

STOP!!

**This manual applies to discharges
July 1, 2011 through December 31, 2011
*only.***

**If you are working with discharges that occurred
January 1, 2012 and later
refer to the
Arizona Hospital Discharge Data
Reporting Specifications Manual,
Version 4, Transmittal 001.**

**Please contact ADHS for assistance
if you have any questions.**

**602-542-8064
courtnd@azdhs.gov**

Arizona

Hospital Discharge Data

Reporting Specifications

Manual



Arizona Department of Health Services
Bureau of Public Health Statistics
Cost Reporting and Discharge Data Review
150 North 18th Avenue, Suite 550
Phoenix, AZ 85007
<http://azdhs.gov/plan/crr/index.htm>

Manual Change History

Change history for the Arizona Hospital Discharge Data Reporting Specifications Manual. This history is being provided as a summary reference of changes. Please note that this history is provided in *reverse order* so the most recent changes are listed first.

Version 3, Transmittal 003, 10/17/11:

- 1) Added DRG Version 29 to requirements. See page C-59.1.
- 2) Added new Thresholds C23, C24, C25 and C26.. See Section E.
- 3) Revised Audits K5, K20 and M11. See Section E.
- 4) Added new Audits L11 and M14. See Section E.
- 5) Added/revised correction assistance for all “C” Thresholds, and Audits K20, L11 and M14. See Section G.
- 6) Updated Audit M11 to recognize DRG 29. See Section E.
- 7) Added link to USPS Address/City/ZIP lookup tool. See Appendices.
- 8) Updates to ISO3166 code list. See Appendices.

Manual Change History

Version 3, Transmittal 002, 11/04/10:

- 1) Change in language describing reporting requirements to include psychiatric hospitals. See page A-1.1.
- 2) Added new Threshold C22. See Section E.
- 3) Update universe A1 to be “sum of errors present in each audit category not otherwise identified in a specific universe.” See Section E.
- 4) Update universe A6 to include Audits K12 & K15. See Section E.
- 5) Update universe A7 to include Audits K13 & K16. See Section E.
- 6) Update universe A8 to be “sum of errors present on all Procedure audits.” See Section E.
- 7) Update universe A9 to be “sum of errors present on all POA audits.” See Section E.
- 8) Update universe A10 to include Audits K11, K14 & K20. See Section E.
- 9) Update universe A11 to be “sum of errors present on all Diagnosis code audits.” See Section E.
- 10) Revised Audits D10, K6, K7, M11. See Section E.
- 11) Reactivated Audits K11, K12, K13, K14, K15, K16. See Section E.
- 12) Added new Audits F44, G63, K20, L10. See Section E.
- 13) Revised Audit Correction Assistance for Audit M11. See Section G.
- 14) Added Audit Correction Assistance for new Audits F44, G63, K20, L10 and reactivated Audits K11, K12, K13, K14, K15, K16. See Section G.

Manual Change History

Version 3, Transmittal 001, 06/15/10:

- 1) Note regarding removal of psychiatric hospital exemption effective for discharges January 1, 2011 and later. See page A-1.1.
- 2) Information explaining visit types and which record type(s) are used to report them. See pages B-1.3 & 4.
- 3) Revise definition of Source of Admission or Visit code “2.” See page C-22.1. The definition of this code (a “Point of Origin” code on the UB04) was changed by the National Uniform Billing Committee, effective for discharges July 1, 2010 and later.
- 4) Removal of Source of Admission or Visit code “7 = Emergency Room.” See page C-22.1. This code (a “Point of Origin” code on the UB04) was discontinued by the National Uniform Billing Committee, effective for discharges July 1, 2010 and later.
- 5) Change to the definition of Discharge Status code “09 = Admitted as an Inpatient to this Hospital.” See pages C-25.1&2. Recent clarification from Medicare on billing for inpatients admitted from the ED will result in “split” billing of the ED and IP portions on some of these patients’ visits. This clarification has made it necessary for Arizona to update the state requirements for this discharge status code. For additional information on use of Discharge Status code “09,” refer manual pages B-1.3 & 4.
- 6) Added DRG Version 28 to requirements, see page C-59.1.
- 7) Added new data element “ED Admission Flag.” See page C-60.1.
- 8) Added new data element “Visit Qualifier.” See page C-61.1.
- 9) Revised Data Layout Section D, page 11 to include the two new data elements.
- 10) Added two new Counts, C19 and C20. See Section E, page 1.
- 11) Added new Thresholds, C18 and C21. See Section E, page 3.
- 12) Revised Audits D2, L2, M3, M4, M7 M11. See Section E, pages 8, 16 and 18.
- 13) Added new Audits D16, D17, D18, D19, D20, D21, E10, L8, L9, M12 and M13. See Section E, pages 9, 10, 17 and 19.

Manual Change History

- 14) Revised Audit Data Layout, Section F, page 6 to include the two new data elements.
- 15) Revised Audit Correction Assistance for Audits D2, L2, M3, M4, M11. See Section G pages 2, 58, 59, 62, 64.
- 16) Added Audit Correction Assistance for new Audits D16, D17, D18, D19, D20, D21, E10, L8, L9, M12 and M13. See Section G, pages 6, 7 8, 12, 60, 61, 64, 65.
- 17) Revised the definition of “Emergency Department Record” in response to clarification from Medicare regarding split ED/IP billing. See page H2.
- 18) Updated Crosswalk to reflect addition of new “ED Admission Flag” and “Visit Qualifier” data elements. See page I-4.1

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Reporting Requirements Overview

Section A A-1.1

Who:

All Arizona *licensed* hospitals, including psychiatric hospitals, are required to report inpatient and emergency department discharge records to the Arizona Department of Health Services (ADHS).

Effective with discharges January 1, 2011 and later, psychiatric hospitals must comply with these data reporting requirements.

When:

Data must be reported twice yearly:

Discharges from January 1st through June 30th must be reported commencing July 1st but no later than August 15th of the same year.

Discharges from July 1st through December 31st must be reported commencing January 1st but no later than February 15th of the following year.

See reporting calendar on page B-1.3 of this manual.

How:

Data is reported in a fixed length ASCII text file to ADHS. Data must be submitted utilizing the ADHS SFTP secure file server. Contact Information and Attestation of Completeness and Accuracy forms must accompany each submission. See section B, File Submission Information, for details on submitting your file.

Questions?

If you have questions regarding any of the data reporting requirements or the reporting process, please contact our office by phone or email. Refer to our home page at <http://azdhs.gov/plan/crr/index.htm> for current contact information. Click on the link “contact staff” to reach specific individuals.

Section A A-1.1

File Submission Information

Section B B-1.1

Files:

1. Files must be submitted as ASCII text. Each discharge record reported in the file is a fixed length record of 1604 characters.
2. Inpatient and emergency department records must be submitted in separate files.
3. All files must be named according to the following naming convention:

AZFACID_data type_reporting period *For Example:* MED1234_IP_200801

“MED1234” = AZFACID, the facility identifier issued by ADHS

“IP” = data type being reported (IP for inpatient; ED for emergency department)

200801 = reporting period, (the time period being reported, 2008 first half)

4. Before sending your files, check for the following common pitfalls that can cause your data to be rejected:
 - a) Is the data properly aligned?
 - b) Are all required fields populated with appropriate data?
 - c) Is the AZFACID correct?
 - d) Is the data formatted according to the data element specifications? (See Sections C & D of this manual). Pay special attention to the “footnotes” on the data layout.
 - e) Are there any blank records? (these must be removed) Blank records may be caused by an extra line field or carriage return at the end of the file, or by end of file markers.
 - f) Are there any missing or invalid dates?
 - g) Is the data for the correct time period, and are all required records present in the file?
 - h) Are there any missing or invalid record type codes?

Section B B-1.1

File Submission Information

Section B B-1.2

Submissions:

5. Data **must** be submitted utilizing the ADHS SFTP secure file server. Every hospital has at least one individual who is an authorized user of this server, with his or her own unique User ID and Password. Every hospital has a designated location on the server in which to deposit their files. Each user receives direct instruction on server protocol at the time they receive their access.
6. If for some reason you are unable to utilize the SFTP, you must immediately notify this office of the reason for your inability to utilize the SFTP, so that the issue may be promptly resolved.
7. If circumstances (such as a HIMS upgrade) may adversely impact your ability to report on time, ***notify our office immediately.***
8. Two forms are required to accompany your submission:
 - a) Contact form – on this form, you provide ADHS with information about who is responsible for your hospital’s data reporting, so we know who to contact if we have questions. This form should be completed by the person who does the “hands on” of data reporting for your hospital.
 - b) Attestation form – on this form, the person responsible for your hospital’s compliance with state law certifies the reporting is, to the best of their knowledge, complete and accurate. This form requires an original signature, so it must be mailed. Faxes will not be accepted.

These forms are available on our website at: <http://www.azdhs.gov/plan/crr/index.htm>

9. Send your forms to:

Discharge Data Reporting
Arizona Department of Health Services
Cost Reporting & Discharge Data Review
150 North 18th Avenue, Suite 550
Phoenix, AZ 85007-3248

Section B B-1.2

File Submission Information

Section B B-1.3

Visit types and how they must be reported:

1) Inpatient – direct admit

This is a “pure” IP visit. The IP visit is reported in the IP file.

2) Emergency Department – treat and release

This is a “pure” ED visit. The ED visit is reported in the ED file.

3) Emergency Department – treated; admitted as an inpatient

Bill Combined: The ED and IP visits are both reported as a single record in the IP file only.
No ED record is reported.
The IP record must have “P7” reported in the ED_Admit field.
Revenue is expected in the R045X field.

Bill Split: The ED portion of the visit is reported in the ED file.
The ED record must have Discharge Status “09”
The ED record must have the R045X revenue (if charged).
The ED record must have “S” reported in the Visit_Qualifier field.

The IP portion of the visit is reported in the IP file.
The IP record must have “P7” reported in the ED_Admit field.
The IP record must *not* have R045X revenue reported.
The IP record must have “S” reported in the Visit_Qualifier field.

NOTE: The number of split records must match. If there are 350 split ED records, there must be 350 corresponding split IP records. Failure to report both records will be considered an error.

4) Emergency Department – treated; moved to observation or other outpatient status

This is a “mixed” ED visit.
The ED visit must be reported in the ED file.
The ED record must have “M” reported in the Visit_Qualifier field.

Section B B-1.3

File Submission Information

Section B B-1.4

Visit types and how they must be reported (con't):

NOTE: It is understood by ADHS that it may be impossible for reporting hospitals to separate the OBS or OP information from the ED portion due to the way accounts are combined/billed in the hospital system and further, that methodologies may vary across hospitals/payers. The OBS/OP portion of the visit is not required in the ED record, and should be excluded if possible. If the information cannot be excluded, it can be left in the record.

Section B B-1.4

Data Element Specifications

Section C C-01.1

Element Name:	Placeholder
Definition:	Reserved for future use.
Parameters:	20 - 60 Positions
Codes/Values:	Blank
Conditions:	Not in use

Notes:

There are a total of 7 Placeholder fields of 20 to 60 characters each inserted throughout the data layout. These positions are to be left blank to reserve room for future revisions.

Section C C-01.1

Data Element Specifications

Section C C-02.1

Element Name:	Reporting Hospital Arizona Facility Identifier (AZFACID)
Definition:	The unique Arizona Facility Identification number assigned to the provider by the Arizona Department of Health Services.
Parameters:	10 Positions Alphanumeric Left-Justified
Codes/Values:	Alpha characters must be UPPER CASE
Conditions:	Required for IP and ED

Notes:

The current list of Arizona Facility Identifiers (AZFACID) is available on the ADHS website at <http://www.azdhs.gov/plan/crr/ddr/hospal/index.htm> .

Section C C-02.1

Data Element Specifications

Section C C-03.1

Element Name:	Reporting Hospital National Provider Identifier (NPI)
Definition:	The unique National Provider Identification number assigned to the provider.
Parameters:	15 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL56
Codes/Values:	Alpha characters must be UPPER CASE
Conditions:	Required for IP and ED

Notes:

The NPI is 10 characters in length, therefore this data element contains 5 blank positions. 15 positions are provided to maintain conformity with UB guidelines (refer to instructions for UB04 FL56 for details).

If your hospital has more than one NPI, for state reporting purposes use the NPI assigned to the main hospital as licensed by the state of Arizona. For assistance in determining which NPI should be utilized for state reporting, contact the Office of Discharge Data Review (see contact information in Section A of this Manual).

Section C C-03.1

Data Element Specifications

Section C C-04.1

Element Name:	Patient Medical/Health Record Number
Definition:	The number assigned to the patient's medical/health record by the provider.
Parameters:	24 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL03b
Codes/Values:	Alpha characters must be UPPER CASE
Conditions:	Required for IP and ED

Notes:

This is the number that identifies a patient's medical/health history of treatment. This number does NOT identify a specific episode of care.

Section C C-04.1

Data Element Specifications

Section C C-05.1

Element Name: Patient Control Number

Definition: Patient's unique number assigned by the provider to facilitate retrieval of a specific record for a specific episode of care.

Parameters: 24 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL03a

Codes/Values: Alpha characters must be UPPER CASE

Conditions: Required for IP and ED

Notes:

To enable the provider to easily retrieve any record requiring review and/or correction.

Sometimes called the "patient account number" or "patient encounter number."

Section C C-05.1

Data Element Specifications

Section C C-06.1

Element Name: Patient Name

Definition: Last name, first name and middle initial of the patient.

Parameters: 29 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL08 Line 2b

Codes/Values: Alpha characters must be UPPER CASE

Report LAST NAME space FIRST NAME space MIDDLE
INITIAL. Example: SMITH JAMES E

Include hyphen in hyphenated names, such as Smith-Jones (if the
hyphen is present in the source system)

First and last names are required

Conditions: Required for IP and ED

Notes:

Do not include punctuation

Do not place spaces inside last names with a prefix, such as McBeth, OConner (report
MCBETH *not* MC BETH)

Do not include apostrophes (report OCONNER, *not* O'CONNER)

Do not report titles (Sir, Msgr, Dr)

Section C C-06.1

Data Element Specifications

Section C C-07.1

Element Name: Patient Social Security Number

Definition: The last 4 digits of the social security number of the patient.

Parameters: 10 Positions
Alphanumeric
Left-Justified

Codes/Values: Report *only* the last 4 digits of the *patient's* social security number even if the entire number is collected.

Conditions: Must be reported for IP and ED

Notes:

Do not report the entire social security number (report 6789, *not* 123456789)

Do not include hyphens (report 6789, *not* -6789)

Do not report the responsible person's SSN (such as a parent or spouse)

For records where you do not have a valid SSN to report:

For newborns, report 1111

For patients who do not have a SSN (foreign nationals), report 2222

For patients where circumstances prevent obtaining the SSN, report 3333

For patients who refuse to provide their SSN, report 9999

Report 1111 only on *newborns* (babies either born in your hospital or where your hospital is the first to attend the infant following an extramural birth). On other infants or pediatric patients where you cannot obtain the SSN, report 3333.

Section C C-07.1

Data Element Specifications

Section C
C-08.1

Element Name: Patient Address

Definition: The street portion of the mailing address of the patient.

Parameters: 40 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL09 Line 1a

Codes/Values: Alpha characters must be UPPER CASE

Recommend using US Postal Service Address Standards

Conditions: Required for IP and ED

Notes:

No punctuation (report 123 E MAIN ST *not* 123 E. MAIN ST.)

If the patient is homeless, enter “HOMELESS” in this field

If circumstances prevent you from obtaining the patient’s address, enter “UNKNOWN” in this field.

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>

Section C
C-08.1

Data Element Specifications

Section C C-08.2

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

For more examples and information, visit the US Postal Service website at:

<http://www.usps.com/supportingourtroops/addressingtips.htm>

US Postal Service address abbreviation standards may be found at: <http://www.usps.com/>

See Section I Appendices for additional resource information.

Section C C-08.2

Data Element Specifications

Section C C-09.1

Element Name: Patient City

Definition: City of the patient's mailing address.

Parameters: 30 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL09 Line 2b

Codes/Values: Alpha characters must be UPPER CASE

US cities must be a valid city name according to US Postal Service.

Conditions: Required for IP and ED

Notes:

If the patient is homeless, leave blank.

If the patient's address is unknown, leave blank.

No punctuation (report ST DAVID *not* ST. DAVID)

If the city name has more than one word, include the space, such as SHOW LOW or NEW RIVER.

Use *only* US Postal Service acceptable abbreviations.

US Postal Service City Names may be verified at: <http://www.usps.com/>

Section C C-09.1

Data Element Specifications

Section C C-10.1

Element Name:	Patient State
Definition:	State of the patient's mailing address.
Parameters:	2 Positions Alphanumeric All positions filled Crosswalk to UB04 FL09 Line 2c
Codes/Values:	Alpha characters must be UPPER CASE. Must be a valid state code according to US Postal Service.
Conditions:	Required for IP and ED unless patient is a resident of a foreign country.

Notes:

If the patient is homeless, leave blank.

If the patient's address is unknown, leave blank.

If the patient is a resident of a foreign country, leave blank.

No punctuation (report AZ *not* A.Z.).

US Postal Service State Abbreviations may be found at <http://www.usps.com/>

Section C C-10.1

Data Element Specifications

Section C C-11.1

Element Name: Patient Zip Code

Definition: Zip code of the patient's mailing address.

Parameters: 9 Positions
Numeric
Left-Justified
Crosswalk to UB04 FL09 Line 2d

Codes/Values: Alpha characters must be UPPER CASE.

Must be valid zip code according to US Postal Service.

Conditions: Required for IP and ED unless patient is a foreign resident.

Notes:

If the patient is homeless, leave blank.

If the patient's address is unknown, leave blank.

If the patient is a foreign resident, leave blank.

Include the + 4 portion of the zip code if known; otherwise leave those 4 spaces blank.

Do not include the hyphen (enter 850073248, NOT 85007-3248)

Zip Codes may be verified on the US Postal Service website at: <http://www.usps.com/>

Section C C-11.1

Data Element Specifications

Section C C-12.1

Element Name:	Patient Country Code
Definition:	Country of patient's mailing address.
Parameters:	2 Positions Alphanumeric All positions filled Crosswalk to UB04 FL09 Line 2e
Codes/Values:	Alpha characters must be UPPER CASE. Must be valid country code from ANSI ISO 3166, use the alpha-2 country codes from Part I of ISO3166.
Conditions:	Required for IP and ED <i>if the patient is a foreign resident.</i>

Notes:

No punctuation.

If the patient is homeless, leave blank.

If the patient's address is unknown, leave blank.

If the patient is a US resident, leave blank.

Codes for countries are based upon:
Codes for Representation of Names Of Countries
ISO 3166 (latest release)

Available from:
American National Standards Institute (ANSI)
11 West 42nd Street, 13th Floor
New York, NY 10036

This list is also in Section I Appendices of this manual, and in spreadsheet format on our website at: <http://www.azdhs.gov/plan/crr/ddr/hospal/index.htm> .

Section C C-12.1

Data Element Specifications

Section C C-13.1

Element Name: Patient Homeless Indicator

Definition: The patient is homeless.

Parameters: 2 Positions
Numeric
All positions filled
Crosswalk to UB04 FL18-28

Codes/Values: 17

Conditions: Situational for IP and ED if the patient is a homeless person.

Notes:

This code communicates to ADHS that the patient is homeless, so this circumstance may be taken into account when auditing the record for completeness and accuracy. If you choose to not utilize this indicator, it may increase the number of errors you receive for records with incomplete or inconsistent information.

Section C C-13.1

Data Element Specifications

Section C C-14.1

Element Name: Patient Birth Date

Definition: The date of birth of the patient.

Parameters: 8 Positions
Numeric
All positions filled
Crosswalk to UB04 FL10

Codes/Values: Must be a valid date.

Format is CCYYMMDD (example: 19570902 = Sept. 2, 1957)

Conditions: Required for IP and ED.

Notes:

If date of birth is unknown, populate this field with zeros. This will communicate to ADHS that the patient birth date is unknown.

Some hospital HIMS won't allow the entry of all zeros in the patient birth date field. This can be resolved programmatically by having hospital staff consistently use one date that is obviously incorrect to identify unknown birthdays (for example, January 1, 1850), and then have the programming for creating the state report convert that incorrect date to zeros in the state report when the extraction is run.

Section C C-14.1

Data Element Specifications

Section C C-15.1

Element Name: Patient Sex

Definition: The patient's gender as recorded at admission or time of emergency department service.

Parameters: 1 Position
Alphanumeric
Crosswalk to UB04 FL11

Codes/Values: Alpha characters must be UPPER CASE.

M = Male
F = Female
U = Unknown

Conditions: Required for IP and ED.

Notes:

Section C C-15.1

Data Element Specifications

Section C C-16.1

Element Name: Patient Race/Ethnicity

Definition: The race/ethnicity of the patient as collected from the patient or patient's representative at the time of admission or emergency department service.

Parameters: 4 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL81, Lines a-d
Code List Qualifier value = B1

Codes/Values:

1	American Indian or Alaska Native
2	Asian
3	Black or African American
4	Hispanic or Latino
5	White
6	Native Hawaiian or other Pacific Islander
9	Refused

Conditions: Required for IP and ED.

Notes:

Patient or patient's representative should be allowed to select more than one choice; up to 4 can be selected.

Do not base Patient Race/Ethnicity on observation.

See Section I Appendices for additional resource information.

Section C C-16.1

Data Element Specifications

Section C C-17.1

Element Name: Patient Marital Status

Definition: Patient's marital status as collected from the patient or patient's representative at the time of admission or emergency department service.

Parameters: 1 Position
Alphanumeric
Crosswalk to UB04 FL81, Lines a-d
Code List Qualifier value = B2

Codes/Values: Alpha characters must be UPPER CASE.

I	Single
M	Married
S	Separated
D	Divorced
W	Widowed
K	Unknown
C	Not Applicable

Conditions: Required for IP and ED.

Notes:

See Section I Appendices for additional resource information.

Section C C-17.1

Data Element Specifications

Section C C-18.1

- Element Name:** Onset of Symptoms/Illness Date
- Definition:** The date identifying the Onset of Symptoms/Illness.
- Parameters:** 8 Positions
Numeric
All positions filled
Crosswalk to UB04 FL31-34, Lines a-b, Code 11
- Codes/Values:** Must be a valid date if populated.

Format is CCYYMMDD (example: 20080521 = May 21, 2008)
- Conditions:** Situational for IP and ED. If the record has Occurrence Code 11, then report the associated date.

Notes:

If there is no Occurrence Code 11 and date in the record, leave this field blank.

Section C C-18.1

Data Element Specifications

Section C C-19.1

Element Name: Admission Date

Definition: The start date for this episode of care. For inpatient services, this is the date of admission. For emergency department services, the date the episode of care began.

Parameters: 8 Positions
Numeric
All positions filled
Crosswalk to UB04 FL12

Codes/Values: Must be a valid date.

Format is CCYYMMDD (example: 20080521 = May 21, 2008)

Conditions: Required for IP and ED.

Notes:

On newborns born in your hospital this date should be the same as the patient's date of birth. (applies to priority of visit 4 with source of admission 5).

On extramural births for which your hospital is the initial admission and therefore you are reporting the baby as a newborn admission, this date may be later than the date of birth by one calendar day (applies to priority of visit 4 with source of admission 6).

Section C C-19.1

Data Element Specifications

Section C
C-20.1

Element Name: Admission Hour

Definition: The code referring to the hour during which the patient was admitted for inpatient or emergency department care.

Parameters: 2 Positions
Numeric
All positions filled
Crosswalk to UB04 FL13

Codes/Values:	Code:	Time (am)
	00	12:00 (midnight) – 12:59
	01	01:00 – 01:59
	02	02:00 – 02:59
	03	03:00 – 03:59
	04	04:00 – 04:59
	05	05:00 – 05:59
	06	06:00 – 06:59
	07	07:00 – 07:59
	08	08:00 – 08:59
	09	09:00 – 09:59
	10	10:00 – 10:59
	11	11:00 – 11:59
		Time (pm)
	12	12:00 (noon) – 12:59
	13	01:00 – 01:59
	14	02:00 – 02:59
	15	03:00 – 03:59
	16	04:00 – 04:59
	17	05:00 – 05:59
	18	06:00 – 06:59
	19	07:00 – 07:59
	20	08:00 – 08:59
	21	09:00 – 09:59
	22	10:00 – 10:59
	23	11:00 – 11:59

Conditions: Required for IP and ED.

Notes:

Section C
C-20.1

Data Element Specifications

Section C C-21.1

Element Name: Priority (Type) of Visit

Definition: A code indicating the priority of this inpatient admission or emergency department visit.

Parameters: 1 Position
Numeric
Crosswalk to UB04 FL14

Codes/Values: 1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn
5 = Trauma
9 = information not available

Conditions: Required for IP and ED.

Notes:

Code 4 = Newborn indicates the baby was born in your hospital, or yours is the first hospital to attend the infant following an extramural birth. Infants born in another health facility and transferred to your hospital for care are transfers and should not be coded as newborn type of visit.

Records that are coded as newborn type of visit require the use of special Source of Admission Codes (see page C-22.1).

Code 5 = Trauma indicates a visit to a trauma center/hospital as designated by the Arizona Division of Emergency Medical Services, or as verified by the American College of Surgeons, **and** involving a trauma activation.

Section C C-21.1

Data Element Specifications

Section C
C-22.1

Element Name: Source of Admission or Visit

Definition: A code indicating the point of patient origin for this admission or emergency department visit.

Parameters: 1 Position
Alphanumeric
Crosswalk to UB04 FL15

Codes/Values: 1 = Non-Health Care Facility Point of Origin
2 = Clinic or Physician’s Office
4 = Transfer from a Hospital (different facility)
5 = Transfer from a Skilled Nursing Facility
6 = Transfer from another Health Care Facility
8 = Court/Law Enforcement
9 = Information not available
D = Transfer from one Distinct Unit to another Distinct Unit
Resulting in a Separate Claim to Payer
E = Transfer from Ambulatory Surgery Center
F = Transfer from Hospice

Code structure for Newborns (Priority of Visit 4)
5 = Born inside this Hospital
6 = Born outside this Hospital

Conditions: Required for IP and ED.

Notes:

The above codes and their definitions are taken from the UB04. These codes and their definitions may change from time to time as determined by the national entities responsible for their management. Since these codes are part of a national standard, 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 practice. The state will make every effort to implement such national changes into the state reporting requirements as they occur. However, the state will generally not announce or even comment upon national changes, unless such changes are viewed as being likely to cause confusion or conflict with existing state requirements. Please be sure you are using current codes and definitions.

Section C
C-22.1

Data Element Specifications

Section C C-23.1

Element Name:	Discharge Date
Definition:	The ending service date for this episode of care, when the patient was released from the care of the reporting hospital.
Parameters:	8 Positions Numeric All positions filled Crosswalk to UB04 FL06
Codes/Values:	Must be a valid date. Format is CCYYMMDD (example: 20080521 = May 21, 2008)
Conditions:	Required for IP and ED

Notes:

This field crosswalks to the UB04 FL06, which is the “Statement Covers Period” data element. For Arizona state reporting purposes, only the “through” portion (corresponding to the right 6 characters of FL06) is reported.

Section C C-23.1

Data Element Specifications

Section C
C-24.1

Element Name: Discharge Hour

Definition: Code indicating the patient's hour of discharge from care.

