

**QUESTIONS FROM PHOENIX AND TUCSON HOSPITAL DISCHARGE DATA
TRAINING SESSIONS - APRIL 22/23 AND MAY 1, 2008**

Q1. About the National Provider Identifier (NPI) – In our hospital we have a Swing Bed unit that has its own NPI. Should we use the Swing Bed NPI when reporting discharge data from those beds? Or do we exclude records of patients in Swing Beds?

A. The only NPI number you should use when reporting discharge data is the NPI for the main hospital as licensed by ADHS. Your hospital may have other NPI numbers that are used for other business, but for hospital discharge data reporting to the state, only the main hospital NPI should be used. (See Manual at C-03.1)

If you have multiple NPI numbers and would like assistance in determining which NPI to use for data reporting, please call ADHS Discharge Data Review.

Regarding swing beds, it is important to remember that “Swing Bed” is a Medicare term. As far as state discharge data reporting is concerned, a swing bed is a licensed hospital bed, and anyone in one of the hospital’s licensed beds is a patient of the hospital. When they are discharged, that discharge is reported to the state like any other discharge.

Q2. About the Patient Control Number - Does this change for each admission? For example, if someone is admitted three times over two months?

A. Yes. The purpose of the Patient Control Number is to make it easy for hospitals to differentiate between admissions of the same person. Some hospitals call this the “Encounter Number” or “Patient Account Number”. (See Manual at C-05.1)

Q3. About the new patient Country Code – What is an ISO and why are we using this?

A. ISO stands for the International Organization for Standardization. In the 1960’s it was realized that many countries, including ours, used a different country code to identify all the other countries in the world. With so many different abbreviations, there was plenty of opportunity for confusion, so a group was formed from businesses, government, and international societies to create a standard list that everyone could agree upon. It was first published in 1974 and has had several updates since then. There is a list of the ISO country codes in the Manual. (See Appendices, Section I-1)

Q4. What about the Onset of Symptoms/Illness Date, code 11? In accidents we may have to use code 05 or one of the other codes 01 - 04 or 06 instead. One of these codes is usually required by the payer in cases of injury or accident, and we can’t use a code in this range and code 11; it is an either/or choice. What should we do about this for state reporting?

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TRAINING SESSIONS - APRIL 22/23 AND MAY 1, 2008**

A. In researching the answer to this question, we learned that the appropriate use of Occurrence Codes 01 – 06 as required by payers will indeed impact the circumstances under which this data element will be available for reporting to the state. As a result, the conditions under which this code is reportable are revised as follows: if there is a date associated with Occurrence Code 11 on a record, then report that date. Otherwise, leave this field blank.

This revision will be included in the next manual update. (See Manual at C-18.1)

Q5. About Provider (Physician) Name – Should we use Last Name first?

A. Yes. The format for ALL name fields is last name space first name space middle initial. A clarification of this was sent out to all hospital data contacts on April 22, 2008. This clarification will be included in the next manual update.

Q6. About the Patient Address field – How should we enter Military Addresses?

A. Military addresses should be entered following the US Postal Service Address Standards for Military Addressing. Include the unit information in the street address. The city should be APO or FPO (Air/Army Post Office or Fleet Post Office). The state should be either a US state abbreviation or Military state abbreviation and the five digit (or nine-digit if available) ZIP Code. (See Manual at C-08.1)

List of APO/FPO Military state abbreviations:

Armed Forces Africa	<u>AE</u>
Armed Forces Americas	<u>AA</u>
Armed Forces Canada	<u>AE</u>
Armed Forces Europe	<u>AE</u>
Armed Forces Middle East	<u>AE</u>
Armed Forces Pacific	<u>AP</u>

Regular US state abbreviations are also valid for some APO/FPO ZIP codes.

APO/FPO zip codes can be checked for validity at <http://zip4.usps.com/zip4/citytown.jsp>

Examples of military addressing:

SGT Robert Smith
PSC 802 Box 74
APO AE 09499-0074

Seaman Joseph Doe
USCGC Hamilton
FPO AP 96667-3931

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TRAINING SESSIONS - APRIL 22/23 AND MAY 1, 2008**

For more examples and information, visit the US Postal Service website at:
<http://www.usps.com/supportingourtroops/addressingtips.htm>

Q7. What can you tell us about the national changes to the definitions of Admission Source Codes 4 and 7?

