Massachusetts Center for Health Information and Analysis

Inpatient Discharge Data from Behavioral Health Facilities

File Submission Guide

August 2017

CHIA.
center for health information and analysis

CHIA has adopted regulation 957 CMR 8.00 to require the reporting of health care data to the Center for Health Information and Analysis. This document provides the technical and data specifications, including edit specifications required for the Inpatient Discharge Data from Behavioral Health Facilities.

This submission guide will be in effect beginning with the quarterly submission of 10/1/2017 – 12/31/2017 data due at CHIA on March 16, 2018.

Table of Contents

Inpatient Discharge Data Submission Overview

Data to Include in Inpatient Discharge Data Submissions

Inpatient Discharge Data shall be reported for all inpatient visits at the reporting facility as required by Regulation 957 CMR 8.00. This document contains the data record descriptions for submissions of merged case mix and billing. The record specifications, data elements definitions, and code tables appear within this document.

It is expected that the discharges reflected in the data submissions will be reflected in the Massachusetts Hospital Cost Reports submitted to CHIA.

Definitions

Terms used in this specification are defined in the regulation's general definition section (957 CMR 8.02) or are defined in this specification document. If a term is not otherwise defined, use any applicable definitions from the other sections of the regulation.

Data File Format

The data must be submitted in a fixed-length text file format using the following format specifications:

Records	250-character rows of text
Record Separator	Carriage return and line feed must be placed at the end of each record

Data Transmission Media Specifications

Data will be transferred to CHIA via a SFTP client. In order to do that in a secure manner CHIA's secure encryption and decryption system (File Secure) must be utilized. You must first download a copy of the secure encryption and decryption system (File Secure) from the CHIA submissions web site. There is a separate installation guide for installing the File Secure program. File Secure will hash specific fields, compress, encrypt, and rename the submission file prior to transmission to CHIA. The newly created encrypted file shall be transferred to CHIA via SFTP client like FileZilla. Providers should contact their CHIA liaison to submit test files.

The edit specifications are incorporated into CHIA's system for receiving and editing incoming data. Edit reports are posted to INET for the provider to download. CHIA recommends that data processing systems incorporate these edits to minimize:

(a) the potential of unacceptable data reaching CHIA and

(b) penalties for inadequate compliance as specified in regulation 957 CMR 8.

Inpatient Discharge Data Record Specification

Record Specification Elements

The Inpatient Discharge Data File is made up of a series of 250 character records. The Record Specifications that follow provide the following data for each field in the record:

Data Element	Definition
Field No	Sequential number for the field in the record (**Field Number**).
Field Name	Name of the Field.
Picture	Data format required for field and length of field.
Spec.	Specification for field (L/B for left-justify, blank fill or R/Z for right-justify, zero fill)
Field Position From - Through	Beginning and ending positions of the field in the 250 character record.

Data Element	Definition
Edit Specifications	Explanation of Conditional Requirements. List of edits to be performed on fields to test for validity of File, Batch, and Discharge.
Error Type	Errors are categorized as A or B errors. Presence of one A or two B errors will cause a discharge to be rejected.

Record Type Inclusion Rules

Patient Discharge Records:

Each patient discharge will be represented by ten record types as follows:

a)	**Record Type ’20’**	Record Type ‘20’ contains selected socio-demographic and clinical information pertaining to the discharged patient. This record is presented once for each patient discharge in the reporting period.
b)	**Record Type ‘25’**	*Record Type ‘25’* contains patient address, health plan ID, and ethnicity information. This record is presented once for each patient discharge in the reporting period.
c)	**Record Type ’30’**	*Record Type ’30’* summarizes the charges billed and the units of service (days) provided in routine and special care accommodations for each patient discharge. This record may be repeated more than once per discharge if it is necessary to report the use of more than five different routine and/or special care accommodations within this episode of care.
d)	**Record Type ’40’**	*Record Type ’40’* summarizes the charges billed and the units of service provided for prescribed ancillary revenue centers. This record may be repeated more than once per discharge if it is necessary to report the use of more than five different ancillary services within this episode of care.

e)	**Record Type '45'**	*Record Type '45'* contains principal medical information such as primary diagnosis, admitting diagnosis, principal external cause, principal procedure, and physician information. This record is presented once for each patient discharge in the reporting period.
f)	**Record Type '50'**	*Record Type '50'* reports associated diagnosis information pertaining to this patient's episode of care. This record may be repeated more than once per discharge if it is necessary to report the use of more than fourteen associated diagnoses within this episode of care.
g)	**Record Type '60'**	*Record Type '60'* reports procedures and additional clinical information pertaining to this patient's episode of care. This record may be repeated more than once per discharge if it is necessary to report the use of more than thirteen significant ICD procedures within this episode of care. **Record Type '60' is for ICD procedure codes only.**
h)	**Record Type '65'**	*Record Type '65'* reports procedures and additional clinical information pertaining to this patient's episode of care. This record may be used to report up to eight significant HCPCS/CPT procedures within this episode of care. **Record Type '65' is for HCPCS/CPT procedure codes only.**
I)	**Record Type '80'**	*Record Type '80'* reports physician information for the patient. This record is provided once for each patient discharge.
j)	**Record Type '90'**	*Record Type '90'* is a control record which balances the counts of each of the several discharge specific records and charges. This record is provided once per patient discharge.

Submission Records.

Submission must also contain four other types of records as follows:

a)	**Record Type '1'**	*Record Type '1'* is the first record appearing on the file and occurs only once per submission. This label record identifies the submitter which may be an individual facility or a processor submitting data for a facility.
b)	**Record Type '10'**	*Record Type '10'* identifies the facility whose data is provided on the file and occurs only once per submission. This is the first record of the provider's batch.
c)	**Record Type '95'**	*Record Type '95'* is a control record which balances selected data from all patient discharges for the facility batch and is the last record of the provider batch. This occurs only once per submission.
d)	**Record Type '99'**	*Record Type '99'* is a control record. This is the last record of the submission and occurs only once per submission.

RECORD TYPE 01 - LABEL DATA

- Required as first record for every file.
- Only one allowed per file.
- Record Type = 01
- Must be followed by a Record Type 10.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type
1	Record Type '01'	XX	L/B	1 2	- Must be first record on file	A
2	Submitter EIN	X(10)	L/B	3 12	- Must be present - Must be numeric	Note
3	Submitter Name	X(18)	L/B	13 30	- Must be present	Note
4	Filler	X		31 31		
5	Receiver Identification	X(5)	L/B	32 36	- Must be present - Must be CHIA.	Note
6	Filler	X(4)		37 40		
7	Processing Date (CCYYMMDD)	X(8)	L/B	41 48	- Must be present - Must be valid date - Must not be later than today's date	Note
8	Filler	X(57)		49 105		

9	Submission Number	9999	R/Z	106 109	- Must be numeric - Must be present	Note
10	Filler	X(141)		110 250		

RECORD TYPE 10 - PROVIDER DATA

- Required for every file.
- Only one allowed per file.
- Must follow a RT01 and be followed by RT 20.
- Record Type = 10

Field No.	Field Name	Pic-ture	Spec.	Field Position From - Through	Edit Specifications	Error Type
1	Record Type ’10’	XX	L/B	1 2	- Must be first record following Label Record Type ’01’	A
2	Filler	X(77)		3 79		
3	Provider Name	X(18)	L/B	80 97	- Must be present	A
4	Provider Address	X(18)	L/B	98 115	- Must be present	Note
5	Provider City	X(15)	L/B	116 130	- Must be present	Note
6	Provider State	XX	L/B	131 132	- Must be present	Note
7	Provider Zip	X(9)	L/B	133 141	- Must be present	Note
8	Filler	X		142 142		

9	Period Starting Date (CCYYMMDD)	X(8)	L/B	143 150	- Must be present - Must be valid date - Must be the first day of the quarter for which data is being submitted	A
10	Period Ending Date (CCYYMMDD)	X(8)	L/B	151 158	- Must be present - Must be valid date - Must be later than Starting Date - - Must be the last day of the quarter for which data is being submitted	A
11	Organization ID for Provider	X(7)	L/B	159 165	-Must be present - Must be valid Organization ID as assigned by the Center for Health Information and Analysis	A
12	National Provider Identifier (NPI) for Provider	X(10)	L/B	166 175	- May be present - If present, must be a valid National Provider Identifier per National Plan and Provider Enumeration System (NPPES)	Note
13	Filler	X(75)		176 250		

RECORD TYPE 20 – PATIENT DATA

- Required for every Discharge.
- Only one allowed per Discharge.

- Must follow either RT 10 or RT 90.
- Must be followed by RT 25.
- Record Type = 20.

