Massachusetts Division of Health Care Finance and Policy

Hospital Inpatient Discharge Data

Electronic Records Submission Specification

October 2008

The Division has adopted regulation 114.1 CMR 17.00 to require the reporting of Hospital Inpatient Discharge Data, Outpatient Emergency Department Visit Data and Outpatient Observation Data to the Division of Health Care Finance and Policy. This document provides the technical and data specifications, including edit specifications required for the Hospital Inpatient Discharge Data.

Table of Contents

Hospital Inpatient Discharge Data Submission Overview

Data To Include in Hospital Inpatient Discharge Data Electronic Submissions

Hospital Inpatient Discharge Data shall be reported for all inpatient visits at the reporting facility as required by Regulation 114.1 CMR 17.00. 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.

Definitions

Terms used in this specification are defined in the regulation's general definition section (114.1 CMR 17.02) 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 the Division via the Internet. In order to do that in a secure manner the Division's Secure Encryption and Decryption System (SENDS) must be utilized. You must first download a copy of the Secure Encryption and Decryption System (SENDS) from the DHCFP web site. There is a separate installation guide for installing the SENDS program. SENDS will take your submission file and compress, encrypt and rename it in preparation of transmitting to the Division. The newly created encrypted file shall be transferred to the Division via its INET

website. Test files may not be submitted via INET. Test files should be submitted to the DHCFP via diskette or CD. Providers should contact their HCF liaison to submit test files.

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

(a) the potential of unacceptable data reaching the Division and

(b) penalties for inadequate compliance as specified in regulation 114.1 CMR 17.

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 or R/Z)
Field Position From - Through	Beginning and ending positions of the field in the 250 character record.
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 eight 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 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 '50'**	*Record Type '50'* reports diagnosis and additional clinical information pertaining to this patient's episode of care. This record is provided once for each patient discharge.

f)	**Record Type '60'**	*Record Type '60'* reports procedures and additional clinical information pertaining to this patient's episode of care. This record is provided once for each patient discharge.
g)	**Record Type '80'**	*Record Type '80'* reports physician information for the patient. This record is provided once for each patient discharge.
h)	**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 hospital or a processor submitting data for a hospital.
b)	**Record Type '10'**	*Record Type '10'* identifies the hospital 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 hospital 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.

The record specifications contain more data elements than are required by the Division of Health Care Finance and Policy. *Those data elements which are marked with an asterisk indicate those data elements which are part of the error checking process and they must be provided*. Though the non-asterisked data elements are not required by the Division of Health Care Finance and Policy, it is acceptable to report them. It is advisable to reserve non-asterisked fields for the data elements described in the specifications; these reserved fields will permit the expansion of the elements captured and reported in the future with little or no additional programming.

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	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	Reel Number	99	R/Z	106 107	- Must be numeric - Must be present	Note
10	Filler	X(143)		108 250		

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	Type of Batch	XX	L/B	3 4	-Must be present and valid code as specified in Inpatient Data Code Tables(5)	Note
*3	Batch Number	XX	L/B	5 6	- Must be present - Must be numeric	Note

4	Filler	X(52)		7 58		
5	Filler	X(4)	L/B	59 62		
6	Filler	X(7)	L/B	63 69		
*7	Provider Telephone No.	X(10)	L/B	70 79	- Must be present	Note
*8	Provider Name	X(18)	L/B	80 97	- Must be present	A
*9	Provider Address	X(18)	L/B	98 115	- Must be present	Note
*10	Provider City	X(15)	L/B	116 130	- Must be present	Note
*11	Provider State	XX	L/B	131 132	- Must be present	Note
*12	Provider Zip	X(9)	L/B	133 141	- Must be present	Note
13	Filler	X		142 142		
*14	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
*15	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

*16	Organization ID for Provider	X(7)	L/B	159 165	-Must be present - Must be valid Organization Id as assigned by the Division of Health Care Finance and Policy	A
17	Filler	X(85)		166 250		

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 except 99 is acceptable in month & day fields - Must not be later than date of admission	A
6	Marital Status Code	X		23 23	- If present must be valid code as specified in Data Code Tables (1) (b)	Note
*7	Patient Employer Zip Code	9(9)	L/B	24 32	- Must be present, if applicable - Must be numeric - Must be a valid US postal zip code	Note
*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(2)	L/B	36 37		
*12	Massachusetts Transfer Hospital Organization ID	X(7)	L/B	38 44	- Must be present if Primary or Secondary Source of Admission is 4, Transfer from an Acute Hospital or 7 Outside Hospital Emergency Room Transfer and the provider from which the transfer occurred is in Massachusetts. - - Must be valid Organization Id as assigned by the Division of Health Care Finance and Policy as specified in Inpatient Data Code Tables(1) (m)	B
*13	Admission Date (CCYYMMDD)	X(8)	L/B	45 52	- Must be present - Must be valid date	A

*14	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	A
*15	Veterans Status	X	L/B	61 61	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(h)	B
*16	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 be compatible with Primary Payer Type as specified in table in Inpatient Data Code Tables(1)(f) - Must not be a Supplemental Payer Source as specified in Inpatient Data Code Tables(1)(g)	A