A. On October 1, 2007, changes were implemented by the National Uniform Billing Committee to the UB04 Point of Origin for Admission or Visit (“Source of Admission”), codes 4 (Transfer from a Hospital) and 7 (Emergency Room). These changes are significant because while these codes have been in use for years, the meaning behind them and the way they are now to be used has changed. In brief, Code 4 has been expanded to include the transfer of a patient who was an *outpatient* at the sending hospital (previously this code applied only to patients who were inpatients at the sending hospital). Code 7 has been narrowed to *exclude* patients who come to the ER from another health facility. For additional details, please refer to the Official UB04 Data Specifications Manual for 2008, Version 2, Form Locator 15.

Please note that the state will always try to notify all Arizona hospitals well in advance of any changes that are **determined by the state**. However, in the case of requirements or standards changes determined and implemented by authorities at the national level, it is the expectation of the state that Arizona hospitals will be aware of, and implement, such changes as a part of their normal business process. The state recognizes the national standards contained within the UB04 and will make every effort to implement such changes into the reporting specifications as they occur. Nevertheless, the state will generally not send notification or even comment upon national changes, unless such changes are viewed as being likely to cause confusion or conflict with existing state requirements.

Q8. We do not use DRGs, since we are a rehabilitation hospital. What should we put in the DRG field?

A. If you are a licensed rehabilitation hospital, and do not use DRGs, leave the DRG field blank. Instead, you would report the IRF PPS CMG Code. (See Manual at C-33.1)

Q9. We have rehabilitation units in the main hospital and have been sending DRGs for these records in our discharge data. Should we continue this?

A. Yes. If you are a licensed acute care hospital with a rehabilitation unit within your hospital, then you would continue to report the DRG, and also report the CMG for those records (if you have it).

**QUESTIONS FROM PHOENIX AND TUCSON HOSPITAL DISCHARGE DATA
TRAINING SESSIONS - APRIL 22/23 AND MAY 1, 2008**

Q10. If we have ED charges on a Transfer, will that cause us to have an error, since the Source of Admission will not reflect the patient came from the emergency department?

A. No, this will not cause you to have an error.

Q11. Revenue codes and other fields used to be zero-filled with leading zeros, but the new specifications say to not zero-fill. Is this correct?

A. That is correct, no leading zero-fill in Revenue code fields or any other fields. However, it is important to also remember that some data elements (for example, diagnosis codes and DRG), have leading zeros that make up part of the valid code. Because these zeros are part of the code, they must be reported.

Q12. We have not seen a screen with Accident State in our HIMS. What do we do about this?

A. This issue should be directed to your HIMS vendor. The Accident State is part of the UB04, and under certain circumstances is required for billing. The state requirements are not as extensive as the UB04 requirements, and it is therefore reasonably expected by the state that this data element would already be present in the hospitals' HIMS. If you have difficulties with your HIMS vendor regarding this, or any other data element required by the state, please contact our office for assistance.

Q13. We are reporting the E-code as appropriate when a patient is in an acute bed. When that patient is moved to a swing bed, that is a separate account, and our system is asking for an E-code for that record, which is separate from the acute stay. Do we assign the E-code again on the swing bed record?

A. It is not required to assign the E-code on the swing bed record. The swing bed record will presumably have a Source of Admission of "4 – transfer from a hospital." If so, you will not receive an error for the E-code not being present in the swing bed record.

Q14. Patient Race/Ethnicity is a four position field. Are you expecting a patient to have multiple values in this field or just one code? Could there be four values if a person is more than one race?

**QUESTIONS FROM PHOENIX AND TUCSON HOSPITAL DISCHARGE DATA
TRAINING SESSIONS - APRIL 22/23 AND MAY 1, 2008**

A. Yes, there could be multiple values. If the hospital collects more than one code, then we want them all, in the order in which they appear in the hospital system, up to the maximum of four. If the hospital has only one value, then that is what they would report. (See Manual at C-16.1)

Q15. What date should go in Admission Date field if there is pre-admission treatment? Is it the first date of treatment or the traditional admission date?

A. The traditional admission date, that is, the date the patient was admitted to the hospital as an inpatient. (See Manual at C-19.1)

Q16. Is the Newborn Birth Weight field zero filled or space filled? The field is right justified.

A. Space filled. Do not zero fill. (See Manual at C-26.1)

Q17. In the DRG field, is it zero filled or space filled? The field is right justified.

A. Spaced filled. However, remember that the DRGs presently are all 3 digits, and the first 99 codes have one or two zeros (for example 005 or 075), as part of the valid code. Because these zeros are part of the code, they must be reported. (See Manual at C-34.1)

Q18. If the POA field is blank in the medical record, should we send a blank or a U?