Parameters: 2 Positions
Numeric
All positions filled
Crosswalk to UB04 FL16

Codes/Values:	Code:	Time (am)
	00	12:00 (midnight) – 12:59
	01	01:00 – 01:59
	02	02:00 – 02:59
	03	03:00 – 03:59
	04	04:00 – 04:59
	05	05:00 – 05:59
	06	06:00 – 06:59
	07	07:00 – 07:59
	08	08:00 – 08:59
	09	09:00 – 09:59
	10	10:00 – 10:59
	11	11:00 – 11:59
		Time (pm)
	12	12:00 (noon) – 12:59
	13	01:00 – 01:59
	14	02:00 – 02:59
	15	03:00 – 03:59
	16	04:00 – 04:59
	17	05:00 – 05:59
	18	06:00 – 06:59
	19	07:00 – 07:59
	20	08:00 – 08:59
	21	09:00 – 09:59
	22	10:00 – 10:59
	23	11:00 – 11:59

Conditions: Required for IP and ED.

Notes:

Section C
C-24.1

Data Element Specifications

Section C
C-25.1

Element Name: Discharge Status

Definition: Code indicating the status of the patient upon discharge.

Parameters: 2 Positions
Numeric
All positions filled
Crosswalk to UB04 FL17

Codes/Values:

- 01 = Discharged to Home or Self Care (routine discharge)
- 02 = Discharged/transferred to a Short-Term General Hospital for Inpatient care
- 03 = Discharged/transferred to a Skilled Nursing Facility
- 04 = Discharged/transferred to an Intermediate Care Facility (Assisted Living Facility)
- 05 = Discharged/transferred to a Designated Cancer Center or Children’s Hospital
- 06 = Discharged/transferred to home under care of Organized Home Health Service Organization
- 07 = Left against medical advice or discontinued care
- 09 = Admitted as an Inpatient to this Hospital (for state reporting, this code must be used, and is valid, **only** on ED records when the patient was admitted as an inpatient from the ED **and** the ED & IP portions of the visit are billed separately)
- 20 = Expired
- 21 = Discharged/Transferred to Court/Law Enforcement
- 41 = Expired in a Medical Facility (hospice patients only)
- 43 = Discharged/transferred to a Federal Health Care Facility
- 50 = Discharged home with Hospice
- 51 = Discharged/transferred to Hospice in a Medical Facility
- 61 = Discharged/transferred to a Swing Bed
- 62 = Discharged/transferred to an Inpatient Rehabilitation Facility (IRF)
- 63 = Discharged/transferred to a Long Term Care Hospital
- 65 = Discharged/transferred to a Psychiatric Hospital
- 66 = Discharged/transferred to a Critical Access Hospital
- 70 = Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

Section C
C-25.1

Data Element Specifications

Section C C-25.2

Conditions: Required for IP and ED.

Notes:

The status codes listed in this manual are the only codes valid for reporting patient discharge status to the state of Arizona. While there are other codes that are valid for hospital billing purposes, the codes indicated are the only codes valid for discharge reporting to the state.

Do not report records for patients who left without being seen/left without treatment **and** who incurred no charges.

Discharge status 01 = Home or Self Care is used in accordance with the UB04 definition of this discharge status, including discharges to *non* state-licensed assisted living facilities (ALF). *Do not* use this discharge status for patients discharged to skilled nursing homes (SNF) or *state licensed* assisted living facilities (ALF), even if the patient was originally admitted to the hospital from the SNF or ALF. Use the appropriate **status of 03** for SNF and **04** for ALF.

Discharge status 04 = Intermediate Care Facility is used for discharges to state-licensed Assisted Living Facilities and **non-certified** nursing facilities.

Discharge status 09 = For the purposes of Arizona hospital discharge data reporting, this code must be used, and is valid, **only** on ED records when the patient was admitted as an inpatient from the ED, **and** the ED & IP portions of the visit are billed separately and therefore are reported to the state separately). This code is considered invalid for reporting under any other circumstances.

There has been some confusion regarding transfers to Medicare and/or Medicaid certified nursing beds/facilities, and how these discharges should be reported.

Discharge status 64 = Is not valid for state reporting. Nursing facilities with “intermediate care” previously existed in Arizona, but this level of care was abolished. Arizona has a law that requires a nursing facility to be Medicare certified before it can obtain Medicaid certification (which is not the case in many other states). The only nursing facility in Arizona that had true “Medicaid only” certification is no longer open.

Section C C-25.2

Data Element Specifications

Section C C-25.3

Notes (con't):

Therefore, in Arizona, except for the “state only” facilities (those with no Medicare or Medicaid certification) all nursing facilities are Medicare certified facilities, and **discharge status 03** would be used for patients discharged/transferred to these facilities.

Section C C-25.3

Data Element Specifications

Section C C-26.1

Element Name: Newborn Birth Weight

Definition: Actual birth weight or weight at time of admission for an extramural birth, reported in grams.

Parameters: 4 Positions
Numeric
Right-Justified
Crosswalk to UB04 FL39-41, Lines a-d, Code 54

Codes/Values: Weight reported in grams

The actual birth weight or, if an extramural birth, the weight at time of admission.

Conditions: Required for IP with Priority (type) of Admission 4 (babies born in your hospital, or when yours is the first hospital to attend the infant following an extramural birth).

Notes:

Do not zero fill.

Do not report newborn weight on infants transferred to your facility after being born in another health care institution.

Section C C-26.1

Data Element Specifications

Section C C-27.1

Element Name:	Do Not Resuscitate Order (DNR)
Definition:	The patient has a valid DNR order on record with the reporting hospital.
Parameters:	2 Positions Alphanumeric All positions filled Crosswalk to UB04 FL18-28
Codes/Values:	P1 Alpha characters must be UPPER CASE.
Conditions:	Must be reported if collected for IP and ED.

Notes:

For state reporting purposes, “Valid DNR Order” means the patient has a properly executed legal advance directive, pre-hospital directive or living will containing a DNR; **or** there is a physician’s order for DNR; **and** the hospital is aware of the DNR **and** has the DNR information present in their HIMS.

This field is populated only if the above criteria for reporting a DNR order are met.

Leave blank if DNR order does not exist, or status is unknown.

Section C C-27.1

Data Element Specifications

Section C C-28.1

Element Name: Bill Creation Date

Definition: Date the bill for this episode of care was created.

Parameters: 8 Positions
Numeric
All positions filled
Crosswalk to UB04 FL45, Line 23

Codes/Values: Must be a valid date.

Format is CCYYMMDD (example: 20080521 = May 21, 2008)

Conditions: Required for IP and ED.

Notes:

Section C C-28.1

Data Element Specifications

Section C C-29.1

Element Name:	Total Charges
Definition:	The total gross charges incurred by the patient for this episode of care.
Parameters:	8 Positions Numeric Right-Justified Crosswalk to UB04 FL47, Line 23, Revenue Code 0001
Codes/Values:	8 positions for whole dollars only
Conditions:	Required for IP and ED.

Notes:

Report total charges only from the last page of the claim, Revenue Code 0001.

Amounts equal to or greater than zero are acceptable values for this data element. If the patient received services but was not charged, it is acceptable to report a zero in this field.

Do not enter decimals

Do not zero fill

Enter whole dollars only, do not enter cents (enter 25353, not 25353.32).

Truncate when dropping cents; do not round

Do not enter negative numbers or alpha characters.

Section C C-29.1

Data Element Specifications

Section C C-30.1

Element Name: Payer Type Code

Definition: Category of the primary payer; the expected source of payment for the majority of the charges associated with this episode of care.

Parameters: 2 Positions
Numeric
All positions filled
Crosswalk to UB04 FL50a

Codes/Values:

00	Self Pay
01	Commercial (Indemnity)
02	HMO
03	PPO
04	Health Care Group
05	Medicare
06	AHCCCS Medicaid
07	CHAMPUS/TRICARE
08	Children's Rehab Services
09	Workers Compensation
10	Indian Health Services
11	Medicare Risk
12	Charity
13	Foreign National
14	Other

Conditions: Required for IP and ED.

Notes:

Section C C-30.1

Data Element Specifications

Section C C-31.1

Element Name: Revenue Code Category Charges

Definition: Total charges for the related revenue code category.

Parameters: 7 Positions
Numeric
Right-Justified
Crosswalk to UB04 FL42 and FL47

Codes/Values: 7 positions for whole dollars only

Reportable categories:

010x - 016x	070x - 081x
018x - 048x	088x
050x	090x - 092x
053x	094x - 099x
061x - 063x	210x
068x	All Other (all codes not listed here, excluding 017x see page C-32.1)

Conditions: Required for IP and ED.

Notes:

Amounts greater than zero are acceptable values for this data element

If there are no charges for a category, leave blank

Do not enter decimals

Do not zero fill

Enter whole dollars only; do not enter cents (enter 25353, not 25353.32)

Truncate when dropping cents; do not round

Do not enter negative numbers or alpha characters

Section C C-31.1

Data Element Specifications

Section C
C-31.2

Report combined charges for every revenue line item in a specific reportable category, for example:

<u>Revenue code</u>	<u>Charges</u>
0621	\$100.15
0623	\$37.03

Report for Revenue Code Category 062X = 137

Section C
C-31.2

Data Element Specifications

Section C C-32.1

Element Name:	Nursery Revenue Code Charges (1-6)
Definition:	Charges for each individual nursery revenue code as indicated below in Codes/Values.
Parameters:	7 Positions Numeric Right-Justified Crosswalk to UB04 FL42 and FL47
Codes/Values:	7 positions for whole dollars only Reportable categories: 0170; 0171; 0172; 0173; 0174; 0179
Conditions:	Required for IP.

Notes:

Amounts greater than zero are acceptable values for this data element

If there are no charges for a category, leave blank

Do not enter decimals

Do not zero fill

Enter whole dollars only; do not enter cents (enter 25353, not 25353.32)

Truncate when dropping cents; do not round

Do not enter negative numbers or alpha characters

Section C C-32.1

Data Element Specifications

Section C C-33.1

Element Name: HIPPS – IRF PPS CMG Code

Definition: The Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. This data element consists of the Case Mix Group (CMG) determined from specific Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) data elements by the grouper software used by Inpatient Rehabilitation Facilities.

Parameters: 5 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL44, Definition 3

Codes/Values: Must be a valid HIPPS IRF PPS CMG code for the time period being reported.

Conditions: Situational IP. Reported by Inpatient Rehabilitation Hospitals. Required when an IRF CMG code exists on the patient bill.

Notes:

Section C C-33.1

Data Element Specifications

Section C C-34.1

Element Name: DRG

Definition: The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

Parameters: 4 Positions
Numeric
Right-Justified
Crosswalk to UB04 FL71

Codes/Values: Must be a valid DRG for the time period being reported.

Conditions: Required for IP

Notes:

Do not zero fill.

DO include the leading zero that is part of the DRG code; for example: 007.

Section C C-34.1

Data Element Specifications

Section C C-35.1

Element Name: ICD Version Indicator

Definition: The qualifier that denotes the version of the International Classification of Diseases (ICD) reported.

Parameters: 1 Positions
Numeric
Crosswalk to UB04 FL66

Codes/Values: Edition of the ICD:
9 – Ninth Revision
0 – Tenth Revision

Conditions: Required for IP and ED.

Notes:

Qualifier Code “9” is required until further notice.

Section C C-35.1

Data Element Specifications

Section C C-36.1

Element Name:	Patient Reason for Visit (1-3)
Definition:	The ICD diagnosis codes describing the patient's stated reason(s) for seeking care at the time of emergency department registration.
Parameters:	8 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL70 a-c
Codes/Values:	Alpha characters must be UPPER CASE. Must be valid ICD codes, based on the ICD version indicated on the record and the time period being reported. The decimal between the third and fourth digits is implied.
Conditions:	Required for ED. Do not report on IP records

Notes:

Do not report decimals.

Do not report E Codes in these fields. E Codes have separate fields designated for the purpose of state reporting.

Follow official coding guidelines for ICD reporting.

Section C C-36.1

Data Element Specifications

Section C C-37.1

Element Name:	Admitting Diagnosis
Definition:	The ICD diagnosis code describing the patient's diagnosis at the time of admission.
Parameters:	8 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL69
Codes/Values:	The decimal between the third and fourth digits is implied. Alpha characters must be UPPER CASE. Must be valid ICD codes, based on the ICD version indicated on the record and the time period being reported.
Conditions:	Required for IP.

Notes:

Do not report decimals.

Do not report an E Code in this field. E Codes have separate fields designated for the purpose of state reporting.

Follow official coding guidelines for ICD reporting.

Section C C-37.1

Data Element Specifications

Section C C-38a.1

Element Name:	Principal Diagnosis Code (see C-38b.1 for Present on Admission Indicator)
Definition:	The ICD Code describing the principal diagnosis (i.e. the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).
Parameters:	7 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL67
Codes/Values:	The decimal between the third and fourth digits of the diagnosis code is implied. Alpha characters must be UPPER CASE. Must be a valid ICD code, based on the ICD version indicated on the record and the time period being reported
Conditions:	Required for IP and ED.

Notes:

Do not report decimals.

Do not report an E Code in this field. E Codes have separate fields designated for the purpose of state reporting.

V codes are acceptable.

Follow official coding guidelines for ICD reporting.

Section C C-38a.1

Data Element Specifications

Section C C-38b.1

Element Name: Principal Diagnosis Present on Admission Indicator (POA)
Definition: The code indicating whether the Principal Diagnosis was present at the time of admission.

Parameters: 1 Position
Alphanumeric
Crosswalk to UB04 FL67

Codes/Values: Alpha characters must be UPPER CASE.

POA Codes:

<u>Code</u>	<u>Definition</u>
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1	Unreported/not used; exempt from POA reporting

Conditions: Required for IP

Reporting for ED discharges on hold, pending determination of a national definition on how this indicator will be assigned in an outpatient setting.

Notes:

Follow official coding guidelines for assignment of the POA Indicator.

Section C C-38b.1

Data Element Specifications

Section C C-39a.1

- Element Name:** Other Diagnosis Code (2-25)
(see C-39b.1 for Present on Admission Indicator)
- Definition:** The ICD diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.
- Parameters:** 7 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL67A-Q
- Codes/Values:** The decimal between the third and fourth digits of the diagnosis code is implied.
- Alpha characters must be UPPER CASE.
- Must be valid ICD codes, based on the ICD version indicated on the record and the time period being reported
- Conditions:** Required for IP and ED.
- Notes:**
- Do not report decimals.
- Do not report E Codes in these fields. E Codes have separate fields designated for the purpose of state reporting.
- V codes are acceptable.

Section C C-39a.1

Data Element Specifications

Section C C-39b.1

Element Name: Other Diagnosis (2-25) Present on Admission Indicator (POA)

Definition: The code indicating whether the Other Diagnoses (2-25) were present at the time of admission.

Parameters: 1 Position
Alphanumeric
Crosswalk to UB04 FL67

Codes/Values: Alpha characters must be UPPER CASE.

POA Codes:

<u>Code</u>	<u>Definition</u>
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1	Unreported/not used; exempt from POA reporting

Conditions: Required for IPs

Reporting for ED discharges on hold, pending determination of a national definition on how this indicator will be assigned in an outpatient setting.

Notes:

Follow official coding guidelines for assignment of the POA Indicator.

Section C C-39b.1

Data Element Specifications

Section C C-40a.1

- Element Name:** External Cause / Place of Injury - E Code (1-6)
(see C-40b.1 for Present on Admission Indicator)
- Definition:** The ICD codes pertaining to external cause and place of injuries, poisonings, adverse affects or misadventures, including the POA indicator where applicable.
- Parameters:** 7 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL72
- Codes/Values:** Alpha characters must be UPPER CASE
- The decimal between the fourth and fifth digit of the E code is implied.
- Must be valid ICD E codes, based on the ICD version indicated on the record and the time period being reported.
- Conditions:** Required for IP and ED when an injury, poisoning, adverse effect or misadventure is the cause for seeking medical treatment or occurs during the medical treatment.
- Notes:**
- Do not report decimals.
- Include the E when reporting.
- Report all E codes (up to 6) *in the order in which they appear* in the hospital system.
- Assign and report the CAUSE of Occurrence E code(s) on all treatments of injury, poisoning, adverse effect or misadventure.
- Assign and report the PLACE of Occurrence E code(s) on all treatments of injury or poisoning.

Section C C-40a.1

Data Element Specifications

Section C C-40a.2

Do not assign E codes for place of occurrence on surgical/medical procedure misadventures and abnormal reactions (E8700-E8799) or adverse drug reactions (E930-E9499).

Refer to national coding guidelines for assistance with proper E code assignment.

Section C C-40a.2

Data Element Specifications

Section C C-40b.1

Element Name: E Code (1-6) Present on Admission Indicator (POA)

Definition: The code indicating whether the External Cause of Injury was present at the time of admission.

Parameters: 1 Position
Alphanumeric
Crosswalk to UB04 FL67

Codes/Values: Alpha characters must be UPPER CASE.

POA Codes:

<u>Code</u>	<u>Definition</u>
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1	Unreported/not used; exempt from POA reporting

Conditions: Required for all Arizona reportable IP discharges

Reporting for ED discharges on hold, pending determination of a national definition on how this indicator will be assigned in an outpatient setting.

Notes:

Follow official coding guidelines for assignment of the POA Indicator.

Section C C-40b.1

Data Element Specifications

Section C C-41.1

Element Name: Accident State

Definition: The two-digit state abbreviation where the accident occurred.

Parameters: 2 Positions
Alphanumeric
All positions filled
Crosswalk to UB04 FL29

Codes/Values: Alpha characters must be UPPER CASE.

Use official United States Postal Service state abbreviation codes. (these abbreviations are the same as the ANSI ISO3166 alpha-2 country subdivision codes from Part I of ISO3166).

Conditions: Required when the services reported in the record are related to an auto accident.

Notes:

Report the two-character *state* abbreviation indicating the state in which the accident occurred.

Refer to the UB04 Form Locator 29 instructions for details regarding when this data element is reportable.

Tip: if this data element is reportable on the UB04, then it must be reported to the state.

Section C C-41.1

Data Element Specifications

Section C C-42.1

Element Name: Principal Procedure Code

Definition: The ICD or HCPCS/CPT code that identifies the principal procedure performed.

Parameters: 7 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL74 (IP) or FL44 (ED)

Codes/Values: The decimal between the second and third digit is implied.

Must be valid ICD or HCPCS/CPT codes, based on the time period being reported, and (if applicable) ICD version indicated in the record.

Conditions: Required for IP and ED if a procedure was performed.

Notes:

Follow official coding guidelines.

On IP records, report *only* ICD codes.

On ED records, report ICD code if available, otherwise report CPT code

On ED records, report CPT code in the following priority:

Surgery	10000 - 69999
Medicine	90000 - 99199
Radiology	70000 - 79999
Pathology & Laboratory	80000 - 89999
Anesthesia	00000 - 01999

If no code exists in a specific category, move to the next category in sequence.

Do not report CPT Evaluation and Management code here; see page C-44.1 & 44.2

Do not report Level II HCPCS codes

Do not report modifiers

Do not report decimals.

Section C C-42.1

Data Element Specifications

Section C C-43.1

Element Name: Principal Procedure Date

Definition: Date of the principal procedure performed.

Parameters: 8 Positions
Numeric
All positions filled
Crosswalk to UB04 FL74 (IP) or FL45 (ED)

Codes/Values: Must be a valid date.

Format is CCYYMMDD (example: 20080521 = May 21, 2008)

Conditions: Required for IP and ED if a procedure was performed.

Notes:

Section C C-43.1

Data Element Specifications

Section C
C-44.1

Element Name: Other Procedure Code (2-12)

Definition: The ICD or HCPCS/CPT codes identifying all significant procedures other than the principal procedure. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Parameters: 7 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL74 (IP) or FL44 (ED)

Codes/Values: The decimal between the second and third digit is implied.

Must be valid ICD or HCPCS/CPT codes, based on the time period being reported, and (if applicable) ICD version indicated in the record.

Conditions: Required for IP and ED if additional procedure(s) (other than the principal procedure) were performed.

Notes:

Follow official coding guidelines.

On IP records, report *only* ICD codes.

On ED records, report ICD codes first if available, then CPT codes

On ED records, report CPT codes in the following priority:

Surgery	10000 - 69999
Medicine	90000 - 99199
Radiology	70000 - 79999
Pathology & Laboratory	80000 - 89999
Anesthesia	00000 - 01999

Report all codes in one category before moving to the next in sequence. If no codes exist in a specific category, move to the next in sequence, until all fields through Procedure Code 11 are filled, or all codes have been reported.

Section C
C-44.1

Data Element Specifications

Section C C-44.2

On ED records, reporting of appropriate CPT Evaluation & Management codes is required. Report the E & M Code in the *Other Procedure Code 12* field. The range to be reported for Type A Emergency Departments is: 99281-99285, 99291. For Type B Emergency Departments, the range to be reported is G0380 – G0384.

It is expected that every ED record reported will have a code in one of the above indicated ranges, and reporting of these codes is required.

Do not report Level II HCPCS codes, unless you are a Type B Emergency Department, reporting the above listed G codes.

Do not report modifier

Do not report decimals.

Section C C-44.2

Data Element Specifications

Section C C-45.1

Element Name:	Other Procedure Date (2-12)
Definition:	Date(s) of the other procedure(s) performed.
Parameters:	8 Positions Numeric All positions filled Crosswalk to UB04 FL74 (IP) or FL45 (ED)
Codes/Values:	Must be a valid date. Format is CCYYMMDD (example: 20080521 = May 21, 2008)
Conditions:	Required for IP and ED if additional procedure(s) (other than the principal procedure) were performed.
Notes:	

Section C C-45.1

Data Element Specifications

Section C C-46.1

Element Name: Attending Provider Name

Definition: The name of the individual health care provider who has overall responsibility for the patient's medical care and treatment reported for this episode of care.

Parameters: 28 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL76 Line 2

Codes/Values: Alpha characters must be UPPER CASE

Report LAST NAME space FIRST NAME space MIDDLE INITIAL. Example: SMITH JAMES E

Include hyphen in hyphenated names, such as Smith-Jones (if the hyphen is present in the source system).

First and last names are required

Conditions: Required for IP and ED.

Notes:

On ED records, report the name of the *first* physician to render care. In the case of a second physician assuming care of the patient due to a shift change, report that second physician under "Other Provider" see page C-54.1.

Do not include punctuation

Do not place spaces inside last names with a prefix, such as McBeth, OConner (report MCBETH *not* MC BETH)

Do not include apostrophes (report OCONNER, *not* O'CONNER).

Do not report titles (MD, DO, DDS).

Section C C-46.1

Data Element Specifications

Section C C-47.1

Element Name:	Attending Provider National Provider Identifier (NPI)
Definition:	The unique National Provider Identification number assigned to the Attending Provider.
Parameters:	11 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL76 Line 1
Codes/Values:	Alpha characters must be UPPER CASE
Conditions:	Required for IP and ED.

Notes:

Section C C-47.1

Data Element Specifications

Section C C-48.1

Element Name: Attending Provider State License Number

Definition: The license number issued by the Arizona licensing board responsible for regulating the medical discipline practiced by the Attending Provider.

Parameters: 8 Positions
Numeric
Right-Justified

Codes/Values: Report numeric portion only.

Conditions: Required for IP and ED.

Notes:

Do not report alpha prefixes of license numbers.

On advanced practice disciplines licensed by the Arizona State Board of Nursing, such as Nurse Practitioner, Nurse Midwife, etc., do NOT report the advanced practice license number; report *only* the original Registered Nurse (RN) license number.

Do NOT report a Physician Assistant as an Attending Provider. Being the “attending provider” (the provider responsible for the overall care of the patient), is out of the scope of practice of a physician assistant, according to their licensing board. Report the information of the licensed physician who is the supervising physician of the physician assistant.

Section C C-48.1

Data Element Specifications

Section C C-49.1

Element Name: Attending Provider State Licensing Board

Definition: The code identifying the Arizona licensing board responsible for regulating the medical discipline practiced by the Attending Provider.

Parameters: 1 Position
Numeric

Codes/Values: 1 = Medical Board (MD)
2 = Dental Examiners (DDS)
3 = Podiatry Examiners (DPM)
4 = Osteopathic Examiners (DO)
5 = Board of Nursing (RN, AP, NP)
6 = Naturopathic Examiners (ND or NMD)
9 = Other

Conditions: Required for IP and ED.

Notes:

Section C C-49.1

Data Element Specifications

Section C C-50.1

Element Name: Operating Provider Name

Definition: The name of the individual health care provider with primary responsibility for performing the principal procedure.

Parameters: 28 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL77 Line 2

Codes/Values: Alpha characters must be UPPER CASE.

Report LAST NAME space FIRST NAME space MIDDLE INITIAL. Example: SMITH JAMES E

Include hyphen in hyphenated names, such as Smith-Jones (if the hyphen is present in the source system)

First and last names are required.

Conditions: Situational.

Required for IP if a procedure was performed.

Required for ED if a procedure was performed and is reported using an ICD-9-CM code, or a CPT code in the range of 10000 – 69999.

Notes:

Do not include punctuation

Do not place spaces inside last names with a prefix, such as McBeth, OConner (report MCBETH *not* MC BETH)

Do not include apostrophes (report OCONNER, *not* O'CONNER).

Do not report titles (MD, DO, DDS, PA, AP, RN).

Section C C-50.1

Data Element Specifications

Section C C-51.1

Element Name:	Operating Provider National Provider Identifier (NPI)
Definition:	The unique National Provider Identification number assigned to the Operating Provider.
Parameters:	11 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL77 Line 1
Codes/Values:	Alpha characters must be UPPER CASE
Conditions:	Situational. Required for IP if a procedure was performed. Required for ED if a procedure was performed and is reported using an ICD-9-CM code, or a CPT code in the range of 10000 – 69999.
Notes:	

Section C C-51.1

Data Element Specifications

Section C C-52.1

Element Name: Operating Provider State License Number

Definition: The license number issued by the Arizona licensing board responsible for regulating the medical discipline practiced by the Operating Provider.

Parameters: 8 Positions
Numeric
Right-Justified

Codes/Values: Report numeric portion only.

Conditions: Situational.

Required for IP if a procedure was performed.

Required for ED if a procedure was performed and is reported using an ICD-9-CM code, or a CPT code in the range of 10000 – 69999.

Notes:

Do not report alpha prefixes of license numbers.

On advanced practice disciplines licensed by the Arizona State Board of Nursing, such as Nurse Practitioner, Nurse Midwife, etc., do NOT report the advanced practice license number; report *only* the original Registered Nurse (RN) license number.

Section C C-52.1

Data Element Specifications

Section C C-53.1

Element Name: Operating Provider State Licensing Board

Definition: The code identifying the Arizona licensing board responsible for regulating the medical discipline practiced by the Operating Provider.

Parameters: 1 Position
Numeric

Codes/Values: 1 = Medical Board (MD)
2 = Dental Examiners (DDS)
3 = Podiatry Examiners (DPM)
4 = Osteopathic Examiners (DO)
5 = Board of Nursing (AP, RN, NP)
6 = Naturopathic Examiners (ND or NMD)
7 = Medical Board - Physician Assistant (PA)
9 = Other

Conditions: Situational.

Required for IP if a procedure was performed.

