charge
2 = Hourly charge
9 = Other skilled nursing

56x Visit — Medical social services such as counseling patients, intervening on behalf of patients, and interpreting problems of social situation rendered to patients on any basis.

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

57x Home Health Aide — Charges made by an HHA for personnel who are primarily responsible for the personal care of the

patient

Subcategory 'x'
0 = General classification
1 = Visit charge
2 = Hourly charge
9 = Other home health aide

58x Other Visits Code indicates the charge by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Subcategory 'x'
0 = General classification
1 = Visit charge
2 = Hourly charge
9 = Other home health visits

59x Units of Service This revenue code is used by an HHA that bills (Home Health) on the basis of units of service.

Subcategory 'x'
0 = General classification
9 = Home health other units

60x Oxygen Code indicates the charges by an HHA for (Home Health) oxygen equipment supplies or contents, excluding purchased equipment. If a bendficiary purchased a stationary oxygen system, and oxygen concentrator or portable equipment, current revenue code 292 or 293 applies. DME (other than oxygen systems) is billed under current revenue codes 291, 292 or 293.

Subcategory 'x'
0 = General classification
1 = Oxygen - state/equip/supply/ or content
2 = Oxygen - state/equip/supply under 1 LPM
3 = Oxygen - state/equip/ over 4 LPM
4 = Oxygen - portable add-on

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

Subcategory 'x'
0 = General classification
1 = Brain including brain stem
2 = Spinal cord including spine
9 = Other MRI

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

Subcategory 'x'
1 = Supplies incident to radiology
2 = Supplies incident to other diagnostic services
3 = Surgical dressing
4 = Investigational device

63x Drugs Requiring Specific Identification
Subcategory 'x'

0 = General classification
1 = Single source drug
2 = Multiple source drug
3 = Restrictive prescription
4 = Erytropepoetin (EPO) - less than 10,000 units
5 = Erytropepoetin (EPO) - 10,000 or more units
6 = Drugs requiring detailed coding

64x Home IV Therapy Services — Charge for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment, and all types of covered therapy.

Subcategory 'x'
0 = General classification
1 = Non-routine nursing
2 = IV site care, central line
3 = IV start/change 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 IV therapy services

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

Subcategory 'x'
0 = General classification
1 = Routine home care
2 = Continuous home care
3 = Reserved
4 = Reserved
5 = Inpatient respite care
6 = General non-respite inpatient care
7 = Physician services
9 = Other hospice

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

Subcategory 'x'
0= General classification
9 = Other cast room

71x None — Recovery room

Subcategory 'x'
0 = General classification
9 = Other recovery room

72x Labor Room/ Delivery Room — 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 gynecological procedures if they are performed in the delivery suite.

Subcategory 'x'
0 = General classification
1 = Labor

2 = Delivery
3 = Circumcision
4 = Birthing center (unit is days)
9 = Other labor room and delivery

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

Subcategory 'x'
0 = General classification
1 = Holter monitor
2 = Telemetry
9 = Other EKG/ECG

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

Subcategory 'x'
0 = General classification
9 = Other EEG

75x	Test		Gastrointestinal services - procedure room charges for endoscopic procedures not performed in the operating room.

Subcategory 'x'
0 = General classification
9 = Other gastrointestinal

76x	None		Treatment or observation room - charges for minor procedures performed outside the operating room

Subcategory 'x'
0 = General classification
1 = Treatment room
2 = Observation room
9 = Other treatment room

77x	Preventative Care Services		Charges for the administration of vaccines

Subcategory 'x'
0 = General classification
1 = Vaccine administration
9 = Other

79x	None		Lithotripsy - charges for the use of lithotripsy in the treatment of kidney stones

Subcategory 'x'
0 = General classification
9 = Other lithotripsy

80x	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 abdominal covering and the tissue (peritoneal dialysis).

Subcategory 'x'
0 = General classification
1 = Inpatient hemodialysis
2 = Inpatient peritoneal
3 = Inpatient continuous ambulatory peritoneal dialysis
4 = Inpatient continuous cycling peritoneal dialysis
9 = Other inpatient dialysis

81x None Organ acquisition - the acquisition of a kidney, liver or heart for use in transplantation

Subcategory 'x'
0 = General classification
1 = Living donor - kidney
2 = Cadaver donor - kidney
3 = Unknown donor - kidney
9 = Other organ acquisition

82x Hemodialysis Outpatient or Home Dialysis — A waste removal performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategory 'x'
0 = General classification
1 = Hemodialysis/composite or other rate
5 = Support services
9 = Other hemodialysis outpatient

83x Peritoneal Dialysis Outpatient or Home — A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory 'x'
0 = General classification
1 = Peritoneal/composite or other rate
5 = Support services
9 = Other peritoneal

84x Continuous Ambulatory Peritoneal Dialysis (CAPD) Outpatient — A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory 'x'
0 = General classification
1 = CAPD/composite or other rate
5 = Support services
9 = Other CAPD dialysis

85x Continuous Cycling — A continuous dialysis process

	Peritoneal Dialysis (CCPD) Outpatient	performed in an outpatient or home setting, which uses the patients peritoneal membrane as a dialyzer.

