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://www.azdhs.gov/preparedness/public-health-statistics/hospital-discharge-data/index.php#reporting-requirements-home

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Reporting Requirements Overview

Section A
A-1.1

Who:

All Arizona *licensed* hospitals (i.e. operating under a license issued by the Arizona Department of Health Services), regardless of license type, are required to report inpatient and emergency department discharge records to the Arizona Department of Health Services (ADHS). Stand-alone (satellite) Emergency Departments operating on a Single Group License arrangement under an acute hospital's main campus license must also report separately from their affiliated main campus.

When:

Data must be reported twice yearly:

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

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

TEST files may be voluntarily submitted for evaluation prior to official reporting. Refer to the Generic Calendar on page B-1.6 of this manual for testing timeframes.

How:

Data is reported in a fixed length/fixed field 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 information 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://www.azdhs.gov/preparedness/public-health-statistics/hospital-discharge-data/index.php#reporting-requirements-home for current contact information.

File Submission Information

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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 with fixed length fields. See Section D of this manual for file layout specifications, and Section C of this manual for specific requirements on each individual data element.

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.txt

   Example: ***MED1234_IP_201801.txt***

   "MED1234" = AZFACID, the facility identifier issued by ADHS
   "IP" = data type being reported (IP for inpatient; ED for emergency department)
   "201801" = reporting period, (the time period reported, e.g. 2018 first half)
   ".txt" required file type extension

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 i.e. each data element is correctly positioned?

   b) Are all required fields populated with appropriate data?

   c) Is the AZFACID correct? See list on our website (link in Section A-1.1).

   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 on the last page of Section D.

   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.

File Submission Information

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B-1.2

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?

Submissions:

5. Data **must** be submitted utilizing the ADHS SFTP secure file server. Every hospital must have 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 (*Arizona Hospital Discharge Data Reporting Information 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 *(Attestation of Completeness and Accuracy Form)* – on this form, the hospital CEO or designee who is responsible for your hospital's compliance with state law certifies the reporting is, to the best of their knowledge, complete and accurate.

   c) All forms must be named according to the following naming conventions:

      AZFACID_form name_reporting period.pdf
      Examples: MED1234_contact_201801.pdf
      MED1234_attest_201801.pdf

These forms are our website at: http://www.azdhs.gov/preparedness/public-health-statistics/hospital-discharge-data/index.php#reporting-requirements-home

File Submission Information

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9. Send your forms:

   By placing on the secure server with your data;

   By scan/email as an attachment to: joseph.spadafino@azdhs.gov

File Submission Information

Section B
B-1.4

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.
If the ED portion of the treatment occurred at an ED satellite location, then the Visit_Qualifier field in the IP record must be populated with the appropriate Satellite identifier. See Facility ID list on the ADHS website or call ADHS for assistance.

Bill Split:

The ED portion of the visit is reported in the ED file.
The ED record must have Discharge Status "09" or "61"
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 should match. If there are 350 split ED records, there should be 350 corresponding split IP records. Failure to report both records will be considered an error. *Exception:* split bills with visit dates that cross state reporting period timeframes are excluded from error (e.g. ED treatment/IP admission on December 30th, discharged from IP on January 2nd).

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

4) Emergency Department – treated; moved to observation or other outpatient status, then released/transferred (not admitted as inpatient)

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.

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.

5) Emergency Department Satellite Campus – treat and release
Records of outpatient only treatments at Satellite ED locations operating with SGL licensure under the main hospital license must be reported in a separate ED file following the requirements explained under items (2) and (4) above.

6) Emergency Department Satellite Campus – treated; admitted as an inpatient to main hospital campus (with or without additional treatment at main hospital campus ED prior to IP admission)
Report following the requirements explained under item (3) above.

Generic Calendar for Arizona Hospital Discharge Data Reporting

January

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28			

March

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

June

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

July

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

August

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

September

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

October

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

November

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

December

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Reporting Period = Jan 1 - Jun 30 “first half” and Jul 1 - Dec 31 “second half”

Official Report Submission/Processing Period = Data reports are due August 15th (first half) and February 15th (second half)
Reporting Deadlines = Data **must** be reported by these dates to avoid possible civil penalties
****Test files may be submitted at any time, as often as needed.****

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.

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 (ASCII file 1 – 10)
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/preparedness/public-health-statistics/hospital-discharge-data/index.php#reporting-requirements-home

Once a hospital has reported discharge data under an assigned number, that number never changes as long as the hospital is open.

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 (ASCII file 11-25)
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).

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 (ASCII file 26-49)
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.

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 (ASCII file 50-73)
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."

This number is unique to the patient **and** the encounter.

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 (ASCII file 94-122)
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)

If circumstances prevent you from obtaining the patient's name, report UNKNOWN.

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 (ASCII file 123-132)
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 will never 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.

Blanks are not a valid value and are not acceptable.

0000 is not a valid value and is not acceptable.

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 (ASCII file 133-172)
Alphanumeric
Left-Justified
Crosswalk to UB04 FL09 Line 1a

Codes/Values: Alpha characters must be UPPER CASE

Use 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 must be entered following the US Postal Service Address Standards for Military Addressing. **Include the unit and APO/FPO/DPO** (Air/Army Post Office™, Fleet Post Office or Diplomatic Post Office) address with the 5 or 9-digit ZIP Code™ (if one is assigned). Include the unit information in the street address. The city should be APO, FPO, or DPO. The state should be either a US state abbreviation or Military state abbreviation.

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

APO/FPO/DPO zip codes can be checked for validity at:

http://zip4.usps.com/zip4/citytown.jsp

Data Element Specifications

Section C
C-08.2

Examples of military addressing:

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

Seaman Joseph Doe
USCGC Hamilton
FPO AP 96667-3931

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

See specifications for City, State and Zip in this manual.

Data Element Specifications

Section C
C-09.1

Element Name: Patient City

Definition: City of the patient's mailing address.

Parameters: 30 Positions (ASCII file 173-202)
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: https://tools.usps.com/go/zip-code-lookup.htm

For Military addresses, the city must be APO, FPO or DPO.

Data Element Specifications

Section C
C-10.1

Element Name: Patient State

Definition: State of the patient's mailing address.

Parameters: 2 Positions (ASCII file 203-204)
Alphanumeric
All positions filled
Crosswalk to UB04 FL09 Line 2c

Codes/Values: Alpha characters must be UPPER CASE.

Must be a **valid US 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/

List of APO/FPO/DPO Military state abbreviations:

Armed Forces Africa	AE
Armed Forces Americas	AA
Armed Forces Canada	AE
Armed Forces Europe	AE
Armed Forces Middle East	AE
Armed Forces Pacific	AP

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 (ASCII file 205-213)
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:
https://tools.usps.com/go/zip-code-lookup.htm

Data Element Specifications

Section C
C-12.1

Element Name: Patient Country Code

Definition: Country of patient's mailing address.

Parameters: 2 Positions (ASCII file 214-215)
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 ***only if the patient is a foreign resident***.

Notes:

No punctuation.

If the patient is homeless, leave blank.

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

Do not report on US residents; 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/preparedness/public-health-statistics/hospital-discharge-data/index.php#reporting-requirements-home**

Data Element Specifications

Section C
C-13.1

Element Name: Patient Homeless Indicator

Definition: The patient is homeless.

Parameters: 2 Positions (ASCII file 216-217)
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.

Data Element Specifications

Section C
C-14.1

Element Name: Patient Birth Date

Definition: The date of birth of the patient.

Parameters: 8 Positions (ASCII file 218-225)
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 (e.g. 00000000). 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.

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 (ASCII file 226)
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:

Data Element Specifications

Section C
C-16.1

Element Name: Patient Race

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

Parameters:
3 Positions (ASCII file 227-229)
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
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 3 can be selected.

Do not base Patient Race on observation.