Required for ED if a procedure was performed and is reported using an ICD-9-CM code, or a CPT code in the range of 10000 – 69999.

Notes:

Section C C-53.1

Data Element Specifications

Section C C-54.1

- Element Name:** Other Provider Name
- Definition:** Other individual healthcare provider involved in the patient's care during this episode of care.
- Parameters:** 28 Positions
Alphanumeric
Left-Justified
Crosswalk to UB04 FL78 Line 2
- Codes/Values:** Alpha characters must be UPPER CASE.

Report LAST NAME space FIRST NAME space MIDDLE INITIAL. Example: SMITH JAMES E

Include hyphen in hyphenated names, such as Smith-Jones (if the hyphen is present in the source system)

First and last names are required.
- Conditions:** Situational. Required for IP and ED when included on the claim for this episode of care.
- Notes:**
- Do not include punctuation
 - Do not place spaces inside last names with a prefix, such as McBeth, OConner (report MCBETH *not* MC BETH)
 - Do not include apostrophes (report OCONNER, *not* O'CONNER).
 - Do not report titles (MD, DO, DDS, PA, AP, RN).
 - On ED records, in the case of a second physician assuming care of the patient due to a shift change, report that second physician here.
 - For priority of reporting Other Providers, see "Other Provider National Provider Identifier (NPI)" page C-55.1

Section C C-54.1

Data Element Specifications

Section C C-55.1

Element Name:	Other Provider National Provider Identifier (NPI)
Definition:	The unique National Provider Identification number assigned to the Other Provider reported in the record.
Parameters:	13 Positions Alphanumeric Left-Justified Crosswalk to UB04 FL78 Line 1
Codes/Values:	Alpha characters must be UPPER CASE Provider Type Qualifier Codes: DN = Referring Provider ZZ – Other Operating Physician 82 = Rendering Provider
Conditions:	Situational. Required for IP and ED if an Other Provider is reported in the record.

Notes:

Reporting of this data element includes the 2 digit Provider Type Qualifier Code preceding the NPI.

Reporting priority:
Other Operating (ZZ)
Rendering (82)
Referring (DN)

Do not redundantly report providers (i.e. do not report as an “other” provider a provider already reported as attending or operating).

Section C C-55.1

Data Element Specifications

Section C C-56.1

Element Name: Other Provider State License Number

Definition: The license number issued by the Arizona licensing board responsible for regulating the medical discipline practiced by the Other Provider reported in the record.

Parameters: 8 Positions
Numeric
Right-Justified

Codes/Values: Report numeric portion only.

Conditions: Situational. Required for IP and ED if an Other Provider is reported in the record.

Notes:

Do not report alpha prefixes of license numbers.

On advanced practice disciplines licensed by the Arizona State Board of Nursing, such as Nurse Practitioner, Nurse Midwife, etc., do NOT report the advanced practice license number; report *only* the original Registered Nurse (RN) license number.

Section C C-56.1

Data Element Specifications

Section C C-57.1

Element Name: Other Provider State Licensing Board

Definition: The code identifying the Arizona licensing board responsible for regulating the medical discipline practiced by the Other Provider reported in the record.

Parameters: 1 Position
Numeric

Codes/Values:

- 1 = Medical Board (MD)
- 2 = Dental Examiners (DDS)
- 3 = Podiatry Examiners (DPM)
- 4 = Osteopathic Examiners (DO)
- 5 = Board of Nursing (AP, RN, NP)
- 6 = Naturopathic Examiners (ND or NMD)
- 7 = Medical Board - Physician Assistant (PA)
- 9 = Other

Conditions: Situational. Required for IP and ED if an Other Provider is reported in the record.

Notes:

Section C C-57.1

Data Element Specifications

Section C C-58.1

Element Name:	Type of Record
Definition:	Indicates the type of discharge record being reported (inpatient or emergency department).
Parameters:	1 Position Numeric
Codes/Values:	1 = Hospital Inpatient 3 = Hospital Emergency Department
Conditions:	Required for IP and ED.

Notes:

Emergency Department records include patients who receive services in the ED, are moved to observation status, and subsequently released without being admitted. The ED services received by these patients must be reported as an Emergency Department record.

Section C C-58.1

Data Element Specifications

Section C C-59.1

Element Name: DRG Version

Definition: Indicates DRG version reported for this record.

Parameters: 2 Positions
Numeric

Codes/Values: 24 = Version 24 (“classic”) DRG
25 = Version 25 (MSDRG)
26 = Version 26 (MSDRG)
27 = Version 27 (MSDRG)
28 = Version 28 (MSDRG)
29 = Version 29 (MSDRG)

Conditions: Required for IP.

Notes:

Section C C-59.1

Data Element Specifications

Section C C-60.1

Element Name: ED Admission Flag

Definition: A code indicating the patient was treated in the reporting hospital's emergency department prior to inpatient admission.

Parameters: 2 Positions
Alphanumeric
All positions filled
Crosswalk to UB04 FL18-28

Codes/Values: P7

Alpha characters must be UPPER CASE.

Conditions: Reported on IP records only.

Conditional; must be reported on IP records if the patient was treated in the reporting hospital's emergency department prior to admission as an inpatient, *regardless* of how the visit is billed. (split or combined).

Notes:

If the reporting conditions described above do not apply, leave this field blank.

Section C C-60.1

Data Element Specifications

Section C C-61.1

Element Name: Visit Qualifier

Definition: A code indicating the visit type being reported is not pure. (For detailed explanation of visit types, refer to page B-1.3 & 4 of this manual).

Parameters: 1 Positions
Alphanumeric
All positions filled

Codes/Values: S = Split Visit (IP or ED)
M = Mixed Visit (ED only)

Alpha characters must be UPPER CASE.

Conditions: Situational reporting on both IP and ED records.

“S” must be reported on both IP and ED records if the patient was treated in the emergency department prior to admission **and** the IP and ED portions are billed separately (“split” bill).

“M” must be reported on ED records if the patient was treated in the emergency department and then moved to observation or other outpatient status (**not** admitted as an inpatient).

Notes:

If the reporting conditions described above do not apply, leave this field blank.

It is understood by ADHS that on “mixed” ED visits, it may be impossible for reporting hospitals to separate the OBS or OP information from the ED portion due to the way accounts are combined/billed in the hospital system and further, that methodologies may vary across hospitals/payers. The OBS/OP portion of the visit is not required to be reported in the ED record, and should be excluded if possible. If the information cannot be excluded, it can be left in the record.

Section C C-61.1

See FOOTNOTES on last page; refer to Specifications Manual for detailed instructions

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Reporting Hospital Arizona Facility Identifier (AZFACID)	10	1	10	IP	ED	n/a	Alphanumeric Left Justified	C02
Reporting Hospital National Provider Identifier (NPI)	15	11	25	IP	ED	FL56	Alphanumeric Left Justified	C03
Patient Medical/Health Record Number	24	26	49	IP	ED	FL03b	Alphanumeric Left Justified	C04
Patient Control Number	24	50	73	IP	ED	FL03a	Alphanumeric Left Justified	C05
Placeholder	20	74	93	n/a	n/a	n/a	Reserved	C01
Patient Name	29	94	122	IP	ED	FL08 Line 2b	Alphanumeric Left Justified	C06
Patient Social Security Number	10	123	132	IP	ED	n/a	Alphanumeric Left Justified	C07
Patient Address	40	133	172	IP	ED	FL09 Line 1a	Alphanumeric Left Justified	C08
Patient City	30	173	202	IP	ED	FL09 Line 2b	Alphanumeric Left Justified	C09
Patient State	2	203	204	IP	ED	FL09 Line 2c	Alphanumeric All positions filled	C10
Patient Zip Code	9	205	213	IP	ED	FL09 Line 2d	Numeric Left Justified	C11
Patient Country Code	2	214	215	IP	ED	FL09 Line 2e	Alphanumeric All positions filled	C12
Patient Homeless Indicator	2	216	217	IP	ED	FL18-28	Numeric All positions filled	C13
Patient Birth Date	8	218	225	IP	ED	FL10	Numeric All positions filled	C14
Patient Sex	1	226	226	IP	ED	FL11	Alphanumeric	C15
Patient Race/Ethnicity	4	227	230	IP	ED	FL81 Lines a - d	Alphanumeric Left Justified Code List Qualifier B1	C16
Patient Marital Status	1	231	231	IP	ED	FL81 Lines a - d	Alphanumeric Code List Qualifier B2	C17
Placeholder	20	232	251	n/a	n/a	n/a	Reserved	(see C1 for details)

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Onset of Symptoms/llness Date	8	252	259	IP	ED	FL31-34 Lines a - b	Numeric All positions filled	C18
Admission Date	8	260	267	IP	ED	FL12	Numeric All positions filled	C19
Admission Hour	2	268	269	IP	ED	FL13	Numeric All positions filled	C20
Priority (Type) of Visit	1	270	270	IP	ED	FL14	Numeric	C21
Source of Admission or Visit	1	271	271	IP	ED	FL15	Alphanumeric	C22
Discharge Date	8	272	279	IP	ED	FL06	Numeric All positions filled	C23
Discharge Hour	2	280	281	IP	ED	FL16	Numeric All positions filled	C24
Discharge Status	2	282	283	IP	ED	FL17	Numeric All positions filled	C25
Newborn Birth Weight	4	284	287	IP	n/a	FL39-41 a - d	Numeric Right Justified	C26
Do Not Resuscitate Order (DNR)	2	288	289	IP	ED	FL18-28	Alphanumeric All positions filled	C27
Placeholder	20	290	309	n/a	n/a	n/a	Reserved	(see C1 for details)
Bill Creation Date	8	310	317	IP	ED	FL45 Line 23	Numeric All positions filled	C28
Total Charges	8	318	325	IP	ED	FL47 Line 23 Rev Code 0001	Numeric Right Justified	C29
Payer Type Code	2	326	327	IP	ED	FL50a	Numeric All positions filled	C30
Revenue Code Category Charges 010x	7	328	334	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 011x	7	335	341	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 012x	7	342	348	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 013x	7	349	355	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 014x	7	356	362	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 015x	7	363	369	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 016x	7	370	376	IP	ED	FL42 and FL47	Numeric Right Justified	C31

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Revenue Code Category Charges 018x	7	377	383	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 019x	7	384	390	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 020x	7	391	397	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 021x	7	398	404	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 022x	7	405	411	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 023x	7	412	418	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 024x	7	419	425	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 025x	7	426	432	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 026x	7	433	439	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 027x	7	440	446	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 028x	7	447	453	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 029x	7	454	460	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 030x	7	461	467	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 031x	7	468	474	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 032x	7	475	481	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 033x	7	482	488	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 034x	7	489	495	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 035x	7	496	502	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 036x	7	503	509	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 037x	7	510	516	IP	ED	FL42 and FL47	Numeric Right Justified	C31

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Revenue Code Category Charges 038x	7	517	523	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 039x	7	524	530	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 040x	7	531	537	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 041x	7	538	544	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 042x	7	545	551	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 043x	7	552	558	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 044x	7	559	565	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 045x	7	566	572	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 046x	7	573	579	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 047x	7	580	586	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 048x	7	587	593	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 050x	7	594	600	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 053x	7	601	607	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 061x	7	608	614	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 062x	7	615	621	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 063x	7	622	628	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 068x	7	629	635	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 070x	7	636	642	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 071x	7	643	649	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 072x	7	650	656	IP	ED	FL42 and FL47	Numeric Right Justified	C31

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Revenue Code Category Charges 073x	7	657	663	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 074x	7	664	670	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 075x	7	671	677	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 076x	7	678	684	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 077x	7	685	691	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 078x	7	692	698	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 079x	7	699	705	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 080x	7	706	712	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 081x	7	713	719	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 088x	7	720	726	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 090x	7	727	733	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 091x	7	734	740	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 092x	7	741	747	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 094x	7	748	754	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 095x	7	755	761	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 096x	7	762	768	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 097x	7	769	775	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 098x	7	776	782	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 099x	7	783	789	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Revenue Code Category Charges 210x	7	790	796	IP	ED	FL42 and FL47	Numeric Right Justified	C31

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Revenue Code Category Charges All Other (excluding revenue code category 017x)	7	797	803	IP	ED	FL42 and FL47	Numeric Right Justified	C31
Nursery Revenue Code Charges 0170	7	804	810	IP	ED	FL42 and FL47	Numeric Right Justified	C32
Nursery Revenue Code Charges 0171	7	811	817	IP	ED	FL42 and FL47	Numeric Right Justified	C32
Nursery Revenue Code Charges 0172	7	818	824	IP	ED	FL42 and FL47	Numeric Right Justified	C32
Nursery Revenue Code Charges 0173	7	825	831	IP	ED	FL42 and FL47	Numeric Right Justified	C32
Nursery Revenue Code Charges 0174	7	832	838	IP	ED	FL42 and FL47	Numeric Right Justified	C32
Nursery Revenue Code Charges 0179	7	839	845	IP	ED	FL42 and FL47	Numeric Right Justified	C32
HIPPS - IRF PPS CMG Code	5	846	850	IP	n/a	FL44 Definition 3	Alphanumeric Left Justified	C33
DRG	4	851	854	IP	n/a	FL71	Numeric Right Justified	C34
DRG Version	2	855	856	IP	n/a	n/a	Numeric	C59
Placeholder	38	857	894	n/a	n/a	n/a	Reserved	(see C1 for details)
ICD Version Indicator	1	895	895	IP	ED	FL66	Numeric	C35
Patient Reason for Visit 1	8	896	903	n/a	ED	FL70 Line a	Alphanumeric Left Justified	C36
Patient Reason for Visit 2	8	904	911	n/a	ED	FL70 Line b	Alphanumeric Left Justified	C36
Patient Reason for Visit 3	8	912	919	n/a	ED	FL70 Line c	Alphanumeric Left Justified	C36
Admitting Diagnosis	8	920	927	IP	n/a	FL69	Alphanumeric Left Justified	C37
Principal Diagnosis Code (1)	7	928	934	IP	ED	FL67	Alphanumeric Left Justified	C38
Principal Diagnosis Code (1) POA Indicator	1	935	935	IP	PENDING	FL67	Alphanumeric	C38
Other Diagnosis Code 2	7	936	942	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 2 POA Indicator	1	943	943	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 3	7	944	950	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 3 POA Indicator	1	951	951	IP	PENDING	FL67	Alphanumeric	C39

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Other Diagnosis Code 4	7	952	958	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 4 POA Indicator	1	959	959	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 5	7	960	966	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 5 POA Indicator	1	967	967	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 6	7	968	974	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 6 POA Indicator	1	975	975	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 7	7	976	982	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 7 POA Indicator	1	983	983	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 8	7	984	990	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 8 POA Indicator	1	991	991	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 9	7	992	998	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 9 POA Indicator	1	999	999	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 10	7	1000	1006	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 10 POA Indicator	1	1007	1007	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 11	7	1008	1014	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 11 POA Indicator	1	1015	1015	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 12	7	1016	1022	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 12 POA Indicator	1	1023	1023	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 13	7	1024	1030	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 13 POA Indicator	1	1031	1031	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 14	7	1032	1038	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 14 POA Indicator	1	1039	1039	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 15	7	1040	1046	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 15 POA Indicator	1	1047	1047	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 16	7	1048	1054	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 16 POA Indicator	1	1055	1055	IP	PENDING	FL67	Alphanumeric	C39

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Other Diagnosis Code 17	7	1056	1062	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 17 POA Indicator	1	1063	1063	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 18	7	1064	1070	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 18 POA Indicator	1	1071	1071	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 19	7	1072	1078	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 19 POA Indicator	1	1079	1079	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 20	7	1080	1086	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 20 POA Indicator	1	1087	1087	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 21	7	1088	1094	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 21 POA Indicator	1	1095	1095	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 22	7	1096	1102	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 22 POA Indicator	1	1103	1103	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 23	7	1104	1110	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 23 POA Indicator	1	1111	1111	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 24	7	1112	1118	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 24 POA Indicator	1	1119	1119	IP	PENDING	FL67	Alphanumeric	C39
Other Diagnosis Code 25	7	1120	1126	IP	ED	FL67	Alphanumeric Left Justified	C39
Other Diagnosis Code 25 POA Indicator	1	1127	1127	IP	PENDING	FL67	Alphanumeric	C39
E Code 1	7	1128	1134	IP	ED	FL72	Alphanumeric Left Justified	C40
E Code 1 POA Indicator	1	1135	1135	IP	PENDING	FL72	Alphanumeric	C40
E Code 2	7	1136	1142	IP	ED	FL72	Alphanumeric Left Justified	C40
E Code 2 POA Indicator	1	1143	1143	IP	PENDING	FL72	Alphanumeric	C40
E Code 3	7	1144	1150	IP	ED	FL72	Alphanumeric Left Justified	C40
E Code 3 POA Indicator	1	1151	1151	IP	PENDING	FL72	Alphanumeric	C40
E Code 4	7	1152	1158	IP	ED	FL72	Alphanumeric Left Justified	C40
E Code 4 POA Indicator	1	1159	1159	IP	PENDING	FL72	Alphanumeric	C40

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
E Code 5	7	1160	1166	IP	ED	FL72	Alphanumeric Left Justified	C40
E Code 5 POA Indicator	1	1167	1167	IP	PENDING	FL72	Alphanumeric	C40
E Code 6	7	1168	1174	IP	ED	FL72	Alphanumeric Left Justified	C40
E Code 6 POA Indicator	1	1175	1175	IP	PENDING	FL72	Alphanumeric	C40
Accident State	2	1176	1177	IP	ED	FL29	Alphanumeric All positions filled	C41
Placeholder	20	1178	1197	n/a	n/a	n/a	Reserved	(see C1 for details)
Principal Procedure Code (1)	7	1198	1204	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C42
Principal Procedure Date	8	1205	1212	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C43
Other Procedure Code 2	7	1213	1219	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 2	8	1220	1227	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 3	7	1228	1234	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 3	8	1235	1242	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 4	7	1243	1249	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 4	8	1250	1257	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 5	7	1258	1264	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 5	8	1265	1272	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 6	7	1273	1279	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 6	8	1280	1287	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 7	7	1288	1294	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 7	8	1295	1302	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 8	7	1303	1309	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Other Procedure Date 8	8	1310	1317	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 9	7	1318	1324	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 9	8	1325	1332	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 10	7	1333	1339	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 10	8	1340	1347	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 11	7	1348	1354	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 11	8	1355	1362	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Other Procedure Code 12	7	1363	1369	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
Other Procedure Date 12	8	1370	1377	IP	ED	FL74 IP FL45 ED	Numeric All positions filled	C45
Placeholder	20	1378	1397	n/a	n/a	n/a	Reserved	(see C1 for details)
Attending Provider Name	28	1398	1425	IP	ED	FL76 Line 2	Alphanumeric Left Justified	C46
Attending Provider National Provider Identifier (NPI)	11	1426	1436	IP	ED	FL76 Line 1	Alphanumeric Left Justified	C47
Attending Provider State License Number	8	1437	1444	IP	ED	n/a	Numeric Right Justified	C48
Attending Provider State Licensing Board	1	1445	1445	IP	ED	n/a	Numeric	C49
Operating Provider Name	28	1446	1473	IP	ED	FL77 Line 2	Alphanumeric Left Justified	C50
Operating Provider National Provider Identifier (NPI)	11	1474	1484	IP	ED	FL77 Line 1	Alphanumeric Left Justified	C51
Operating Provider State License Number	8	1485	1492	IP	ED	n/a	Numeric Right Justified	C52
Operating Provider State Licensing Board	1	1493	1493	IP	ED	n/a	Numeric	C53
Other Provider Name	28	1494	1521	IP	ED	FL78 Line 2	Alphanumeric Left Justified	C54
Other Provider National Provider Identifier (NPI)	13	1522	1534	IP	ED	FL78 Line 1	Alphanumeric Left Justified	C55
Other Provider State License Number	8	1535	1542	IP	ED	n/a	Numeric Right Justified	C56

Section D

Data Element	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Uniform Billing Locator Number/Line	Field Attributes	Specifications Manual Element Number
Other Provider State Licensing Board	1	1543	1543	IP	ED	n/a	Numeric	C57
Placeholder	57	1544	1600	n/a	n/a	n/a	Reserved	(see C1 for details)
ED Admission Flag	2	1601	1602	IP	n/a	FL18-28	Alphanumeric	C60
Visit Qualifier	1	1603	1603	IP	ED	n/a	Alphanumeric	C61
Type of Record	1	1604	1604	IP	ED	n/a	Numeric	C58

File must be ASCII text, containing fixed-length records of 1604 characters

"Alphanumeric" field attribute means letters or numbers are acceptable in this data element

"Numeric" field attribute means only numbers may be entered in this data element

All alpha characters must be UPPER CASE

Do NOT include any punctuation (except for hyphens, if applicable, in person's names)

Do NOT include any special characters

Do NOT enter negative values in revenue codes or total charges

Do NOT zero fill; "leading" zeros acceptable only as part of a valid code, for example DRG 007.

Check our website for updates at: www.azdhs.gov/plan/crr/index.htm

Introduction:

All data reported is evaluated for completeness and accuracy. For evaluation purposes, the data elements fall into one of two categories: 1) those elements that are expected to be present in all records (for example, the principal diagnosis); and 2) those elements that are present only on a specific type of patient record (for example, newborn birth weight).

A small margin of error is allowed on most audits. However, some audits are considered *fatal*, which means that a single error of this type will result in the rejection of the entire data set in which the error resides.

Data Evaluation:

The auditing process starts with an evaluation of the data set, by counting occurrences of certain items in the data set. These items may or may not be errors, depending upon the item and the specific hospital. Some items have a specific threshold over which they become suspect and subject to additional review. The items reviewed are:

C1. Total Inpatient Records Submitted
(count of the number of (rec_typ) = 1)

C2. Total Emergency Department Records Submitted
(count of the number of (rec_typ) = 3)

C3. Distinct Facilities Reported
(count of the number of unique (fac_id))

C4. Distinct Discharge Dates
(count of the unique discharge dates (dis_dt) present in the data set)

Subset of Distinct Discharge Dates by Month, C4A – C4L
(count of the unique discharge dates (dis_dt) present in the data set, grouped by month).

C19: Mixed Records Count
(count of the number of records where (rec_typ) = 3 and (vst_qual) = M)

C20: Split Records Count
(count of the number of records where (vst_qual) = S)
NOTE: IP & ED split records will be compared later in the audit process and must balance.

Data Evaluation (cont'd):

The following items have specific thresholds applied:

- C5. Type of Admission Not Available**
(count of the number of records where (adm_typ) = 9)
threshold 5% of the total number of records in the data set
- C6. Source of Admission Not Available**
(count of the number of records where (adm_src) = 9)
threshold 5% of the total number of records in the data set
- C7. Place of Injury Coded Other**
(count of the number of occurrences of E8498 in (E1 - E6)
threshold 15% of the total number of reported E codes in the range of E8490 – E8499 (urban facilities)
threshold 20% of the total number of reported E codes in the range of E8490 – E8499 (rural facilities)
- C8. Place of Injury Coded Unspecified**
(count of the number of occurrences of E8499 in (E1 - E6)
threshold 5% of the total number of reported E codes in the range of E8490 – E8499
- C9. Pharmacy Charges Zero**
(count of the number of records where (r025x) and (r063x) both = zero)
threshold 5% of the total number of records on inpatient files, excluding newborns
threshold 47% of the total number of records on emergency department files
- C10. Palliative Care**
(count of the number of records where V667 appears at least once in (PDX1 - DX25)
threshold 5% of the total number of records in the data set
- C11. Patient Marital Status Unknown**
(count of the number of records where (mar_st) = K)
threshold 10% of the total number of records in the data set
- C12. Patient Sex Unknown**
(count of the number of records where (sex) = U)
threshold 0.5% of the total number of records in the data set

Data Evaluation (cont'd):

- C13. Attending Provider License Board Other**
(count of the number of records where (att_brd) = 9)
threshold 0.5% of the total number of records in the data set
- C14. Operating Provider License Board Other**
(count of the number of records where (opr_brd) = 9)
threshold 5% of the number of records with an operating provider license board reported
- C15. Other Provider License Board Other**
(count of the number of records where oth_brd = 9)
threshold 10% of the number of records with an other provider license board reported
- C16. Date of Birth = 00000000**
(count of the number of records where (dob) = 00000000)
threshold 0.5% of the total number of records in the data set
- C17. More Mothers than Babies**
(count of the number of records where (adm_src) = 5 or 6 **OR** (adm_typ) = 4 **OR** (pr1) = 72.x – 75.x)
threshold 51% of the total number of records identified in above count
- C18. Inpatients Not Admitted from ED**
(count of the number of records where (rec_typ) = 1 **and** (ed_adm) = blank)
threshold 52% of the total number of records identified
- C21. Patient Race Refused**
(count of the number of records where (race) = 9)
threshold 4% of the total number of records in the data set
- C22. POA is Unknown**
(count of the total number of POA indicators reported in fields (poa1) through (poa25) that = “U.”)
threshold 1/2 of a percent of total reported POA indicators.
- C23. Payer is Other (14)**
(count of the number of records where (pay_type) = 14)
threshold 3% of the total number of records in the data set.

Data Evaluation (cont'd):

C24. PRV1 = PDX1

(count of the number of records where (prv1) = (pdx1)
threshold 99.9% of the total number of records in the data set

C25. Zero Mixed Visits Reported

(count of the number of emergency department records where (vst_qual) = M.
threshold = number counted must be greater than zero.

C26. Mixed Visits With No Observation Charges

(count of the number of records where (vst_qual) = M and (r076x) = blank)
threshold 10% of the total number of records identified in above count

Audit Dictionary**Section E****Data Universes:**

All error allowances for the audits are determined by percentage. The data elements are assigned to a data universe, based upon whether the data element being audited is expected to be present in every record, or only in records of a certain type. The error allowance for that universe is then calculated accordingly. For example, when auditing newborn records, the universe will consist of all newborn records in the data set, and the error allowance will be a percentage of that universe.

A1. Total Records Universe/Allowance

- a. **Universe** = the total number of records in the data set.
- b. **Allowance** = 1.5% of the universe
- c. **Application** = sum of errors present in each audit category not otherwise identified in a specific universe.

A2. E-Codes Universe/Allowance – H11

- a. **Universe** = the number of records containing at least one diagnosis code (pdx1 - dx25) in the range of 800 - 99999.
- b. **Allowance** = 3% of the universe.
- c. **Application** = audit H11

A3. E-Codes Universe/Allowance – Main

- a. **Universe** = the number of records containing at least one diagnosis code (pdx1 - dx25) in the range of 800 - 99999.
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on all category H audits, excluding H10 & H11.

A4. Injury by Fall Universe/Allowance – H10

- a. **Universe** = the number of occurrences of an E code (e1 - e6) in the range of E8800 - E8889
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = audit H10

Data Universes (cont'd):**A5. Newborn Universe/Allowance**

- a. **Universe** = the number of records in the data set with type of admission (adm_typ) of 4.
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on all category J audits.

A6. Operating Provider Universe/Allowance

- a. **Universe** = the number of records in the data set with an operating provider (opr_nam) reported.
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on audits K4, K5, K6, K9, K12, K15.

A7. Other Provider Universe/Allowance

- a. **Universe** = the number of records in the data set with an other provider (oth_nam) reported.
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on audits K7, K10, K13, K16.

