

Administrative Bulletin 14-05

114.1 CMR 17.00 Requirement for the Submission of Hospital Case Mix and Charge Data

April 11, 2014

The Center for Health Information and Analysis (CHIA) is issuing this Administrative Bulletin in accordance with 114.1 CMR 17.06(2) to notify acute hospitals of changes to the Case Mix and Charge Data file submission guidelines.

Changes to the guidelines reflect the anticipated transition from International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9) to International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) in accordance with the Centers for Medicare and Medicaid Services requirement that all payers and hospitals transition to ICD-10 on or after October 1, 2015. The changes also increase the number of diagnosis and procedure codes providers may submit for each discharge or visit. Further, the changes to the guidelines increase the length of the charge fields to allow for larger amounts of information and update several code tables.

An updated File Submission Guide is posted on CHIA's website at <http://www.mass.gov/chia/docs> to advise acute hospitals of the revised file format and specifications for submitting ICD-9 and eventually ICD-10 data to CHIA in accordance with applicable CMS requirements. The changes noted herein will be in effect beginning with the quarterly submission of 10/1/2014 – 12/31/2014 data due at CHIA on March 16, 2015.

The following tables list new/updated ICD data records that must be submitted and also lists the fields affected by this update.

Inpatient Discharge Data File New/Updated Record Types:

Record Type '45'	<i>Record Type '45'</i> contains principal medical information such as primary diagnosis, admitting diagnosis, principal external cause of injury, principal procedure, physician information. This record is presented once for each discharge in the reporting period.
Record Type '50'	<i>Record Type '50'</i> reports associated diagnosis information pertaining to this patient's episode of care. This record may be repeated more than once per discharge, if necessary, to report more than fourteen (14) associated diagnoses within this episode of care.
Record Type '60'	<i>Record Type '60'</i> 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 necessary, to report more than thirteen (13) significant procedures within this episode of care.

Emergency Department (“ED”) Data File New/Updated Record Types:

Record Type '20'	<i>Record Type '20'</i> contains patient ED visit data including primary diagnosis and principal external cause of injury. This record is presented once for each patient visit in the reporting period.
Record Type '50'	<i>Record Type '50'</i> reports associated diagnosis information pertaining to this patient's episode of care. This record may be repeated more than once per visit, if necessary, to report more than fourteen associated diagnoses within this ED visit.
Record Type '55'	<i>Record Type '55'</i> reports procedures pertaining to this patient's ED visit. This record may be repeated more than once per visit, if necessary, to report more than thirteen significant procedures within this episode of care.

New/Updated Fields:

Field Name
Principal External Cause of Injury Code
Principal Diagnosis Code
Admitting Diagnosis Code
Discharge Diagnosis Code
Associate Diagnosis Codes
Principal Procedure Code
Significant Procedure Codes
ICD Indicator
Total Charge Fields

Code Table Updates:

Field Name
Clinician Type
Marital Status Code
Source of Admission Code
Patient Status Code
Payer Source Code
POA Code
Ethnicity Code

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