See Section I Appendices for additional resource information.

RACE is an identifier of **Genetic Ancestry** – this is different than ETHNICITY. Every human on earth is genetically one (or more than one) of the Race categories available in this state reporting Race code set.

Data Element Specifications

Section C
C-16.2

Element Name: Patient Ethnicity

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

Parameters:
1 Position (ASCII file 230)
Alphanumeric
Crosswalk to UB04 FL81, Lines a-d
Code List Qualifier value = B1

Codes/Values:

1	Hispanic/Latino
2	Non-Hispanic/Latino
9	Refused

Conditions: Required for IP and ED.

Notes:

Do not base Patient Ethnicity on observation.

See Section I Appendices for additional resource information.

ETHNICITY is an identifier of **Cultural/Social Orientation** – this is different than RACE.

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 (ASCII file 231)
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 (minors too young to legally marry)

Conditions: Required for IP and ED.

Notes:

See Section I Appendices for additional resource information.

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 (ASCII file 252-259)
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.

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 (ASCII file 260-267)
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).

Data Element Specifications

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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 (ASCII file 268-269)
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.

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 (ASCII file 270)
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. If the record contains charges in Revenue Category R068x, then Code 5 **must** be used.

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 (ASCII file 271)
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
G = Transfer from a Designated Disaster Alternate Care Site

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 National Uniform Bill (currently 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.

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 (ASCII file 272-279)
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.

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 (ASCII file 280-281)
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.

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 (ASCII file 282-283)
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
69 = Discharged/transferred to a Designated Disaster Alternative Care Site
70 = Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List
81 = Discharged to Home or Self Care (routine discharge) with a planned acute care hospital inpatient readmission

Data Element Specifications

Section C
C-25.2

Codes/Values: (cont)

82 = Discharged/transferred to a Short-Term General Hospital for Inpatient care with a planned acute care hospital inpatient readmission
83 = Discharged/transferred to a Skilled Nursing Facility with a planned acute care hospital inpatient readmission
84 = Discharged/transferred to an Intermediate Care Facility (Assisted Living Facility) with a planned acute care hospital inpatient readmission
85 = Discharged/transferred to a Designated Cancer Center or Children's Hospital with a planned acute care hospital inpatient readmission
86 = Discharged/transferred to home under care of Organized Home Health Service Organization with a planned acute care hospital inpatient readmission
87 = Discharged/Transferred to Court/Law Enforcement with a planned acute care hospital inpatient readmission
88 = Discharged/transferred to a Federal Health Care Facility with a planned acute care hospital inpatient readmission
89 = Discharged/transferred to a Swing Bed with a planned acute care hospital inpatient readmission
90 = Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) with a planned acute care hospital inpatient readmission
91 = Discharged/transferred to a Long Term Care Hospital with a planned acute care hospital inpatient readmission
93 = Discharged/transferred to a Psychiatric Hospital with a planned acute care hospital inpatient readmission
94 = Discharged/transferred to a Critical Access Hospital with a planned acute care hospital inpatient readmission
95 = Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List with a planned acute care hospital inpatient readmission

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.

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

Data Element Specifications

Section C
C-25.3

Notes (cont'd):

Discharge status 01 or 81 = Home or Self Care is used in accordance with the UB04 definition of this discharge status, including discharges to *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 or 84 = 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 discharges to Medicare/Medicaid certified nursing beds/facilities, and which discharge codes should be assigned.

Discharge status 64 and 92 = Are not valid. Arizona has a law that requires a skilled nursing facility to be Medicare certified before it can obtain Medicaid certification (which is not the case in many other states). **"Medicaid only" certified nursing homes do not exist in Arizona.**

Therefore, 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.

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 (ASCII file 284-287)
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).

Required for ED if the baby is born in your emergency room **or** treated in your ED following an extramural birth **and prior** to being transferred to another hospital for inpatient treatment.

Notes:

Do not zero fill.

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

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 (ASCII file 288-289)
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.

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 (ASCII file 310-317)
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:

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 (ASCII file 318-325)
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.

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 (ASCII file 326-327)
Numeric
All positions filled
Crosswalk to UB04 FL50a

Codes/Values:

00	Self Pay
01	Commercial (Indemnity)
02	HMO
03	PPO
04	Discontinued/Reserved
05	Medicare
06	AHCCCS Medicaid (see APRDRG specs page C-62)
07	TRICARE
08	Children's Rehab Services
09	Workers Compensation
10	Indian Health Services
11	Medicare Risk (Medicare Advantage Plans)
12	Charity
13	Foreign National
14	Other

Conditions: Required for IP and ED.

Notes:

See Payer Type Guidance in Section I, page I-7.1-3.

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 (ASCII file 328 – 803, see Section D for details)
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

Data Element Specifications

Section C
C-31.2

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

Revenue code	Charges
0621	$100.15
0623	$37.03

Report for Revenue Code Category 062X = 137

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 (ASCII file 804 – 845, see Section D for details)
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

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 (ASCII file 846-850)
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 from other hospitals when an IRF CMG code exists on the patient bill.

Notes:

Data Element Specifications

Section C
C-34.1

Element Name: DRG

Definition: The MSDRG code assigned to the claim.

Parameters: 4 Positions (ASCII file 851-854)
Numeric
Right-Justified
Crosswalk to UB04 FL71

Codes/Values: Must be a valid MSDRG code for the time period and version being reported.

Conditions: Required for IP on all records, except for AHCCCS payer records on which an APRDRG code is reported instead. See page C62.1

Notes:

Do not zero fill.

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

DO NOT report APRDRGs here in positions 851-854. See page C62.1 for APRDRG reporting specifications.

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 Position (ASCII file 895)
Numeric
Crosswalk to UB04 FL66

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

Conditions: Required for IP and ED.

Notes:

Effective for all discharges occurring on October 1, 2015 and later, only ICD-10-CM diagnosis codes may be reported, and ICD Version Indicator **0 (zero)** must be reported.

Regarding non-HIPAA covered entities that may not transition to ICD-10-CM on the national implementation date, the Arizona statute that mandates hospital data reporting requires that hospital discharge data collection substantially follow federal Health and Human Services billing requirements. Therefore, all discharges occurring on/after the date of national implementation *must* be reported with ICD-10-CM coding.

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 (ASCII file 896-919, see Section D for details)
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 External Cause Codes in these fields. External Cause Codes (ICD-10-CM = V,W,X, Y) have separate fields designated for the purpose of state reporting.

Follow official coding guidelines for ICD reporting.

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 (ASCII file 920-927)
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 External Cause Codes in this field. External Cause Codes (ICD-10-CM = V,W,X, Y) have separate fields designated for the purpose of state reporting.

Follow official coding guidelines for ICD reporting.

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 (ASCII file 928-934)
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 External Codes in this field. External Codes (ICD-10-CM = V,W,X, Y) have separate fields designated for the purpose of state reporting.

Z codes are acceptable.

Follow official coding guidelines for ICD reporting.

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 (ASCII file 935)
Alphanumeric
Crosswalk to UB04 FL67

Codes/Values: Alpha characters must be UPPER CASE.

POA Codes:

Code	Definition
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1	Exempt

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:

Reporting of POA Indicators is required of **all** Arizona hospitals regardless of hospital type, including but not limited to: acute, rehabilitation, long term, surgical specialty, children's, cancer, psychiatric and critical access

Follow official coding guidelines for assignment of the POA Indicator.

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 (ASCII file starting at 936, see Section D for details)
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 External Codes in these fields. External Codes (ICD-10-CM = V,W,X, Y) have separate fields designated for the purpose of state reporting.

Z codes are acceptable.

Follow official coding guidelines for ICD reporting.

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 (ASCII file starting at 943, see Section D for details)
Alphanumeric
Crosswalk to UB04 FL67

Codes/Values: Alpha characters must be UPPER CASE.