A8. Procedure Universe/Allowance

- a. **Universe** = the number of procedure codes in the data set
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on all Procedure audits.

A9. POA Universe/Allowance

- a. **Universe** = the number of total records
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on all POA audits.

Data Universes (cont'd):

A10. Attending Physician Universe/Allowance

- a. **Universe** = the total number of records in the data set
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on audits K1, K2, K3, K8, K11, K14 K17, K20.

A11. Diagnosis Code Universe/Allowance

- a. **Universe** = the total number of records in the data set
- b. **Allowance** = 1.5% of the universe.
- c. **Application** = sum of errors present on all Diagnosis code audits.

Audit Dictionary**Section E****Audits:**

The audits are divided into categories, based upon the type of audit. Each audit has a letter/number identifier. The letter indicates the category, and the number identifies the specific audit within that category. The categories are:

D	Fatal
E	Patient Demographic
F	Diagnoses
G	Present on Admission Indicators
H	External Cause Codes
I	<i>not used</i>
J	Newborns
K	Providers (clinicians such as physicians and nurses)
L	Revenue
M	Miscellaneous
N	Procedures

The following pages contain descriptions of the audits. To further clarify audit function, some of the audits are color-coded.

Key: No Highlighting = validation within a variable
Yellow = continuity check between variables
Green = lookup function; utilizes outside lookup table for validation.
 Gray = multiple function
Blue = special note

D – N Audit Detail Pages**D - Fatal**

- D1. Record Type Invalid**
records where (rec_typ) does **not** = 1; 3
- D2. Discharge Status Invalid**
records where (dis_st) does **not** = 01; 02; 03; 04; 05; 06; 07; 20; 21; 41; 43;
50; 51; 61; 62; 63; 65; 66; 70
exclude from errors records where (rec_typ) = 3 and (dis_st) = 09
- D3. Birth Date Invalid**
records where (dob) is **not** = 00000000 and is blank, or is **not** a valid date.
- D4. Admission Date Invalid**
records where (adm_dt) is blank, or is **not** a valid date
- D5. Discharge Date Invalid**
records where (dis_dt) is blank, or is **not** a valid date
- D6. Patient Age = > 105 Years**
records where the difference between (dob) and (adm_dt) is = >105 years.
- D7. Duplicate Record**
records where on more than one record the (mrn; pcn; dob; adm_dt; adm_hr;
dis_dt; dis_hr; pdx1; pr1) are identical.
- D8. Invalid Record**
records where (dis_st) = 07 and (tot_chg) = blank or zero
- D9. Outpatient Proc Code in ED Record**
records where (rec_typ) = 3 and (pr1; pr2; pr3; pr4; pr5; pr6; pr7; pr8; pr9; pr10;
pr11; pr12) contains at least one occurrence of 99201-99205; 99211-99215
- D10. E Code in Diagnosis Code Field**
records where any of (adm_dx; prv1; prv2; prv3; pdx1; dx2; dx3; dx4; dx5; dx6;
dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19;
dx20; dx21; dx22; dx23; dx24; dx25) begin with E.
- D11. Principal Diagnosis is Blank**
records where (pdx1) = blank

Audit Dictionary

Section E

D12. Admission or Discharge Before Date of Birth

records where (adm_dt) or (dis_dt) are < (dob)

D13. Admission After Discharge

records where (adm_dt) is > (dis_dt)

D14. Length of Stay over One Year

Records where (dis_dt) is = > 365 days after (adm_dt)

D 15. Record Mismatch

records where (mrn) are identical; but at least one of (sex; race; dob) is different.

D16. Hospital NPI is Invalid

records where (fac_npi) is **not** = 10 character value

D17. Invalid Visit Qualifier Flag

Records where (rec_typ) = 3 and (vst_qual) does **not** = M; S; blank.

Records where (rec_typ) = 1 and (vst_qual) does **not** = S; blank.

D18. ED Admission Flag is Invalid

records where (rec_typ) = 3 and (ed_adm) does **not** = blank

records where (rec_typ) = 1 and (ed_adm) does **not** = P7 or blank

D19. Split Record Discharge Status Mismatch

records where (rec_typ) = 3 and (dis_st) = 09 and (vst_qual) does **not** = S

records where (rec_typ) = 3 and (vst_qual) = S and (dis_st) does **not** = 09

D20. Split Record Inpatient Orphan

records where (rec_typ) = 1 and (vst_qual) = S but no corresponding ED record is reported. Data elements used for matching are MRN, DOB, IP admission date and ED discharge date.

D21. Split Record Emergency Department Orphan

records where (rec_typ) = 3 and (vst_qual) = S but no corresponding IP record is reported. Data elements used for matching are MRN, DOB, IP admission date and ED discharge date.

Audit Dictionary**Section E****E - Demographic****E1. Race Code Invalid**

records where (race) does **not** = 1; 2; 3; 4; 5; 6; 9

NOTE: This variable may contain between one and four characters. The acceptable codes indicated above may occur in any order in the variable.

E2. Race Code Redundant

records where (race) has more than one occurrence of 1; 2; 3; 4; 5; 6; 9

E3. Marital Status Code Invalid

records where (mar_st) does **not** = I; M; S; D; W; K; C

E4. Sex Code Invalid

records where (sex) does **not** = M; F; U

E5. Arizona City/Zip Code Mismatch

records where (hmls) does **not** = 17 and (st) = AZ and (cty) or (zip) reported do **not** match lookup table of valid city/zip code combinations.

E6. Patient Name is Blank

records where (pt_nam) = blank

E7. City/Zip not Provided

records where (cc) = blank and (cty) or (zip) = blank, and (hmls) is **not** = 17.

E8. Race Code Mismatch

records where (race) contains 9 and at least one of 1; 2; 3; 4; 5; 6 is also present

E9. Marital Status Inappropriate

records where the difference between (dob) and (adm_dt) is = >18 years and (mar_st) = C.

E10. State not Provided

records where (cc) = blank and (st) = blank and (hmls) is **not** = 17.

Audit Dictionary

Section E

F - Diagnoses**F1. Admitting Diagnosis is Invalid**

records where (rec_typ) = 1 and (adm_dx) does **not** match external lookup table of valid ICD-9-CM diagnosis codes

F2. Patient Reason for Visit 1 is Blank

records where (rec_typ) = 3 and (prv1) = blank

F3. Admitting Diagnosis is Blank

records where (rec_typ) = 1 and (adm_dx) = blank

F4. Diagnosis Codes Sequence Break

records where there is a blank variable in between any populated variables of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25).

F5. Redundant Principal Diagnosis

records where (pdx1) is repeated in any of (dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25).

F6. Principal Diagnosis Invalid

records where (pdx1) does **not** match external lookup table of valid ICD-9-CM diagnosis codes (this was audit F6).

Diagnoses 2 through 25 are audited as follows:
(Audits F7 through F30)

F7. Diagnosis 2 Invalid

records where (*insert dx code here, for example (dx2)*) does **not** match external lookup table of valid ICD-9-CM diagnosis codes

F31 – F36 Not Used

F37. Patient Reason for Visit 1 is Invalid

records where (prv1) does **not** match external lookup table of valid ICD-9-CM diagnosis codes

F38. Patient Reason for Visit 2 is Invalid

records where (prv2) does **not** match external lookup table of valid ICD-9-CM diagnosis codes

Audit Dictionary

Section E

F39. Patient Reason for Visit 3 is Invalid

records where (prv3) does **not** match external lookup table of valid ICD-9-CM diagnosis codes

F40. Admitting Diagnosis on ED Record

records where (rec_typ) = 3 and (adm_dx) is **not** blank

F41. Patient Reason for Visit 1 on IP Record

records where (rec_typ) = 1 and (prv1) is **not** blank

F42. Patient Reason for Visit 2 on IP Record

records where (rec_typ) = 1 and (prv2) is **not** blank

F43. Patient Reason for Visit 3 on IP Record

records where (rec_typ) = 1 and (prv3) is **not** blank

F44. Patient Reason for Visit is Redundant

records where (rec_typ) = 3 and (prv1) = (prv2) OR (prv1) = (prv3) OR (prv2) = (prv3).

Audit Dictionary

Section E

G – Present on Admission

POA indicator codes 1 – 25 are audited for validity as follows:
(Audits G1 through G25)

G1. POA Code is Invalid

records where (rec_typ) = 1 and (*insert dx code here, for example (pdx1)*) is populated and (*insert POA code here, for example (poa1)*) is blank or does **not** = 1; Y; N; U; W.

POA indicator codes 1 – 25 are audited for appropriateness as follows:
(Audits G26 through G50)

G26. POA Code is Not Appropriate

records where (rec_typ) = 1 and (*insert POA code here, for example (poa1)*) = Y; N; U; W and (*insert dx code here, for example (pdx1)*) = any code present on the external lookup table of exempt ICD-9-CM codes; **OR** (rec_typ) = 1 and (*insert POA code here, for example (poa1)*) = 1 and (*insert dx code here, for example (pdx1)*) does **not** = any code present on the external lookup table of exempt ICD-9-CM codes.

POAE indicator codes 1 – 6 are audited for validity as follows:
(Audits G51 through G56)

G51. POAE Code is Invalid

records where (rec_typ) = 1 and (*insert E code here, for example (e1)*) is populated and (*insert POAE code here, for example (poae1)*) is blank or does **not** = 1; Y; N; U; W.

POAE indicator codes 1 – 6 are audited for appropriateness as follows:
(Audits G57 through G62)

G57. POAE Code is Not Appropriate

records where (rec_typ) = 1 and (*insert POAE code here, for example (poae1)*) = Y; N; U; W and (*insert E code here, for example (e1)*) = any code present on the

external lookup table of exempt ICD-9-CM codes; **OR** (*insert POAE code here, for example (poae1)*) = 1 and (*insert E code here, for example (e1)*) does **not** = any code present on the external lookup table of exempt ICD-9-CM codes.

G63. POA reported on ED record

records where (rec_typ) = 3 and any of (poa1 – poa25 or e1poa – e6poa) is **not** blank.

H – External Cause Codes**H1. E Code Contains Decimal**

records where any of (e1; e2; e3; e4; e5; e6) contains a decimal.

H2. E Codes Sequence Break

records where there is a blank variable in between any populated variables of (e1; e2; e3; e4; e5; e6).

H3. RESERVED

E Codes 1 through 6 are audited as follows:
(Audits H4 through H9)

H4. E Code 1 is Not Valid

records where (*insert E code here, for example (e1)*) does **not** match external lookup table of valid ICD-9-CM E Codes

H10. Place Code Missing on Fall Injury

records where one or more of (e1; e2; e3; e4; e5; e6) contains an E code in the range of E8800 - E8889 but there is no corresponding E code in the range of E8490 - E8499 present in (e1; e2; e3; e4; e5; e6). *Exclude* from errors records where (rec_typ) = 3 and (dis_st) = 07 (patients who left without treatment).

H11. ICD-9-CM with External Cause Missing E code

records where one or more of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = range of 800 – 99529; 9954 - 99559; 9958 – 99589; 996 – 99999, and there is no corresponding E code in (e1; e2; e3; e4; e5; e6) excluding range of E8490-E8499. *Exclude* from errors records where (rec_typ) = 3 and (dis_st) = 07 (patients who left without treatment).

NOTE: ‘T’ not used in Audit series.

Audit Dictionary

Section E

J - Newborns**J1. Newborn Source of Admission is Invalid**

records where (adm_typ) = 4 and (adm_src) does **not** = 5; 6

J2. Newborn Type of Admission Age Over Zero Days

records where (adm_typ) = 4 and (dob) is prior to (adm_dt)

J3. Newborn DRG Age Over Zero Years

records where (drg) = a valid newborn DRG for the time period being reported, and the difference between (dob) and (adm_dt) is = > 365 days

J4. Newborn Birth Weight Not 100 - 6350 Grams

records where (adm_typ) = 4 and (new_bwt) does **not** = 100 - 6350.

J5. Zero Age at Admit Not Newborn

records where (adm_src) does **not** = 4 and (dob) = (adm_dt) and (adm_typ) does **not** = 4.

J6. Diagnosis Conflicts with Birth Weight

records where any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76401; 76411; 76421; 76491; 76501; 76511) and (new_bwt) does **not** = < 500; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76402; 76412; 76422; 76492; 76502; 76512) and (new_bwt) does **not** = 500 - 749; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76403; 76413; 76423; 76493; 76503; 76513) and (new_bwt) does **not** = 750 - 999; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76404; 76414; 76424; 76494; 76504; 76514) and (new_bwt) does **not** = 1000 - 1249; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76405; 76415; 76425; 76495; 76505; 76515) and (new_bwt) = does **not** 1250 - 1499; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76406; 76416; 76426; 76496; 76506; 76516) and (new_bwt) does **not** = 1500 - 1749; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76407; 76417; 76427; 76497; 76507; 76517) and (new_bwt) does **not** = 1750 - 1999; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18;

Audit Dictionary

Section E

dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76408; 76418; 76428; 76498; 76508; 76518) and (new_bwt) does **not** = 2000 - 2499; OR any of (pdx1; dx2; dx3; dx4; dx5; dx6; dx7; dx8; dx9; dx10; dx11; dx12; dx13; dx14; dx15; dx16; dx17; dx18; dx19; dx20; dx21; dx22; dx23; dx24; dx25) = (76409; 76419; 76429; 76499; 76509; 76519) and (new_bwt) does **not** = > 2500.

J7. Principal Diagnosis Conflicts with Admission Source

records where (pdx1) = V3000; V3001; V3100; V3101; V3200; V3201; V3300; V3301; V3400; V3401; V3500; V3501; V3600; V3601; V3700; V3701; V3900; V3901 and (adm_src) does **not** = 5 OR (pdx1) = V301; V311; V321; V331; V341; V351; V361; V371; V391 and (adm_src) does **not** = 6.

J8. Birthweight on Non-Newborn

records where (adm_typ) = 1; 2; 3; 5; 9 and (new_bwt) is **not** blank.

Audit Dictionary

Section E

K – Providers**K1. Attending Provider Name Not Reported**

records where (att_nam) = blank

records where (rec_typ) = 3 and (dis_st) = 07 and (pr12) = blank are *excluded* from errors.

K2. Attending Provider License Number Not Reported

records where (att_lic) = blank

records where (rec_typ) = 3 and (dis_st) = 07 and (pr12) = blank are *excluded* from errors.

K3. Attending Provider License Board Not Reported

records where (att_brd) = blank

records where (rec_typ) = 3 and (dis_st) = 07 and (pr12) = blank are *excluded* from errors.

K4. Operating Provider Reported, No Principal Procedure

records where (opr_nam) or (opr_lic) is **not** blank and (pr1) = blank

K5. Principal Procedure Reported, No Operating Provider

records where (pr1) is **not** blank and (opr_nam) or (opr_lic) = blank. *Exclude* from errors those records where (pr1) = 00000 – 01999; 70000 – 99199; 36415; 36416; 36593; 36430; 36591; 36592; 31720; 51701; 51702; 43760; 62270; 36600. *Exclude from errors those records where (rec_typ) = 1 and (adm_typ) = 4 and (pr1) = 9955.*

K6. Operating Provider Information Incomplete

records where at least one of (opr_nam; opr_npi; opr_lic; opr_brd) is **not** blank and at least one of (opr_nam; opr_lic; opr_brd) = blank

K7. Other Provider Information Incomplete

records where at least one of (oth_nam; oth_npi; oth_lic; oth_brd) is **not** blank and at least one of (oth_nam; oth_lic; oth_brd) = blank

K8. Attending Provider License Number is not Numeric

records where (att_lic) contains at least one character that is **not** = 0; 1; 2; 3; 4; 5; 6; 7; 8; 9

K9. Operating Provider License Number is not Numeric

records where (opr_lic) is **not** blank and contains at least one character that is **not** = 0; 1; 2; 3; 4; 5; 6; 7; 8; 9,

Audit Dictionary

Section E

- K10. Other Provider License Number is not Numeric**
records where (oth_lic) is **not** blank and contains at least one character that is **not** = 0; 1; 2; 3; 4; 5; 6; 7; 8; 9,
- K11. Invalid Attending Provider License Number**
records where (att_lic) does **not** match external lookup table of valid provider license numbers of the type indicated by the (att_brd) reported in the record.
- K12. Invalid Operating Provider License Number**
records where (opr_lic) does **not** match external lookup table of valid provider license numbers of the type indicated by the (opr_brd) reported in the record.
- K13. Invalid Other Provider License Number**
records where (oth_lic) does **not** match external lookup table of valid provider license numbers of the type indicated by the (oth_brd) reported in the record.
- K14. Mismatched Attending Provider Name/License**
records where (att_lic) and the first three letters of the last name in (att_nam) do **not** match external lookup table of the provider type indicated by the (att_brd) reported in the record.
- K15. Mismatched Operating Provider Name/License**
records where (opr_lic) and the first three letters of the last name in (opr_nam) do **not** match external lookup table of the provider type indicated by the (opr_brd) reported in the record.
- K16. Mismatched Other Provider Name/License**
records where (oth_lic) and the first three letters of the last name in (oth_nam) do **not** match external lookup table of the provider type indicated by the (oth_brd) reported in the record.
- K17. Attending Provider is PA**
records where (att_brd) = 7
- K18. RESERVED**
- K19. RESERVED**
- K20. Attending Provider NPI Not Reported**
Records where (att_npi) = blank. *Exclude from errors those records where (att_brd) = 5.*

Audit Dictionary

Section E

L - Revenue**L1. Total Charges = Zero**

records where (dis_st) does **not** = 07 and (tot_chg) = blank or zero.

L2. Emergency Room Admission without ER Charges

records where (rec_typ) = 3 and (r045x) = blank or zero

records where (rec_typ) = 1 and (ed_adm) = P7 and (r045x) = blank or zero

records where (rec_typ) = 1 and (vst_qual) = S are *excluded* from errors

records where (rec_typ) = 3 and (dis_st) = 07 and (pr12) = blank are *excluded* from errors.

L3. Total Charges Discrepancy

records where the difference between (tot_chg) and the sum of (r010x; r011x; r012x; r013x; r014x; r015x; r016x; r018x; r019x; r020x; r021x; r022x; r023x; r024x; r025x; r026x; r027x; r028x; r029x; r030x; r031x; r032x; r033x; r034x;

r035x; r036x; r037x; r038x; r039x; r040x; r041x; r042x; r043x; r044x; r045x; r046x; r047x; r048x; r050x; r053x; r061x; r062x; r063x; r068x; r070x; r071x; r072x; r073x; r074x; r075x; r076x; r077x; r078x; r079x; r080x; r081x; r088x; r090x; r091x; r092x; r094x; r095x; r096x; r097x; r098x; r099x; r210x; r_oth; r0170; r0171; r0172; r0173; r0174; r0179) is = > \$50.

L4. Charge not Numeric

records where a non-numeric value has been entered at least once in one of (r010x; r011x; r012x; r013x; r014x; r015x; r016x; r018x; r019x; r020x; r021x; r022x; r023x; r024x; r025x; r026x; r027x; r028x; r029x; r030x; r031x; r032x; r033x; r034x; r035x; r036x; r037x; r038x; r039x; r040x; r041x; r042x; r043x; r044x; r045x; r046x; r047x; r048x; r050x; r053x; r061x; r062x; r063x; r068x; r070x; r071x; r072x; r073x; r074x; r075x; r076x; r077x; r078x; r079x; r080x; r081x; r088x; r090x; r091x; r092x; r094x; r095x; r096x; r097x; r098x; r099x; r210x; r_oth; r0170; r0171; r0172; r0173; r0174; r0179)

L5. Negative Charge

records where a negative value has been entered at least once in one of (r010x; r011x; r012x; r013x; r014x; r015x; r016x; r018x; r019x; r020x; r021x; r022x; r023x; r024x; r025x; r026x; r027x; r028x; r029x; r030x; r031x; r032x; r033x; r034x; r035x; r036x; r037x; r038x; r039x; r040x; r041x; r042x; r043x; r044x; r045x; r046x; r047x; r048x; r050x; r053x; r061x; r062x; r063x; r068x; r070x; r071x; r072x; r073x; r074x; r075x; r076x; r077x; r078x; r079x; r080x; r081x; r088x; r090x; r091x; r092x; r094x; r095x; r096x; r097x; r098x; r099x; r210x; r_oth; r0170; r0171; r0172; r0173; r0174; r0179)

Audit Dictionary

Section E

L6. OR Charges without Procedure

records where (r036x) is populated, and (pr1) = blank.

L7. Trauma Charges without Trauma Admit

records where (r068x) is populated, and (adm_typ) does **not** = 5

L8. ER Charges without Emergency Room Admission

records where (rec_typ) = 1 and (r045x) does **not** = blank and (ed_adm) = blank.

L9: Trauma Activation Charges/Not a Trauma Center

records where (r068x) is **not** blank and (fac_id) does **not** = MED0219;
MED0201; MED0222; MED0223; MED2170; MED2125; MED0235; MED0257;
MED0203; MED0247; MED0196; MED0246; MED0207; MED0245; MED0195
(internal list in audit of designated trauma centers)

L10. IP Room & Board Charges Not Reported

records where (rec_typ) = 1 and (r010x, r011x, r012x, r013x, r014x, r015x,
r016x, r018x, r019x, r020x, r021x, r0170, r0171, r0172, r0173, r0174, r0179) =
blank.

L11. ED Charges on IP Split Bill

records where (rec_typ) = 1 and (vst_qual) = S and (r045x) does **not** = blank.

Audit Dictionary

Section E

M - Miscellaneous**M1. Hour of Admission is Invalid**

records where (adm_hr) does **not** = 00; 01; 02; 03; 04; 05; 06; 07; 08; 09; 10; 11; 12; 13; 14; 15; 16; 17; 18; 19; 20; 21; 22; 23

M2. Hour of Discharge is Invalid

records where (dis_hr) does **not** = 00; 01; 02; 03; 04; 05; 06; 07; 08; 09; 10; 11; 12; 13; 14; 15; 16; 17; 18; 19; 20; 21; 22; 23

M3. DRG is Ungroupable

records where (rec_typ) = 1 and (drg_ver) = 24 and (drg) = 470 OR (rec_typ) = 1 and (drg_ver) = 25 or 26 or 27 or 28 or 29 and (drg) = 999

M4. Principal Diagnosis Invalid as Discharge Diagnosis

records where (rec_typ) = 1 and (drg_ver) = 24 and (drg) = 469 OR (rec_typ) = 1 and (drg_ver) = 25 or 26 or 27 or 28 or 29 and (drg) = 998.

M5. Payer Code is Invalid

records where (pay_typ) does **not** = 00; 01; 02; 03; 04; 05; 06; 07; 08; 09; 10; 11; 12; 13; 14

M6. Type of Admission is Invalid

records where (adm_typ) does **not** = 1; 2; 3; 4; 5; 9

M7. Source of Admission is Invalid

records where (adm_type) is **not** 4 and (adm_src) does **not** = 1; 2; 4; 5; 6; 8; 9; D; E; F

M8. Country Code Invalid

records where (cc) does **not** match external lookup table of valid ISO3166 country codes. (see: <http://www.azdhs.gov/plan/crr/ddr/hospa1/index.htm>)

M9. DRG Invalid

records where (rec_typ) = 1 and (drg_ver) does **not** match external lookup table of valid drg codes for that reported version.

M10. CMG Invalid – (rehab hospitals)

records where (rec_typ) = 1 and (cmg) does **not** match external lookup table of valid cmg codes (blanks are acceptable).

Audit Dictionary**Section E****M11. DRG Indicator is Invalid**

records where (rec_typ) = 1 and
 (drg_ver) = '25' and (dis_dt =< '20070930' or => '20081001') OR
 (drg_ver) = '26' and (dis_dt =< '20080930' or => '20091001') OR

 (drg_ver) = '27' and (dis_dt =< '20090930' or => '20101001') OR
 (drg_ver) = '28' and (dis_dt =< '20100930' or => '20111001') OR
 (drg_ver) = '29' and (dis_dt =< '20110930' or => '20121001').

M12. Trauma Admit/Not a Trauma Center

records where (adm_typ) = 5 and (fac_id) does **not** = MED0219; MED0201;
 MED0222; MED0223; MED2170; MED2125; MED0235; MED0257; MED0203;
 MED0247; MED0196; MED0246; MED0207; MED0245; MED0195 (internal
 list in audit of designated trauma centers)

M13. Surgical DRG without Procedure

records where (rec_typ) = 1 and (drg) is a surgical procedure type (in the external
 lookup table of valid drg codes based on (drg_ver) reported) and (pr1) = blank

M14. Law Enforcement Admit/Discharge Mismatch

records where (dis_st) = 21 and (adm_src) does **not** = 8.

Audit Dictionary

Section E

N - Procedures**N1. Procedure Code Contains Decimal**

records where any of (pr1; pr2; pr3; pr4; pr5; pr6; pr7; pr8; pr9; pr10; pr11; pr12) contains a decimal.

N2. Procedure Codes Sequence Break

records where (rec_typ) = 1 and there is a blank variable in between any populated variables of (pr1; pr2; pr3; pr4; pr5; pr6; pr7; pr8; pr9; pr10; pr11; pr12) OR (rec_typ) = 3 and there is a blank variable in between any populated variables of (pr1; pr2; pr3; pr4; pr5; pr6; pr7; pr8; pr9; pr10; pr11)

Procedures 1 – 12 and corresponding dates are audited as follows:
(Audits N3 through N14)

N3. Procedure 1 /Procedure Date 1 not Reported

records where (*insert procedure code here, for example (pr1)*) is reported and (*insert procedure date here, for example (pr1_dt)*) is blank; OR (*insert procedure date here, for example (pr1_dt)*) is reported and (*insert procedure code here, for example (pr1)*) is blank.

Procedures 1 – 12 are audited for validity as follows:
(Audits N15 through N26)

N15. Invalid Principal Procedure Code

records where (rec_typ) = 1 and (*insert procedure code here, for example (pr1)*) does **not** match external lookup table of valid ICD-9-CM procedure codes; OR (rec_typ) = 3 and (*insert procedure code here, for example (pr1)*) does **not** match external lookup table of valid ICD-9-CM or CPT procedure codes.

N27. Required Evaluation & Management Code Missing

records where (rec_typ) = 3 and (pr12) does **not** = 99281-99285; 99291, G0380-G0384. *Exclude* records as errors that have (dis_st) = 07.