Field No.	Field Name	Pic-ture	Spec.	Field Position From - Through	Edit Specifications	Error Type
1	Record Type ’20’	XX	L/B	1 2	- Must be first record following Provider Record Type ’10’ or follow Patient Control Record Type ’90’	A
2	Medical Record Number	X(10)	L/B	3 12	- Must be present	A
3	Patient Sex	X		13 13	- Must be present - Must be valid code as specified in Inpatient Data Code Tables(1)(a)	A
4	Filler	X		14 14		
5	Patient Birthday (CCYYMMDD)	X(8)	L/B	15 22	- Must be present - Must be valid date - Must not be later than date of admission	A
6	Marital Status Code	X		23 23	- May be present - If present, must be valid code as specified in Data Code Tables (1) (b)	Note
7	Filler	X(9)	L/B	24 32		

8	Type of Admission	X		33 33	- Must be present - Must be valid code as specified in Inpatient Data Code Tables(1)(c)	B
9	Primary Source of Admission	X		34 34	- Must be present - Must be valid code as specified in Inpatient Data Code Tables(1)(d) - If the Source of Admission is Observation, code 'X', observation room charges must be present in the Observation Ancillary Revenue Code 762.	B
10	Secondary Source of Admission	X		35 35	- Must be present, if applicable -Must be valid code as specified in Inpatient Data Code Tables(1) (d) - If the Source of Admission is Observation, code 'X', observation room charges must be present in the Observation Ancillary Revenue Code 762.	B
11	Filler	X(9)	L/B	36 44		
12	Admission Date (CCYYMMDD)	X(8)	L/B	45 52	- Must be present - Must be valid date	A

13	Discharge Date (CCYYMMDD)	X(8)	L/B	53 60	- Must be present - Must be valid date - Must be greater than or equal to admission date - Must not be earlier than Period Starting Date or later than Period Ending Date from Provider Record 10	A
14	Veterans Status	X	L/B	61 61	- May be present - If present, must be a valid code as specified in Inpatient Data Code Tables(1)(h)	Note
15	Primary Source of Payment	X(3)	L/B	62 64	- Must be present - Must be valid code as specified in Inpatient Data Code Tables(1)(g) - If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment. - Must not be a Supplemental Payer Source as specified in Inpatient Data Code Tables(1)(g)	A

16	Patient Status	XX	L/B	65 66	- Must be present - Must be valid code as specified in Inpatient Data Code Tables(1) (e)	A
17	Billing Number	X(17)	L/B	67 83	- Must be present - First digit must not be blank - May include alpha, numeric slash (/) or dash (-), but no special characters.	A
18	Primary Payer Type	X		84 84	- Must be present - Must be valid as specified in Inpatient Data Code Tables(1) (f) - If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment.	A
19	Filler	X(10)	L/B	85 94		
20	Patient Social Security Number	X(9)	L/B	95 103	- Must be present - Must be valid social security number or ’000000001’ if unknown	A
21	DNR Status	X	L/B	104 104	- May be present - If present, must be valid as specified in Inpatient Data Code Tables(1)(i)	Note
22	Filler	X(8)		105 112		

23	Secondary Payer Type	X		113 113	- Must be present - Must be valid as specified in Inpatient Data Code Tables(1)(f) - If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment. - If not applicable, must be coded as “N” as specified in Inpatient Data Code Tables (1) (f) for Payer Type and “159” as specified in Inpatient Data Code Tables (1) (g) for Payer Source.	A
24	Secondary Source of Payment	X(3)	L/B	114 116	- Must be present if secondary payer type is other than "N" - If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment. - Must be valid code as specified in Inpatient Data Code Tables(1)(g)	A
25	Filler	X(21)	L/B	117 137		

26	Filler	X(22)	L/B	138 159		
27	Hospital Service Site Reference	X(7)	L/B	160 166	- Must be present if provider is approved to submit multiple campuses in one file -- Must be valid Organization Id as assigned by the Center for Health Information and Analysis	A
28	Homeless Indicator	X	L/B	167 167	-Include if applicable -Must be valid code as specified in Inpatient Data Code Tables (1) (j).	B
29	Medicaid Claim Certificate Number (New MMIS ID/ Medicaid ID)	X(12)	L/B	168 179	- Must be present if primary or secondary Payer Type Code is "4" (Medicaid) or "B" (Medicaid Managed Care) as in Inpatient Data Code Tables (1)(f) - Must be blank if neither primary nor secondary payer is Medicaid or Medicaid Managed Care - First position must not be blank if the field contains data - May include alpha, numeric slash (/) or dash (-), but no special characters If present, length must be 12.	A
30	Patient Last Name	X (35)	L/B	180 214	-Must be present	A

31	Patient First Name	X(25)	L/B	215 239	-Must be present	A
32	Court/Criminal Referral	9(2)	R/Z	240 241	-May be present -If present, must be valid code as specified in Inpatient Data Code Tables (1) (l).	Note
33	Patient's Sexual Orientation	9(2)	R/Z	242 243	-May be present -If present, must be valid code as specified in Inpatient Data Code Tables (1) (m).	Note
34	Patient's Gender Identity	9(2)	R/Z	244 245	-May be present -If present, must be valid code as specified in Inpatient Data Code Tables (1) (n).	Note
35	Filler	X(5)	L/B	246 250		

RECORD TYPE 25 – PATIENT ADDRESS AND ETHNICITY DATA

- Required for every Discharge.
- Only one allowed per Discharge.
- Must follow a RT 20.
- Must be followed by RT 30.
- Record Type = 25.

Field No.	Field Name	Pic-ture	Spec.	Field Position From - Through	Edit Specifications	Error Type
1	Record Type ’25’	XX	L/B	1 2	- Must be first record following Provider Record Type ’10’ or follow Patient Control Record Type ’90’	A
2	Medical Record Number	X(10)	L/B	3 12	- Must be present	A
3	Permanent Patient Street Address	X(30)	L/B	13 42	-Must be present when Patient Country is ‘US’ unless Homeless Indicator is ‘Y’	B
4	Permanent Patient City/Town	X(25)	L/B	43 67	-Must be present when Patient Country is ‘US’	B
5	Permanent Patient State	X(2)	L/B	68 69	-Must be present when Patient Country is ‘US’ -Must be valid U.S. postal code for state	B
6	Permanent Patient Zip Code	9(5)	L/B	70 74	- Must be present - Must be numeric - Must be a valid US postal zip code. - Must be 0’s if zip code is unknown or Patient Country (Record 25 field 7) is not ‘US’	B

7	Permanent Patient Country	X(2)	L/B	75 76	- Must be present - Must be a valid International Standards Organization (ISO-3166) 2-digit country code	B
8	Filler	X(70)	L/B	77 146		
9	Race 1	X(6)	L/B	147 152	-May be present - If present, must be valid code as specified in Inpatient Data Code Tables(2)(a)	Note
10	Race 2	X(6)	L/B	153 158	-May only be entered if Race 1 is entered. - If present, must be valid code as specified in Inpatient Data Code Tables(2)(a)	Note
11	Filler	X(15)	L/B	159 173		
12	Hispanic Indicator	X	L/B	174 174	-May be present - If present, must be valid code as specified in Inpatient Data Code Tables(2)(b)	Note
13	Ethnicity 1	X(6)	L/B	175 180	-May be present -If present, must be valid code as specified in Inpatient Data Code Tables (2)(c)	Note

14	Ethnicity 2	X(6)	L/B	181 186	-May only be entered if Ethnicity 1 is entered. -If present, must be valid code as specified in Inpatient Data Code Tables (2)(c)	Note
15	Filler	X(20)	L/B	187 206		
16	Health Plan Member ID	X(40)	L/B	207 246	Must be present when Primary Payer Type Code is <u>not</u>: "1" (Self Pay) "2" (Worker's Comp) "4" Medicaid "9" (Free Care) "T" (Auto Insurance) Report Health Plan Subscriber ID if Member ID is unknown.	A
17	Filler	X(4)	L/B	247 250		

RECORD TYPE 30 – IP ACCOMMODATIONS

- Required for every discharge.
- Must follow RT 25 or RT 30.
- Must be followed by RT 30 or RT 40.
- Record Type = 30.

Field No.	Field Name	Pic-ture	Spec.	Field Position From - Through	Edit Specifications	Error Type
1	Record Type ’30’	XX	L/B	1 2	- Must be first record following Discharge Record Type ’25’ or must follow previous Record Type ’30’	A
2	Sequence	99	R/Z	3 4	- Must be numeric - If first record following Discharge Record Type ’25’ sequence must =’01’ - For each subsequent occurrence of Record Type ’30’ sequence must be Incremented by one. - Accumulate count for balancing against Record Type 3x Count field in Patient Control Record Type ’90’	A
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record number from Discharge Record Type ’20’	A
4	Filler	X(7)		15 21		
	ACCOMMODATIONS 1♦	X(33)		22 54		A

5	Revenue Code (Accommodations)	X (4)	L/B	22 25	- If present must be valid code as specified in Inpatient Data Code Tables(3)	A
6	Filler	X (4)		26 29		
7	Unit of Service (Accom. Days)	X(5)	R/Z	30 34	- Must be present if related Revenue Code is present	A
8	Filler	X		35 35		
9	Total Charges (Accom.)	9(10)	R/Z	36 45	- Must be present if related Revenue Code is present - Must exceed one dollar - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070 - Accumulate Total Charges (Accom.) for balancing against Total Charges (All Charges) in Patient Control Record Type '90'	A
10	Filler	X(9)		46 54		
11	Accommodations 2[++]	X(33)		55 87	- May only be present if Accommodations 1 present[+] - Same as Accommodations 1	A

12	Accommodations 3[++]	X(33)		88 120	- May only be present if Accommodations 2 present[+] - Same as Accommodations 1	A
13	Accommodations 4[++]	X(33)		121 153	- May only be present if Accommodations 3 present[+] - Same as Accommodations 1	A
14	Accommodations 5[++]	X(33)		154 186	- May only be present if Accommodations 4 present[+] - Same as Accommodations 1	A
15	Filler	X(64)		187 250		

♦ Accommodations may occur up to 5 times.