POA Codes:

Code	Definition
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1	Exempt

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:

Reporting of POA Indicators is required of **all** Arizona hospitals regardless of hospital type, including but not limited to: acute, rehabilitation, long term, surgical specialty, children's, cancer, psychiatric and critical access

Follow official coding guidelines for assignment of the POA Indicator.

Data Element Specifications — Section C

C-40a.1

Element Name: External Cause / Place of Injury Codes (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 (ASCII file starting at 1128, see Section D for details)
Alphanumeric
Left-Justified
Crosswalk to UB04 FL72

Codes/Values: Alpha characters must be UPPER CASE

The decimal between the third and fourth digit of the External code is implied.

Must be valid ICD External codes, based on the ICD version indicated on the record and the time period being reported.

Conditions: Both Cause and Place codes are required for IP and ED on all treatments of injury, adverse effect, misadventure or complication, and all other health conditions due to an external cause.

Notes: **See separate guidance for CODING and REPORTING, below.**

CODING: Refer to national coding guidelines for assistance with proper External code assignment.

For PLACE codes, assign the PLACE of Occurrence code on all *initial* treatments of injury, poisoning, toxic or adverse effect, misadventure or complication and all other health conditions due to an external cause **(initial treatments are identified by the 7th digit of "A," "B," or "C" in the triggering Diagnosis and/or External Cause code).**

In accordance with national coding guidelines, **do not assign PLACE code Y929 if the place is not stated in the record.**

REPORTING:

Do not report decimals.

Report up to six (6) External Cause or Place codes (V, W, X, Y) *in the order in which they appear* in the hospital system.

Data Element Specifications

Section C
C-40b.1

Element Name: External Cause 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 (ASCII file starting at 1135, see Section D for details)
Alphanumeric
Crosswalk to UB04 FL67

Codes/Values: Alpha characters must be UPPER CASE.

POA Codes:

Code	Definition
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1	Exempt

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:

Reporting of POA Indicators is required of **all** Arizona hospitals regardless of hospital type, including but not limited to: acute, rehabilitation, long term, surgical specialty, children's, cancer, psychiatric and critical access.

Follow official coding guidelines for assignment of the POA Indicator.

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 (ASCII file 1176-1177)
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.

Data Element Specifications

Section C
C-42.1

Element Name: Principal Procedure Code

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

Parameters: 7 Positions (ASCII file 1198-1204)
Alphanumeric
Left-Justified
Crosswalk to UB04 FL74 (IP) or FL44 (ED)

Codes/Values: Must be valid ICD or 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-10-PCS codes.

On ED records: report ***only*** 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 CPT 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.

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

Do not report Level II HCPCS codes

Do not report modifiers

Data Element Specifications

Section C
C-43.1

Element Name: Principal Procedure Date

Definition: Date of the principal procedure performed.

Parameters: 8 Positions (ASCII file 1205-1212)
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: Must be the date of service (date the procedure was performed).

Data Element Specifications

Section C
C-44.1

Element Name: Other Procedure Code (2-12)

Definition: The ICD or 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 (ASCII file starting at 1213, see Section D for details)
Alphanumeric
Left-Justified
Crosswalk to UB04 FL74 (IP) or FL44 (ED)

Codes/Values: Must be valid ICD or 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-10-PCS codes.

On ED records: report ***only*** 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 CPT 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.

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 an Evaluation and Management 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 modifiers

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 (ASCII file starting at 1220, see Section D for details)
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: Must be the date of service (date the procedure was performed).

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 (ASCII file 1398-1425)
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

First and last names are required

Conditions: Required for IP and ED.

Notes:

Must be licensed individual clinicians. DO NOT report groups or generic identifiers.

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 apostrophes (report OCONNER, *not* O'CONNER). Hyphens *are allowed* such as Smith-Jones (if the hyphen is present in the source system).

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

Do not report titles in this name field (MD, DO, DDS).

Do NOT report a physician assistant as Attending Provider. Under A.R.S. §32-2531 the supervising physician *retains professional and legal responsibility* for care rendered by the physician assistant. Report the information of the licensed physician who is the supervising physician of the physician assistant.

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 (ASCII file 1426-1436)
Alphanumeric
Left-Justified
Crosswalk to UB04 FL76 Line 1

Codes/Values: Alpha characters must be UPPER CASE

Conditions: Required for IP and ED.

Notes:

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 (ASCII file 1437-1444)
Numeric
Right-Justified

Codes/Values: Report numeric portion only.

Conditions: Required for IP and ED.

Notes:

Do not report alpha prefixes of license numbers; report only the numeric portion of the license.

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.**

The Arizona State Board of Nursing has licensing reciprocity with many other state. As a result, RNs may practice in Arizona with a license issued by another state that has been recognized by the AzSBON.. These license numbers begin with "MSL." When reporting an RN with this type of license, report the MSL license number, **numeric portion only.**

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.

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 (ASCII file 1445)
Numeric

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

Conditions: Required for IP and ED.

Notes:

In Arizona, Physician Assistants cannot be reported as Attending Providers. The Attending Provider has overall responsibility for the patient's medical care and treatment, and this level of responsibility is out of the PA scope of practice according to their licensing board. For this reason, the State License Board Code for Physician Assistants is not listed here. The code is listed under both Operating and Other Provider State Board Code reporting, as Physician Assistants may be reported as Operating or Other providers.

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 (ASCII file 1446-1473)
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

.

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 a CPT code in the range of 10000 – 69999.

Notes:

Must be licensed individual clinicians. DO NOT report groups or generic identifiers.

Do not include apostrophes (report OCONNER, *not* O'CONNER). Hyphens *are allowed* such as Smith-Jones (if the hyphen is present in the source system).

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

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

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 (ASCII file 1474-1484)
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 a CPT code in the range of 10000 – 69999.

Notes:

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 (ASCII file 1485-1492)
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 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.**

The Arizona State Board of Nursing has licensing reciprocity with many other state. As a result, RNs may practice in Arizona with a license issued by another state that has been recognized by the AzSBON.. These license numbers begin with "MSL." When reporting an RN with this type of license, report the MSL license number, **numeric portion only.**

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 (ASCII file 1493)
Numeric

Codes/Values:
1 = Medical Board (MD)
2 = Dental Examiners (DDS)
3 = Podiatry Examiners (DPM)
4 = Osteopathic Examiners (DO)
5 = Board of Nursing (RN)
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 a CPT code in the range of 10000 – 69999.

Notes:

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 (ASCII file 1494-1521)
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

First and last names are required.

Conditions: Situational. Required for IP and ED when a Referring, Other Operating or Rendering Provider is included on the claim for this episode of care.

Notes:

Must be licensed individual clinicians. DO NOT report groups or generic identifiers.

Do not include apostrophes (report OCONNER, *not* O'CONNER). Hyphens *are allowed* such as Smith-Jones (if the hyphen is present in the source system).

Do not report titles (MD, DO, DDS, PA, 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

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 (ASCII file 1522-1534)
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 "other" a provider already reported as attending or operating).

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 (ASCII file 1535-1542)
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.**

The Arizona State Board of Nursing has licensing reciprocity with many other state. As a result, RNs may practice in Arizona with a license issued by another state that has been recognized by the AzSBON.. These license numbers begin with "MSL." When reporting an RN with this type of license, report the MSL license number, **numeric portion only.**

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 (ASCII file 1543)
Numeric

Codes/Values:
1 = Medical Board (MD)
2 = Dental Examiners (DDS)
3 = Podiatry Examiners (DPM)
4 = Osteopathic Examiners (DO)
5 = Board of Nursing (RN)
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:

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 (ASCII file 1604)
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.

Data Element Specifications

Section C
C-59.1

Element Name: DRG Version

Definition: Indicates the MSDRG code set version reported for this record.