Subcategory 'x'
0 = General classification
1 = CCPD/composite or other rate
5 = Support services
9 = Other CCPD dialysis

86x	Reserved for Dialysis (National Assignment)	
87x	Reserved for Dialysis (State Assignment)	
88x	Session	Miscellaneous dialysis - charges for dialysis services not identified elsewhere

Subcategory 'x'
0 = General classification
1 = Ultrafiltration
9 = Other miscellaneous dialysis

89x	None	Other donor bank - charges for the acquisition, storage and preservation of all human organs, excluding kidneys

Subcategory 'x'
0 = General classification
1 = Bone
2 = Organ other than kidney
3 = Skin
4 = Activity therapy
9 = Other donor bank

90x	Visit	Psychological treatments

Subcategory 'x'
0 = General classification
1 = Electroshock treatment
2 = Milieu therapy
3 = Play therapy
4 = Activity therapy
9 = Other
6 = Family therapy

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

Subcategory 'x'
0 = General classification
1 = Rehabilitation
2 = Partial hospitalization
4 = Individual therapy
5 = Group therapy
7 = Biofeedback
8 = Testing
9 = Other

92x	Test	Other diagnostic services

Subcategory 'x'
0 = General classification
1 = Peripheral vascular lab.
2 = Electromyelogram
3 = Pap smear
4 = Allergy test
5 = Pregnancy test
9 = Other diagnostic service

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

Subcategory 'x'
0 = General classification
1 = Recreational therapy
2 = Education or training
3 = Cardiac rehabilitation
4 = Drug rehabilitation
5 = Alcohol rehabilitation
6 = Routine complex medical equipment
7 = Ancillary complex medical equipment
9 = Other therapeutic services

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

Subcategory 'x'
0 = General classification
1 = Psychiatric
2 = Ophthalmology
3 = MD anesthesiologist
4 = CRNA anesthetist
9 = Other professional fees

97x None — Professional fees – continued

Subcategory 'x'
1 = Laboratory
2 = Radiology - diagnostic
3 = Radiology - therapeutic
4 = Radiology - nuclear medicine
5 = Operating room
6 = Respiratory therapy
7 = Physical therapy
8 = Occupational therapy
9 = Speech pathology

98x None — Professional fees - continued

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

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

covered

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

RESOURCE LIST

Current Procedural Terminology
Published by the American Medical Association;*ISBN 3-89970-792-0.*
May be purchased from:

Order Department
Reference OP054194HA
American Medical Association
PO Box 10950
Chicago, IL 60610
(800) 621-8335

HCFA Common Procedural Coding System (HCPCS)
Published by the Centers for Medicare and Medicaid Service, (formerly HCFA)

International Classification of Diseases, Ninth Edition (ICD-9)
Published by the Centers for Medicare and Medicaid Service, and the National Center for Health Static.

The materials published by the Centers for Medicare and Medicaid Service may be purchased from:

U.S. Department of Commerce
National Technical Information Service
Subscription Department
5285 Port Royal Road
Springfield, VA 22161
(800) 553-6847

Some materials may also be purchased from large commercial bookstores and from medical office supply firms. These documents are also available for use by the general public at the Arkansas State Library and may be available from your local library by an interlibrary loan.

Arkansas State Library
Documents Service
One Capitol Mall
Little Rock, AR 72201
(501) 682-2326

RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM

(Typed Version of scanned pages 6-8 of this document are supplied to insure legibility of these 1997 Rules and Regulations.)

SECTION I. AUTHORITY. The following Rules and Regulations pertaining to the Hospital Discharge System are duly adopted and promulgated by the Arkansas Board of Health pursuant to the authority expressly conferred by the State of Arkansas including, without limitation Act 670 of 1995 (the Act), as amended, the same being A.C.A. 20-7-301 et seq.

The Act established the State Health Data Clearing House within the Arkansas Department of Health. The Clearing House is mandated by the ACT to acquire and disseminate health care information in order to understand patterns and trends in the availability, use and costs of health care services in the state. Subsection (h) of the Act directs the Arkansas State Board of Health to prescribe and enforce such rules and regulations as may be necessary to carry out the purpose of this Act.

SECTION II. PURPOSE. It is the purpose of these regulations to provide direction about the required collection, submission, management and dissemination of health data.

SECTION III. DEFINITIONS. For the purposes of these Regulations, the following words and phrases when herein shall be construed as follows:

A. "Act" means the State Health Data Clearing House Act 670 of 1995, 20-7-301 et seq:

B. "Aggregate data set" means a compilation of raw data that has been subject to a critical edit check and consists of at least a small cell count. Aggregate data sets shall not include the following data elements: hospital control number, patient control number, attending physician number, or any element which might be used to identify an individual patient;

C. "Board" or "State Board" means the Arkansas State Board of Health;

D. "Confidential information" means that information which the State Board has defined to be confidential in these regulations and procedures;

E. "Department" means the Arkansas Department of Health;

F. "Director" means the director of the Arkansas Department of Health;

G. "Hospital" means any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which is subject to licensure by the Arkansas Department of Health (A.C.A.20-9-201 et seq.);

H. "Submit," "submission" or "submittal" means, with respect to data, reports, surveys, statements and documents required to be filed with the Department;

1) delivery to the Arkansas Department of Health, by the close of business on the prescribed filing date or

2) deposit with the United States Postal Service, postage prepaid, addressed to the Arkansas Department of Health, in sufficient time so that

the mailed materials will arrive by the close of business on the prescribed filing date;

I. "guide" means the Hospital Discharge Data Submittal Guide published by the Arkansas Department of Health. The Guide contains technical information relating to data format, media and submittal time frames.