[+] Accommodations 1 - 5 are required as applicable.

[++] Accommodations 2 - 5 require the same format as Accommodation 1.

RECORD TYPE 40 – ANCILLARY SERVICES

- Required for every discharge.
- Must follow RT 30 or RT 40.
- Must be followed by RT 40 or RT 50.
- Record Type = 40.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type

1	Record Type ’40’	XX	L/B	1 2	- Must be first record following last occurrence of IP Accommodations Record Type ’30’ or following previous Record Type ’40’	A
2	Sequence	99	R/Z	3 4	- Must be numeric - If first record following IP Accommodations Record Type ’30’ sequence must = ’01’ - For each subsequent occurrence of Record Type ’40’ sequence must be incremented by one	A
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Discharge Record Type ’20’	A
4	Filler	X(7)		15 21		
	ANCILLARIES 1♦	X(33)		22 54		A
5	Revenue Code (Ancillary)	X (4)	L/B	22 25	- If present must be valid code as specified in Inpatient Data Code Tables(3)	A
6	Filler	X (4)		26 29		

7	Units of Service (Ancillary)	X(5)	R/Z	30 34	- Must be present if related Revenue Code is present - Must be greater than zero if Revenue Code 762 or 769 are present	A
8	Filler	X		35 35		
9	Total Charges (Service)	9(10)	R/Z	36 45	- Must be present if related Revenue Code is present - Must exceed one dollar - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070 - Accumulate Total Charges (Service) for balancing against Total Charges (Ancillaries) in Patient Control Record Type '90'	A
10	Filler	X(9)		46 54		
11	Ancillaries 2[++]	X(33)		55 87	- May only be present if Ancillaries 1 present[+] - Same as Ancillaries 1	A

12	Ancillaries 3[++]	X(33)		88 120	- May only be present if Ancillaries 2 present[+] - Same as Ancillaries 1	A
13	Ancillaries 4[++]	X(33)		121 153	- May only be present if Ancillaries 3 is present[+] - Same as Ancillaries 1	A
14	Ancillaries 5[++]	X(33)		154 186	- May only be present if Ancillaries 4 present[+] - Same as Ancillaries 1	A
15	Filler	X(64)		187 250		

♦ Ancillaries may occur up to 5 times.

[+] Ancillaries 1 - 5 are required as applicable.

[++] Ancillaries 2 - 5 require the same format as Ancillaries 1.

RECORD TYPE 45 – PRINCIPAL MEDICAL INFORMATION

- Required for each discharge.
- Only one allowed per discharge.
- Must follow RT 40.
- Must be followed by RT 50.
- Record Type = 45.

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
1	Record Type ‘45’	XX	L/B	1 2	- Must be first record following last occurrence of Ancillary Services Record Type ’40’	A
2	Medical Record Number	X(10)	L/B	3 12	- Must be present - Must equal Medical Record Number from Discharge Record Type ’20’	A
3	Principal External Cause Code	X(7)	L/B	13 19	- Must be present if principal diagnosis is ICD-10-CM codes (S00-S99), - Must be present if principal diagnosis is one of the following ICD-10-CM T-Codes: (T07) unspecified multiple injuries (T14) injury of unspecified body region (T20-T32) burns and corrosions (T33-T34) frostbite (T66) radiation sickness (T67) effects of heat/light (T68) heatstroke/sunstroke (T69) other effects of reduced temperatures (T70) effects of air pressure and water pressure (T74) confirmed cases of abuse/neglect --- - If present, must be a valid ICD-10-CM External Cause Code (V00-Y99) ---	B

					- Must agree with ICD Indicator --- ---- Principal External Cause code shall be recorded in designated field and not be present in Diagnosis Codes.	
4	Filler	X		20 20		
5	Principal Diagnosis Code	X(7)	L/B	21 27	- Must be present - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis -Must agree with ICD Indicator	A
6	Filler	X(2)		28 29		
7	Admitting Diagnosis Code	X(7)	L/B	30 36	- Must be present - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis -Must agree with ICD Indicator	B
8	Filler	X(2)		37 38		

9	Discharge Diagnosis Code	X(7)	L/B	39 45	- Must be present - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis -Must agree with ICD Indicator	Note
10	Condition Present on Admission – Principal External Cause Code	X		46 46	- Must be present when Principal External Cause Code is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
11	Condition Present on Admission – Principal Diagnosis Code	X		47 47	-Must be present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
12	Principal ICD Procedure Code	X(7)	L/B	48 54	- If entered must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
13	Filler	X(4)		55 58		
14	Date of Principal ICD Procedure (CCYYMMDD)	X(8)	L/B	59 66	- Must be present if Principal ICD Procedure code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

15	ICD Indicator	X	L/B	67 67	- International Classification of Diseases version Report the value that defines the version of ICD diagnoses on the claim. - 0 for ICD-10-CM	A
16	Other Caregiver	X	L/B	68 68	- May be present - If present must be a valid code as specified in Inpatient Data Code Tables (4)(a)	B
17	Attending Physician National Provider Identifier (NPI)	X(10)	L/B	69 78	- Must be present - Must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	A
18	Operating Physician National Provider Identifier (NPI)	X(10)	L/B	79 88	- Must be present if Principal ICD Procedure Code is present - If present, must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	A
19	Additional Caregiver National Provider Identifier (NPI)	X(10)	L/B	89 98	- May be present - If present, must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	A
20	Number of ANDs	9(4)	R/Z	99 102	- May be present - If present,: - Must be numeric - Must not exceed total accommodation days	Note
21	DSM Diagnosis	X(7)	L/B	103 109	- May be present - If present, must be valid DSM-5 code	Note

22	Discharge Facility National Provider Identifier (NPI)	X(10)	L/B	110 119	- May be present - If present, must be a valid National Provider Identifier per National Plan and Provider Enumeration System (NPPES)	Note
23	Filler	X(131)	L/B	120 250		

RECORD TYPE 50 – MEDICAL DIAGNOSIS

- Required for each discharge.
- Must follow RT 45 or RT 50
- Must be followed by RT 50 or RT 60.
- Record Type = 50.

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
1	Record Type ‘50’	XX	L/B	1 2	- Must be first record following last occurrence of Principal Medical Information Record Type ’45’	A
2	Sequence	99	R/Z	3 4	- Must be numeric - If first record following Principal Medical Information Record Type ’45’ sequence must = ’01’ - For each subsequent occurrence of Record Type ’50’ sequence must be incremented by one	A
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Discharge Record Type ’20’	A
4	Filler	X(12)		15 26		
5	Assoc. Diagnosis	X(7)	L/B	27 33	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
	Code I				- Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	
6	Assoc. Diagnosis Code II	X(7)	L/B	34 40	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: - ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status). If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A
7	Assoc. Diagnosis	X(7)	L/B	41 47	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
	Code III				- Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	
8	Assoc. Diagnosis Code IV	X(7)	L/B	48 54	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A
9	Assoc. Diagnosis Code V	X(7)	L/B	55 61	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
					Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status). If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	
10	Assoc. Diagnosis Code VI	X(7)	L/B	62 68	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A
11	Assoc. Diagnosis Code VII	X(7)	L/B	69 75	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes. If reporting an External Cause code, the Principal External Cause must be	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
					present: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) -Must agree with ICD Indicator	
12	Assoc. Diagnosis Code VIII	X(7)	L/B	76 82	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A
13	Assoc. Diagnosis Code IX	X(7)	L/B	83 89	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status). If reporting an External Cause code, the Principal External Cause must be present.	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
					-Must agree with ICD Indicator	
14	Assoc. Diagnosis Code X	X(7)	L/B	90 96	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A
15	Assoc. Diagnosis Code XI	X(7)	L/B	97 103	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status). If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
16	Assoc. Diagnosis Code XII	X(7)	L/B	104 110	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A
17	Assoc. Diagnosis Code XIII	X(7)	L/B	111 117	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
18	Assoc. Diagnosis Code XIV	X(7)	L/B	118 124	- Only permitted if prior diagnosis is entered - Must be valid ICD code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis - Associated Diagnosis fields 1-14 may be used for additional External Cause codes: ICD-10-CM (V00-Y84.9) and codes: (Y90-Y99) (place of injury, activity, status) If reporting an External Cause code, the Principal External Cause must be present. -Must agree with ICD Indicator	A
19	Filler	X(56)		125 180		
20	Condition Present on Admission – Assoc. Diagnosis Code I	X		181 181	-Must be present when Assoc. Diagnosis Code I is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
21	Condition Present on Admission – Assoc.	X		182 182	-Must be present when Assoc. Diagnosis Code II is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
	Diagnosis Code II					
22	Condition Present on Admission – Assoc. Diagnosis Code III	X		183 183	-Must be present when Assoc. Diagnosis Code III is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
23	Condition Present on Admission – Assoc. Diagnosis Code IV	X		184 184	-Must be present when Assoc. Diagnosis Code IV is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
24	Condition Present on Admission – Assoc. Diagnosis Code V	X		185 185	-Must be present when Assoc. Diagnosis Code V is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
25	Condition Present on Admission – Assoc. Diagnosis Code VI	X		186 186	-Must be present when Assoc. Diagnosis Code VI is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
26	Condition Present on Admission – Assoc. Diagnosis Code VII	X		187 187	-Must be present when Assoc. Diagnosis Code VII is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
27	Condition Present on Admission – Assoc. Diagnosis Code VIII	X		188 188	-Must be present when Assoc. Diagnosis Code VIII is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
28	Condition Present on Admission – Assoc. Diagnosis Code IX	X		189 189	-Must be present when Assoc. Diagnosis Code IX is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
29	Condition Present on Admission – Assoc. Diagnosis Code X	X		190 190	-Must be present when Assoc. Diagnosis Code X is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
30	Condition Present on	X		191 191	-Must be present when Assoc. Diagnosis Code XI is present	B