Parameters: 2 Positions (ASCII file 855-856)
Numeric

Codes/Values: 41 = Version 41 (MSDRG) – discharges 10/1/2023 – 09/30/2024
42= Version 42 (MSDRG) – discharges 10/1/2024 – 09/30/2025

Conditions: Required for IP when an MSDRG code is reported.

Notes:

The reported DRG Version identifies the MSDRG code set used to calculate the MSDRG code reported in the record.

The current MS-DRG Version is based upon the current Federal fiscal year. This means that in the second half of state reporting each year, you are going to have 3 months in one Federal fiscal year, and 3 months in the next. As a result, during second half reporting to the state, you will have two DRG Versions to report. *Example: 2021-02 reporting will have July - Sept discharges as Version 38, and Oct - Dec discharges as Version 39.*

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 (ASCII file 1601-1602)
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.

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 Position (ASCII file 1603)
Alphanumeric
All positions filled

Codes/Values: S = Split Visit (IP or ED)
M = Mixed Visit (ED only)
0-9 = Satellite ED Identifier (IP 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 and then discharged (**not** admitted as an inpatient).

"0" through "9" single digit numeric value must be reported on IP records if the patient received treatment at a satellite ED location prior to inpatient admission at the main affiliated hospital campus location. The numeric value identifies the specific ED satellite location that provided the ED treatment. See Facility ID list on the ADHS website for the satellite identifier value, or contact ADHS for assistance.

Notes:

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

Data Element Specifications

Section C
C-62.1

Element Name: APRDRG

Definition: The APRDRG code assigned to the claim for reimbursement from the Arizona Health Care Cost Containment System (AHCCCS)

Parameters: 4 Positions (ASCII file 857-860)
Numeric
All positions filled
Crosswalk to UB04 FL71

Codes/Values: Must be a valid APRDRG for the time period and version being reported.

Conditions: IP records only, when the reported Payer is 06=AHCCCS.

Due to the provisions of Arizona Administrative Code R9-22-712.61.A.(1) (2) and (3), hospitals operating under a *License Type* of Psychiatric, Rehabilitation or Long Term are currently exempt from this requirement. This exemption ***does not*** apply to units inside hospitals operating under other License Types (e.g. a psychiatric unit located inside a hospital operating under a License Type of Short-Term Acute Care).

Notes:

DO include the leading zero that is part of the APRDRG code; for example:0411.

Report the base (3 digit) code and the severity identifier (4th digit). *Exclude* the dash (-). Example: report 0411 not 041-1.

If you are uncertain regarding your hospital's License Type, contact ADHS for assistance.

Data Element Specifications

Section C
C-63.1

Element Name: APR DRG Version

Definition: Indicates the APR DRG code set version reported for this record.

Parameters: 2 Positions (ASCII file 861-862)
Numeric

Codes/Values: 34 = Version 34 (APRDRG) - discharges through 9/30/2021
38 = Version 38 (APRDRG) – discharges 10/1/2021 onward (until updated by AHCCCS)

Conditions: Required for IP when an APRDRG code is reported in the record.

Hospitals operating under a License Type of Psychiatric, Rehabilitation, or Long Term are exempt from this requirement. See conditions under APRDRG on previous page, C-62.1

Notes:

Report the current APRDRG Version as determined by the Arizona Health Care Cost Containment System (AHCCCS).

If you are uncertain regarding your hospital's License Type, contact ADHS for assistance.

For a list of current valid APRDRG codes required by AHCCCS, please visit this link: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html

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	3	227	229	IP	ED	FL81 Lines a - d	Alphanumeric Left Justified Code List Qualifier B1	C16
Patient Ethnicity	1	230	230	IP	ED	FL81 Lines a - d	Alphanumeric All positions filled Code List Qualifier B1	C16
Patient Marital Status	1	231	231	IP	ED	FL81 Lines a - d	Alphanumeric Code List Qualifier B2	C17

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
Placeholder	20	232	251	n/a	n/a	n/a	Reserved	(see C1 for details)
Onset of Symptoms/Illness 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

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 016x	7	370	376	IP	ED	FL42 and FL47	Numeric Right Justified	C31
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

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 037x	7	510	516	IP	ED	FL42 and FL47	Numeric Right Justified	C31
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

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 072x	7	650	656	IP	ED	FL42 and FL47	Numeric Right Justified	C31
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

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 210x	7	790	796	IP	ED	FL42 and FL47	Numeric Right Justified	C31
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
APR DRG	4	857	860	IP	n/a	FL71	Numeric All positions filled	C62
APR Version	2	861	862	IP	n/a	n/a	Numeric	C63
Placeholder	32	863	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

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 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
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

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 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
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
External Cause or Place Code 1	7	1128	1134	IP	ED	FL72	Alphanumeric Left Justified	C40
External Cause Code 1 POA Indicator	1	1135	1135	IP	PENDING	FL72	Alphanumeric	C40
External Cause or Place Code 2	7	1136	1142	IP	ED	FL72	Alphanumeric Left Justified	C40
External Cause/Place Code 2 POA Indicator	1	1143	1143	IP	PENDING	FL72	Alphanumeric	C40
External Cause or Place Code 3	7	1144	1150	IP	ED	FL72	Alphanumeric Left Justified	C40
External Cause/Place Code 3 POA Indicator	1	1151	1151	IP	PENDING	FL72	Alphanumeric	C40

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
External Cause or Place Code 4	7	1152	1158	IP	ED	FL72	Alphanumeric Left Justified	C40
External Cause/Place Code 4 POA Indicator	1	1159	1159	IP	PENDING	FL72	Alphanumeric	C40
External Cause or Place Code 5	7	1160	1166	IP	ED	FL72	Alphanumeric Left Justified	C40
External Cause/Place Code 5 POA Indicator	1	1167	1167	IP	PENDING	FL72	Alphanumeric	C40
External Cause or Place Code 6	7	1168	1174	IP	ED	FL72	Alphanumeric Left Justified	C40
External Cause/Place 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

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 Code 8	7	1303	1309	IP	ED	FL74 IP FL44 ED	Alphanumeric Left Justified	C44
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

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 License Number	8	1535	1542	IP	ED	n/a	Numeric Right Justified	C56
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

FOOTNOTES:
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.
All data elements with no reportable value must be left blank.

Audit Information **Section E**

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.

Data Universes:

All error allowances for the audits are determined by percentage. All 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.

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	*not used*
J	Newborns
K	Providers (clinicians such as physicians and nurses)
L	Revenue
M	Miscellaneous
N	Procedures

Audit Information **Section E**

Error Allowances and Thresholds:

Universe ID	Description	Allowance or Threshold
A1 – A8	All Audits Categories E, F, G, H, J, K, L, M, N	1.5%
A9	Fatal – Audit Category D	0%
T1	Thresholds C1,C2,C3,C5,C6,C9,C10(IP)	5%
T2	Thresholds C4,C7,C8	0.5%
T3	Threshold C10(ED)	47%
T4	Threshold C13	97%
T5	Threshold C11	5%
T6 - T8	Threshold C12, C15, C16	1.5%
n/a	Threshold C14	>0
V1	Discharge Volume	15%

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.

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

The function of Category C audits is to look at specific subsets of data for reporting patterns that appear inaccurate or implausible. These audits are called "Thresholds."

C1. 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.

C2. 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.

C3. Patient Marital Status Unknown

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

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.

C4. 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.

C5. 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 language available on the internet. Please see the Appendices of the state reporting manual for details.

C6. Patient Ethnicity Refused

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

Correction: Review the records to identify the correct Patient Ethnicity, 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 language available on the internet. Please see the Appendices of the state reporting manual for details.

C7. 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. Although 0000000 is the default value for unknown date of birth, if you have received this error it means there are an excessive number of records reported with the default value. If you cannot correct these records you must notify ADHS.

C8. 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.

C9. 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 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.

C10. 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.