Section IV. GENDER AND NUMBER. All terms used in any one gender or number shall be construed to include any other gender or number.

Section V. HOSPITAL DISCHARGER DATA SUBMITTAL. Each Arkansas hospital which performs activities meeting the definition of inpatient discharges, as set forth in the Guide, shall submit data to the department in a manner that complies with the provisions of the Guide for all inpatient hospital discharges occurring on or after January 1, 1966.

SECTION VI. ADDITIONAL DATA REQUIRED TO BE SUBMITTED. In addition to data prescribed for submission in the Guide, the following data must be submitted according to the schedule provided:

Each hospital shall provide a complete and accurate copy of the American Hospital Association's Annual Survey to the Arkansas Department of Health or the Arkansas Hospital Association. The required submission data will be published annually with the distribution of the survey.

SECTION VII. EXTENSION OF TIME. The State Board or the Director shall, upon a showing of good cause and if time permits, extend the time allowed for the performance of any function or duty required by the provisions of the Act or of these regulations and rules. In making any determination with regard to good cause, the Board and the Director shall give due consideration to all relevant facts and circumstances, including such considerations as the complexity of the issues or the existence of extraordinary circumstances or unforeseen events which have led to the request for an extension of time.

The State Board or the Director shall act upon a request for an extension of time within thirty (30) days of receiving the written request by the hospital. Failure to act within thirty (30) days shall be deemed as a grant of the extension.

SECTION VIII. ACCESS TO AGGREGATE REPORTS. All reports generated by the Department from the aggregate data set for a member of the general public are open for inspection. The Department shall provide copies of these reports, upon request, at a cost of $.25 per page.

The Department shall determine fees to be charged to cover the direct and indirect costs for providing other information requests or special compilations from aggregate data sets. The fee shall include staff time, computer time, copying cost, postage and supplies.

SECTION IX. PENALTIES FOR NON-COMPLIANCE. A.C.A.20-7-301 et seq. sets forth civil and criminal penalties for non-compliance with provisions of the Act and of rules and regulations adopted by the Arkansas State Board of Health to implement the Act, as follows:

A. Any person, firm, corporation organization or institution that violates any of the provisions of A.C.A.20-7-301 et seq., or any rules or regulations promulgated there under, regarding confidentiality of information, shall be guilty of a misdemeanor and, upon conviction there of, shall be fined not less than one hundred dollars ($100) nor more than ($500), or by

imprisonment not exceeding one month, or both. Each day of violation shall constitute a separate offense.

B. Any person, firm, corporation, organization or institution knowingly violating any of the provisions of A.C.A.20-7-301 et seq., or any rules or regulations promulgated there under shall be guilty of a misdemeanor and, upon a plea of guilty, a plea of nolo contendere or conviction, shall be fined no more than five hundred dollars ($500).

C. Every person, firm corporation, organization or institution that violates any of the rules or regulations adopted by the Arkansas State Board of Health or that violates any provision of Act 670 may be assessed a civil penalty by the Board. The penalty shall not exceed two hundred fifty dollars ($250) for each violation. No civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure Act, Ark. Code Ann. 25-15-101. et seq.

SECTION X. HEARING AND APPEAL. Hearings and appeals will be conducted according to the Adjudication and Rule Making Sections of the Department's Administrative Procedures previously promulgated by the department and any revisions thereto.

SECTION XI. MANTENACNE OF REGULATIONS AND PROCEDURES. All pages of these regulations and rules, and of the Hospital Discharge Data Submittal Guide, issued by the Department are dated at the bottom. As changes occur, replacement pages will be issued. All replacement pages will be dated so that the users may be certain they are referring to the most recent information.

SECTION XII. INCORPORATION BY REFERENCE. The following documents are hereby incorporated by reference:

A. The most recent edition of the International Classification of Diseases, Clinical Modifications. Copies are available from the World Health Organization, P.O. Box 5284, Church Street Station, New York, New York 10249.

B. Uniform Hospital Billing Form 1992 (UB92/HCFA-1450). Copies are available from the Office of Public Affairs, Health Care Financing Administration, Humphrey Building, Room 428-H, 200 Independence Avenue S.W., Washington, D.C. 20201.

All incorporated material is available for public review at the central administrative office of the Department.

SECTION XIII. SEVERABILTY. If any provision of these Rules and Regulations or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications, and to this end the provisions hereto are declared severable.

SECTION XIV. REPEAL. All regulations and parts of regulations in conflict herewith are hereby repealed.