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
	Admission – Assoc. Diagnosis Code XI				-Must be valid code as specified in Inpatient Data Code Tables(4)(b)	
31	Condition Present on Admission – Assoc. Diagnosis Code XII	X		192 192	-Must be present when Assoc. Diagnosis Code XII is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
32	Condition Present on Admission – Assoc. Diagnosis Code XIII	X		193 193	-Must be present when Assoc. Diagnosis Code XIII is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
33	Condition Present on Admission – Assoc. Diagnosis Code XIV	X		194 194	-Must be present when Assoc. Diagnosis Code XIV is present -Must be valid code as specified in Data Code Tables (4)(b)	B
34	Filler	X(56)		195 250		

RECORD TYPE 60 – MEDICAL PROCEDURE (ICD Codes)

- Required for each discharge.
- Must follow RT 50 or RT 60.
- Must be followed by RT 60 or RT 65.
- Record Type = 60.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type
1	Record Type ‘60’	XX	L/B	1 2	- Must be first record following Medical - Diagnosis Record Type ’50’	A
2	Sequence	99	R/Z	3 4	- Must be numeric - If first record following Medical - Diagnosis Record Type ’50’ sequence must = ’01’ - For each subsequent occurrence of Record Type ’60’ sequence must be incremented by one	A
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Discharge Record Type ’20’	A
4	Filler	X(15)		15 29		

5	Significant ICD Procedure I	X(7)	L/B	30 36	- May only be present if Principal ICD Procedure Code is present - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
6	Filler	X(2)		37 38		
7	Significant ICD Procedue I Date (CCYYMMDD)	X(8)	L/B	39 46	- Must be present if Significant ICD Procedure Code I is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
8	Significant ICD Procedure II	X(7)	L/B	47 53	- May only be present if Significant ICD Procedure I present - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
9	Filler	X(2)		54 55		

10	Significant ICD Procedure II Date (CCYYMMDD)	X(8)	L/B	56 63	- Must be present if Significant ICD Procedure II code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
11	Significant ICD Procedure III	X(7)	L/B	64 70	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
12	Filler	X(2)		71 72		
13	Significant ICD Procedure III Date (CCYYMMDD)	X(8)	L/B	73 80	- Must be present if Significant ICD Procedure III code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

14	Significant ICD Procedure IV	X(7)	L/B	81 87	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
15	Filler	X(2)		88 89		
16	Significant ICD Procedure IV Date (CCYYMMDD)	X(8)	L/B	90 97	- Must be present if Significant ICD Procedure IV code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
17	Significant ICD Procedure V	X(7)	L/B	98 104	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
18	Filler	X(2)		105 106		

19	Significant ICD Procedure V Date (CCYYMMDD)	X(8)	L/B	107 114	- Must be present if Significant ICD Procedure V code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
20	Significant ICD Procedure VI	X(7)	L/B	115 121	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
21	Filler	X(2)		122 123		
22	Significant ICD Procedure VI Date (CCYYMMDD)	X(8)	L/B	124 131	- Must be present if Significant ICD Procedure VI code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

23	Significant ICD Procedure VII	X(7)	L/B	132 138	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
24	Filler	X(2)		139 140		
25	Significant ICD Procedure VII Date (CCYYMMDD)	X(8)	L/B	141 148	- Must be present if Significant ICD Procedure VII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
26	Significant ICD Procedure VIII	X(7)	L/B	149 155	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
27	Filler	X(2)		156 157		

28	Significant ICD Procedure VIII Date (CCYYMMDD)	X(8)	L/B	158 165	- Must be present if Significant ICD Procedure VIII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
29	Significant ICD Procedure IX	X(7)	L/B	166 172	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
30	Filler	X(2)		173 174		
31	Significant ICD Procedure IX Date (CCYYMMDD)	X(8)	L/B	175 182	- Must be present if Significant ICD Procedure IX code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

32	Significant ICD Procedure X	X(7)	L/B	183 189	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
33	Filler	X(2)		190 191		
34	Significant ICD Procedure X Date (CCYYMMDD)	X(8)	L/B	192 199	- Must be present if Significant ICD Procedure X code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
35	Significant ICD Procedure XI	X(7)	L/B	200 206	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
36	Filler	X(2)		207 208		

37	Significant ICD Procedure XI Date (CCYYMMDD)	X(8)	L/B	209 216	- Must be present if Significant ICD Procedure XI code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
38	Significant ICD Procedure XII	X(7)	L/B	217 223	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
39	Filler	X(2)		224 225		
40	Significant ICD Procedure XII Date (CCYYMMDD)	X(8)	L/B	226 233	- Must be present if Significant ICD Procedure XII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

41	Significant ICD Procedure XIII	X(7)	L/B	234 240	- May only be present if all previous procedure fields are entered - Must be valid ICD code - Must be valid for patient sex -Must agree with ICD Indicator	A
42	Filler	X(2)		241 242		
43	Significant ICD Procedure XIII Date (CCYYMMDD)	X(8)	L/B	243 250	- Must be present if Significant ICD Procedure XIII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

RECORD TYPE 65 – MEDICAL PROCEDURE (HCPCS/CPT Codes)

- Required for each discharge.
- Only one allowed per Discharge.
- Must follow RT 60
- Must be followed by RT 80.
- Record Type = 65.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type

1	Record Type ‘65’	XX	L/B	1 2	- Must be first record following Medical - Diagnosis Record Type ’60’	A
2	Sequence	99	R/Z	3 4	- Must be numeric - If first record following Medical - Diagnosis Record Type ’60’ sequence must = ’01’ - For each subsequent occurrence of Record Type ’65’ sequence must be incremented by one	A
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Discharge Record Type ’20’	A
4	Filler	X(15)		15 29		
5	Significant HCPCS/CPT Procedure I	X(10)	L/B	30 39	- May only be present if Principal HCPCS/CPT Procedure Code is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
6	Procedure Code Type for Significant HCPCS/CPT Procedure I	X		40 40	- Must be present if Significant HCPCS/CPT Procedure Code I is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A

7	First Modifier for Significant HCPCS/CPT Procedure I	X(2)	L/B	41 42	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be valid HCPCS/CPT code modifier	B
8	Second Modifier for Significant HCPCS/CPT Procedure I	X(2)	L/B	43 44	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be valid HCPCS/CPT code modifier	B
9	Third Modifier for Significant HCPCS/CPT Procedure I	X(2)	L/B	45 46	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be valid HCPCS/CPT code modifier	B
10	Fourth Modifier for Significant HCPCS/CPT Procedure I	X(2)	L/B	47 48	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be valid HCPCS/CPT code modifier	B

11	Significant HCPCS/CPT Procedure I Date (CCYYMMDD)	X(8)	L/B	49 56	- Must be present if Significant HCPCS/CPT Procedure Code I is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
12	Significant HCPCS/CPT Procedure II	X(10)	L/B	57 66	- May only be present if Significant HCPCS/CPT Procedure Code I is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
13	Procedure Code Type for Significant HCPCS/CPT Procedure II	X		67 67	- Must be present if Significant HCPCS/CPT Procedure Code II is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A
14	First Modifier for Significant HCPCS/CPT Procedure II	X(2)	L/B	68 69	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be valid HCPCS/CPT code modifier	B