A. Send a blank. The U should be sent only if that is what is coded in the individual medical record. (See Manual at C-38b.1 and C-39b.1)

Q19. We are a rehabilitation hospital and our principal diagnosis codes are V codes, which are on the list of codes that are “exempt” from POA. We do business in many different states besides Arizona, and the other states are accepting a code of “Y” in the POA field on these exempt diagnoses. Will Arizona accept “Y” on these codes? It will be confusing for our staff if we must do these codes differently for Arizona than we are for the other states.

A. The determination of which codes are “exempt” was made at the national level, and Arizona has adopted and is implementing that determination. Accepting “Y” on records that are exempt

**QUESTIONS FROM PHOENIX AND TUCSON HOSPITAL DISCHARGE DATA
TRAINING SESSIONS - APRIL 22/23 AND MAY 1, 2008**

is not in accordance with the national coding guidelines. Exempt codes must have a “1” reported. The state will not accept a present on admission indicator of “Y” on exempt codes.

Q20. Should we send a CPT code for an IP record? If an ED record has both ICD-9 procedures and CPT, should we send both?

A. On IP records, only ICD-9-CM codes are to be reported, even if the patient came from the ED. This will be clarified in the next manual update. ED records may contain ICD and/or CPT. If an ED record has both ICD & CPT, then both might be sent, depending upon how many codes there are in a particular record. (See Manual at Page C-42.1 for details on the reporting priority.)

Q21. Do we need to report ALL the CPTs relating to all the charges for the ED visit? Some of these codes are captured at the charge level via the chargemaster.

A. We understand that some of these codes are populated via the chargemaster and others via abstracting. However, there is apparently no consistency between hospitals as to which codes are from the chargemaster and which are abstracted. We spoke with several software vendors and hospitals regarding this issue, and they all stated that even beyond the differences between vendors, there were differences between hospitals using the same vendor. The vendors stated their systems are set up to the individual hospital's preference.

Report the CPT codes on ED records according to the priority indicated in the manual, regardless of source.

Q22. I am confused about “Other Procedure Code 2 – 12.” Shouldn’t this element be named “Other Procedure Code 2 – 11” instead of 12, because the 12th field is for the Evaluation and Management Code?

A. Regarding the E&M codes, as CPT codes they are, by definition, procedure codes. The designation of a specific location within the range of reported ED procedure codes (procedure code 12), for the E&M code was done in response to hospital/vendor request in order to enable easier programming for the ED report. Also, although this question is pertaining to ED records, the data specifications are for reporting both IP and ED records. On an IP record, “Other Procedure Code 12” would contain an ICD-9 procedure code (if reported).

We would like to thank the representatives from the following Arizona hospitals who attended one of the hospital discharge data training sessions in Phoenix and Tucson this past month and asked such wonderful questions!

Arizona Heart Hospital
Arrowhead Hospital
Banner Health Hospitals
Benson Hospital
Casa Grande Regional Medical Center
Carondelet Hospitals
Chandler Regional Hospital
Cobra Valley Community Hospital
Copper Queen Community Hospital
Cornerstone Hospital of Southeast Arizona
Flagstaff Medical Center
Gilbert Hospital
Havasu Regional Medical Center
John C. Lincoln Hospitals
Kindred Hospital – Tucson
Kingman Regional Medical Center
Little Colorado Medical Center
Los Ninos Hospital
Maricopa Medical Center
Maryvale Hospital Medical Center
Mayo Clinic Hospital
Mount Graham Community Hospital
Mountain Valley Regional Rehab Hospital
Mountain Vista Medical Center

Northern Cochise Community Hospital
Paradise Valley Hospital
Payson Regional Medical Center
Phoenix Baptist Hospital
Phoenix Childrens Hospital
Sage Memorial Hospital
St. Joseph’s Hospital (Phoenix)
St. Luke’s Medical Center
Scottsdale Healthcare
Sierra Vista Regional Health Center
Southeast Arizona Medical Center
Summit Healthcare Regional Medical Center
Sun Health Hospitals
Surgical Specialty Hospital
Tucson Heart Hospital
Tucson Medical Center
University Physicians Hospital at Kino
University Medical Center
Verde Valley Medical Center
West Valley Hospital
White Mountain Regional Medical Center
Wickenburg Community Hospital
Yavapai Regional Medical Center

ATTENDANCE BY SESSION

Phoenix - April 22nd – 26

Phoenix - April 23rd – 42

Tucson – May 1st – 36

TOTAL: 104

ATTENDANCE BY DISCIPLINE

IT Staff – 29

Medical Records – 29

Finance – 16

Quality Assurance – 10

Admissions - 20