ARIZONA DEPARTMENT OF HEALTH SERVICES
HOSPITAL DISCHARGE REPORTING

Audit Data Layout

Audit Element Name	Data Element Description	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Reporting Specifications Manual Element Number
FAC_ID	Reporting Hospital Arizona Facility Identifier	10	1	10	IP	ED	C02
FAC_NPI	Reporting Hospital National Provider Identifier	15	11	25	IP	ED	C03
MRN	Patient Medical/Health Record Number	24	26	49	IP	ED	C04
PCN	Patient Control Number	24	50	73	IP	ED	C05
PH1	Placeholder	20	74	93	n/a	n/a	C01
PT_NAM	Patient Name	29	94	122	IP	ED	C06
SSN	Patient Social Security Number	10	123	132	IP	ED	C07
ADD	Patient Address	40	133	172	IP	ED	C08
CTY	Patient City	30	173	202	IP	ED	C09
ST	Patient State	2	203	204	IP	ED	C10
ZIP	Patient Zip Code	9	205	213	IP	ED	C11
CC	Patient Country Code	2	214	215	IP	ED	C12
HMLS	Patient Homeless Indicator	2	216	217	IP	ED	C13
DOB	Patient Birth Date	8	218	225	IP	ED	C14
SEX	Patient Sex	1	226	226	IP	ED	C15
RACE	Patient Race/Ethnicity	4	227	230	IP	ED	C16
MAR_ST	Patient Marital Status	1	231	231	IP	ED	C17
PH2	Placeholder	20	232	251	n/a	n/a	(see C1 for details)
SYM_DT	Onset of Symptoms/Illness Date	8	252	259	IP	ED	C18
ADM_DT	Admission Date	8	260	267	IP	ED	C19
ADM_HR	Admission Hour	2	268	269	IP	ED	C20
ADM_TYP	Priority (Type) of Visit	1	270	270	IP	ED	C21
ADM_SRC	Source of Admission or Visit	1	271	271	IP	ED	C22
DIS_DT	Discharge Date	8	272	279	IP	ED	C23
DIS_HR	Discharge Hour	2	280	281	IP	ED	C24
DIS_ST	Discharge Status	2	282	283	IP	ED	C25
NEW_BWT	Newborn Birth Weight	4	284	287	IP	n/a	C26
DNR	Do Not Resuscitate Order (DNR)	2	288	289	IP	ED	C27
PH3	Placeholder	20	290	309	n/a	n/a	(see C1 for details)
BILL_DT	Bill Creation Date	8	310	317	IP	ED	C28
TOT_CHG	Total Charges	8	318	325	IP	ED	C29
PAY_TYP	Payer Type Code	2	326	327	IP	ED	C30
R010X	Revenue Code Category Charges 010x All Inclusive Rate	7	328	334	IP	ED	C31
R011X	Revenue Code Category Charges 011x Room & Board - Private (1 bed)	7	335	341	IP	ED	C31
R012X	Revenue Code Category Charges 012x Room & Board - Semi-Private (2 beds)	7	342	348	IP	ED	C31
R013X	Revenue Code Category Charges 013x Room & Board - (3 & 4 beds)	7	349	355	IP	ED	C31
R014X	Revenue Code Category Charges 014x Room & Board - Deluxe Private	7	356	362	IP	ED	C31

Audit Element Name	Data Element Description	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Reporting Specifications Manual Element Number
R015X	Revenue Code Category Charges 015x Room & Board - Ward	7	363	369	IP	ED	C31
R016X	Revenue Code Category Charges 016x Room & Board - Other	7	370	376	IP	ED	C31
R018X	Revenue Code Category Charges 018x Leave of Absence	7	377	383	IP	ED	C31
R019X	Revenue Code Category Charges 019x Subacute care	7	384	390	IP	ED	C31
R020X	Revenue Code Category Charges 020x Intensive Care Unit	7	391	397	IP	ED	C31
R021X	Revenue Code Category Charges 021x Coronary Care Unit	7	398	404	IP	ED	C31
R022X	Revenue Code Category Charges 022x Special Charges	7	405	411	IP	ED	C31
R023X	Revenue Code Category Charges 023x Incremental Nursing Charge	7	412	418	IP	ED	C31
R024X	Revenue Code Category Charges 024x All Inclusive Ancillary	7	419	425	IP	ED	C31
R025X	Revenue Code Category Charges 025x Pharmacy	7	426	432	IP	ED	C31
R026X	Revenue Code Category Charges 026x IV Therapy	7	433	439	IP	ED	C31
R027X	Revenue Code Category Charges 027x Med/Surg Supplies & Devices	7	440	446	IP	ED	C31
R028X	Revenue Code Category Charges 028x Oncology	7	447	453	IP	ED	C31
R029X	Revenue Code Category Charges 029x Durable Medical Equipment (not renal)	7	454	460	IP	ED	C31
R030X	Revenue Code Category Charges 030x Laboratory	7	461	467	IP	ED	C31
R031X	Revenue Code Category Charges 031x Laboratory Pathology	7	468	474	IP	ED	C31
R032X	Revenue Code Category Charges 032x Radiology - Diagnostic	7	475	481	IP	ED	C31
R033X	Revenue Code Category Charges 033x Radiology - Therapeutic/Chemo Admin	7	482	488	IP	ED	C31
R034X	Revenue Code Category Charges 034x Nuclear Medicine	7	489	495	IP	ED	C31
R035X	Revenue Code Category Charges 035x CT Scan	7	496	502	IP	ED	C31
R036X	Revenue Code Category Charges 036x Operating Room Services	7	503	509	IP	ED	C31
R037X	Revenue Code Category Charges 037x Anesthesia	7	510	516	IP	ED	C31
R038X	Revenue Code Category Charges 038x Blood & Blood Components	7	517	523	IP	ED	C31
R039X	Revenue Code Category Charges 039x Admin, Proc, Storage/Blood & Blood Comp.	7	524	530	IP	ED	C31
R040X	Revenue Code Category Charges 040x Other Imaging Services	7	531	537	IP	ED	C31
R041X	Revenue Code Category Charges 041x Respiratory Services	7	538	544	IP	ED	C31
R042X	Revenue Code Category Charges 042x Physical Therapy	7	545	551	IP	ED	C31
R043X	Revenue Code Category Charges 043x Occupational Therapy	7	552	558	IP	ED	C31

Audit Element Name	Data Element Description	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Reporting Specifications Manual Element Number
R044X	Revenue Code Category Charges 044x Speech Therapy - Language Pathology	7	559	565	IP	ED	C31
R045X	Revenue Code Category Charges 045x Emergency Room	7	566	572	IP	ED	C31
R046X	Revenue Code Category Charges 046x Pulmonary Function	7	573	579	IP	ED	C31
R047X	Revenue Code Category Charges 047x Audiology	7	580	586	IP	ED	C31
R048X	Revenue Code Category Charges 048x Cardiology	7	587	593	IP	ED	C31
R050X	Revenue Code Category Charges 050x Outpatient Services	7	594	600	IP	ED	C31
R053X	Revenue Code Category Charges 053x Osteopathic Services	7	601	607	IP	ED	C31
R061X	Revenue Code Category Charges 061x Magnetic Resonance Technology (MRT)	7	608	614	IP	ED	C31
R062X	Revenue Code Category Charges 062x Med/Surg Supplies - Extension of 027x	7	615	621	IP	ED	C31
R063X	Revenue Code Category Charges 063x Pharmacy - Extension of 025x	7	622	628	IP	ED	C31
R068X	Revenue Code Category Charges 068x Trauma Response	7	629	635	IP	ED	C31
R070X	Revenue Code Category Charges 070x Cast Room	7	636	642	IP	ED	C31
R071X	Revenue Code Category Charges 071x Recovery Room	7	643	649	IP	ED	C31
R072X	Revenue Code Category Charges 072x Labor Room/Delivery	7	650	656	IP	ED	C31
R073X	Revenue Code Category Charges 073x EKG/ECG (Electrocardiogram)	7	657	663	IP	ED	C31
R074X	Revenue Code Category Charges 074x EEG (Electroencephalogram)	7	664	670	IP	ED	C31
R075X	Revenue Code Category Charges 075x Gastro-Intestinal (GI) Services	7	671	677	IP	ED	C31
R076X	Revenue Code Category Charges 076x Specialty Room - Treatment/Observation	7	678	684	IP	ED	C31
R077X	Revenue Code Category Charges 077x Preventive Care Services	7	685	691	IP	ED	C31
R078X	Revenue Code Category Charges 078x Telemedicine	7	692	698	IP	ED	C31
R079X	Revenue Code Category Charges 079x Extra-Corporeal Shock Wave Therapy	7	699	705	IP	ED	C31
R080X	Revenue Code Category Charges 080x Inpatient Renal Dialysis	7	706	712	IP	ED	C31
R081X	Revenue Code Category Charges 081x Acquisition of Body Components	7	713	719	IP	ED	C31
R088X	Revenue Code Category Charges 088x Miscellaneous Dialysis	7	720	726	IP	ED	C31
R090X	Revenue Code Category Charges 090x Behavioral Health Treatment/Services	7	727	733	IP	ED	C31
R091X	Revenue Code Category Charges 091x Behavior Health - Extension of 090x	7	734	740	IP	ED	C31
R092X	Revenue Code Category Charges 092x Other Diagnostic Services	7	741	747	IP	ED	C31
R094X	Revenue Code Category Charges 094x Other Therapeutic Services	7	748	754	IP	ED	C31

Audit Element Name	Data Element Description	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Reporting Specifications Manual Element Number
R095X	Revenue Code Category Charges 095x Other Therapeutic Services - Ext of 094x	7	755	761	IP	ED	C31
R096X	Revenue Code Category Charges 096x Professional Fees	7	762	768	IP	ED	C31
R097X	Revenue Code Category Charges 097x Professional Fees - Extension of 096x	7	769	775	IP	ED	C31
R098X	Revenue Code Category Charges 098x Professional Fees - Extension of 096x/097x	7	776	782	IP	ED	C31
R099X	Revenue Code Category Charges 099x Patient Convenience Items	7	783	789	IP	ED	C31
R210X	Revenue Code Category Charges 210x Alternative Therapy Services	7	790	796	IP	ED	C31
R_OTH	Revenue Code Category Charges All Other (excluding revenue code category 017x)	7	797	803	IP	ED	C31
R0170	Nursery Revenue Code Charges 0170 General Classification	7	804	810	IP	ED	C32
R0171	Nursery Revenue Code Charges 0171 Newborn - Level I	7	811	817	IP	ED	C32
R0172	Nursery Revenue Code Charges 0172 Newborn - Level II	7	818	824	IP	ED	C32
R0173	Nursery Revenue Code Charges 0173 Newborn - Level III	7	825	831	IP	ED	C32
R0174	Nursery Revenue Code Charges 0174 Newborn - Level IV	7	832	838	IP	ED	C32
R0179	Nursery Revenue Code Charges 0179 Other	7	839	845	IP	ED	C32
CMG	HIPPS - IRF PPS CMG Code	5	846	850	IP	n/a	C33
DRG	DRG	4	851	854	IP	n/a	C34
DRG_VER	DRG Version Indicator	2	855	856	IP	n/a	C59
PH4	Placeholder	38	857	894	n/a	n/a	(see C1 for details)
ICD	ICD Version Indicator	1	895	895	IP	ED	C35
PRV1	Patient Reason for Visit 1	8	896	903	IP	ED	C36
PRV2	Patient Reason for Visit 2	8	904	911	IP	ED	C36
PRV3	Patient Reason for Visit 3	8	912	919	IP	ED	C36
ADM_DX	Admitting Diagnosis	8	920	927	IP	n/a	C37
PDX1	Principal Diagnosis Code (1)	7	928	934	IP	ED	C38
POA1	Principal Diagnosis Code (1) POA Indicator	1	935	935	IP	ED	C38
DX2	Other Diagnosis Code 2	7	936	942	IP	ED	C39
POA2	Other Diagnosis Code 2 POA Indicator	1	943	943	IP	ED	C39
DX3	Other Diagnosis Code 3	7	944	950	IP	ED	C39
POA3	Other Diagnosis Code 3 POA Indicator	1	951	951	IP	ED	C39
DX4	Other Diagnosis Code 4	7	952	958	IP	ED	C39
POA4	Other Diagnosis Code 4 POA Indicator	1	959	959	IP	ED	C39
DX5	Other Diagnosis Code 5	7	960	966	IP	ED	C39
POA5	Other Diagnosis Code 5 POA Indicator	1	967	967	IP	ED	C39
DX6	Other Diagnosis Code 6	7	968	974	IP	ED	C39
POA6	Other Diagnosis Code 6 POA Indicator	1	975	975	IP	ED	C39
DX7	Other Diagnosis Code 7	7	976	982	IP	ED	C39
POA7	Other Diagnosis Code 7 POA Indicator	1	983	983	IP	ED	C39
DX8	Other Diagnosis Code 8	7	984	990	IP	ED	C39
POA8	Other Diagnosis Code 8 POA Indicator	1	991	991	IP	ED	C39
DX9	Other Diagnosis Code 9	7	992	998	IP	ED	C39
POA9	Other Diagnosis Code 9 POA Indicator	1	999	999	IP	ED	C39
DX10	Other Diagnosis Code 10	7	1000	1006	IP	ED	C39

Audit Element Name	Data Element Description	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Reporting Specifications Manual Element Number
POA10	Other Diagnosis Code 10 POA Indicator	1	1007	1007	IP	ED	C39
DX11	Other Diagnosis Code 11	7	1008	1014	IP	ED	C39
POA11	Other Diagnosis Code 11 POA Indicator	1	1015	1015	IP	ED	C39
DX12	Other Diagnosis Code 12	7	1016	1022	IP	ED	C39
POA12	Other Diagnosis Code 12 POA Indicator	1	1023	1023	IP	ED	C39
DX13	Other Diagnosis Code 13	7	1024	1030	IP	ED	C39
POA13	Other Diagnosis Code 13 POA Indicator	1	1031	1031	IP	ED	C39
DX14	Other Diagnosis Code 14	7	1032	1038	IP	ED	C39
POA14	Other Diagnosis Code 14 POA Indicator	1	1039	1039	IP	ED	C39
DX15	Other Diagnosis Code 15	7	1040	1046	IP	ED	C39
POA15	Other Diagnosis Code 15 POA Indicator	1	1047	1047	IP	ED	C39
DX16	Other Diagnosis Code 16	7	1048	1054	IP	ED	C39
POA16	Other Diagnosis Code 16 POA Indicator	1	1055	1055	IP	ED	C39
DX17	Other Diagnosis Code 17	7	1056	1062	IP	ED	C39
POA17	Other Diagnosis Code 17 POA Indicator	1	1063	1063	IP	ED	C39
DX18	Other Diagnosis Code 18	7	1064	1070	IP	ED	C39
POA18	Other Diagnosis Code 18 POA Indicator	1	1071	1071	IP	ED	C39
DX19	Other Diagnosis Code 19	7	1072	1078	IP	ED	C39
POA19	Other Diagnosis Code 19 POA Indicator	1	1079	1079	IP	ED	C39
DX20	Other Diagnosis Code 20	7	1080	1086	IP	ED	C39
POA20	Other Diagnosis Code 20 POA Indicator	1	1087	1087	IP	ED	C39
DX21	Other Diagnosis Code 21	7	1088	1094	IP	ED	C39
POA21	Other Diagnosis Code 21 POA Indicator	1	1095	1095	IP	ED	C39
DX22	Other Diagnosis Code 22	7	1096	1102	IP	ED	C39
POA22	Other Diagnosis Code 22 POA Indicator	1	1103	1103	IP	ED	C39
DX23	Other Diagnosis Code 23	7	1104	1110	IP	ED	C39
POA23	Other Diagnosis Code 23 POA Indicator	1	1111	1111	IP	ED	C39
DX24	Other Diagnosis Code 24	7	1112	1118	IP	ED	C39
POA24	Other Diagnosis Code 24 POA Indicator	1	1119	1119	IP	ED	C39
DX25	Other Diagnosis Code 25	7	1120	1126	IP	ED	C39
POA25	Other Diagnosis Code 25 POA Indicator	1	1127	1127	IP	ED	C39
E1	E Code 1	7	1128	1134	IP	ED	C40
POAE1	E Code 1 POA Indicator	1	1135	1135	IP	ED	C40
E2	E Code 2	7	1136	1142	IP	ED	C40
POAE2	E Code 2 POA Indicator	1	1143	1143	IP	ED	C40
E3	E Code 3	7	1144	1150	IP	ED	C40
POAE3	E Code 3 POA Indicator	1	1151	1151	IP	ED	C40
E4	E Code 4	7	1152	1158	IP	ED	C40
POAE4	E Code 4 POA Indicator	1	1159	1159	IP	ED	C40
E5	E Code 5	7	1160	1166	IP	ED	C40
POAE5	E Code 5 POA Indicator	1	1167	1167	IP	ED	C40
E6	E Code 6	7	1168	1174	IP	ED	C40
POAE6	E Code 6 POA Indicator	1	1175	1175	IP	ED	C40
ACC_ST	Accident State	2	1176	1177	IP	ED	C41
PH5	Placeholder	20	1178	1197	n/a	n/a	(see C1 for details)
PR1	Principal Procedure Code (1)	7	1198	1204	IP	ED	C42
PR1_DT	Principal Procedure Date	8	1205	1212	IP	ED	C43
PR2	Other Procedure Code 2	7	1213	1219	IP	ED	C44
PR2_DT	Other Procedure Date 2	8	1220	1227	IP	ED	C45
PR3	Other Procedure Code 3	7	1228	1234	IP	ED	C44
PR3_DT	Other Procedure Date 3	8	1235	1242	IP	ED	C45
PR4	Other Procedure Code 4	7	1243	1249	IP	ED	C44

Audit Element Name	Data Element Description	Number of Characters	Start Position	End Position	Required For File Type IP	Required For File Type ED	Reporting Specifications Manual Element Number
PR4_DT	Other Procedure Date 4	8	1250	1257	IP	ED	C45
PR5	Other Procedure Code 5	7	1258	1264	IP	ED	C44
PR5_DT	Other Procedure Date 5	8	1265	1272	IP	ED	C45
PR6	Other Procedure Code 6	7	1273	1279	IP	ED	C44
PR6_DT	Other Procedure Date 6	8	1280	1287	IP	ED	C45
PR7	Other Procedure Code 7	7	1288	1294	IP	ED	C44
PR7_DT	Other Procedure Date 7	8	1295	1302	IP	ED	C45
PR8	Other Procedure Code 8	7	1303	1309	IP	ED	C44
PR8_DT	Other Procedure Date 8	8	1310	1317	IP	ED	C45
PR9	Other Procedure Code 9	7	1318	1324	IP	ED	C44
PR9_DT	Other Procedure Date 9	8	1325	1332	IP	ED	C45
PR10	Other Procedure Code 10	7	1333	1339	IP	ED	C44
PR10_DT	Other Procedure Date 10	8	1340	1347	IP	ED	C45
PR11	Other Procedure Code 11	7	1348	1354	IP	ED	C44
PR11_DT	Other Procedure Date 11	8	1355	1362	IP	ED	C45
PR12	Other Procedure Code 12	7	1363	1369	IP	ED	C44
PR12_DT	Other Procedure Date 12	8	1370	1377	IP	ED	C45
PH6	Placeholder	20	1378	1397	n/a	n/a	(see C1 for details)
ATT_NAM	Attending Provider Name	28	1398	1425	IP	ED	C46
ATT_NPI	Attending Provider National Provider Identifier	11	1426	1436	IP	ED	C47
ATT_LIC	Attending Provider State License Number	8	1437	1444	IP	ED	C48
ATT_BRD	Attending Provider State Licensing Board	1	1445	1445	IP	ED	C49
OPR_NAM	Operating Provider Name	28	1446	1473	IP	ED	C50
OPR_NPI	Operating Provider National Provider Identifier	11	1474	1484	IP	ED	C51
OPR_LIC	Operating Provider State License Number	8	1485	1492	IP	ED	C52
OPR_BRD	Operating Provider State Licensing Board	1	1493	1493	IP	ED	C53
OTH_NAM	Other Provider Name	28	1494	1521	IP	ED	C54
OTH_NPI	Other Provider National Provider Identifier	13	1522	1534	IP	ED	C55
OTH_LIC	Other Provider State License Number	8	1535	1542	IP	ED	C56
OTH_BRD	Other Provider State Licensing Board	1	1543	1543	IP	ED	C57
PH7	Placeholder	57	1544	1600	n/a	n/a	(see C1 for details)
ED_ADM	ED Admission Flag	2	1601	1602	IP	n/a	C60
VST_QUAL	Visit Qualifier	1	1603	1603	IP	ED	C61
REC_TYP	Type of Record	1	1604	1604	IP	ED	C58

Audit Correction Assistance**Section G****Introduction:**

The purpose of this Section is to provide guidance and assistance in correcting errors. This section is arranged by Audit Category, and then in numerical order by Audit Number inside each category.

Some of the information is redundant, i.e., the methodology for correcting an invalid diagnosis code in the 14th position in a record is the same as for correcting one in the 3rd position. However, information for each individual Audit is provided, to facilitate the user in going directly to the specific Audit with which they are working.

When working on corrections, if you believe that no correction is necessary because the record already accurately reflects what transpired during that patient's episode of care, then notify ADHS. Likewise, if you find that a particular error cannot be corrected due to some insurmountable problem, contact ADHS for assistance.

Audit Information:**C – Data Evaluation/Thresholds**

Some of the functions in Category C are simple counts. Others look at specific subsets of data for reporting patterns that appear inaccurate or implausible, and are called "Thresholds." The Category C Thresholds are included below:

C5. Type of Admission Not Available

Error: An excessive number of records have been reported with an Admission Type of "not available."

Correction: Review the records to identify the correct admission type, and correct the record as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

C6. Source of Admission Not Available

Error: An excessive number of records have been reported with an Admission Source of “not available.”

Correction: Review the records to identify the correct admission source, and correct the records as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

C7. Place of Injury Coded Other

Error: An excessive number of records have been coded with the Place of Injury E code E849.8

Correction: Review the records to identify the correct place of injury, and assign the appropriate place E code.

If the place of occurrence is not sufficiently documented in the record to allow accurate assignment of the place code, then do not assign any code. Communicate this circumstance to ADHS.

NOTE: if you have a significant number of records where the E Code for place cannot be assigned due to missing or inadequate documentation in the record, this issue must be addressed.

C8. Place of Injury Coded Unspecified

Error: An excessive number of records have been coded with the Place of Injury E code E849.9. According to National Coding Guidelines, this code is **not** to be used if the place of injury is not provided in the record.

Correction: Review the records to identify the correct place of injury, and assign the appropriate place E code.

If the place of occurrence is not sufficiently documented in the record to allow accurate assignment of the place code, **then do not** assign any code. Communicate this circumstance to ADHS.

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NOTE: if you have a significant number of records where the E Code for place cannot be assigned due to missing or inadequate documentation in the record, this issue must be addressed.

C9. Pharmacy Charges Zero

Error: An excessive number of records have been reported with no pharmacy charges.

Correction: Review the record to determine if the patient incurred pharmacy charges. If so, report those charges as appropriate. Also, the Total Charges field must be updated accordingly so the individual Revenue Code Category charges reported balance with the Total Charges reported.

If you have a large quantity of missing pharmacy charges that are present in your system but missing from the state report, it may be due to a problem in the programming used to extract the state report. In this case, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If you have a significant number of records with no pharmacy charges and you determine this is correct, you must communicate this information to ADHS.

C10. Palliative Care

Error: An excessive number of records have been reported with palliative care code V667.

Correction: Review the record to determine if the patient really received services as an inpatient or emergency department patient. If **not**, this is likely a programming error in the state report extract. For example, if your hospital has a *separately licensed* hospice unit (not licensed on the main hospital license), then services provided to those patients are not reportable.

However, if the patient **was** truly an inpatient or emergency department patient, then determine if the palliative care code is appropriate. If you have a significant number of hospice and/or patients who are receiving palliative care as inpatients or emergency department patients, then there is nothing for you to correct but you must notify ADHS.

C11. Patient Marital Status Unknown

Error: An excessive number of records have been reported with a Marital Status of “unknown.”

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Correction: Review the records to identify the correct Marital Status, and correct the record as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

C12. Patient Sex Unknown

Error: An excessive number of records have been reported with a Patient Sex of “unknown.”

Correction: Review the records to identify the correct Patient Sex, and correct the record as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

C13. Attending Provider License Board Other

Error: An excessive number of records have been reported with an Attending Provider License Board of “other.”

Correction: Review the records to identify the correct Attending Provider License Board, and correct the record as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If your hospital utilizes a significant number of clinicians who are *not* licensed by any of the Arizona licensing boards, and therefore the Board Code of “other” is correct, you must notify ADHS.

C14. Operating Provider License Board Other

Error: An excessive number of records have been reported with an Operating Provider License Board of “other.”

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Correction: Review the records to identify the correct Operating Provider License Board, and correct the record as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If your hospital utilizes a significant number of clinicians who are *not* licensed by any of the Arizona licensing boards, and therefore the Board Code of “other” is correct, you must notify ADHS.

C15. Other Provider License Board Other

Error: An excessive number of records have been reported with an Other Provider License Board of “other.”

Correction: Review the records to identify the correct Other Provider License Board, and correct the record as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If your hospital utilizes a significant number of clinicians who are *not* licensed by any of the Arizona licensing boards, and therefore the Board Code of “other” is correct, you must notify ADHS.

C16. Date of Birth = 00000000

Error: An excessive number of records have been reported with a Date of Birth of “00000000.”

Correction: Review the records to identify the correct patient Date of Birth and correct the record as appropriate. If you cannot correct the record because the patient’s Date of Birth is unknown, you must notify ADHS.

C17. More Mothers than Babies

Error: The file has more female patients delivering babies than there are newborns reported in the file.

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Correction: Review the affected records. When beginning review, it is beneficial to sort the error list by the patient name column. This should group the mothers/babies with each other.

Look to see if any mothers are missing an accompanying baby record. Any baby record missing from the error list must be researched. In the baby record, an incorrect Admission Source and/or Admission Type will cause the record to not be accurately counted on this Threshold. Verify and correct these two data elements as appropriate in the baby's record.

If the missing baby record is because the baby was stillborn, then notify ADHS of this circumstance.

C18. Inpatients Not Admitted from ED

Error: The number of inpatient admissions from/through the emergency department is exceptionally low. ADHS takes each individual hospital's usual ED to IP volume into account on this Threshold. Receiving this error means that not only does the file not pass the state Threshold, but it also does not reflect what is usual for your hospital.

Correction: If your hospital has recently made process changes that would significantly lower the number of ED to IP admissions, and the reported volume is correct, then you must contact ADHS to discuss what has changed and document those changes. Otherwise, this is almost always a programming error. Consult with your internal IT and/or software vendor as appropriate to address this issue.

C21. Patient Race Refused

Error: An excessive number of records have been reported with a Patient Race of "refused."

Correction: Review the records to identify the correct Patient Race, and correct the record as appropriate. If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If your registration staff is having difficulty collecting this information, there is an excellent and FREE toolkit that assists with collecting race/ethnicity/primary

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language available on the internet. Please see the Appendices of the state reporting manual for details.

C22. POA is Unknown

Error: An excessive number of records have been reported with a POA indicator of “U”.

Correction: Review the records to determine the correct POA Indicator code and correct as appropriate.

If you have a large quantity of these errors, it may be due to a mapping problem in the programming used to extract the state report. Compare the records in your host system to the copy of the records provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If reporting “U” is due to actual coding, although the value of “U” is a valid value, legitimate use of this code should be very infrequent. When a patient is admitted and subsequently diagnosed with a specific disease or condition the POA Indicator code could be:

Y – the patient definitely had this condition at the time they were admitted (for example, the patient is discovered to be diabetic);

N – the patient did not have this condition when they were admitted, but contracted it during their hospital stay (for example, fell out of bed and sprained their elbow);

W – the patient’s physician has documented that it cannot be clinically determined whether the condition was present on admission or not (this doesn’t happen very often).

To assign a POA of “U” = **unknown** is saying that the hospital has identified the patient has a particular condition, but has no idea when, in relation to the patient’s time of admission, the patient actually contracted that condition. If you truly have patients on which the POA status is “unknown”, this is indicative of incomplete documentation in the patient’s record.