15	Second Modifier for Significant HCPCS/CPT Procedure II	X(2)	L/B	70 71	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be valid HCPCS/CPT code modifier	B
16	Third Modifier for Significant HCPCS/CPT Procedure II	X(2)	L/B	72 73	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be valid HCPCS/CPT code modifier	B
17	Fourth Modifier for Significant HCPCS/CPT Procedure II	X(2)	L/B	74 75	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be valid HCPCS/CPT code modifier	B
18	Significant HCPCS/CPT Procedure II Date (CCYYMMDD)	X(8)	L/B	76 83	- Must be present if Significant HCPCS/CPT Procedure Code II is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

19	Significant HCPCS/CPT Procedure III	X(10)	L/B	84 93	- May only be present if Significant HCPCS/CPT Procedure Code II is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
20	Procedure Code Type for Significant HCPCS/CPT Procedure III	X		94 94	- Must be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A
21	First Modifier for Significant HCPCS/CPT Procedure III	X(2)	L/B	95 96	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code modifier	B
22	Second Modifier for Significant HCPCS/CPT Procedure III	X(2)	L/B	97 98	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code modifier	B
23	Third Modifier for Significant HCPCS/CPT Procedure III	X(2)	L/B	99 100	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code modifier	B

24	Fourth Modifier for Significant HCPCS/CPT Procedure III	X(2)	L/B	101 102	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code modifier	B
25	Significant HCPCS/CPT Procedure III Date (CCYYMMDD)	X(8)	L/B	103 110	- Must be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
26	Significant HCPCS/CPT Procedure IV	X(10)	L/B	111 120	- May only be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
27	Procedure Code Type for Significant HCPCS/CPT Procedure IV	X		121 121	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A

28	First Modifier for Significant HCPCS/CPT Procedure IV	X(2)	L/B	122 123	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
29	Second Modifier for Significant HCPCS/CPT Procedure IV	X(2)	L/B	124 125	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
30	Third Modifier for Significant HCPCS/CPT Procedure IV	X(2)	L/B	126 127	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
31	Fourth Modifier for Significant HCPCS/CPT Procedure IV	X(2)	L/B	128 129	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B

32	Significant HCPCS/CPT Procedure IV Date (CCYYMMDD)	X(8)	L/B	130 137	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
33	Significant HCPCS/CPT Procedure V	X(10)	L/B	138 147	- May only be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
34	Procedure Code Type for Significant HCPCS/CPT Procedure V	X		148 148	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A
35	First Modifier for Significant HCPCS/CPT Procedure V	X(2)	L/B	149 150	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B

36	Second Modifier for Significant HCPCS/CPT Procedure V	X(2)	L/B	151 152	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
37	Third Modifier for Significant HCPCS/CPT Procedure V	X(2)	L/B	153 154	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
38	Fourth Modifier for Significant HCPCS/CPT Procedure V	X(2)	L/B	155 156	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
39	Significant HCPCS/CPT Procedure V Date (CCYYMMDD)	X(8)	L/B	157 164	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

40	Significant HCPCS/CPT Procedure VI	X(10)	L/B	165 174	- May only be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
41	Procedure Code Type for Significant HCPCS/CPT Procedure VI	X		175 175	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A
42	First Modifier for Significant HCPCS/CPT Procedure VI	X(2)	L/B	176 177	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
43	Second Modifier for Significant HCPCS/CPT Procedure VI	X(2)	L/B	178 179	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
44	Third Modifier for Significant HCPCS/CPT Procedure VI	X(2)	L/B	180 181	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B

45	Fourth Modifier for Significant HCPCS/CPT Procedure VI	X(2)	L/B	182 183	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
46	Significant HCPCS/CPT Procedure VI Date (CCYYMMDD)	X(8)	L/B	184 191	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
47	Significant HCPCS/CPT Procedure VII	X(10)	L/B	192 201	- May only be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
48	Procedure Code Type for Significant HCPCS/CPT Procedure VII	X		202 202	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A

49	First Modifier for Significant HCPCS/CPT Procedure VII	X(2)	L/B	203 204	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
50	Second Modifier for Significant HCPCS/CPT Procedure VII	X(2)	L/B	205 206	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
51	Third Modifier for Significant HCPCS/CPT Procedure VII	X(2)	L/B	207 208	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
52	Fourth Modifier for Significant HCPCS/CPT Procedure VII	X(2)	L/B	209 210	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B

53	Significant HCPCS/CPT Procedure VII Date (CCYYMMDD)	X(8)	L/B	211 218	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
54	Significant HCPCS/CPT Procedure VIII	X(10)	L/B	219 228	- May only be present if Significant HCPCS/CPT Procedure Code III is present - Must be valid HCPCS/CPT code - Must be valid for patient sex	A
55	Procedure Code Type for Significant HCPCS/CPT Procedure VIII	X		229 229	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid type of code as specified in Inpatient Data Code Tables(1)(o)	A
56	First Modifier for Significant HCPCS/CPT Procedure VIII	X(2)	L/B	230 231	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B

57	Second Modifier for Significant HCPCS/CPT Procedure VIII	X(2)	L/B	232 233	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
58	Third Modifier for Significant HCPCS/CPT Procedure VIII	X(2)	L/B	234 235	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
59	Fourth Modifier for Significant HCPCS/CPT Procedure VIII	X(2)	L/B	236 237	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid HCPCS/CPT code modifier	B
60	Significant HCPCS/CPT Procedure VIII Date (CCYYMMDD)	X(8)	L/B	238 245	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be valid date - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
61	Filler	X(5)		246 250		

RECORD TYPE 80 – PHYSICIAN DATA

- Required for each discharge.
- Must be preceded by RT 65.
- Must be followed by RT 90.
- Record Type = 80.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type
1	Record Type ’80’	XX	L/B	1 2	- Must be first record following Medical - Procedure Record Type ‘65’	A
2	Filler	XX		3 4		
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Patient Record Type ’20’	A
4	Attending Physician License Number (Board of Registration in Medicine Number)	X(6)	L/B	15 20	- Must be present - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be NURSEP, PHYAST. or “OTHER”, as specified in Inpatient Data Elements Definitions (11) (a).	B
5	Filler	XX	L/B	21 22		

6	Operating Physician for Principal ICD Procedure (Board of Registration in Medicine Number)	X(6)	L/B	23 28	- Must be present if Principal ICD Procedure Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be "", NURSEP, PHYAST, or "OTHER" as specified in Inpatient Data Elements Definitions (11) (b).	Note
7	Filler	XX	L/B	29 30		
8	Operating Physician for Significant HCPCS/CPT Procedure I (Board of Registration in Medicine Number)	X(6)	L/B	31 36	- Must be present if Significant HCPCS/CPT Procedure I Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be "", NURSEP, PHYAST, or "OTHER" as specified in Inpatient Data Elements Definitions (9) (b).	Note
9	Filler	X(214)	L/B	37 250		

RECORD TYPE 90 – PATIENT CONTROL

- Required for each discharge.
- Must be preceded by RT 80.
- May be followed by RT 20 or RT 95.
- Record Type = 90.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type
1	Record Type ’90’	XX	L/B	1 2	- Must be first record following Physician Data Record Type ‘80’	A
2	Filler	XX		3 4		
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Patient Record Type ’20’	A
4	Filler	X(7)		15 21		
5	Physical Record Count	9(3)	R/Z	22 24	- Must equal total number of all Records Type ’20’, ‘25’, ’30’, ‘45’, ’40’, ’50’, ‘60’, ‘65’ and 80	A
6	Record Type 20 Count	99	R/Z	25 26	- Must equal number of Record Type’20’ records - Must = ’01’	A

7	Record Type 25 Count	99	R/Z	27 28	- Must equal number of Record Type'25' records - Must = '01'	A
8	Record Type 30 Count	99	R/Z	29 30	- Must equal number of Record Type'30' records	A
9	Record Type 40 Count	99	R/Z	31 32	- Must equal number of Record Type'40' records	A
10	Record Type 45 Count	99	R/Z	33 34	- Must equal number of Record Type'45' records - Must = '01'	A
11	Record Type 5x Count	99	R/Z	35 36	- Must equal number of Record Type'50' records	A
12	Record Type 6x Count	99	R/Z	37 38	- Must equal number of Record Type'60' records	A
13	Record Type 6x Count	99	R/Z	39 40	- Must equal number of Record Type'65' records - Must = '01'	A

14	Record Type 8x Count	99	R/Z	41 42	- Must equal number of Record Type'80' records - Must = '01'	A
15	Filler	X(4)		43 46		
16	Total Charges Spec. Services	9(12)	R/Z	47 58	- Must be numeric - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	A
17	Total Charges Routine Services	9(12)	R/Z	59 70	- Must be numeric - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	A
18	Total Charges Ancillaries	9(12)	R/Z	71 82	- Must equal sum of Total Charges (Services) from Ancillary Services Record Type '40' records - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	A