C11. Place of Injury Coded Other

Error: An excessive number of records have been coded with the PLACE of External Cause code Y9289.

Correction: Review the records to identify the correct PLACE, and assign the appropriate place Y 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 Code for place cannot be assigned due to missing or inadequate documentation in the record, this issue must be addressed.

C12. Place of Injury Coded Unspecified

Error: An excessive number of records have been coded with the PLACE of External Cause code Y929. 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 Y 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 Code for place cannot be assigned due to missing or inadequate documentation in the record, this issue must be addressed.

C13. 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.

C14. 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 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* provide observation services, then this information must be documented in writing to ADHS on hospital letterhead.

C15. Mixed Visits Missing Data

Error: On an ED file, there are an excessive number of records identified as Mixed Visits that do not have any R076x charges reported (indicating observation services) or operating provider/procedure information 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 or non-ED treatment room charges incurred?

If the patient had outpatient surgery (rather than observation or treatment room services) then check to be sure the operating provider and procedure information is completely and correctly reported in the file.

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.

C16. Observation Charges not Mixed Visit

Error: On an ED file, there are an excessive number of records with R076x charges that are not reported as Mixed Visits. A patient treated in the ED, then moved to Observation or non-ED treatment room and subsequently discharged without ever being admitted, is required to be identified in the state report as a Mixed Visit, as these patients consume more hospital resources than the usual ED “treat and release” patient.

Audit Correction Assistance **Section G**

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?

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.

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). 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 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 codes 64 and 92 are 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.

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 Over 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 in both the birth date and date of admission, or 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 that should be unique (patient control number and admission date) and therefore appear to be duplicates.

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. Record Invalid

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. Discharge Date Outside Reportable Range

Error: The reported Discharge Date is either prior to the first date of the reporting period, or after the last date of the reporting period.

Correction: Review the record to determine when the patient was discharged. If the discharge occurred during the reporting period, correct the discharge date.

If the discharge occurred before or after the date range of the current reporting period, this indicates the state data report was extracted using an incorrect date range. When generating your corrected file, ensure the correct reporting date range for your report is selected.

D10. External Code in Diagnosis Code Field

Error: At least one diagnosis code field has a code that begins with “V, W, X or Y”

Correction: This error is usually due to incorrect programming for extracting the state report. Most hospitals store External Cause codes in the diagnosis code fields in their HIMS. When the state report is run, the programming identifies and excludes the External Cause codes from being reported with the diagnosis codes. If you have this error, check with 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 External Cause codes separately from the diagnosis codes, then check the records with errors to identify the diagnosis code fields that contain External Cause 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. If the record has not been coded because it is in some suspension status (e.g. "compliance hold" "auditing" etc.) the record must still be coded and reported to the state. All discharges occurring within the reporting period date range must be included in the state report with appropriate coding, *regardless* of the record's "status" in the hospital HIMS.

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 an admission 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, or the Admission Date or Discharge Date are invalid so the Length of Stay cannot accurately be calculated.

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 reported sex, race, ethnicity 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 social security number, sex, race, ethnicity 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 Missing

Error: The NPI field is blank.

Correction: This error is usually due to incorrect programming for extracting the state report. Check with whoever is responsible for programming your state report extraction to ensure it is set up correctly. 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, 1, 2, 3, 4, 5, 6, 7, 8, 9, 0, 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. If the IP record is for a patient who was admitted following treatment in *a satellite ED of your hospital*, populate the field with the one-digit satellite identifier for that satellite location.

Otherwise, leave the field blank. Call ADHS if you have questions regarding appropriate reporting from your satellite ED(s).

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 or 61, indicating the patient was admitted as an inpatient or CAH swing bed patient, 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 or 61.

Correction: Determine if the patient was admitted as an inpatient or CAH swing bed patient. If yes, determine if the IP/ED bills were split. If yes, revise the record so the Discharge Status is 09 or 61 (as appropriate) 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.

Tip: When working on corrections to D19, also look to see if you have any errors on D20, D21 and L11.

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

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, it means the corresponding ED record cannot be identified. You must find and ensure proper coding of 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 may 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.

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

ADHS takes into account that a patient may be discharged from the ED and admitted as an inpatient in one reporting period, (for example, on June 30th) but not discharged from inpatient until the next reporting period (for example, July 2nd). Inpatient records with an admission date in the prior reporting period are automatically excluded from the D20 error list by the state.

Tip: When working on corrections to D20, also look to see if you have any errors on D19, D21 and L11.

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: If you determine that the visit was NOT split billed, then remove the "S" from the Visit Qualifier field, and check the discharge status field for a correct value.

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, it means the corresponding IP record cannot be identified. 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 may 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 as identified as split, and take corrective action to ensure that record is accurately reported when the corrected state IP report is generated.

ADHS takes into account that a patient may be discharged from the ED and admitted as an inpatient in one reporting period, (for example, on June 30th) but not discharged from inpatient until the next reporting period (for example, July 2nd). Records that appear to be of this type are excluded from the error list.

However, if the inpatient has a long length of stay the ED record may show up on your D21 error list (for example, discharged from the ED on June 10th, but not discharged from inpatient until July 2nd). If this is the case, then no record correction is required, but you must notify ADHS that the missing IP record falls into the following reporting period timeframe.

Tip: When working on corrections to D21, also look to see if you have any errors on D19, D20, and L11.

D22. ED Admission Reported by Hospital Without ED

Error: The IP record contains an ED Admission Flag, indicating the patient was treated in the reporting hospital's ED prior to admission, but the reporting hospital *does not have* an emergency department.

Correction: The ED Admission Flag field is populated by the programming used to extract the state report from your HIMS. Contact whoever is responsible for programming

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

D23. ED Charges Reported by Hospital Without ED

Error: The IP record contains charges for emergency department services in the R045x revenue category field, indicating the patient was treated in the reporting hospital's ED prior to admission, but the reporting hospital *does not* have an emergency department.

Correction: Research the record in your HIMS to determine if revenue has been placed in the wrong revenue category. If so, correct as appropriate. If the information reported to the state does not match what you see in your HIMS, then contact whoever is responsible for programming your state report extraction to ensure it is set up correctly. Call ADHS for assistance if necessary.

D24. Record Contains Foreign Characters

Error: The record contains punctuation or other special characters that are not allowed in the state report. Only upper case letters, numbers 0 - 9, hyphens -, and spaces are allowed in the file.

Correction: Correct the source record as appropriate to remove foreign characters or correct lower case letters.

D25. DRG/DRG Version Reported in ED Record

Error: The ED records contain a reported DRG and/or DRG Version value. DRG and DRG Version apply only to Inpatient visits and therefore are not applicable to emergency department visits.

Correction: The DRG Version field is populated by the programming used to extract the state report from your HIMS. Additionally, the state report programming should not report DRG on an ED record even if one is present in the source record in your HIMS. Therefore, for errors on this Audit, contact whoever is responsible for programming your state report extraction to make the necessary adjustments. Call ADHS for assistance if necessary.

D26. Test Record in Data Set

Error: One or more fields in the record have the word "TEST" indicating that the record is not a valid patient record but is a bogus record created within the hospital HIMS for testing purposes

Correction: Test records must be removed from the data set(s). Only legitimate patient records are to be reported. If you have a patient with a last name of "TEST" then notify ADHS that the record is a legitimate patient record.

D27. Incorrect ICD Version Reported

Error: The reported ICD Version Indicator is not appropriate for the reported discharge date on the record. For discharges 10/01/2015 and after, only ICD-10-CM codes may be reported, and the ICD Version Indicator field must contain a **0** (zero).

Correction: This field is populated by the state report programming at the time the report is extracted from your HIMS. Contact whoever is responsible for programming your state report to get this error corrected in the programming.

D28. Invalid Facility ID

Error: The reported unique facility ID does not match the external lookup table of valid facility IDs.