C23. Payer is Other (14)

Error: An excessive number of records have been reported with Payer of “14 - other,” indicating the primary payer type does not fit into one of the specifically

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described payer categories used for reporting payer type. This is very unusual, as most payers fit into one of the provided reporting categories.

Correction: Review the record to identify the payer. Identify to which of the state payer type categories that payer belongs. Once you have determined this information, correcting these errors involves either correcting the payer category assigned to the specific payer in the host system, correction of mapping methodology in the programming used to extract the state report, or sometimes both.

Compare the information in your host system to the copy of the record provided on the state error list. If you see correct information in your system but incorrect information in the state report, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

C24. PRV1 = PDX1

Error: On an ED file, 100% of records have a reported Patient Reason for Visit 1 and Principal Diagnosis that are identical. *This indicates that 100% of patients presenting in the ED for treatment already knew exactly what their principal diagnosis would be.*

Correction: Review the records in your host system. If the records in your host system reflect 100% of records with the same Patient Reason for Visit 1 and Principal Diagnosis, then this is a coding issue and the medical record must be reviewed and the coding corrected as appropriate.

If the review of records in your host system reveals that there are at least *some* records where the Patient Reason for Visit 1 and Principal Diagnosis are *not* identical, then these errors are due to a problem in the programming used to extract the state report. In this case, you should consult with your internal IT and/or software vendor as appropriate to address that issue.

C25. Zero Mixed Visits Reported

Error: On an ED file, there are zero Mixed Visits reported. Any patient treated in the ED and then moved to some other outpatient status (such as observation or outpatient surgery) must be reported, and the record must be flagged with a value of "M" in the Visit Qualifier field. Having this field blank on all ED records indicates either 1) ED to OBS and ED to OPT visits are not being reported; or 2) these visits are being reported as required, but not appropriately flagged.

Correction: Does your emergency department move patients to observation and later discharge or transfer without ever admitting as inpatient? If so, then this error is

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due to a problem in the programming used to extract the state report and you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If your emergency department does *not* refer patients to observation, then this information must be documented in writing to ADHS on hospital letterhead.

C26. Mixed Visits With No Observation Charges

Error: On an ED file, there are an excessive number of records identified as Mixed Visits that do not have any r076x observation charges reported.

Correction: Review the records in both your host system and the copy of the records provided on the state error list. Do the two records match? Are the records on the state error list really ED patient visits that were moved to observation? Were there any observation charges incurred?

If you identify errors in your host system, correct as appropriate. If you see correct information in your system but incorrect information in the state report, it is most likely due to an error in the programming used to extract the state report and , you should consult with your internal IT and/or software vendor as appropriate to address that issue.

If the records reflect true observation stays on which no r076x charges were incurred, this information must be communicated to ADHS.

D - Fatal

D1. Record Type Invalid

Error: The Record Type has not been correctly populated with either a “1” (for inpatient) or “3” (for emergency department).

Correction: This data element is usually populated programmatically when the state report is run. If there are many errors, it may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

If there are only a few errors, it is possible that the data in the record(s) with the error is out of alignment, which may push the record type indicator out of its proper position in the layout.

Data out of alignment is usually due to extra or missing characters or spaces in the record. One possible cause of this is if you made manual corrections to your file.

To confirm the data in your file is correctly aligned, open the file in a text editor (such as Text Pad, Notepad or Word Pad). Scroll to the far right so you can see the end of the records, then scroll down through the file, watching to see if the ends of the records are uniform. Any record that is not in alignment with the others will cause a D1 error. These records should be viewed to determine the reason for the misalignment so it can be corrected.

D2. Discharge Status Invalid

Error: The Discharge Status is not one of the valid codes for this reporting period, as indicated in the reporting specifications manual, page C-25.1

Correction: Look for blanks, and for codes that are not present on the specification code list. Consider if a code has been retired or implemented by CMS in the middle of a reporting period (usually October 1). Remember that code 64 is not valid in Arizona. Code 09 is valid only for ED records where the patient was admitted as an inpatient and the IP and ED portions of the visit were billed separately.

D3. Birth Date Invalid

Error: The Birth Date is not a valid date reported as YYYYMMDD. For unknown birth dates, 00000000 is to be reported and will not cause an error on this audit. Blanks are not acceptable.

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Correction: Look for blanks, invalid formatting (not YYYYMMDD), dates that are in the future and typographical errors.

D4. Admission Date Invalid

Error: The Admission Date is not a valid date reported as YYYYMMDD. Blanks are not acceptable.

Correction: Look for blanks, invalid formatting (not YYYYMMDD), dates that are in the future and typographical errors.

D5. Discharge Date Invalid

Error: The Discharge Date is not a valid date reported as YYYYMMDD. Blanks are not acceptable.

Correction: Look for blanks, invalid formatting (not YYYYMMDD), dates that are in the future and typographical errors.

D6. Patient Age = > 105 Years

Error: The difference between the date of admission and the patient birth date is equal to or greater than 105 years.

Correction: If the patient really is 105 years of age or older, no correction is required, but you must notify ADHS when resubmitting your file.

Otherwise, look for typographical errors, and bogus dates used internally to identify unknown birth dates (such as 18500101). Replace bogus birthdates with 00000000; this communicates to ADHS that the birthdate is unknown.

If your hospital staff routinely uses a standard bogus date for unknown birthdates, then the program that generates the state report should be coded to recognize that bogus date and convert it to zeros in the state report to eliminate the need for manual correction.

D7. Duplicate Record

Error: Two or more records have identical fields (medical records number, date of birth, admission date, admission hour, discharge date, discharge hour, principal diagnosis and principal procedure) and therefore appear to be duplicates.

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Correction: Review the records to determine if they are duplicates. Only one record is to be reported for each patient visit, even if multiple bills have been generated. Records may be combined or the redundant records excluded, depending upon the specific circumstance as determined by the reporting hospital.

D8. Invalid Record

Error: The record has a discharge status of left without being seen/discontinued care, and there are no charges present in the record.

Correction: Determine if it is correct that the person either left without being seen or discontinued care, and incurred no charges. If this is **not** correct, revise the discharge status and/or revenue code(s) and total charge fields accordingly.

If the person really received no care and incurred no charges, then the record of that visit is not considered a patient discharge for state reporting purposes. Exclude the record from the report.

D9. Outpatient Proc Code in ED Record

Error: At least one evaluation and management code specific to outpatient (99201-99205; 99211-99215) has been reported in the ED file.

Correction: Review the record to determine if the patient is an outpatient or an ED patient. If the patient was really treated in the ED, but has outpatient codes because they were first seen in your urgent care center, then this is acceptable.

If the patient is really an outpatient (for example, in your hospital's urgent care center) and was not treated in your ED, then the record is not reportable and must be excluded from the report.

D10. E Code in Diagnosis Code Field

Error: At least one diagnosis code field has a code that begins with "E"

Correction: This error is usually due to incorrect programming for extracting the state report. Most hospitals store E codes in the diagnosis code fields in their HIMS. When the state report is run, the programming identifies and excludes the E codes from being reported with the diagnosis codes. If you have this error, check with

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whoever is responsible for programming your state report extraction to ensure it is set up correctly. Call ADHS for assistance if necessary.

If your HIMS stores E codes separately from the diagnosis codes, then check the records with errors to identify the fields that contain E codes and correct within your HIMS as appropriate.

D11. Principal Diagnosis is Blank

Error: The Principal Diagnosis field is empty.

Correction: Principal Diagnosis *must* be reported on all records. Verify the record has been coded into your HIMS. If not, have the record coded. If you have extenuating circumstances that you believe prevent you from having the record coded, notify ADHS.

D12. Admission or Discharge Before Date of Birth

Error: The Admission or Discharge date reported is prior to the patient's reported Date of Birth.

Correction: Check the Admission Date, Discharge Date and Patient Date of Birth for accuracy. Correct as appropriate. Note that newborns cannot be admitted before the date they are born. The mother's record may reflect a date prior to the baby's birth date, but the baby's record cannot.

D13. Admission After Discharge

Error: The Admission date reported is after the Discharge Date reported

Correction: Check both the Admission Date and Discharge Date and correct as appropriate.

D14. Length of Stay over One Year

Error: Records where the Discharge Date is at least 365 days after the Admission Date.

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Correction: Verify the Admission and Discharge dates. Correct if necessary. If the patient was really in your hospital for the time period originally indicated, no change is required. Simply notify ADHS that the record is correct as reported.

D15. Record Mismatch

Error: Two or more records where the medical record number is identical, but the sex, race and/or date of birth is different.

Correction: First, verify that the MRN is correct so you know that the records in question do pertain to the same patient. If not, correct the MRN as appropriate.

If the MRN is accurate, then review the records to determine the correct sex, race and/or date of birth for the patient. Make corrections as appropriate. If you cannot correct the sex between two or more records because the patient is transgender, then no change is required; simply notify ADHS of this circumstance.

D16. Hospital NPI is Invalid

Error: The NPI field is either blank, or contains a value that is not exactly 10 characters in length.

Correction: Verify and report the correct NPI for your hospital.

D17. Invalid Visit Qualifier Flag

Error: The record is an ED record and contains a value other than M, S, or blank.

OR

The record is an IP record and contains a value other than S or blank.

Correction: If the ED record is for a patient that was treated in the ED and then moved to observation or other outpatient status, populate the field with M. If the patient was treated in the ED, then admitted as an inpatient, *and the bills were split*, populate the field with S. Otherwise, leave the field blank.

If the IP record is for a patient who was treated in the ED, then admitted as an inpatient, *and the bills were split*, populate the field with S. Otherwise, leave the field blank.

D18. ED Admission Flag is Invalid

Error: The record is an ED record and the ED Admission Flag is not blank.

OR

The record is an IP record and the ED Admission Flag is not P7 or blank.

Correction: On an ED record, make the field blank.

On an IP record, if the patient was treated in the ED prior to admission as an inpatient, then populate the field with P7. Otherwise, make the field blank.

D19. Split Record Discharge Status Mismatch

Error: The record is an ED record. The Discharge Status is 09, indicating the patient was admitted as an inpatient, but the Visit Qualifier field does not have a value of S (split bill). Or, the Visit Qualifier is S, but the Discharge Status is not 09.

Correction: Determine if the patient was admitted as an inpatient. If yes, determine if the IP/ED bills were split. If yes, revise the record so the Discharge Status is 09 and the Visit Qualifier is S. If the patient was not admitted, or was admitted but the bills were not split, then revise the record so the Visit Qualifier is blank and the Discharge Status reflects the correct Discharge Status.

D20. Split Record Inpatient Orphan

Error: The IP record has a Visit Qualifier of "S" indicating it is the IP portion of a split billed ED/IP visit, but there is no corresponding ED record reported in the ED file. *Data elements used for matching are MRN, DOB, IP admission date and ED discharge date.*

Correction: On split billed ED/IP visits, both the IP and ED records must be reported in their respective files. If you have this D20 error, you must find the missing ED record.

It is possible that the ED record of the visit was reported, but was not matched to the IP portion because of errors in one or both records. If this is the case, then the ED record will also show up on the error list, but with error D21. Take the error list provided by the state and sort by MRN. Determine if the missing ED record is present on the list. If so, compare the match variables (indicated above) in the IP and ED records to determine where the discrepancy is, and correct that information as appropriate.

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If you cannot find the matching ED record on the state error list, then you must determine why that record was not reported in the ED file, and take corrective action to ensure that record is reported when the corrected state ED report is generated.

If you determine that the visit was NOT split billed, then remove the “S” from the Visit Qualifier field.

D21. Split Record Emergency Department Orphan

Error: The ED record has a Visit Qualifier of “S” indicating it is the ED portion of a split billed ED/IP visit, but there is no corresponding IP record reported in the IP file. *Data elements used for matching are MRN, DOB, IP admission date and ED discharge date.*

Correction: On split billed ED/IP visits, both the IP and ED records must be reported in their respective files. If you have this D21 error, you must find the missing IP record.

It is possible that the IP record of the visit was reported, but was not matched to the ED portion because of errors in one or both records. If this is the case, then the IP record will also show up on the error list, but with error D20. Take the error list provided by the state and sort by MRN. Determine if the missing IP record is present on the list. If so, compare the match variables (indicated above) in the IP and ED records to determine where the discrepancy is, and correct that information as appropriate.

If you cannot find the matching IP record on the state error list, then you must determine why that record was not reported in the IP file, and take corrective action to ensure that record is reported when the corrected state IP report is generated.

If you determine that the visit was NOT split billed, then remove the “S” from the Visit Qualifier field.

E - Demographic

E1. Race Code Invalid

Error: The Patient Race Code(s) reported is not a valid code, as indicated reporting specifications manual, page C-16.1.

Valid codes are 1; 2; 3; 4; 5; 6; 9

Correction: Note: in the state report, this data element may contain between one and four characters. The acceptable codes indicated above may occur in any order in the variable.

Review the record to determine the appropriate race. Verify the accurate code(s) have been entered in your HIMS. Correct as appropriate.

At some hospitals, the codes used in your HIMS may be different than the codes reported to the state. If this is the case, and the codes in your HIMS are correct, these errors are probably an issue of mapping for the state report. Check with whoever is responsible for programming your state report extraction to ensure that patient race mapping is set up correctly. Contact ADHS for assistance if necessary.

E2. Race Code Redundant

Error: The same Patient Race Code has been reported more than once in a record.

Correction: Review the record to determine the appropriate race. Verify the accurate code(s) have been entered in your HIMS. Correct as appropriate by removing redundant code or replacing with accurate code.

At some hospitals, the codes used in your HIMS may be different than the codes reported to the state. If this is the case, and the codes in your HIMS are correct, these errors are probably an issue of mapping for the state report. Check with whoever is responsible for programming your state report extraction to ensure that patient race mapping is set up correctly. Contact ADHS for assistance if necessary.

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E3. Marital Status Code Invalid

Error: The Marital Status Code reported is not a valid code, as indicated in the reporting specifications manual, page C-17.1.

Valid codes are I; M; S; D; W; K; C

Correction: Review the record to determine the appropriate marital status. Verify the accurate code has been entered in your HIMS. Correct as appropriate. At some hospitals, the codes used in your HIMS may be different than the codes reported to the state. If this is the case, and the codes in your HIMS are correct, these errors are probably an issue of mapping for the state report. Check with whoever is responsible for programming your state report extraction to ensure that marital status mapping is set up correctly. Contact ADHS for assistance if necessary.

E4. Sex Code Invalid

Error: The Patient Sex code reported is not a valid code, as indicated in the reporting specifications manual, page C-15.1.

Valid codes are M; F; U.

Correction: Review the record to determine the appropriate patient sex. Verify the accurate code has been entered in your HIMS. Correct as appropriate.

E5. Arizona City/Zip Code Mismatch

Error: The City and Zip Code reported in the record do not correspond.

Correction: Verify the patient city and zip code, and correct as appropriate.

Check for typographical errors in both the zip code and city name. Make sure the city is appropriate for the street address (for example, the city may say “Glendale” but the street address is actually in Peoria). Remove any punctuation. Pay particular attention to city name abbreviations. Watch out for city names that aren’t really cities, such as Williams Air Force Base or Deer Valley.

For quick verification of correct spelling and abbreviations, check the postal service website at: <http://zip4.usps.com/zip4/welcome.jsp>

This USPS site allows you to look up by city, zip code or street address.

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If the patient is homeless and the address is unavailable, you may communicate this information to ADHS by one of two methods: 1) populate the Homeless data element with 17 (see page C-13.1 of the manual); or 2) enter HOMELESS in the street address field. If you provide this information at the time your file is first submitted, it may reduce the number of errors you receive on this audit.

E6. Patient Name is Blank

Error: The patient name has not been provided in the record.

Correction: Verify that the patient name is present in your HIMS. If not, populate your HIMS with the appropriate patient name information.

If the patient name is in your HIMS but is not coming out on the state report, it is probably a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

E7. City/Zip not Provided

Error: The city and/or zip code is missing from the record.

Correction: Verify the patient city and zip code, and correct as appropriate.

If the patient has a foreign address and you have received this error, it is because the Patient Country Code field has not been populated with the appropriate ISO3166 country code. No city or zip code is expected on patients with a foreign address. To correct this error on a foreign address, populate the Country Code field with the appropriate two-digit code for the patient's country of residence.

E8. Race Code Mismatch

Error: At least one race code has been reported, along with race code 9, indicating the patient refused to provide race information. This is contradictory.

Correction: Review the record to determine the correct patient race information.

Correct the record as appropriate. Ensure that 9 does not appear in conjunction with any other codes.

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E9. Marital Status Inappropriate

Error: A Marital Status of “not applicable” has been reported on a patient who is legally an adult, and therefore *could* be married.

Correction: Verify that the Date of Birth is correct – is the patient is really age 18 or over? If not, correct Date of Birth.

If the Date of Birth is correct (the patient is really age 18 or over) correct the Marital Status with the appropriate code.

E10. State not Provided

Error: The State field is blank.

Correction: Is the patient a US resident? If so, provide the State code.

If the patient has reported a foreign address, then leave the State field blank, but instead report the ISO3166 Country Code in the Country Code field.

If the patient is a US resident but is homeless, then leave the State field blank, but instead report 17 in the Patient Homeless Indicator field.

F - Diagnoses

F1. Admitting Diagnosis is Invalid

Error: The record is an inpatient record with a reported Admitting Diagnosis, but the diagnosis code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Admitting Diagnosis code.

F2. Patient Reason for Visit 1 is Blank

Error: The record is an emergency department record, but no Patient Reason for Visit 1 code has been provided.

Correction: Determine and provide the correct Patient Reason for Visit 1 code.

F3. Admitting Diagnosis is Blank

Error: The record is reported as an inpatient record, but no Admitting Diagnosis code has been provided.

Correction: Verify the record is really an inpatient record. If the record *is* an inpatient record, determine and provide the correct Admitting Diagnosis code.

If the record is not an inpatient record, determine the correct record type. If an emergency department record, report in the ED file with Record Type 3, and no Admitting Diagnosis is required. If any other type of record (i.e., ambulatory surgery, clinic, urgent care), do not report the record.

F4. Diagnosis Codes Sequence Break

Error: There are multiple Diagnosis Codes reported, but within the sequence of reported Diagnosis Codes, there is one or more Diagnosis Code fields that are blank. For example: The Principal Diagnosis Code field and Diagnosis Code fields 2, 3, 5, and 6 are reported. Diagnosis Code field 4 is blank.

Correction: This is a programming issue in the extraction that creates your state report. Refer this problem to whoever is responsible for programming your state report.

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The most common cause of this error is the exclusion in the state report extraction of E Codes that are stored in the hospital HIMS diagnosis code fields, but failure to eliminate the resulting voids in the sequence of diagnosis codes.

F5. Redundant Principal Diagnosis

Error: There are at least two Diagnosis Codes reported, and the code reported as the Principal Diagnosis Code is repeated again in one of the secondary (Diagnosis Codes 2 – 25) fields.

Correction: Check your HIMS to see if the same code is present twice. If so, correct as appropriate.

If you do not find the same code present twice, then this is probably a programming issue. Refer this problem to whoever is responsible for programming your state report extraction to ensure the reporting of principal and secondary diagnosis codes is set up correctly.

F6. Principal Diagnosis Invalid

Error: The Principal Diagnosis code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Principal Diagnosis code.

F7. Diagnosis 2 Invalid

Error: Diagnosis 2 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 2 code.

F8. Diagnosis 3 Invalid

Error: Diagnosis 3 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 3 code.

F9. Diagnosis 4 Invalid

Error: Diagnosis 4 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 4 code.

F10. Diagnosis 5 Invalid

Error: Diagnosis 5 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 5 code.

F11. Diagnosis 6 Invalid

Error: Diagnosis 6 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 6 code.

F12. Diagnosis 7 Invalid

Error: Diagnosis 7 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 7 code.

F13. Diagnosis 8 Invalid

Error: Diagnosis 8 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 8 code.

F14. Diagnosis 9 Invalid

Error: Diagnosis 9 code is not a valid ICD-9-CM code for the time period being reported.

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Correction: Determine and provide the correct Diagnosis 9 code.

F15. Diagnosis 10 Invalid

Error: Diagnosis 10 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 10 code.

F16. Diagnosis 11 Invalid

Error: Diagnosis 11 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 11 code.

F17. Diagnosis 12 Invalid

Error: Diagnosis 12 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 12 code.

F18. Diagnosis 13 Invalid

Error: Diagnosis 13 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 13 code.

F19. Diagnosis 14 Invalid

Error: Diagnosis 14 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 14 code.

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F20. Diagnosis 15 Invalid

Error: Diagnosis 15 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 15 code.

F21. Diagnosis 16 Invalid

Error: Diagnosis 16 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 16 code.

F22. Diagnosis 17 Invalid

Error: Diagnosis 17 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 17 code.

F23. Diagnosis 18 Invalid

Error: Diagnosis 18 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 18 code.

F24. Diagnosis 19 Invalid

Error: Diagnosis 19 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 19 code.

F25. Diagnosis 20 Invalid

Error: Diagnosis 20 code is not a valid ICD-9-CM code for the time period being reported.

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Correction: Determine and provide the correct Diagnosis 20 code.

F26. Diagnosis 21 Invalid

Error: Diagnosis 21 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 21 code.

F27. Diagnosis 22 Invalid

Error: Diagnosis 22 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 22 code.

F28. Diagnosis 23 Invalid

Error: Diagnosis 23 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 23 code.

F29. Diagnosis 24 Invalid

Error: Diagnosis 24 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis code 24.

F30. Diagnosis 25 Invalid

Error: Diagnosis 25 code is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Diagnosis 25 code.

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F37. Patient Reason for Visit 1 is Invalid

Error: Patient Reason for Visit 1 is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Patient Reason for Visit 1 code.

F38. Patient Reason for Visit 2 is Invalid

Error: Patient Reason for Visit 2 is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Patient Reason for Visit 2 code.

F39. Patient Reason for Visit 3 is Invalid

Error: Patient Reason for Visit 3 is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct Patient Reason for Visit 3 code.

F40. Admitting Diagnosis on ED Record

Error: The record is reported as an emergency department record (indicating patient was not admitted), but an Admitting Diagnosis has been reported.

Correction: Verify the record is really an emergency department record. If so, correct by removing the Admitting Diagnosis.

If the record is not an emergency department record, determine the correct record type. If an inpatient record, report the record in the IP file with Record Type 1. If any other type of record (i.e., ambulatory surgery, clinic, urgent care), do not report the record.

F41. Patient Reason for Visit 1 on IP Record

Error: The Patient Reason for Visit 1 is reported on an inpatient record.

Correction: This data element is not reportable on IP records. Remove the Patient Reason for Visit 1 from the record.

F42. Patient Reason for Visit 2 on IP Record

Error: The Patient Reason for Visit 2 is reported on an inpatient record.

Correction: This data element is not reportable on IP records. Remove the Patient Reason for Visit 2 from the record.

F43. Patient Reason for Visit 3 on IP Record

Error: The Patient Reason for Visit 3 is reported on an inpatient record.

Correction: This data element is not reportable on IP records. Remove the Patient Reason for Visit 3 from the record.

F44. Patient Reason for Visit is Redundant

Error: The same diagnosis code appears in more than one of the Patient Reason for Visit 1, 2 or 3 fields.

Correction: Identify the *second* occurrence of the same code and remove it from the record.

G – Present on Admission

G1. POA1 Code is Invalid

Error: On inpatient records, there is a Principal Diagnosis reported, but the Present on Admission Indicator code for the Principal Diagnosis is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for the Principal Diagnosis.

G2. POA2 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 2 reported, but the Present on Admission Indicator code for Other Diagnosis Code 2 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 2.

G3. POA3 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 3 reported, but the Present on Admission Indicator code for Other Diagnosis Code 3 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 3.

G4. POA4 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 4 reported, but the Present on Admission Indicator code for Other Diagnosis Code 4 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 4.

G5. POA5 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 5 reported, but the Present on Admission Indicator code for Other Diagnosis Code 5 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 5.

G6. POA6 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 6 reported, but the Present on Admission Indicator code for Other Diagnosis Code 6 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 6.

G7. POA7 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 7 reported, but the Present on Admission Indicator code for Other Diagnosis Code 7 is either

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blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 7.

G8. POA8 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 8 reported, but the Present on Admission Indicator code for Other Diagnosis Code 8 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 8.

G9. POA9 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 9 reported, but the Present on Admission Indicator code for Other Diagnosis Code 9 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 9.

G10. POA10 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 10 reported, but the Present on Admission Indicator code for Other Diagnosis Code 10 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

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Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 10.

G11. POA11 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 11 reported, but the Present on Admission Indicator code for Other Diagnosis Code 11 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 11.

G12. POA12 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 12 reported, but the Present on Admission Indicator code for Other Diagnosis Code 12 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 12.

G13. POA13 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 13 reported, but the Present on Admission Indicator code for Other Diagnosis Code 13 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 13.

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G14. POA14 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 14 reported, but the Present on Admission Indicator code for Other Diagnosis Code 14 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 14.

G15. POA15 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 15 reported, but the Present on Admission Indicator code for Other Diagnosis Code 15 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 15.

G16. POA16 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 16 reported, but the Present on Admission Indicator code for Other Diagnosis Code 16 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 16.

G17. POA17 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 17 reported, but the Present on Admission Indicator code for Other Diagnosis Code 17 is

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either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 17.

G18. POA18 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 18 reported, but the Present on Admission Indicator code for Other Diagnosis Code 18 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 18.

G19. POA19 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 19 reported, but the Present on Admission Indicator code for Other Diagnosis Code 19 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 19.

G20. POA20 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 20 reported, but the Present on Admission Indicator code for Other Diagnosis Code 20 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

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Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 20.

G21. POA21 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 21 reported, but the Present on Admission Indicator code for Other Diagnosis Code 21 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 21.

G22. POA22 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 22 reported, but the Present on Admission Indicator code for Other Diagnosis Code 22 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 22.

G23. POA23 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 23 reported, but the Present on Admission Indicator code for Other Diagnosis Code 23 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 23.

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G24. POA24 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 24 reported, but the Present on Admission Indicator code for Other Diagnosis Code 24 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 24.

G25. POA25 Code is Invalid

Error: On inpatient records, there is an Other Diagnosis Code 25 reported, but the Present on Admission Indicator code for Other Diagnosis Code 25 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission code for Other Diagnosis Code 25.

G26. POA1 Code is Not Appropriate

Error: On inpatient records, there is a valid Principal Diagnosis Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for the Principal Diagnosis.

Report 1 for exempt ICD diagnosis codes.

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Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G27. POA2 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 2 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 2.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G28. POA3 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 3 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 3.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G29. POA4 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 4 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 4.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G30. POA5 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 5 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 5.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G31. POA6 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 6 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 6.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G32. POA7 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 7 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 7.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G33. POA8 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 8 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 8.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G34. POA9 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 9 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 9.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G35. POA10 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 10 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 10.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G36. POA11 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 11 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 11.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G37. POA12 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 12 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 12.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G38. POA13 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 13 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 13.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G39. POA14 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 14 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 14.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G40. POA15 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 15 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 15.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G41. POA16 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 16 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 16.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G42. POA17 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 17 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 17.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G43. POA18 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 18 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 18.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G44. POA19 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 19 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 19.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G45. POA20 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 20 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 20.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G46. POA21 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 21 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 21.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G47. POA22 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 22 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 22.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G48. POA23 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 23 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 23.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G49. POA24 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 24 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 24.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

G50. POA25 Code is Not Appropriate

Error: On inpatient records, there is a valid Other Diagnosis Code 25 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the ICD code to which it corresponds.