19	Filler	X(4)		83 86		
20	Total Charges (All Chgs)	9(14)	R/Z	87 100	- Must equal sum of Total Charges Special Services, Total Charges Routine Services, and Total Charges Ancillaries from Patient Control Record Type ’90’ record - Must equal sum of Total Charges Accommodations from IP Accommodations Record Type ’30’ records and Total Charges (Services) from Ancillary Services Record Type ’40’ records - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	A
21	Filler	X(150)		101 250		

RECORD TYPE 95 – PROVIDER BATCH CONTROL

- Required for every Batch.
- Only one 95 record and Batch per File.
- Must be preceded by RT 90.
- Record Type = 95.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type
1	Record Type ’95’	XX	L/B	1 2	- Must follow Patient Control Record Type ’90’	A
2	Filler	X(10)		3 12		
3	Number of Discharges	9(5)	R/Z	13 17	- Must equal number of Patient Control Record Type ’90’records	A
4	Total Days	9(5)	R/Z	18 22	- Must equal total accommodation days from all Record Type ’30’ Records	Note

5	Total Charges Accommodations	9(14)	R/Z	23 36	Must equal sum of Total Charges Spec. Services and Total Charges Routine Services. from Patient Control Record Type '90' records - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	A
6	Filler	X(4)		37 40		
7	Total Charges Ancillaries	9(14)	R/Z	41 54	Must equal sum of Total Charges Ancillaries from Patient Control Record Type '90' records - Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	A
8	Filler	X(196)		55 250		

RECORD TYPE 99 – FILE CONTROL

- Required for every Batch.
- Only one 99 record and Batch per File.
- Must be preceded by RT 95.
- Record type = 99.

Field No.	Field Name	Picture	Spec.	Field Position From - Through	Edit Specifications	Error Type
1	Record Type '99'	XX	L/B	1 2	- Must follow Provider Batch Control Record Type '95'	A
2	Submitter EIN	9(10)	L/B	3 12	- Must equal Submitter EIN from Label Record Type '01' record	Note
3	Filler	X(8)		13 20		
4	No. of Providers on File	9(3)	R/Z	21 23	- Must equal number of Provider Record Type '10' records - Must equal 1.	Note
5	Filler	X(5)		24 28		
6	Count of Batches	9(4)	R/Z	29 32	- Must equal number of Provider Batch Control Record Type '95' records - Must equal 1.	Note

7	Filler	X(218)		33 250		

Inpatient Data Element Definitions

Definitions are presented in the sequential order that the data elements appear in the record types. (e.g., Data elements from record type ’01’ requiring definition are presented first; those from record type ’10’ follow.) The code tables for all data elements which require code value descriptions are defined in the section Inpatient Data Code Tables.

(1) Record Type ’01’

(a) Submitter Name: The name of the organization submitting the file which may be an individual facility or a processor submitting data for one or more facilities.

(b) Receiver Identification: A control field for insuring the correct file is being forwarded to CHIA. Code this field ‘CHIA’.

(c) Processing Date: The date the file is created.

(d) Submission Number: The sequential number of the file used as a control.

(2) Record Type ’10’

(a) Period Starting/Ending Dates: These dates must coincide with the first day and last day of the quarter for which data is being submitted.

(b) CHIA Organization ID for Provider: A unique code assigned by the Center for Health Information and Analysis for each health care organization providing data.

(3) Record Type ’20’

(a) Medical record number: The unique number assigned to each patient within the hospital that distinguishes the patient and the patient’s hospital record(s) from all others in that institution.

(b) Patient Birth Date: The date of birth of the patient. Record two digits for century, two digits for year, two digits for month, and two digits for day. If exact century and year are unknown, estimate.

(c) Type of Admission: A code indicating the priority status of the admission.

(d) Source of Admission: A code indicating the source referring or transferring this patient to inpatient status in the hospital. The Primary Source of Admission should be the originating referring or transferring facility or primary referral source causing the patient to enter the hospital's care. The Secondary Source of Admission should be the secondary referring or transferring source for the patient. If the patient has been transferred from a SNF to the hospital's Clinic and is then admitted, report the Primary Source of Admission as "5 - Transfer from SNF" and report the Secondary Source of Admission as "Within Hospital Clinic Referral".

The method for determining the Primary Source of Admission to report for each discharge should be based on the following Source of Admission hierarchy:

	Primary Source of Admission Hierarchy		**Source of Admission Codes***	
1.	Transferred from another facility	Yes	4, 5, or 6	If no, refer to #2.
2.	Referred or transferred from Outside Hospital Clinic or Outside Ambulatory Surgery	Yes	L, or T	If no, refer to #3.
3.	Transferred from Outside Hospital Emergency Room	Yes	7	If no, refer to #4
4.	Referred or transferred from Court/Law Enforcement	Yes	8	If no, refer to #5
5.	Direct Physician Referral, Direct Health Plan/HMO Referral or Walk-In/Self-Referral	Yes	1, 3, or M	If no, refer to #6
6.	Referred or transferred from Within Hospital Clinic or Ambulatory Surgery	Yes	2 or Y	If no, refer to #7.
7.	Observation Referral	Yes	X	If no, refer to #8.
8.	Other or information not available	Yes	9 or 0	

*** Note: Refer to Inpatient Data Code Tables (1) (d) for detailed listing of Source of Admission codes and definitions.**

(e) Observation: If the Observation Source of Admission (code 'X') is reported, related observation room charges must also be reported for the Observation Ancillary Revenue Code 762. However, if the patient has been seen in Observation as well as another outpatient department and is then admitted, use Revenue Code 762 to report observation room charges and use the alternate outpatient department as the Source of Admission.

(f) Admission Date: The date the patient was admitted to the hospital as an inpatient for this episode of care.

(g) Discharge Date: The date the patient was discharged from inpatient status in the hospital for this episode of care.

(**h) Patient Status:** A code indicating the patient's status upon discharge and/or the destination to which the patient was referred or transferred upon discharge.

(i) Intermediate Care Facility (ICF): An ICF is a facility that provides routine services or periodic availability of skilled nursing, restorative and other therapeutic services, in addition to the minimum basic care and services required for patients whose condition is stabilized to the point that they need only supportive nursing care, supervision and observation. A facility is an ICF if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR, 150.001(B)(3): Supportive Nursing Care Facilities (Level III).

(**j) Rest Home:** A Rest Home is a facility that provides or arranges to provide a supervised supportive and protective living environment and support services incident to old age for residents having difficulty in caring for themselves. This facility's services and programs seek to foster personal well-being, independence, an optimal level of psychosocial functioning, and integration of residents into community living. A facility is a Rest Home if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR 150.001(B)(4): Resident Care Facilities (Level IV).

(k) Skilled Nursing Facility (SNF): A SNF is a facility that provides continuous skilled nursing care and meaningful availability of restorative services and other therapeutic services in addition to the minimum basic care and services required for patients who show potential for improvement or restoration to a stabilized condition or who have a deteriorating condition requiring skilled care. A facility is a SNF if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR, 150.001(B)(2): Skilled Nursing Care Facilities (Level II). Use Routine Accommodation Revenue Code 198 for SNF.

(**l) Billing number:** The unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution. Newborns must have their own billing number separate from that of their mother.

(m) Claim Certificate Number: This number is also referred to as the newMMIS ID or MassHealth ID. If the Payer Type Code is equal to "4" (Medicaid) or "B" (Medicaid Managed Care) as specified in Inpatient Data Code Tables (1) (f), the newMMIS ID must be recorded.

(n) Veteran Status: A code indicating the patient's status as a United States veteran.

(o) Patient Social Security Number: The patient's social security number is to be reported as a nine digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record", by reporting the social security number as "000000001". The number to be reported for the patient's social security number is the patient's social security number, not the social security number of some other person, such as the husband or wife of the patient.

(p) Do Not Resuscitate (DNR) Status: A status indicating that the patient had a physician order not to resuscitate or the patient had a status of receiving palliative care only. Do not resuscitate status means not to revive from potential or apparent death or that a patient was being treated with comfort measures only.

(q) Hospital Service Site Reference: Hospital Organization ID as assigned by the Center for Health Information and Analysis for the site where care was given. Required if provider is approved to submit multiple campuses in one file.

(r) Patient's Sexual Orientation: The patient's self-reported sexual orientation as specified in Inpatient Data Code Table (1) (m).

(s) Patient's Gender Identity: The patient's self-reported gender identity as specified in Inpatient Data Code Table (1) (n).

(4) Record Type '25'

(a) Permanent Patient Street Address: The street address of the patient. This is required if the patient is a United States citizen. If the patient is homeless, this field may be left blank.

(b) Permanent Patient City/Town: The city/town where the patient resides. This is required if the patient is a United States citizen.

(c) Permanent Patient State: The US Postal Service code for the state where the patient resides. This is required if the patient is a United States citizen.

(d) Patient Zip Code: The U.S. Post Office (five digit) zip code which designates the patient's residence. If the patient's residence is outside of the United States, or if the zip code is unknown record 0's.

(e) Patient Country: The International Standards Organization (ISO-3166) code for the country where the patient resides. This is their permanent country of residence. This is required for all patients.