Correction: The facility ID is either hard-coded into your data report, or entered at the time the report is created by the person running the report. Verify the correct facility ID for your hospital by checking the master facility ID list available on the ADHS website and ensure the correct ID is placed into the report.

D29. MRN or PCN is Missing

Error: The medical record number and / or patient control number are missing.

Correction: Locate and provide the missing information. If the information is visible in your HIMS but not showing in the error lists provided by the state, this indicates a problem with the programming used to extract the state report from your HIMS. Contact the person responsible for creating the report for your hospital.

D30. Placeholder is not Blank

Error: One or more of the Placeholder fields (1-7) in the state report is not blank.

Correction: This is a programming issue. The state report format contains several empty areas called placeholders to allow for future changes without affecting the overall format of the file. If you have received this error, this indicates that either legitimate data in the file is reported in an incorrect position, or those empty spaces are being used for some internal purpose at your hospital, but not appropriately emptied prior to submitting the file to the state. Contact the person responsible for creating the report for your hospital.

D31. ED LOS Exceeds 1 Day

Error: In an ED record, based upon the reported Admission Date and Discharge Date, the patient was in the emergency department for more than one full day, without receiving observation services or some other level of outpatient care in addition to the usual ED treat/release services.

Correction: Check the reported Admission and Discharge Dates, and correct if needed. If the reported dates are already correct, determine why the patient was in ED status for over one full day. If Observation or other outpatient services were provided, make sure the associated charges are correctly reported in the record Revenue Categories and included in the reported Total Charges. Also ensure that the state data element *Visit_Qualifier* is populated in your state report with a value of "M" to indicate the patient received a level of care greater than the normal treat/release ED visit. If the patient received only treat/release care but was in the ED for more than one full day, this information must be communicated to ADHS.

D32. Procedure Date Outside Reportable Range

Error: There are one or more Procedure Dates reported that are either after the Discharge Date or more than three calendar days prior to the Admission Date.

Correction: Check the reported Admission Date, Discharge Date, and all Procedure Dates. Correct as appropriate. Errors on this audit are predominantly caused by typographical input errors, or reporting of the date lab results were returned or the billed date instead of the date of service. Reporting of dates other than the date of service may be a programming error; consult whoever is responsible for programming your state report.

D33. ED Patient Discharged Before Admission

Error: In an ED record, the Admission Date and Discharge Date are the same date, and the Discharge Hour is prior to the Admission Hour.

Correction: Check the reported Admission Date, Admission Hour, Discharge Date and Discharge Hour. Correct as appropriate.

E - Demographic

E1. Race Code Invalid

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

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

Correction: Review the record to determine the appropriate race. Verify the accurate code has been entered in your HIMS. Correct as appropriate. NOTE: "Hispanic" is **not** a Race (genetic ancestry). "Hispanic" is an Ethnicity (social/cultural orientation).

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.

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 verification of correct abbreviations, access to postal addressing standards, and verification of city, zip code or street address, including correct spelling of city names and lookups by address, check the postal service website.

If the patient is homeless and the address is unavailable, leave the city and zip code blank and populate the Homeless data element with 17 (see page C-13.1 of the manual).

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 zip code can be reported 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.

For US address, you must report valid **City, State, Zip**.

For non-US address you *must* report **Country Code**; you *may* report City, ***do not* report State or Zip.**

E8. SSN is Missing or Invalid

Error: The Patient Social Security is reported as blank, with a value of '0000' or contains an upper case alpha character(s).

Correction: Verify the Patient's Social Security Number. If the number is unavailable, refer to the list of acceptable default codes in this manual, Section C, page C-07.1 and provide the appropriate default code.

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.

For US address, you must report valid **City, State, Zip**.

For non-US address you *must* report **Country Code**; you *may* report City, ***do not* report State or Zip.**

E11. SSN = 1111 Patient not Infant

Error: The record is reported with a default Social Security Number value of '1111' indicating the patient is an infant, but the patient is over 1 year of age.

Correction: Verify the Patient's Social Security Number. Provide if found.

If the newborn default code (1111) appears appropriate, then verify the date of birth, admission date and discharge date for accuracy and correct as necessary.

If the Social Security Number is unavailable, and the patient is not an infant, refer to the list of acceptable default codes in this manual, Section C, page C-07.1 and provide the appropriate default code.

E12. Ethnicity Code Invalid

Error: The Patient's Ethnicity is either blank, or reported as a value other than 1 (Hispanic), 2 (non-Hispanic) or 9 (refused).

Correction: Verify the Patient's Ethnicity. Correct as necessary. If the Ethnicity appears correct in your system but not in the state report, then there may be an error in the

programming that extracts the state data report. Contact the person responsible for generating your hospital's state data report. Contact ADHS for assistance if necessary.

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-10-CM code for the time period being reported, or the reported Discharge Date is invalid, making it impossible to validate the Diagnosis code.

Correction: Determine and provide the correct Admitting Diagnosis code, or correct the Discharge Date, if invalid.

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. The most common cause of this error is the exclusion in the state report extraction of External Cause 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-10-CM code for the time period being reported, or the reported Discharge Date is invalid, making it impossible to validate the Diagnosis code.

Correction: Determine and provide the correct Principal Diagnosis code, or correct the Discharge Date, if invalid.

F7. - F30. Diagnosis 2 Invalid *through* Diagnosis 25 is Invalid

Error: The indicated Diagnosis code is not a valid ICD-10-CM code for the time period being reported, or the reported Discharge Date is invalid, making it impossible to validate the Diagnosis code.

Correction: Determine and provide the correct Diagnosis code, or correct the invalid Discharge Date.

F37. Patient Reason for Visit 1 is Invalid
F38. Patient Reason for Visit 2 is Invalid
F39. Patient Reason for Visit 3 is Invalid

Error: The indicated Patient Reason for Visit is not a valid ICD-10-CM code for the time period being reported, or the reported Discharge Date is invalid, making it impossible to validate the reported code.

Correction: Determine and provide the correct Patient Reason for Visit code, or correct the invalid Discharge Date.

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
F42. Patient Reason for Visit 2 on IP Record
F43. Patient Reason for Visit 3 on IP Record

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

Correction: These data elements are not reportable on IP records. Remove the indicated Patient Reason for Visit 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. – G25. POA1 Code is Invalid *through* POA25 Code is Invalid

Error: On inpatient records, the indicated Diagnosis Code is reported, but the Present on Admission Indicator code for that reported 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 POA codes are: 1; Y; N; U; W.

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

G26. – G50. POA1 Code is Not Appropriate *through* POA25 Code is not Appropriate

Error: On inpatient records, for the indicated Diagnosis code, there is a valid Present on Admission Indicator code reported. However, the POA indicator code is not appropriate for the ICD code to which it pertains.

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 indicated Diagnosis.

Report 1 for exempt ICD diagnosis codes.

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

G51. – G56. POAE1 Code is Invalid *through* POAE6 Code is Invalid

Error: On inpatient records, the indicated External Code is reported, but the Present on Admission Indicator code for that reported External Code 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 indicated External Code.

G57. – G62. POAE1 Code is Not Appropriate *through* POAE6 Code is Not Appropriate

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

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 code for the indicated External Code.

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. RESERVED

H2. External Codes Sequence Break

Error: There are multiple External Codes reported but, within the sequence of reported codes, there are one or more fields that are blank. For example: The External Codes 1, 3 and 4 fields are populated, but External Code field 2 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.

H3. RESERVED

H4. – H9. External Code 1 Invalid *through* External Code 6 Invalid

Error: The indicated External Code is not a valid ICD-10-CM V, W, X or Y Code for the time period being reported, or the reported Discharge Date is invalid, making it impossible to validate the External Cause Code.

Correction: Determine and provide the correct External Code, or correct the invalid Discharge Date.