This means one of the following has occurred:

- 1) The diagnosis code is exempt, but a code of Y, N, U or W has been reported.
- 2) The diagnosis code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for Other Diagnosis Code 25.

Report 1 for exempt ICD diagnosis codes.

Report Y, N U or W (as appropriate) for non-exempt ICD diagnosis codes.

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G51. POAE1 Code is Invalid

Error: On inpatient records, there is an E Code 1 reported, but the Present on Admission Indicator code for E Code 1 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 1.

G52. POAE2 Code is Invalid

Error: On inpatient records, there is an E Code 2 reported, but the Present on Admission Indicator code for E Code 2 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 2.

G53. POAE3 Code is Invalid

Error: On inpatient records, there is an E Code 3 reported, but the Present on Admission Indicator code for E Code 3 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 3.

G54. POAE4 Code is Invalid

Error: On inpatient records, there is an E Code 4 reported, but the Present on Admission Indicator code for E Code 4 is either blank, or has a code

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reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 4.

G55. POAE5 Code is Invalid

Error: On inpatient records, there is an E Code 5 reported, but the Present on Admission Indicator code for E Code 5 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 5.

G56. POAE6 Code is Invalid

Error: On inpatient records, there is an E Code 6 reported, but the Present on Admission Indicator code for E Code 6 is either blank, or has a code reported that is not a valid code, as indicated in the reporting specifications manual, page C-38b.1

Valid codes are: 1; Y; N; U; W.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 6.

G57. POAE1 Code is Not Appropriate

Error: On inpatient records, there is a valid E Code 1 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the E Code to which it corresponds.

This means one of the following has occurred:

- 1) The E Code is exempt, but a code of Y, N, U or W has been reported.

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- 2) The E Code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 1.

Report 1 for exempt E Codes.

Report Y, N U or W (as appropriate) for non-exempt E Codes.

G58. POAE2 Code is Not Appropriate

Error: On inpatient records, there is a valid E Code 2 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the E Code to which it corresponds.

This means one of the following has occurred:

- 1) The E Code is exempt, but a code of Y, N, U or W has been reported.
- 2) The E Code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 2.

Report 1 for exempt E Codes.

Report Y, N U or W (as appropriate) for non-exempt E Codes.

G59. POAE3 Code is Not Appropriate

Error: On inpatient records, there is a valid E Code 3 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the E Code to which it corresponds.

This means one of the following has occurred:

- 1) The E Code is exempt, but a code of Y, N, U or W has been reported.
- 2) The E Code is *not* exempt, but a code of 1 has been reported.

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Correction: Determine and provide the correct Present on Admission Indicator code for E Code 3.

Report 1 for exempt E Codes.

Report Y, N U or W (as appropriate) for non-exempt E Codes.

G60. POAE4 Code is Not Appropriate

Error: On inpatient records, there is a valid E Code 4 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the E Code to which it corresponds.

This means one of the following has occurred:

- 1) The E Code is exempt, but a code of Y, N, U or W has been reported.
- 2) The E Code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 4.

Report 1 for exempt E Codes.

Report Y, N U or W (as appropriate) for non-exempt E Codes.

G61. POAE5 Code is Not Appropriate

Error: On inpatient records, there is a valid E Code 5 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the E Code to which it corresponds.

This means one of the following has occurred:

- 1) The E Code is exempt, but a code of Y, N, U or W has been reported.
- 2) The E Code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 5.

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Report 1 for exempt E Codes.

Report Y, N U or W (as appropriate) for non-exempt E Codes.

G62. POAE6 Code is Not Appropriate

Error: On inpatient records, there is a valid E Code 6 Present on Admission Indicator code reported; however, the indicator code is not appropriate for the E Code to which it corresponds.

This means one of the following has occurred:

- 1) The E Code is exempt, but a code of Y, N, U or W has been reported.
- 2) The E Code is *not* exempt, but a code of 1 has been reported.

Correction: Determine and provide the correct Present on Admission Indicator code for E Code 6.

Report 1 for exempt E Codes.

Report Y, N U or W (as appropriate) for non-exempt E Codes.

G63. POA reported on ED record

Error: At least one POA indicator is reported on an emergency department record.

Correction: This data element is not reportable on ED records. Remove the POA indicator(s) from the record.

H – External Cause Codes

H1. E Code Contains Decimal

Error: In one or more of the E Code fields 1 – 6, there is a decimal reported as part of the E Code.

Correction: This is usually a programming error. Regardless of how the E Codes are stored in the hospital HIMS , the state report programming should be set up to ensure there are no decimals in the file sent to the state. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

H2. E Codes Sequence Break

Error: There are multiple E Codes reported, but within the sequence of reported E Codes, there are one or more E Code fields that are blank. For example: The E Code 1 field and E Code 3 and 4 fields are reported, but E Code 2 field is blank.

Correction: This is a programming issue in the extraction that creates your state report. Refer this problem to whoever is responsible for programming your state report.

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H4. E Code 1 is Not Valid

Error: E Code 1 is not a valid ICD-9-CM E Code for the time period being reported.

Correction: Determine and provide the correct E Code 1.

H5. E Code 2 is Not Valid

Error: E Code 2 is not a valid ICD-9-CM E Code for the time period being reported.

Correction: Determine and provide the correct E Code 2.

H6. E Code 3 is Not Valid

Error: E Code 3 is not a valid ICD-9-CM E Code for the time period being reported.

Correction: Determine and provide the correct E Code 3.

H7. E Code 4 is Not Valid

Error: E Code 4 is not a valid ICD-9-CM E Code for the time period being reported.

Correction: Determine and provide the correct E Code 4.

H8. E Code 5 is Not Valid

Error: E Code 5 is not a valid ICD-9-CM E Code for the time period being reported.

Correction: Determine and provide the correct E Code 5.

H9. E Code 6 is Not Valid

Error: E Code 6 is not a valid ICD-9-CM E Code for the time period being reported.

Correction: Determine and provide the correct E Code 6.

H10. Place Code Missing on Fall Injury

Error: In one or more of the E Code fields 1 – 6, there is one or more E Codes reported in the range of E8800 – E8889, indicating injury by fall, but there is no corresponding E Code for *place* of occurrence (range E8490 – E8499) reported.

Correction: Assign and report the missing place of occurrence code for the fall injury. If the place of occurrence is not sufficiently documented in the record to allow accurate assignment of the place code, then do not assign any code. Communicate this circumstance to ADHS.

NOTE: if you have a large number of records where the E Code for place cannot be assigned due to missing or inadequate documentation in the record, this issue must be addressed.

H11. ICD-9-CM with External Cause Missing E code

Error: In one or more of the Diagnosis Code fields (Principal and 2 – 25) there is an ICD-9-CM diagnosis code that indicates an external cause (injury, poisoning, adverse reaction, misadventure), but no cause of occurrence E code has been reported.

Correction: Assign and report the missing cause of occurrence code

If the cause of occurrence is not sufficiently documented in the record to allow accurate assignment of the cause code, then communicate this circumstance to ADHS.

NOTE: if you have a large number of records where the E Code cannot be assigned due to missing or inadequate documentation in the record, this issue must be addressed.

NOTE: "T" not used in Audit series.

J - Newborns

J1. Newborn Source of Admission is Invalid

Error: The Priority of Visit (type of admission) is reported as 4, indicating the patient is a newborn baby, but the Source of Admission code is not a 5 (born in hospital) or 6 (born outside hospital).

Correction: Determine if the patient is really a baby that was either born in your hospital, or yours is the first hospital to attend the infant following an extramural birth. (these are the only babies that should have Priority of Visit code 4). If not, then correct the Priority of Visit code. Infants born in another health facility and transferred to your hospital for care are transfers (even if they are only a few hours old), and should not be coded as newborns for Priority of Visit.

If the patient really was either born in your hospital, or yours is the first hospital to attend the baby following an extramural birth, then correct the Source of Admission code to be either 5 or 6 as appropriate.

J2. Newborn Type of Admission, Age Over Zero Days

Error: The Priority of Visit (type of admission) is reported as 4, indicating the patient is a newborn baby, but the patient is at least 1 day or more of age.

Correction: Determine if the patient is really a baby that was either born in your hospital, or yours is the first hospital to attend the infant following an extramural birth. (these are the only babies that should have Priority of Visit code 4). If not, then correct the Priority of Visit code.

If the patient really was a newborn, then either the Admission Date or Patient Birth Date is incorrect. Check these two dates and correct as appropriate.

J3. Newborn DRG, Age Over Zero Years

Error: The DRG reported is an infant DRG, but the patient is over 1 year of age.

Correction: Check the Admission Date and Patient Date of Birth. Correct as appropriate.

J4. Newborn Birth Weight Not 100 - 6350 Grams

Error: The Priority of Visit (type of admission) is reported as 4, indicating the patient is a newborn baby, but the Newborn Birth Weight is either blank, or has been reported as less than 100 grams or more than 6350 grams.

Correction: Determine if the patient is really a baby that was either born in your hospital, or yours is the first hospital to attend the infant following an extramural birth. (these are the only babies that should have Priority of Visit code 4). If not, then correct the Priority of Visit code. Infants born in another health facility and transferred to your hospital for care are transfers (even if they are only a few hours old), and should not be coded as newborns for Priority of Visit.

If the patient really was either born in your hospital, or yours is the first hospital to attend the baby following an extramural birth, then correct the Newborn Birth Weight.

J5. Zero Age at Admit Not Newborn

Error: The Patient Birth Date and Admission Date are the same (indicating a newborn baby) but the Priority of Visit (type of admission) code is not 4 (newborn). The Admission Source does not indicate the patient is a transfer.

Correction: Determine if the patient is really a baby that was either born in your hospital, or yours is the first hospital to attend the infant following an extramural birth. If so, correct the Priority of Visit (type of admission) code to be 4 (newborn).

If the patient was transferred to your hospital, then correct the Source of Admission code to reflect the appropriate facility type from which the patient was transferred.

If the Priority of Visit (type of admission) and Source of Admission codes are already correct, then either the Admission Date or Patient Birth Date is incorrect. Check these two dates and correct as appropriate.

J6. Diagnosis Conflicts with Birth Weight

Error: In one or more of the Diagnosis Code fields (Principal and 2 – 25) there is an ICD-9-CM diagnosis code reported that includes a newborn birth weight range which does not correspond to the reported Newborn Birth Weight.

Correction: Review the Diagnosis Codes and Newborn Birth Weight for accuracy. Correct as appropriate.

J7. Principal Diagnosis Conflicts with Admission Source

Error: The Principal Diagnosis Code is a V Code indicating the patient is a baby that was born in your hospital, but the Source of Admission code is not 5 (born in hospital).

OR. . .

The Principal Diagnosis is a V Code indicating the patient is a baby that was first attended after birth by your hospital, but the Source of Admission code is not 6 (born outside hospital).

Correction: Determine how the baby became your patient. If born in your hospital, correct the Source of Admission code to be 5. If born outside your hospital, correct the Source of admission code to be 6. If the baby was transferred to your hospital, make sure the Priority of Visit (type of admission) and source of admission codes are appropriate, and correct the Principal Diagnosis Code.

J8. Birth Weight on Non-Newborn

Error: The Newborn Birth Weight is reported, but the Priority of Visit (type of admission) reported is not 4 (newborn).

Correction: Determine if the patient is a baby that was either born in your hospital, or yours is the first hospital to attend the infant following an extramural birth. If so, then correct the Priority of Visit code to be 4 (newborn). Also check the Source of Admission code to be sure it is a 5 (born in hospital), or 6 (born outside of hospital).

If the patient is **not** a baby meeting the above criteria for newborn, then the Newborn Birth Weight should not be reported. Correct by removing the birth weight from the record.

K – Providers

K1. Attending Provider Name Not Reported

Error: The Attending Provider Name field is blank.

Correction: Provide the Attending Provider Name. Check the Attending Provider National Provider Identifier, State License Number and State Licensing Board fields to be sure they are correctly reported.

If the information is present in your source system but not in the state report, this may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K2. Attending Provider License Number Not Reported

Error: The Attending Provider State License Number field is blank.

Correction: Provide the Attending Provider State License Number. Check the Attending Provider Name, National Provider Identifier, and State Licensing Board fields to be sure they are correctly reported.

If the information is present in your source system but not in the state report, this may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K3. Attending Provider License Board Not Reported

Error: The Attending Provider State Licensing Board is blank.

Correction: Provide the Attending Provider State Licensing Board. Check the Attending Provider Name, National Provider Identifier, and State License Number fields to be sure they are correctly reported.

If the information is present in your source system but not in the state report, this may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K4. Operating Provider Reported, No Principal Procedure

Error: No Principal Procedure has been reported, but the name and/or license number of an Operating Provider has been reported.

Correction: Determine if a procedure was performed. If so, provide the ICD-9-CM code (on IP or ED records) or CPT code (ED records only).

If no procedure was performed, remove the operating physician information from the record (name, npi, license number, board code).

K5. Principal Procedure Reported, No Operating Provider

Error: Principal Procedure has been reported, but Operating Provider information has not been reported.

Correction: Determine if a procedure was really performed. If so, provide Operating Provider Name, National Provider Identifier, State License Number and State Licensing Board.

If no procedure was performed, remove Principal Procedure information from the record.

K6. Operating Provider Information Incomplete

Error: In the Operating Provider Name, National Provider Identifier, State License Number and State Licensing Board fields, some fields are provided and some are not.

Correction: Determine if the record really has an Operating Provider. If so, provide the missing information.

If the record should not have an Operating Provider, remove the partial information from the fields as appropriate.

If there is data in these fields in the state report but not in your HIMS, then this may be a programming error. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K7. Other Provider Information Incomplete

Error: In the Other Provider Name, National Provider Identifier, State License Number and State Licensing Board fields, some fields are provided and some are not.

Correction: Determine if the record really has an Other Provider. If so, provide the missing information.

If the record should not have an Other Provider, remove the partial information from the fields as appropriate.

If there is data in these fields in the state report but not in your HIMS, then this may be a programming error. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K8. Attending Provider License Number is not Numeric

Error: The Attending Provider State License Number contains either letters or special characters.

Correction: Only the numeric portion of license numbers are to be reported to the state, regardless of how they are stored in your source system. So, there are two pieces to this correction: 1) is the license number stored correctly in your source system, according to your internal requirements for physician records; and 2) is the state report programming correct?

First, check to see if the license number is in your source system correctly. If not, perform the necessary correction.

If the license number is correct in your source system, then this error may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K9. Operating Provider License Number is not Numeric

Error: The Operating Provider State License Number contains either letters or special characters.

Correction: Only the numeric portion of license numbers are to be reported to the state, regardless of how they are stored in your source system. So, there are two pieces to this correction: 1) is the license number stored correctly

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in your source system, according to your internal requirements for physician records; and 2) is the state report programming correct?

First, check to see if the license number is in your source system correctly. If not, perform the necessary correction.

If the license number is correct in your source system, then this error may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K10. Other Provider License Number is not Numeric

Error: The Other Provider State License Number contains either letters or special characters.

Correction: Only the numeric portion of license numbers are to be reported to the state, regardless of how they are stored in your source system. So, there are two pieces to this correction: 1) is the license number stored correctly in your source system, according to your internal requirements for physician records; and 2) is the state report programming correct?

First, check to see if the license number is in your source system correctly. If not, perform the necessary correction.

If the license number is correct in your source system, then this error may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

K11. Invalid Attending Provider License Number

Error: The Attending Provider State License Number is not a valid license number according to the records of the Arizona licensing board indicated for this provider.

Correction: Verify that the state licensing board code reported for this provider is correct. If not, provide the correct code and verify the license number.

If the board code is correct, check and correct the license number. Look for typographical errors, transposed numbers or wrong number reported.

Tips: Make sure you are reporting the Arizona state license number, and not an NPI or other identifier. On nurses with advanced practice licenses,

report only the RN number. On residents who now have their physician license, the resident number is no longer acceptable.

K12. Invalid Operating Provider License Number

Error: The Operating Provider State License Number is not a valid license number according to the records of the Arizona licensing board indicated for this provider.

Correction: Verify that the state licensing board code reported for this provider is correct. If not, provide the correct code and verify the license number.

If the board code is correct, check and correct the license number. Look for typographical errors, transposed numbers or wrong number reported.

Tips: Make sure you are reporting the Arizona state license number, and not an NPI or other identifier. On nurses with advanced practice licenses, report only the RN number. On residents who now have their physician license, the resident number is no longer acceptable.

K13. Invalid Other Provider License Number

Error: The Other Provider State License Number is not a valid license number according to the records of the Arizona licensing board indicated for this provider.

Correction: Verify that the state licensing board code reported for this provider is correct. If not, provide the correct code and verify the license number.

If the board code is correct, check and correct the license number. Look for typographical errors, transposed numbers or wrong number reported.

Tips: Make sure you are reporting the Arizona state license number, and not an NPI or other identifier. On nurses with advanced practice licenses, report only the RN number. On residents who now have their physician license, the resident number is no longer acceptable.

K14. Mismatched Attending Provider Name/License

Error: The Attending Provider State License Number reported does not correspond to the last name of the reported Attending Provider.

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Correction: Verify the license number and name. Look for typographical errors, transposed numbers or names (first and last name in wrong order), wrong license number reported, or spaces in the name where they don't belong (MC DONALD instead of MCDONALD).

Tip: Make sure your provider license record matches that of the licensing board that issues the provider's license. The records of the licensing board are the official records of clinician licensing. Clinicians are required to keep their information current with their applicable licensing board. If a clinician practicing in your hospital tells you that the records of the licensing board are incorrect, it is the responsibility of the clinician to contact their licensing board and correct their information.

K15. Mismatched Operating Provider Name/License

Error: The Operating Provider State License Number reported does not correspond to the last name of the reported Operating Provider.

Correction: Verify the license number and name. Look for typographical errors, transposed numbers or names (first and last name in wrong order), wrong license number reported, or spaces in the name where they don't belong (MC DONALD instead of MCDONALD).

Tip: Make sure your provider license record matches that of the licensing board that issues the provider's license. The records of the licensing board are the official records of clinician licensing. Clinicians are required to keep their information current with their applicable licensing board. If a clinician practicing in your hospital tells you that the records of the licensing board are incorrect, it is the responsibility of the clinician to contact their licensing board and correct their information.

K16. Mismatched Other Provider Name/License

Error: The Other Provider State License Number reported does not correspond to the last name of the reported Other Provider.

Correction: Verify the license number and name. Look for typographical errors, transposed numbers or names (first and last name in wrong order), wrong license number reported, or spaces in the name where they don't belong (MC DONALD instead of MCDONALD).

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Tip: Make sure your provider license record matches that of the licensing board that issues the provider's license. The records of the licensing board are the official records of clinician licensing. Clinicians are required to keep their information current with their applicable licensing board. If a clinician practicing in your hospital tells you that the records of the licensing board are incorrect, it is the responsibility of the clinician to contact their licensing board and correct their information.

K17. Attending Provider is PA

Error: If you receive this error, you have reported a Physician Assistant as an Attending Provider (which is out of their scope of practice).

Correction: If you have reported a Physician Assistant as an Attending Provider, this is out of their scope of practice according to their licensing board. Correct the record by replacing the physician assistant's information with the information of the licensed physician who is their supervising physician.

K18. RESERVED

K19. RESERVED

K20. Attending Provider NPI Not Reported

Error: The National Provider Identifier number for the reported Attending Provider has not been reported in the record. .

Correction: Provide the Attending Provider NPI. Also check the Attending Provider Name, State License Number and State Licensing Board fields to be sure they are correctly reported.

If the provider works only in your hospital and therefore *does not have an NPI*, communicate this information to ADHS.

If the information is present in your source system but not in the state report, this may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

L - Revenue**L1. Total Charges = Zero**

Error: There are no Total Charges reported for the patient visit.

Correction: Determine if services were rendered to the patient, and if the patient incurred charges. If so, populate the Total Charges as appropriate. Verify all other Revenue Code Category fields in that record, to ensure they balance with the Total Charges.

If the patient received services, but did **not** incur any charges (for example, a visit for suture removal where the charges for suture removal were included in the charges for the original procedure), then make sure the appropriate codes for the services provided are in the record, and then notify ADHS which services were provided at no charge.

If the patient received **no** services and incurred **no** charges (left AMA or LWOB, discharge status 07), then do not report the record. This type of visit does not constitute a valid discharge for the purposes of state reporting.

L2. Emergency Room Admission without ER Charges

Error: On an ED record there are no emergency room charges (revenue code category 045x) reported.

OR

On an IP record the ED Admission Flag is populated with P7 (indicating the patient was seen in the ED prior to admission as an inpatient), and the record is **not** a “split billed” record but there are no emergency room charges (revenue code category 045x) reported.

Correction: On ED records, report the charges incurred in Revenue Code Category 045x. Verify that the Total Charges field balances with the other Revenue Code Category fields in the record. If the patient received services in the emergency room but no charges were incurred, notify ADHS of the circumstances.

On IP records, determine if the patient really received services in the emergency room. If not, remove the ED Admission Flag.

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If the patient did receive services in the emergency room, and the IP and ED bills were **not** split, then report the charges incurred in Revenue Code Category 045x. Verify that the Total Charges field balances with the other Revenue Code Category fields in the record. If the patient received services in the emergency room but no charges were incurred, notify ADHS of the circumstances.

If the patient received services in the emergency room, but the 045x revenue is not reported in the IP record because the IP and ED bills **were** split, then populate the Visit Qualifier with “S” to indicate the record is split billed.

L3. Total Charges Discrepancy

Error: The difference between the Total Charges reported and the sum of all other reported revenue is greater than fifty dollars.

Correction: Review individual Revenue Code Category Charges and the Total Charges. If they do not balance, make corrections as appropriate.

If the individual Revenue Code Category Charges and the Total Charges do balance, then this is probably a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

L4. Charge not Numeric

Error: There is a letter or special character entered in at least one of the reported Revenue Code Category fields.

Correction: Locate and remove the letters or special characters. If these are present in the report but not in your source system, this is probably a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

L5. Negative Charge

Error: There is a negative value entered in at least one of the reported Revenue Code Category fields.

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Correction: Locate and remove the negative values. If these are present in the report but not in your source system, this is probably a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

L6. OR Charges without Procedure

Error: There are charges in the record for the operating room (revenue code category 036x), but no Principal Procedure is reported.

Correction: Determine if a procedure was performed. If so, provide the Principal Procedure Code and Date information. Also verify that the appropriate Operating Provider information (name, NPI, license number and board) are also reported.

If no procedure was performed, the charges should probably be removed. However, if the charges are correct because a procedure was prepared or started but never completed, ensure that the appropriate V Code is reported in the record.

L7. Trauma Charges without Trauma Admit

Error: There are trauma activation charges in the record (revenue code category 068x), but the Priority of Visit (type of admission) is not 5 (trauma).

Correction: Is your hospital a designated trauma center? If not, you cannot report these 068x charges.

If your hospital is a trauma center, verify that the patient visit did include a trauma activation. If not, remove the charges from Revenue Code Category 068x.

If the visit did include a trauma activation, then correct the Priority of Visit (type of admission) to be 5 (trauma).

L8. ER Charges without Emergency Room Admission

Error: On an inpatient record, there are emergency department charges (revenue code category 045x) reported but the ED Admission Flag field does not contain P7.

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Correction: Did the patient receive services in the ED before being admitted as an inpatient? If so, populate the ED Admission Flag field with the value P7. If the patient did **not** receive ED services, remove the charges from the 045x revenue category field. Verify that the Total Charges field balances with the sum of the other Revenue Code Category fields in the record.

L9: Trauma Activation Charges/Not a Trauma Center

Error: The record contains Trauma Activation charges (revenue code category 068x), but the reporting hospital is not a designated Trauma Center.

Correction: Only designated Trauma centers may report revenue code category 068x. Remove the charges from the 045x revenue category field. Verify that the Total Charges field balances with the sum of the other Revenue Code Category fields in the record.

L10: IP Room & Board Charges Not Reported

Error: On an inpatient record, there are no room and board charges of any kind reported.

Correction: Identify the type(s) of room and board charges incurred by the patient during this stay, and report those charges in the appropriate revenue charge category in the record.

It is expected that every IP record will have at least one reported revenue category for room and board charges.

L11: ED Charges on an IP Split Bill

Error: On an inpatient record, there are emergency department charges reported, but the record is identified as a “split bill” meaning the IP and ED accounts are separate, and therefore the ED charges should be on the ED account, not the IP account.

Correction: Determine if the charges for the ED and IP services were in fact separately billed.

If the bills **are** separate, then the ED charges must be removed from the IP record, and the Total Charges field must be updated accordingly so the individual Revenue Code Category charges reported balance with the Total Charges reported.

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Also, verify that the ED charges **are** appropriately reported on the corresponding ED record, and that the ED record is being reported to the state in the ED file as required.

If the bills are **not** separate, then the “S” value that is reported in the Visit_Qualifier field in the state report must be removed. If you have this circumstance, the inappropriate presence of that “S” value is most likely due to an error in the programming used to extract the state report, and you should consult with your internal IT and/or software vendor as appropriate to address that issue.

M - Miscellaneous

M1. Hour of Admission is Invalid

Error: The Admission Hour is not a valid code, as indicated in the reporting specifications manual, page C-20.1.

Valid codes are the same as used on the UB04.

Correction: Identify and provide the correct hour of admission code.

M2. Hour of Discharge is Invalid

Error: The Discharge Hour is not a valid code, as indicated in the reporting specifications manual, page C-24.1.

Valid codes are the same as used on the UB04.

Correction: Identify and provide the correct hour of discharge code.

M3. DRG is Ungroupable

Error: On an inpatient record, the DRG Version is 24 and the reported DRG is 470.

OR...

On an inpatient records, the DRG Version is 25, 26, 27, 28 or 29 and the reported DRG is 999.

Correction: Review the record and resolve any incorrect or missing information that would cause the record to be ungroupable. Regroup the record and report the valid DRG.

M4. Principal Diagnosis Invalid as Discharge Diagnosis

Error: On an inpatient record, the DRG Version is 24 and the reported DRG is 469.

OR...

On an inpatient records, the DRG Version is 25, 26, 27, 28 or 29 and the reported DRG is 998.

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Correction: Review the record and correct the Principal Diagnosis Code. Regroup the record and report the valid DRG.

M5. Payer Code is Invalid

Error: The Payer Type Code is not a valid code, as indicated in the reporting specifications manual, page C-30.1.

Valid codes are: 00; 01; 02; 03; 04; 05; 06; 07; 08; 09; 10; 11; 12; 13; 14

Correction: Identify and provide the correct Payer Type Code.

If the payer code is correct in your HIMS but not on the state report, or if there are many errors, it may be a programming issue. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

M6. Type of Admission is Invalid

Error: The Priority of Visit (type of admission) is not a valid code, as indicated in the reporting specifications manual, page C-21.1.

Valid codes are the same as used on the UB04.

Correction: Identify and provide the correct Priority of Visit (type of admission) code.

M7. Source of Admission is Invalid

Error: The Source of Admission is not a valid code, as indicated in the reporting specifications manual, page C-22.1.

Valid codes are the same as used on the UB04.