(f) Patient's Race 1 and Race 2: The patient's self-reported Race 1 and Race 2 as specified in Inpatient Data Code Table (2)(a).

(g) Patient's Hispanic Indicator: The patient's self-reported response as specified in Inpatient Data Code Table (2)(b).

(h) Patient's Ethnicity 1 and Ethnicity 2: The patient's self-reported Ethnicity 1 and Ethnicity 2 as specified in Inpatient Data Code Table (2)(c).

(i) Health Plan Member ID: The unique health plan / payer member ID for the patient. If the member ID is unavailable, report the subscriber ID

(5) Record Type '30'

(a) Sequence: A code to identify multiple occurrences of Record Type '30' when a single reporting of this record is not sufficient to capture all of the routine and special care accommodations used by this discharged patient. This code is a sequential recording of the number of occurrences of this record, e.g. '01' or '02'.

(b) Revenue Code: A numeric code which identifies a particular routine or special care accommodation. The revenue codes are taken from the Uniform Billing (UB) revenue codes and correspond to specific cost centers in the CHIA-403 cost report.

(c) Units of Service: A quantitative measure of utilization of specific hospital services corresponding to prescribed revenue codes. For routine and special care accommodations the units of service are "days".

(d) Total Charges (Accommodation): The full, undiscounted, usual and customary charges summarized by specific accommodation revenue code(s). Total charges should not include charges for telephone service, television or private duty nurses. Any charges for a leave of absence period are to be included in the routine accommodation charges for the appropriate service (medical/surgical, psychiatry) from which the patient took the leave of absence. Any other routine admission charges or daily charges under which expenses are allocated to the routine or special care reporting centers on the CHIA-403 must be included in the total charges.

(6) Record Type '40'

(a) Sequence: A code to identify multiple occurrences of Record Type '40' when a single reporting of this record is not sufficient to capture all of the ancillary services used by this discharge patient. This code is a sequential recording of the number of occurrences of this record, e.g. '01' or '02'.

(b) Revenue Code: A numeric code which identifies a particular ancillary service. The revenue codes are taken from the UB revenue codes and correspond to specific cost centers in the CHIA-403 cost report.

For Observation Treatment the expected revenue codes are:

1. Revenue Center 760 - General Observation/Treatment Room: This ancillary revenue center is designated for any other charges associated with "observation" or "Treatment Room" that are not captured in revenue centers 761, 762, or 769.

2. Revenue Center 762 - Observation Room: This ancillary revenue center is designated for Observation Room charges only. Charges should be reported under revenue center code 762 for any patient that uses an Observation Room and is admitted

3. Revenue Center 769 - Other Treatment/Observation Room: This ancillary revenue center is designated for other atypical inpatient Observation Room charges only. An example of atypical inpatient Observation Room charges might be room charges for a patient held for observation purposes before being discharged that is not categorized as "observation status" or not placed in an observation bed.

(c) Units of Service: For the majority of ancillary services, the units of service are not specified and zeros should be used to fill the blanks. The Unit of Service for Ancillary Services is required for Revenue Center 762 - Observation Room and 769 - Other Observation Room. The required unit of service for Observation Room is hours. For hospitals that collect this information in a range, report the information using the end point and round up to the highest whole number. For example, if the range is 0 - 4 hours, then '4' should be reported. Hospitals that collect this unit as days will need to convert it to an hour equivalent. For example, 1 day should be reported as '24' (for 24 hours).

(d) Total Charges (Ancillary Services): The full, undiscounted, usual and customary charges summarized by a specific ancillary service revenue code(s).

(7) Record Type '45'

(a) External Cause Code: International Classification of Diseases, 10th Revision, Clinical Modification (ICD) V-codes, and or W-codes, X-codes, or Y-codes (V00-Y99) are used to categorize events and conditions describing the external cause of injuries, poisonings, and adverse effects. Codes adequate to describe the external cause shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings of the ICD-10 (S00-T88) demonstrate that an additional External Cause Code is appropriate. The principal external cause code shall describe the mechanism that caused the most severe injury, poisoning, or adverse effect. Additional codes used to report place of occurrence or to completely describe the mechanism(s) that contributed to the injury or poisoning or the causal circumstances surrounding any injury or poisoning should be reported in the Associated Diagnosis Code section.

(b) Principal Diagnosis Code: The ICD diagnosis code corresponding to the condition established after study to be chiefly responsible for the admission of the patient for hospital care.

(c) Admitting Diagnosis Code: The ICD diagnosis code indicating patient's diagnosis at admission.

(d) Discharge Diagnosis Code: The ICD diagnosis code indicating patient's diagnosis at discharge.

(e) Principal ICD Procedure Code: The ICD procedure code that is usually the procedure most related to the principal diagnosis and performed for definitive treatment of the principal diagnosis rather than for diagnostic or exploratory purposes, or necessary to treat a complication of the principal diagnosis.

(f) Date of Principal ICD Procedure: The century, year, month, and day on which this procedure was performed.

(g) ICD Indicator: Code to indicate the version of the ICD coding system on the diagnosis codes. Only one ICD coding system is allowed per Patient discharge.

(h) Other Caregiver: The primary caregiver responsible for the patient's care other than the Attending Physician, Operating Room Physician as specified in Inpatient Data Code Tables 4(a).

(i) Number of Administratively Necessary Days: The number of days which were deemed clinically unnecessary in accordance with review by the Division of Medical Assistance.

(j) DSM Diagnosis: The diagnosis according to the **Diagnostic and Statistical Manual for Mental Disorders** from the American Psychiatric Association.

(k) Principal HCPCS / CPT Procedure Code: The HCPCS/CPT procedure code that is usually the procedure most related to the principal diagnosis and performed for definitive treatment of the principal diagnosis rather than for diagnostic or exploratory purposes, or necessary to treat a complication of the principal diagnosis.

(l) Principal HCPCS / CPT Procedure Code Modifiers: Report up to four modifiers related to each Principal HCPCS /CPT Procedure code.

(m) Date of Principal HCPCS / CPT Procedure: The century, year, month, and day on which this procedure was performed.

(8) Record Type '50'

(a) Sequence: A code to identify multiple occurrences of Record Type '50' when a single reporting of this record is not sufficient to capture all of the diagnosis codes used by this discharge patient. This code is a sequential recording of the number of occurrences of this record, e.g. '01' or '02'.

(b) Associated Diagnosis Code: The ICD diagnosis code corresponding to conditions that co-exist with the principal diagnosis at the time of admission, or develop subsequently, which affect the treatment received or the length of the patient's hospital stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

(c) Condition Present on Admission: A qualifier for each diagnosis code indicating the onset of diagnosis preceded or followed admission.

(9) Record Type '60'

(a) Sequence: A code to identify multiple occurrences of Record Type '60' when a single reporting of this record is not sufficient to capture all of the ICD procedure codes used by this discharge patient. This code is a sequential recording of the number of occurrences of this record, e.g. '01' or '02'.

(b) Significant ICD Procedure Code: The ICD procedure code usually corresponding to additional procedures which carry an operative or anesthetic risk or require highly trained personnel, special equipment or facilities.

(c) Date of Significant ICD Procedure: The century, year, month, and day on which this procedure was performed.

(10) Record Type '65'

(a) Sequence: A code to identify multiple occurrences of Record Type '65' when a single reporting of this record is not sufficient to capture all of the HCPCS /CPT procedure codes used by this discharge patient. This code is a sequential recording of the number of occurrences of this record, e.g. '01' or '02'.

(b) Significant HCPCS / CPT Procedure Code: The HCPCS / CPT procedure code usually corresponding to additional procedures which carry an operative or anesthetic risk or require highly trained personnel, special equipment or facilities.

(c) Significant HCPCS / CPT Procedure Code Modifiers. Report up to four modifiers related to each Significant HCPCS /CPT Procedure code.

(d) Date of Significant HCPCS / CPT Procedure: The century, year, month, and day on which this procedure was performed.

(11) Record Type '80'

(a) Attending Physician License Number: The Massachusetts Board of Registration in Medicine license number of the clinician of record at discharge who is responsible for the discharge summary, who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode. If the attending physician does not have a license number from the Massachusetts Board of Registration in Medicine, use the following codes in the indicated circumstances:

NURSEP	for each Nurse Practitioner
PHYAST	for each Physician Assistant
OTHER	for other situations where no permanent license number is assigned or if a limited license number is assigned.

(b) Procedure/Operating Physician License Number: The Massachusetts Board of Registration in Medicine license number for the clinician who performed each procedure. If the operating physician does not have a license number from the Massachusetts Board of Registration in Medicine, use the following codes in the indicated circumstances:

NURSEP	for each Nurse Practitioner
PHYAST	for each Physician Assistant
OTHER	for other situations where no permanent license number is assigned or if a limited license number is assigned.

(12) Record Type '90'

(a) Physical Record Count. The count of the total number of records provided for this particular patient discharge excluding Record Type '90'.