H10. Place Code Not Reported

Error: There is one or more External Cause (W,X, Y or Z) Codes **OR** Diagnosis Codes (Principal and 2 – 25) reported that indicate initial treatment of a condition with an external cause (injury, adverse effect, misadventure or complication); but there is no PLACE code in the range of Y92 reported in any of the External Code fields 1 – 6.

Correction: Assign and report the missing ICD-10-CM Y92 code for PLACE.

NOTE: if you have a large number of records where the code for PLACE cannot be assigned due to missing or inadequate documentation in the records, this is a deficiency that must be addressed. Contact ADHS for assistance.

H11. External Cause Code not Reported

Error: In one or more of the Diagnosis Code fields (Principal and 2 – 25) there is an ICD-10-CM diagnosis code that indicates an external cause (injury, adverse effect, misadventure or complication) but no External Cause V,W, X or Y Code has been reported.

Correction: Assign and report the missing cause of occurrence code. Also report the accompanying PLACE of occurrence code (range of Y92).

NOTE: if you have a large number of records where the External Cause Code cannot be assigned due to missing or inadequate documentation in the records, this is a deficiency that must be addressed. Contact ADHS for assistance.

NOTE: "I" 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: **ICD-10-CM (effective for discharges on/after October 1, 2015):**
In one of the Diagnosis Code fields (Principal and 2 – 25) there is an ICD-10-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: **ICD-10-CM (effective for discharges on/after October 1, 2015):**

The Principal Diagnosis Code is a Z 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 Z Code indicating the patient is a baby that was first attended *after* extramural 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
K7. Other Provider Information Incomplete

Error: In the indicated 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 or Other Provider. If so, provide the missing information.

If the record should not have an Operating or 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 State License Board Code Invalid
K9. Operating Provider State License Board Code Invalid
K10. Other Provider State License Board Code Invalid

Error: On the indicated Provider type, the reported Provider State License Board code is not equal to 1, 2, 3, 4, 5, 6 7 or 9.

Correction: Verify the type of clinician reported, and refer to Section C of this manual for definitions of the above codes. Assign the correct code for that clinician. Also check the Provider Name, NPI and State License Number fields to be sure they are correctly reported.

K11. Invalid or Mismatched Attending Provider Name/License
K12. Invalid or Mismatched Operating Provider Name/License
K13. Invalid or Mismatched Other Provider Name/License

Error: The indicated State License Number is not a valid license number **or** it does not belong to the Provider Name reported, according to the records of the Arizona licensing board reported in your data for this provider.

Correction: Verify the license number, name and reported board code. Look for typographical errors, transposed numbers or names (first and last name in wrong order), wrong license number reported, wrong board code (i.e. MD reported as a DO) the presence of alpha characters in the license number, or spaces in the name where they don't belong (e.g. MC DONALD instead of MCDONALD).

Tips: Make sure your provider license record matches that of the licensing board that issues the provider's license. **Do not use the NPI lookup for validating Arizona licenses.** 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.

Make sure you are reporting the Arizona state license number, numeric portion only, and not an NPI or other identifier. **On nurses with advanced practice licenses, report only the RN number, numeric portion only.** On nurses with a MSL (multi-state license, i.e. a valid RN license issued by a state other than Arizona but recognized as valid by the Arizona State Board of Nursing, report that MSL RN License number, numeric portion only.

On residents who now have their physician license, the resident number is not acceptable.

K14. 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.

K15. Attending Provider is PA

Error: If you receive this error, you have reported a Physician Assistant as an Attending Provider (which is outside 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.

K16. Attending Provider Manual Review Required
K17. Operating Provider Manual Review Required
K18. Other Provider Manual Review Required

Error: Board Code 9 = Other should only be used for clinicians licensed by a Board not listed in the state reporting manual (such as Chiropractic). Files with clinicians reported under Board Code 9 will be rejected for validation, and documentation of clinician type will be required if the hospital asserts Board Code 9 is correct.

Correction: Review the reported clinician information for accuracy, ensuring that the Name, License Number and State Board Code are *all* correct. Correct errors as appropriate. If the clinician is reported with Board Code = 9 and that clinician meets the criteria described above then no data correction is required but provide documentation to the Department regarding the clinician type.

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. 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 IP record is split billed. Also, check the ED account portion of the visit, to ensure the Discharge Status is 09 or 61 and the Visit Qualifier is also populated with "S".

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 is 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.

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 ensure 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 ICD 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 bill for or report these 068x charges.

If your hospital is a designated 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.

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 068x 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.

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 of the record 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 contact your internal IT and/or software vendor as appropriate to correct.

Tip: When working on corrections to L11, also look to see if you have any errors on D19, D20 and/or D21.

L12: Mom/Baby Charges on Same Record

Error: On an inpatient record, there are charges in **both** the r072x Labor/Delivery Revenue Category **and** at least one of the Nursery Room and Board Revenue Categories, r0170, r0171, r0172, r0173, r0174, or r0179.

Correction: Determine if the record is for the mother or the newborn, and correct as appropriate. Mother and newborn are separate patients and a separate record must be reported to the state for each.

If the newborn is a male baby on which circumcision was performed, ensure that the circumcision procedure code and date of procedure are correctly reported in the record. Reporting the procedure will allow the 0723 charges for the circumcision to be present in the record without causing an error on this Audit.

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/APRDRG is Ungroupable

Error: On an inpatient records, the MSDRG Version is 31 or greater and the reported DRG is 999 or the APRDRG Version is 31 or greater and the reported DRG is 9560.

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 31 or greater and the reported DRG is 998 or the APRDRG Version is 31 or greater and the reported DRG is 9550.

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; 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 listed 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 listed 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 listed in the reporting specifications manual, page C-12.1. and Appendix I-1, pages 1-6.

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, this field must be blank.

For US address, you must report valid City, State, Zip.

For non-US address you *must* report Country Code; you *may* report City, *do not* report State or Zip.

M9. DRG Invalid

Error: On an inpatient record, reported MSDRG code is not a valid code for the DRG Version reported.

Correction: Verify the correct MSDRG Version is being reported. If not, correct the DRG Version.

If the DRG Version correct, determine and provide the correct MSDRG 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/APRDRG Indicator is Invalid

Error: On an inpatient record, the reported MSDRG or APRDRG Version Indicator is not valid for the reported patient discharge date in the record.

Correction: Determine which DRG Version is appropriate for the patient discharge date reported in the record.

Tip: The current MS-DRG Version is based upon the current Federal fiscal year. The current APR-DRG Version is determined by the Arizona Health Care Cost Containment System (AHCCCS). For AHCCCS claims, report the APR-DRG Version designated by AHCCCS for the time period of the record being reported.

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. APRDRG is Invalid

Error: On an inpatient record, the reported APRDRG code is not a valid code for the APRDRG Version reported.

Correction: Verify the correct APRDRG Version is being reported. If not, correct the APRDRG Version.

If the APRDRG Version correct, determine and provide the correct APRDRG for the record.

Tip: Valid APRDRG codes are 4 digits; the 3-digit base code, and the fourth digit Severity of Illness (SOI) indicator. Reporting of all 4 digits is required.

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.

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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.

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N - Procedures

N1. Reserved

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. – N14. Procedure 1 Code /Date *through* Procedure 12 Code /Date not Reported

Error: The indicated Procedure is reported without a date, or the indicated Procedure Date is reported but there is no reported Procedure Code.

Correction: Was a procedure performed? If so, provide the missing information. If no procedure was performed, remove the incorrectly reported information.

N15. – N26. Invalid Principal Procedure Code *through* Invalid Procedure Code 12

Error: The indicated Procedure code is not a valid ICD-10-PCS or CPT code for the time period being reported.

Correction: Determine and provide the correct procedure code.

For inpatient records report ICD-10-PCS codes only.