Correction: Identify and provide the correct Source of Admission code.

M8. Country Code Invalid

Error: The Country Code is reported, but it is not a valid ISO3166 country code, as indicated in the reporting specifications manual, page C-12.1. and Appendix I-1, pages 1-6.

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Valid codes are the same as used on the UB04.

Correction: If the patient is a foreign resident, identify and provide the correct country code. If the patient is a US resident, leave this field blank.

M9. DRG Invalid

Error: On an inpatient record, reported DRG code is not a valid code for the DRG Version reported.

Correction: Determine which DRG version was used on the record and verify the correct DRG Version is being reported. If not, correct the DRG Version.

If the DRG Version correct, determine and provide the correct DRG for the record.

M10. CMG Invalid

Error: On an inpatient rehabilitation record, the CMG is reported, but it is not a valid code for the time period being reported.

Correction: Determine and provide the correct CMG code.

M11. DRG Indicator is Invalid

Error: On an inpatient record, the reported DRG Version is not valid for the date range indicated by the reported patient discharge date in the record.

Correction: Determine which DRG Version was *actually used for billing* the primary payer and correct as appropriate.

The majority of bills are processed using the current MS-DRG Version, which is updated effective for discharges on/after the first day of every Federal fiscal year, October 1. With each update, the DRG Version is incremented by one.

(example: for fiscal 2011, discharges 10/1/10 – 09/30/11, the DRG Version is 28).

Tip: If your hospital has payers that require billing under the “classic” DRG (non-severity adjusted, DRG Version 24), please notify ADHS so we may adjust our auditing process to accommodate this circumstance.

Audit Correction Assistance

Section G

M12. Trauma Admit/Not a Trauma Center

Error: The reported Admission Type is 5 (Trauma) but the reporting hospital is not a designated Trauma Center.

Correction: Only designated Trauma Centers may use Admission Type 5. Correct as appropriate.

M13. Surgical DRG without Procedure

Error: On inpatient records only, the reported DRG is a **surgical** DRG, but there is no principal procedure reported.

Correction: Provide the missing procedure code and date, or correct the DRG if no procedure was performed.

M14: Law Enforcement Admit/Discharge Mismatch

Error: The record has a Discharge Status of 21, indicating the patient was discharged into the custody of law enforcement. However, the record does **not** have a Source of Admission of 8, indicating the patient was admitted under the custody of law enforcement.

Correction: Identify where the patient came from and where the patient was discharged to. Correct the Source of Admission and/or Discharge Status as appropriate.

Tip: If a patient comes from jail or is otherwise brought in under the custody and/or control of a law enforcement official, the correct Source of Admission is 8.

The only exception to this is if the patient is brought in by a law enforcement official who is simply providing transportation to that patient, and the patient is not in custody, and the patient is free to go when their care is complete. In this exception the Source of Admission would be 1, non-healthcare facility point of origin. This guidance is based upon national UB04 definition.

N - Procedures

N1. Procedure Code Contains Decimal

Error: In one or more of the Procedure Code fields (Principal and Other Procedure Code 2-12) there is a decimal reported as part of the Procedure Code.

Correction: This is usually a programming error. Regardless of how the Procedure Codes are stored in the hospital HIMS, the state report programming should be set up to ensure there are no decimals in the file sent to the state. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly.

N2. Procedure Codes Sequence Break

Error: There are multiple Procedure Codes reported, but within the sequence of reported Procedure Codes, there are one or more Procedure Code fields that are blank. For example: The Principal Procedure Code field and Other Procedure Code 3 and 4 fields are reported, but Procedure Code 2 field is blank.

Correction: This is a programming issue in the extraction that creates your state report. Refer this problem to whoever is responsible for programming your state report.

N3. Procedure 1 /Procedure Date 1 not Reported

Error: There is a Principal Procedure (procedure 1) reported without a date, or the Principal Procedure Date is reported but there is no Principal Procedure.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N4. Procedure 2 /Procedure Date 2 not Reported

Error: There is a Procedure 2 reported without a date, or the Procedure 2 Date is reported but there is no procedure 2.

Audit Correction Assistance

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Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N5. Procedure 3 /Procedure Date 3 not Reported

Error: There is a Procedure 3 reported without a date, or the Procedure 3 Date is reported but there is no procedure 3.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N6. Procedure 4 /Procedure Date 4 not Reported

Error: There is a Procedure 4 reported without a date, or the Procedure 4 Date is reported but there is no procedure 4.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N7. Procedure 5 /Procedure Date 5 not Reported

Error: There is a Procedure 5 reported without a date, or the Procedure 5 Date is reported but there is no procedure 5.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N8. Procedure 6 /Procedure Date 6 not Reported

Error: There is a Procedure 6 reported without a date, or the Procedure 6 Date is reported but there is no procedure 6.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N9. Procedure 7 /Procedure Date 7 not Reported

Error: There is a Procedure 7 reported without a date, or the Procedure 7 Date is reported but there is no procedure 7.

Audit Correction Assistance

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Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N10. Procedure 8 /Procedure Date 8 not Reported

Error: There is a Procedure 8 reported without a date, or the Procedure 8 Date is reported but there is no procedure 8.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N11. Procedure 9 /Procedure Date 9 not Reported

Error: There is a Procedure 9 reported without a date, or the Procedure 9 Date is reported but there is no procedure 9.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N12. Procedure 10 /Procedure Date 10 not Reported

Error: There is a Procedure 10 reported without a date, or the Procedure 10 Date is reported but there is no procedure 10.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N13. Procedure 11 /Procedure Date 11 not Reported

Error: There is a Procedure 11 reported without a date, or the Procedure 11 Date is reported but there is no procedure 11.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N14. Procedure 12 /Procedure Date 12 not Reported

Error: There is a Procedure 12 reported without a date, or the Procedure 12 Date is reported but there is no procedure 12.

Audit Correction Assistance

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Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N15. Invalid Principal Procedure Code

Error: The Principal Procedure (procedure code 1) is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-42.1.

N16. Invalid Procedure Code 2

Error: Other Procedure Code 2 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N17. Invalid Procedure Code 3

Error: Other Procedure Code 3 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N18. Invalid Procedure Code 4

Error: Other Procedure Code 4 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N19. Invalid Procedure Code 5

Error: Other Procedure Code 5 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N20. Invalid Procedure Code 6

Error: Other Procedure Code 6 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N21. Invalid Procedure Code 7

Error: Other Procedure Code 7 is not a valid ICD-9-CM or CPT code for the time period being reported.

Audit Correction Assistance

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Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N22. Invalid Procedure Code 8

Error: Other Procedure Code 8 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N23. Invalid Procedure Code 9

Error: Other Procedure Code 9 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N24. Invalid Procedure Code 10

Error: Other Procedure Code 10 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

Audit Correction Assistance

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For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N25. Invalid Procedure Code 11

Error: Other Procedure Code 11 is not a valid ICD-9-CM or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, report ICD-9-CM or CPT codes as appropriate. Refer to the reporting specification manual, page C-44.

N26. Invalid Procedure Code 12

Error: On inpatient records, Other Procedure Code 12 is not a valid ICD-9-CM code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-9-CM codes only.

For emergency department records, only a valid ED Evaluation and Management Code may be reported in this field. Refer to the reporting specification manual, page C-44. See audit N27, below.

N27. Required Evaluation & Management Code Missing

Error: On emergency department records, Other Procedure Code 12 is not a valid emergency department CPT Evaluation and Management Code.

Valid codes are: 99281-99285; 99291 or (for Type B EDs only) G0380 – G0384

Correction: Determine and provide the correct code.

Glossary

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Allowance: the percentage and record count of error allowed on a specific audit or set of audits on a single data set.

Attestation Form: the “Attestation of Completeness and Accuracy” form required to accompany the data submission. (see definition of *submission*) This form must be submitted *once per reporting period*. On this form, the CEO or responsible designee attests to the completeness and accuracy of the reported data. The intent of this form is to ensure that hospital upper management is aware of the report(s) being sent to the state. The current version of this form is available on the ADHS website at: <http://www.azdhs.gov/plan/crr/ddr/hospa1/index.htm> .

Audit: methods used by the Arizona Department of Health Services to evaluate submitted data for completeness and accuracy. Audits involve both computerized and manual evaluation of the data.

Civil Penalty: monetary penalty imposed on a hospital by the Arizona Department of Health Services for failure to comply with the reporting requirements.

Contact Form: the “Hospital Discharge Data Information Form” required to accompany the data submission. (see definition of *submission*) This form must be submitted *once per reporting period*. On this form, the reporting hospital provides information regarding the data submission, contact person and (if applicable) vendor information. The current version of this form is available on the ADHS website at: <http://www.azdhs.gov/plan/crr/ddr/hospa1/index.htm> .

Correction Period: the time allowed for a hospital to make required corrections and resubmit their data.

Data Universe: the number of records sharing common data elements on which an error allowance is determined, and upon which audits specific to those common data elements are conducted. For example, all records of newborn infants present in an inpatient data set would comprise the data universe for newborn auditing. Audits specific to data elements found only in newborn records (such as birth weight), will apply only to those records, and the allowable threshold of error is calculated upon the total number of records in that newborn data universe.

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Glossary

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Emergency Department Record: a record containing the data elements specified in this manual, reflecting the care of a patient who received services in the reporting hospital's emergency department, and who then was: 1) released from the reporting hospital's care without being admitted as an inpatient; or, 2) admitted as an inpatient to the reporting hospital with a separate bill for ED services. The ED record for patients treated in the ED and subsequently moved to observation status, outpatient surgery, etc, must be reported.

Fatal Error: an error on any audit that requires 100% accuracy. A single fatal error will cause the entire data set in which it resides to be rejected.

First Half: the time period of January 1 through June 30 of each year that comprises the first reporting period for hospital discharge data. (see Second Half).

Inpatient Discharge Record: a record containing the data elements specified in this manual, reflecting the care of a patient of the reporting hospital who was an inpatient as defined under A.A.C. R9-10-201.

Reporting Period: the two six-month time periods for which data is reported each year. The "first half" being January 1 through June 30 and the "second half" being July 1 through December 31 of each year.

Resubmission: the submission of a corrected data set a subsequent time after the original official reporting for any given reporting period.

Submission: the official reporting of data and accompanying required forms by a reporting hospital to the Arizona Department of Health Services. For a hospital that is required to report both inpatient and emergency department data, a submission consists of both the inpatient and emergency department data sets and accompanying Contact and Attestation forms.

Submission Period: the time allotted for hospitals to report their data, that is, January 1 through February 15 for "second half" data, and July 1 through August 15 for "first half" data of each year.

Second Half: the time period of July 1 through December 31 of each year that comprises the second reporting period for hospital discharge data. (see First Half).

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Glossary

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Test Period: the 30-day period immediately preceding the end of each reporting period, during which test data may be submitted to the Arizona Department of Health Services for evaluation. Test periods are June 1 through 30 and December 1 through 31 of each year.

Test submission: a data set submitted by a hospital to the Arizona Department of Health Services during the Test Period, to be evaluated for the purpose of providing assistance to the hospital in meeting the reporting requirements.

Threshold: a computerized evaluation process conducted on each submitted data set to determine, for specifically selected data element values, if a level of usage at which the data becomes suspect is present in the data set.

Trauma Center: a health care institution that is designated pursuant to rules adopted by the Arizona Department of Health Services to provide a specific level of trauma care. (reference A.R.S. § 36-2225.B.2.)

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COUNTRY NAME	CODE
AFGHANISTAN	AF
ALAND ISLANDS	AX
ALBANIA	AL
ALGERIA	DZ
AMERICAN SAMOA	AS
ANDORRA	AD
ANGOLA	AO
ANGUILLA	AI
ANTARCTICA	AQ
ANTIGUA AND BARBUDA	AG
ARGENTINA	AR
ARMENIA	AM
ARUBA	AW
AUSTRALIA	AU
AUSTRIA	AT
AZERBAIJAN	AZ
BAHAMAS	BS
BAHRAIN	BH
BANGLADESH	BD
BARBADOS	BB
BELARUS	BY
BELGIUM	BE
BELIZE	BZ
BENIN	BJ
BERMUDA	BM
BHUTAN	BT
BOLIVIA, PLURINATIONAL STATE OF	BO
BONAIRE, SINT EUSTATIUS AND SABA	BQ
BOSNIA AND HERZEGOVINA	BA
BOTSWANA	BW
BOUVET ISLAND	BV
BRAZIL	BR
BRITISH INDIAN OCEAN TERRITORY	IO
BRUNEI DARUSSALAM	BN
BULGARIA	BG
BURKINA FASO	BF
BURUNDI	BI
CAMBODIA	KH
CAMEROON	CM
CANADA	CA
CAPE VERDE	CV
CAYMAN ISLANDS	KY
CENTRAL AFRICAN REPUBLIC	CF
CHAD	TD
CHILE	CL
CHINA	CN
CHRISTMAS ISLAND	CX

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COUNTRY NAME	CODE
COCOS (KEELING) ISLANDS	CC
COLOMBIA	CO
COMOROS	KM
CONGO	CG
CONGO, THE DEMOCRATIC REPUBLIC OF THE	CD
COOK ISLANDS	CK
COSTA RICA	CR
CÔTE D'IVOIRE	CI
CROATIA	HR
CUBA	CU
CURACAO	CW
CYPRUS	CY
CZECH REPUBLIC	CZ
DENMARK	DK
DJIBOUTI	DJ
DOMINICA	DM
DOMINICAN REPUBLIC	DO
ECUADOR	EC
EGYPT	EG
EL SALVADOR	SV
EQUATORIAL GUINEA	GQ
ERITREA	ER
ESTONIA	EE
ETHIOPIA	ET
FALKLAND ISLANDS (MALVINAS)	FK
FAROE ISLANDS	FO
FIJI	FJ
FINLAND	FI
FRANCE	FR
FRENCH GUIANA	GF
FRENCH POLYNESIA	PF
FRENCH SOUTHERN TERRITORIES	TF
GABON	GA
GAMBIA	GM
GEORGIA	GE
GERMANY	DE
GHANA	GH
GIBRALTAR	GI
GREECE	GR
GREENLAND	GL
GRENADA	GD
GUADELOUPE	GP
GUAM	GU
GUATEMALA	GT
GUERNSEY	GG
GUINEA	GN
GUINEA-BISSAU	GW

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COUNTRY NAME	CODE
GUYANA	GY
HAITI	HT
HEARD ISLAND AND MCDONALD ISLANDS	HM
HOLY SEE (VATICAN CITY STATE)	VA
HONDURAS	HN
HONG KONG	HK
HUNGARY	HU
ICELAND	IS
INDIA	IN
INDONESIA	ID
IRAN, ISLAMIC REPUBLIC OF	IR
IRAQ	IQ
IRELAND	IE
ISLE OF MAN	IM
ISRAEL	IL
ITALY	IT
JAMAICA	JM
JAPAN	JP
JERSEY	JE
JORDAN	JO
KAZAKHSTAN	KZ
KENYA	KE
KIRIBATI	KI
KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF	KP
KOREA, REPUBLIC OF	KR
KUWAIT	KW
KYRGYZSTAN	KG
LAO PEOPLE'S DEMOCRATIC REPUBLIC	LA
LATVIA	LV
LEBANON	LB
LESOTHO	LS
LIBERIA	LR
LIBYAN ARAB JAMAHIRIYA	LY
LIECHTENSTEIN	LI
LITHUANIA	LT
LUXEMBOURG	LU
MACAO	MO
MACEDONIA, THE FORMER YUGOSLAV REPUBLIC OF	MK
MADAGASCAR	MG
MALAWI	MW
MALAYSIA	MY
MALDIVES	MV
MALI	ML
MALTA	MT
MARSHALL ISLANDS	MH
MARTINIQUE	MQ

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COUNTRY NAME	CODE
MAURITANIA	MR
MAURITIUS	MU
MAYOTTE	YT
MEXICO	MX
MICRONESIA, FEDERATED STATES OF	FM
MOLDOVA	MD
MONACO	MC
MONGOLIA	MN
MONTENEGRO	ME
MONTSERRAT	MS
MOROCCO	MA
MOZAMBIQUE	MZ
MYANMAR	MM
NAMIBIA	NA
NAURU	NR
NEPAL	NP
NETHERLANDS	NL
NEW CALEDONIA	NC
NEW ZEALAND	NZ
NICARAGUA	NI
NIGER	NE
NIGERIA	NG
NIUE	NU
NORFOLK ISLAND	NF
NORTHERN MARIANA ISLANDS	MP
NORWAY	NO
OMAN	OM
PAKISTAN	PK
PALAU	PW
PALESTINIAN TERRITORY, OCCUPIED	PS
PANAMA	PA
PAPUA NEW GUINEA	PG
PARAGUAY	PY
PERU	PE
PETITE SERCQ, ÎLE DE	GG
PHILIPPINES	PH
PITCAIRN	PN
POLAND	PL
PORTUGAL	PT
PUERTO RICO	PR
QATAR	QA
RÉUNION	RE
ROMANIA	RO
RUSSIAN FEDERATION	RU
RWANDA	RW
SAINT BARTHELEMY	BL
SAINT HELENA, ASCENSION AND TRISTAN DA CUNHA	SH

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COUNTRY NAME	CODE
SAINT KITTS AND NEVIS	KN
SAINT LUCIA	LC
SAINT MARTIN	MF
SAINT PIERRE AND MIQUELON	PM
SAINT VINCENT AND THE GRENADINES	VC
SAMOA	WS
SAN MARINO	SM
SAO TOME AND PRINCIPE	ST
SAUDI ARABIA	SA
SENEGAL	SN
SERBIA	RS
SEYCHELLES	SC
SIERRA LEONE	SL
SINGAPORE	SG
SINT MAARTEN (DUTCH PART)	SX
SLOVAKIA	SK
SLOVENIA	SI
SOLOMON ISLANDS	SB
SOMALIA	SO
SOUTH AFRICA	ZA
SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS	GS
SOUTH SUDAN	SS
SPAIN	ES
SRI LANKA	LK
SUDAN	SD
SURINAME	SR
SVALBARD AND JAN MAYEN	SJ
SWAZILAND	SZ
SWEDEN	SE
SWITZERLAND	CH
SYRIAN ARAB REPUBLIC	SY
TAIWAN, PROVINCE OF CHINA	TW
TAJIKISTAN	TJ
TANZANIA, UNITED REPUBLIC OF	TZ
THAILAND	TH
TIMOR-LESTE	TL
TOGO	TG
TOKELAU	TK
TONGA	TO
TRINIDAD AND TOBAGO	TT
TUNISIA	TN
TURKEY	TR
TURKMENISTAN	TM
TURKS AND CAICOS ISLANDS	TC
TUVALU	TV
UGANDA	UG
UKRAINE	UA

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COUNTRY NAME	CODE
UNITED ARAB EMIRATES	AE
UNITED KINGDOM	GB
UNITED STATES MINOR OUTLYING ISLANDS	UM
URUGUAY	UY
UZBEKISTAN	UZ
VANUATU	VU
Vatican City State see HOLY SEE	
VENEZUELA, Bolivarian Republic of	VE
VIET NAM	VN
VIRGIN ISLANDS, BRITISH	VG
VIRGIN ISLANDS, U.S.	VI
WALLIS AND FUTUNA	WF
WESTERN SAHARA	EH
YEMEN	YE
ZAMBIA	ZM
ZIMBABWE	ZW

Appendices

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External Code Sources List

State abbreviations and ZIP Codes:

National ZIP Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual
Available from:
U.S. Postal Service
Washington, DC 20260

Look up Address/City/Zip here: http://zip4.usps.com/zip4/citytown_zip.jsp

Country Codes:

Codes for Representation of Names of Countries, ISO 3166 (Latest Release)
Available from:
American National Standards Institute (ANSI)
11 West 42nd Street, 13th Floor
New York, NY 10036

<http://www.iso.org/iso/en/prods-services/iso3166ma/index.html>

Race/Ethnicity Codes:

Standards for the Classification of Federal Data on Race and Ethnicity
Code Source: ASC X12 External Code Source 859
Health Information and Surveillance Systems Board

Marital Status Codes:

Code Source: ASC X12 Data Element 1067

NOTE: ADHS uses only a subset of this list for Arizona Hospital Discharge Data reporting.

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Collecting Patient Race Data

As of January 1, 2003, Federal programs were required by the U.S. Office of Management and Budget to adopt revised standards for collecting and reporting racial and ethnic status. These standards were published in the Federal Register on October 30, 1997, as "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity." The notice is posted on the OMB web-site at:

<http://www.whitehouse.gov/omb/fedreg/ombdir15.html>

The following is an excerpt from the Federal Register:

This classification provides a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies.

The standards have five categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for data on ethnicity: "Hispanic or Latino," and "Not Hispanic or Latino."

1. Categories and Definitions

The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting are defined as follows:

-- **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

-- **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

-- **Black or African American.** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

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-- **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

-- **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

-- **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Respondents shall be offered the option of selecting one or more racial designations. Recommended forms for the instruction accompanying the multiple response question are "Mark one or more" and "Select one or more."

For assistance

There is an excellent toolkit available on the Internet from the Health Research and Educational Trust for collecting patient race information in health care organizations. It is designed to help hospitals, health systems, community health centers, health plans, and other potential users in understanding the importance of accurate data collection, assessing organizational capacity to do so, and implementing a framework designed specifically for obtaining information from patients/enrollees about their race and ethnicity in an efficient, effective and respectful manner.

To access this toolkit, visit their website at:

<http://www.hretdisparities.org/>

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ADHS Data Element	ADHS Element Number	UB04 Data Element	Form Locator Number
Placeholder	C01	None	
Reporting Hospital Arizona Facility Identifier	C02	None	
Reporting Hospital National Provider Identifier	C03	National Provider Identifier - Billing Provider	FL56
Patient Medical/Health Record Number	C04	Medical/Health Record Number	FL03b
Patient Control Number	C05	Patient Control Number	FL03a
Patient Name	C06	Patient Name/Identifier	FL08
Patient Social Security Number	C07	None	
Patient Address	C08	Patient Address	FL09
Patient City	C09	Patient Address	FL09
Patient State	C10	Patient Address	FL09
Patient Zip Code	C11	Patient Address	FL09
Patient Country Code	C12	Patient Address	FL09
Patient Homeless Indicator	C13	Condition Codes	FL18-28
Patient Birth Date	C14	Patient Birth Date	FL10
Patient Sex	C15	Patient Sex	FL11
Patient Race/Ethnicity	C16	Code-Code Field	FL81
Patient Marital Status	C17	Code-Code Field	FL81
Onset of Symptoms/Illness Date	C18	Occurrence Codes and Dates	FL31-34
Admission Date	C19	Admission/Start of Care Date	FL12
Admission Hour	C20	Admission Hour	FL13
Priority (Type) of Visit	C21	Priority (Type) of Visit	FL14
Source of Admission or Visit	C22	Point of Origin for Admission or Visit	FL15
Discharge Date	C23	Statement Covers Period	FL06
Discharge Hour	C24	Discharge Hour	FL16
Discharge Status	C25	Patient Discharge Status	FL17
Newborn Birth Weight	C26	Value Codes and Amounts	FL39-41
Do Not Resuscitate Order (DNR)	C27	Condition Codes	FL18-28
Bill Creation Date	C28	Service Date	FL45
Total Charges	C29	Total Charges	FL47
Payer Type Code	C30	Payer Name	FL50
Revenue Code Category Charges	C31	Revenue Codes & Total Charges	FL42 & FL47
Nursery Revenue Code Charges (1-6)	C32	Revenue Codes & Total Charges	FL42 & FL47

ADHS Data Element	ADHS Element Number	UB04 Data Element	Form Locator Number
HIPPS - IRF PPS CMG Code	C33	HCPCS/Accommodation Rates/HIPPS Rate Codes	FL44
DRG	C34	Prospective Payment System (PPS) Code	FL71
ICD Version Indicator	C35	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	FL66
Patient Reason for Visit (1-3)	C36	Patient's Reason for Visit	FL70a-c
Admitting Diagnosis	C37	Admitting Diagnosis Code	FL69
Principal Diagnosis Code	C38	Principal Diagnosis Code and Present on Admission Indicator	FL67
Other Diagnosis Code (2-25)	C39	Other Diagnosis Codes	FL67A-Q
External Cause of Injury - E Code (1-6)	C40	External Cause of Injury (ECI) Code	FL72a-c
Accident State	C41	Accident State	FL29
Principal Procedure Code	C42	Principal Procedure Code and Date	FL74
Principal Procedure Date	C43	Principal Procedure Code and Date	FL74
Other Procedure Code (2-12)	C44	Other Procedure Codes and Dates	FL74a-e
Other Procedure Date (2-12)	C45	Other Procedure Codes and Dates	FL74a-e
Attending Provider Name	C46	Attending Provider Name and Identifiers	FL76
Attending Provider National Provider Identifier (NPI)	C47	Attending Provider Name and Identifiers	FL76
Attending Provider State License Number	C48	None	
Attending Provider State Licensing Board	C49	None	
Operating Provider Name	C50	Operating Physician Name and Identifiers	FL77
Operating Provider National Provider Identifier (NPI)	C51	Operating Physician Name and Identifiers	FL77
Operating Provider State License Number	C52	None	
Operating Provider State Licensing Board	C53	None	
Other Provider Name	C54	Other Provider Name and Identifiers	FL78-79
Other Provider National Provider Identifier (NPI)	C55	Other Provider Name and Identifiers	FL78-79
Other Provider State License Number	C56	None	
Other Provider State Licensing Board	C57	None	
ED Admission Flag	C60	Condition Codes	FL18-28
Visit Qualifier	C61	None	
Type of Record	C58	None	

Regulatory Information

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Legal Authority:

Reporting of hospital inpatient and emergency department discharge records by Arizona licensed hospitals is mandated under Arizona Revised Statute (A.R.S.) 36-125.05 and Arizona Administrative Code (A.A.C) Title 9, Chapter 11, Articles 4 & 5.

Civil penalties for failure to comply with the reporting requirements are authorized under Arizona Revised Statute A.R.S. 36-126. Civil penalties of up to three hundred dollars per violation may be imposed, with each day that a violation continues constituting a separate violation.

Procedures and Timeframes:

Data must be reported no later than the two reporting deadlines of February 15th and August 15th each year.

Facilities that fail to report by close of business on the reporting deadline will receive a letter notifying them of their failure to report, and warning of civil penalties if they do not report immediately. Facilities that fail to report after receiving the warning letter will be referred to enforcement.

All data sets are audited by ADHS, utilizing a standardized auditing process. Facilities that fail to substantially meet the reporting requirements for data completeness and accuracy are required to make corrections and resubmit their data. For the first data submission requiring corrections, the facility is allowed 21 days from the date of the ADHS notification letter to make the required corrections and resubmit their data. For a second submission requiring corrections, the facility is allowed 7 days from the date of the ADHS notification letter to make the required corrections and resubmit their data. Upon a third submission requiring corrections, the facility is referred to enforcement.

Enforcement:

Any facility referred to enforcement is evaluated for reporting history, compliance history and specifics of the present non-compliance. If enforcement action is taken, the facility has the opportunity to request an Administrative hearing. A facility that requests a hearing may also request an informal dispute resolution process with the Section of Cost Reporting and Discharge Data Review. Details regarding facility rights and responsibilities are provided to the facility at the time any enforcement action is taken.

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