(b) Record Type Count. The count of the number of each type of separate records from record '20' through '80'. For instance. Record Type "3X" is the count of all record types '30'.

(c) Total Charges Special Care Services. The full, undiscounted, usual and customary charges for patient care summarized by prescribed revenue code for accommodation services in those special care units which provide patient care of a more intensive nature than that provided in the general medical care units, as specified in Inpatient Data Code Tables(3).

(d) Total Charges Routine Services. The full, undiscounted, usual and customary charges for patient care summarized by prescribed revenue code for routine accommodation services as specified in Inpatient Data Code Tables(3).

(e) Total Charges Ancillaries. The full, undiscounted, usual and customary charges for patient care summarized by prescribed revenue code for ancillary services as specified in Inpatient Data Code Tables(3).

(f) Total Charges (All Charges) . The full, undiscounted, usual and customary charges for patient care summarized by prescribed revenue code for special care, routine accommodation, and ancillary services. Total charges should not include charges for telephone service, television or private duty nurses. Any charges for a leave of absence period are to be included in the routine accommodation charges for the appropriate service from which the patient took the leave of absence. Any other routine admission charges or daily charges under which expenses are allocated to the reporting centers on the CHIA-403 must be included in total charges.

(13) Record Type '95'

(a) Total Days. The count of total patient days represented by discharges in this quarter net of any leave of absence days.

(14) Record Type '99'

(a) Count of Batches. The total number of batches included on this file. Only one batch is allowed per file.

Inpatient Data Code Tables

The following are the code tables for all data elements requiring codes not otherwise specified. They are listed in order of record type.

(1) Record Type '20'

(a)

* SEX CODE	* Patient Sex Definition
M	Male
F	Female
U	Unknown

(b)

* MARSTA CODE	* Marital Status Definition
S	Never Married
M	Married
X	Legally Separated
D	Divorced
W	Widowed
C	Common Law Married
P	Domestic Partnership
U	Unknown

(c)

* TYPADM CODE	* Type of Admission Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Information Unavailable

(d)

* SRCADM CODE	* Source of Admission Definition
0	Information Not Available
1	Direct Physician Referral
2	Within Hospital Clinic Referral
3	Direct Health Plan Referral/HMO Referral
4	Transfer from an Acute Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from Intermediate Care Facility
7	Outside Hospital Emergency Room Transfer
8	Court/Law Enforcement
9	Other (to include level 4 Nursing Facility)
F	Transfer from a Hospice Facility
L	Outside Hospital Clinic Referral
M	Walk-In/Self-Referral
T	Transfer from Another Institution's Ambulatory Surgery
X	Observation
Y	Within Hospital Ambulatory Surgery Transfer

(e)

For Patient Status reporting:

Use the codes found in Standard Facility Billing Elements: National Uniform Billing Committee (NUBC)

http://www.nubc.org/

(f) PAYER TYPE:

* PAYER TYPE CODE	PAYER TYPE ABBREVIATION	* PAYER TYPE DEFINITION
1	SP	Self Pay
2	WOR	Worker's Compensation
3	MCR	Medicare
F	MCR-MC	Medicare Managed Care
4	MCD	Medicaid
B	MCD-MC	Medicaid Managed Care
5	GOV	Other Government Payment
6	BCBS	Blue Cross
C	BCBS-MC	Blue Cross Managed Care
7	COM	Commercial Insurance
D	COM-MC	Commercial Managed Care
8	HMO	HMO

9	FC	Free Care
0	OTH	Other Non-Managed Care Plans
E	PPO	PPO and Other Managed Care Plans Not Elsewhere Classified
H	HSN	Health Safety Net
J	POS	Point-of-Service Plan
K	EPO	Exclusive Provider Organization
T	AI	Auto Insurance
N	None	None (Valid only for Secondary Payer)
Q	CommCare	Commonwealth Care / ConnectorCare Plans
Z	DEN	Dental Plans

(g) SOURCE OF PAYMENT: For Source of Payment, refer to this link on CHIA's website for Payer Source Codes: http://www.chiamass.gov/hospital-data-specification-manuals/

(h)

* VESTA CODE	* VETERAN STATUS DEFINITION
1	YES
2	NO (includes never in military, currently in active duty, national guard or reservist with 6 months or less active duty)
3	Not applicable
4	Not Determined (unable to obtain information)

(i)

*DNR CODE	DO NOT RESUSCITATE STATUS DEFINITION
1	DNR order written
2	Comfort measures only
3	No DNR order or comfort measures ordered

(j)

Patient Homeless Indicator	
Valid Entries	**Definition**
Y	Patient is known to be homeless.
N	Patient is not known to be homeless.

(k) TRANSFER ORG IDs; For Transfer Organization IDs, refer to this link on CHIA's website for the Transfer Organization ID (ORG ID) List: http://www.chiamass.gov/hospital-data-specification-manuals/

(l)

Court / Criminal Referral Indicator	Description
1	State/Federal Court
2	Other court
3	Probation/Parole
4	Other Recognized Legal Entity
5	Diversionary Program
6	Prison
7	DUI/DWI
8	Other
9	Not applicable
10	Unknown

(m)

Patient's Sexual Orientation	Description
1	Heterosexual
2	Gay or Lesbian
3	Bisexual
4	Other
5	Unknown
6	Don't understand the question / Refuse to Answer

(n)

Patient's Gender Identity	Description
1	Male
2	Female
3	Male-to-Female(MTF) / Transgender Female
4	Female-to-Male (FTM) / Transgender Male
5	Genderqueer / Gender Non-Conforming / Not Exclusively Male or Female

6	Other
7	Unknown
8	Don’t understand the question / Refuse to Answer

(o)

Procedure Code Type Identifier	Description
1	CPT or HCPCS Level 1 Code
2	HCPCS Level II Code
3	HCPCS Level III Code (State Medicare code).
4	American Dental Association (ADA) Procedure Code (Also referred to as CDT code.)
5	State defined Procedure Code
6	CPT Category II
7	CPTCategory III Code

(2) Record Type '25'

(a)

Race Code	Patient Race Definition
R1	American Indian/Alaska Native
R2	Asian
R3	Black/African American
R4	Native Hawaiian or other Pacific Islander
R5	White
R9	Other Race
UNKNOW	Unknown/not specified

(b)

Patient Hispanic Indicator	
Valid Entries	**Definition**
Y	Patient is Hispanic/Latino/Spanish.
N	Patient is not Hispanic/Latino/Spanish.

(c)

Ethnicity Codes – Utilize full list of standard codes, per Center for Disease Control, and those listed below:
http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf

Ethnicity Code	Ethnicity Definition
AMERCN	American
BRAZIL	Brazilian
CVERDN	Cape Verdean
CARIBI	Caribbean Island
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
OTHER	Other Ethnicity
UNKNOW	Unknown/not specified

(3) Record Types '30' and '40'

For Routine Accommodations, Special Care Accommodations, and Ancillary Services, please use the revenue codes found in:

Standard Facility Billing Elements: National Uniform Billing Committee (NUBC)

http://www.nubc.org/

(4) Record Types '45' and '50'

(a)

*OTH CARE CODE	*TYPE OF OTHER CAREGIVER DEFINITION
1	Resident
2	Intern
3	Nurse Practitioner
5	Physician Assistant

(b)

Condition Present on Admission Flag Code	Condition Present on Admission Description
Y	Yes
N	No
U	Unknown
W	Clinically undetermined
1	Not applicable (only valid for NCHS official published list of not applicable ICD codes for POA flag.)
Blank field	Not applicable (only valid for NCHS official published list of not applicable ICD codes for POA flag.)

Inpatient Data Quality Standards

(1) The data will be edited for compliance with the edit specifications set forth in the Inpatient Data Record Specifications. The standards to be employed for rejecting data submissions from facilities will be based upon the presence of errors in data elements categorized as A or B errors in the Error Type column of the Record Table Specifications above.

(2) All errors will be recorded for each patient discharge. A patient discharge will be rejected under the following conditions:

(a) Presence of one or more error flags for Category A elements.

(b) Presence of two or more errors for Category B elements.

(3) An entire file will be rejected and returned to submitter if:

(a) Any Category A elements of Provider Record (Record Type 10) or Provider Batch Control Record (Record Type = 95) are in error or

(b) Any Category A errors on Label Record (Record Type = 01).

(c) Any Category A errors on file Control Record (Record Type = 99).

(d) Any required record types are missing or out of order.

(e) If 1% or more of discharges are rejected or

(f) If 50 consecutive records are rejected.

(4) Acceptance of data files under the edit check procedures shall not be deemed acceptance of the factual accuracy of the data contained therein.

Submittal Schedule

Inpatient Discharge Data Files must be submitted quarterly to the CHIA according to the following schedule:

Quarter	Quarter Begin & End Dates	Due Date for Data File: 75 days following the end of the reporting period
1	10/1 – 12/31	3/16
2	1/1 – 3/31	6/14
3	4/1 – 6/30	9/13
4	7/1 – 9/30	12/14