For emergency department records, report CPT codes only. Refer to the reporting specification manual, page C-42.1 for guidance on reporting of CPT procedure codes.

For **emergency department records**, in the **Procedure Code 12 field**, only a valid ED Evaluation and Management Code may be reported in this field. Refer to the reporting specification manual, page C-44.2. 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.

****

V1. Discharge Volume >15% Change

Error: On the identified FILE the number of reported records has changed by more than 15% compared to the number of records of the same file type (IP or ED) in the previous reporting period half file.
(e.g. first half 2016 IP file is compared to first half 2015 IP file).

Correction: This may be due to incomplete reporting, programming errors, or an actual change in hospital patient volume during the reporting period.

Volume increase:
Check to ensure that only the correct six months of the reporting period are present in the file.
Check to ensure that only reportable records are included in the file.
Check to determine if changes in services or practice patterns account for a legitimate increase.

Volume decrease:
Check to ensure that the correct six months are fully reported.
Check to ensure that all reportable records are included in the file.
Check to determine if changes in services or practice patterns account for a legitimate decrease.

Correct the file as appropriate.
If the change in volume is legitimate, notify ADHS.

Glossary

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/preparedness/public-health-statistics/hospital-discharge-data/index.php#reporting-requirements-home

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/preparedness/public-health-statistics/hospital-discharge-data/index.php#reporting-requirements-home

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 newborn error allowance is calculated upon the total number of records in that newborn data universe.

Glossary

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. Dates are based upon the discharge date of the patient. .

Resubmission: the submission of a corrected data set a subsequent time after the original official reporting for any given reporting period.

Satellite Emergency Department: a free-standing emergency department operating under the hospital license of an acute-care hospital at a physically separate location.

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).

Glossary

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. Testing is voluntary.

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.)

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

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

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
LIBYA	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

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
PALESTINE, STATE OF	PS
PANAMA	PA
PAPUA NEW GUINEA, INDEPENDENT STATE OF	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

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, FEDERAL REPUBLIC OF	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

COUNTRY NAME	CODE
UNITED ARAB EMIRATES	AE
UNITED KINGDOM	GB
UNITED STATES (valid only for "accident state" in state data report)	US
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

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

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.

Appendices

Section I
I-3.1

Collecting Patient Race and Ethnicity 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 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."

1. Categories and Definitions
When race and ethnicity are collected separately, ethnicity shall be collected first. The minimum categories for separately collected data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting are defined as follows:

Patient Ethnicity:

-- **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."

-- **Not Hispanic or Latino.**

Patient Race:

-- **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.

-- **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

-- **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."

-- **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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/

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	C16	Code-Code Field	FL81
Patient 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

ADHS Data Element	ADHS Element Number	UB04 Data Element	Form Locator Number
Nursery Revenue Code Charges (1-6)	C32	Revenue Codes & Total Charges	FL42 & FL47
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/Place 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	
Type of Record	C58	None	
DRG Version Indicator	C59	None	
ED Admission Flag	C60	Condition Codes	FL18-28
Visit Qualifier	C61	None	

ADHS Data Element	ADHS Element Number	UB04 Data Element	Form Locator Number
APR DRG	C62	Prospective Payment System (PPS) Code	FL71
APR DRG Version Indicator	C63	None	

Appendices

Section I
I-5.1

Payer Type Reporting Guidance

The Payer Type a given payer plan fits into at each hospital may depend upon not only the payer, but also the plan type and that hospital's contractual arrangement (or absence of such arrangement) with the specific payer and plan.

Due to the fact that most hospitals and many insurance payers are private businesses that negotiate their own contractual arrangements with each other, it is difficult for the state to tell any hospital which of the state reporting Payer Type categories any of their many payers may fit into.

For all of the Payer Type categories, to determine correct mapping of your various payers to the state codes, the question that must be answered is: *What is my hospital's contractual arrangement with this specific insurance plan?* Remember that a given carrier may have more than one plan. Carrier A may have "Plan 1" that is Commercial, and "Plan 2" that is PPO in which your hospital is a preferred 'in-network' provider. In this example, those two plans would be mapped to 01-Commercial and 03-PPO, respectively, in the state data report.

Below is some basic information to assist with determining the appropriate Payer Type category.

00 Self Pay
The patient, or other private, non-insurance source (such as a relative or friend) is paying directly for the care provided.

01 Commercial (Indemnity)
The patient may go to any health care provider they choose. The patient has a yearly deductible that they must pay out-of-pocket before the coverage will pay any benefits. The patient is responsible for a designated percentage of the charges approved for payment by the insurance carrier, and is usually responsible for any non-covered charges. Your hospital does not have to be contracted with the carrier.

02 HMO (Health Maintenance Organization)
The patient must receive their care from in-network providers contracted with their HMO carrier. They have a Primary Care Physician (PCP) who serves as a 'coordinator' for the care they need; referrals to specialists or other caregivers are required. If the patient receives care at a *non*-network provider, the care will generally not be covered by insurance, except in cases of emergency.

Payer Type Reporting Guidance (cont'd)

03 PPO (Preferred Provider Organization)
The patient pays lower out-of-pocket costs if they receive their care from in-network providers. They are not required to have a Primary Care Physician. Care received from *non*-network providers is still covered, but the patient pays a higher percentage.

05 Medicare
"Original" Medicare. Paid for by Medicare funding through the Centers for Medicare & Medicaid Services (CMS) via the certified hospital's Medicare fiscal intermediary.

06 AHCCCS/Medicaid (Arizona Health Care Cost Containment System)
Care is paid for by Medicaid funding through Arizona's Medicaid agency, via the AHCCCS Program Contractor that manages the specific Medicaid coverage type of the individual patient.

07 Tricare
Coverage for civilian healthcare provided to federal Uniformed Services personnel, including commissioned US public health service corps, active military, retired military, and their eligible dependents. For Arizona, administered through the Western Region managed care support contractor (as of 2015, *UnitedHealthcare Military & Veterans*).

08 Children's Rehab Services
Coverage for Medicaid eligible children with complex healthcare needs. Administered by AHCCCS.

09 Worker's Compensation
Coverage provided through the patient's employer by a carrier of the employer's choosing for treatment of illness or injury incurred by the patient while working.

10 Indian Health Services
Coverage provided to enrolled members of recognized American Indian (Native American) tribes, through the federal Indian Health Services agency.

Payer Type Reporting Guidance (cont'd)

11 Medicare Risk
Medicare Advantage Plans that are **not** "Original" Medicare. Coverage may vary but must meet the minimum Medicare coverage requirements. Paid for by Medicare funding via the insurance carrier that issues the coverage. Patient coverage, co-pays and deductibles vary by carrier and hospital provider status with the carrier. These plans are referred to as "Risk" because Medicare pays the carriers a set amount per person for providing coverage (capitation). The carrier therefore assumes the "risk" that it will cost them less to pay for all provided care than they are receiving in payment for all covered persons.

12 Charity
The patient is receiving care and the hospital is not being paid for that care. Examples include care identified as charity before the care is provided, or charges written off as charity after the care has been provided when it is determined that payment cannot be made. Also, care provided for which no reimbursement is received during qualification for initial Medicare certification.

13 Foreign National
The patient is a resident of a foreign country and is covered by an insurance carrier based in that foreign country.

14 Other
This category is appropriate for payers that are not primarily in the health arena, such as a carrier like State Farm or Allstate paying via an automobile policy for someone's medical care due to injuries sustained in a motor vehicle accident. Another example is when U.S. Border Patrol pays out of their budget for care of illegal immigrants who have been injured while attempting to elude capture. The *Other* category is rarely appropriate.

Regulatory Information

Section J
J-1

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.

STOP!!

This manual applies to discharges July 1, 2021 and later *only.*

Please contact ADHS for assistance if you have any questions.

Joseph.spadafino@azdhs.gov