*17	Patient Status	XX	L/B	65 66	- Must be present - Must be valid code as specified in Inpatient Data Code Tables(1) (e)	A
*18	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
*19	Primary Payer Type	X		84 84	- Must be present - Must be valid as specified in Inpatient Data Code Tables(1) (f) - Must be compatible with primary source of payment as specified in tables 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.	A
20	Filler	X(10)	L/B	85 94		
*21	Patient Social Security Number	X(9)	L/B	95 103	- Must be present - Must be valid social security number or '000000001' if unknown	B

*22	Birth Weight-grams	9(4)	R/Z	104 107	- Must be present if type of admission is 'newborn' - Must be present if type of admission is other than 'newborn' and age is less than 29 days. - Must not be present if type of admission is other than 'newborn' and age is 29 days or greater - Must be numeric - Must be less than 7300 - Must be greater than 0	B
*23	DNR Status	X	L/B	108 108	- May be present - Must be valid as specified in Inpatient Data Code Tables(1)(i)	B
24	Filler	X(4)		109 112		

*25	Secondary Payer Type	X		113 113	- Must be present - Must be valid as specified in Inpatient Data Code Tables(1)(f) - Must be compatible with secondary source of payment as specified in tables 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. - 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

*26	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) - Must be compatible with secondary Payer Type as specified in Inpatient Data Code Tables (1)(f)	
*27	Mother's Social Security Number	X(9)	L/B	117 125	- Must be present for newborn or if age less than 1 year -Must be a valid social security number or '000000001' if unknown	B
*28	Mother's Medical Record Number	X(10)	L/B	126 135	- Must be present for newborns, born in the hospital	A
29	Filler	X(2)	L/B	136 137		
*30	Primary National Payer Identification Number	X(10)	L/B	138 147	- May be present when available	
*31	Secondary National Payer Identification Number	X(10)	L/B	148 157	-May be present when available	

*32	ED Flag	X	L/B	158 158	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(j)	A
*33	Outpatient Observation Stay Flag	X	L/B	159 159	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(k)	A
*37	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 Division of Health Care Finance and Policy	A
*38.	Homeless Indicator	X	L/B	167 167	-Include if applicable. -Must be valid code as specified in Inpatient Data Code Tables (1) (l).	B

*39	Medicaid Claim Certificate Number	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	
40.	Filler	X(71)		180 250		

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(9)	L/B	70 78	- 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	79 80	- Must be present - Must be a valid International Standards Organization (ISO-3166) 2-digit country code	B
*8	Temporary US Patient Street Address	X(30)	L/B	81 110	- Must be present when Patient Country (Record Type 25 field 7) is not ‘US’	B
*9	Temporary US Patient City/Town	X(25)	L/B	111 135	- Must be present when Patient Country (Record Type 25 field 7) is not ‘US’	B
*10	Temporary US Patient State	X(2)	L/B	136 137	- Must be present when Patient Country (Record Type 25 field 7) is not ‘US’ - Must be a valid US 2 digit postal state code	B
*11	Temporary US Patient Zip Code	X(9)	L/B	138 146	- Must be present when Patient Country (Record Type 25 field 7) is not ‘US’ - Must be a valid US postal zip code - Must be 0's if zip code is unknown	B

*12	Race 1	X(6)	L/B	147 152	-Must be present - Must be valid code as specified in Inpatient Data Code Tables(2)(a)	B
*13	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)	B
*14	Other Race	X(15)	L/B	159 173	-May only be entered if Race 1 is entered. - Must be entered if Race 1 is R9 – Other Race.	B
*15	Hispanic Indicator	X	L/B	174 174	-Must be present - Must be valid code as specified in Inpatient Data Code Tables(2)(b)	B
*16	Ethnicity 1	X(6)	L/B	175 180	-Must be present -Must be valid code as specified in Inpatient Data Code Tables (2)(c)	B
*17	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)	B

*18	Other Ethnicity	X(20)	L/B	187 206	-May only be entered if Ethnicity 1 is entered.	B
21	Filler	X(44)	L/B	207 250		

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) and (b)+	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(6)	R/Z	36 41	- Must be present if related Revenue Code is present - Must exceed one dollar - Must be whole numbers, no decimals - Accumulate Total Charges (Accom.) for balancing against Total Charges (All Charges) in Patient Control Record Type '90'	A
10	Filler	X(13)		42 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	Leave of Absence Days	9(3)	R/Z	187 189	- If present must be less than total length of stay	A
16	Filler	X(61)		190 250		

♦ 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)(c)+	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(6)	R/Z	36 41	- Must be present if related Revenue Code is present - Must exceed one dollar - Must be whole numbers, no decimals - Accumulate Total Charges (Service) for balancing against Total Charges (Ancillaries) in Patient Control Record Type '90'	A
10	Filler	X(13)		42 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	Leave of Absence Days	9(3)		187 189		A
16	Filler	X(61)		190 250		

♦ 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 50 – MEDICAL DIAGNOSIS

- Required for each discharge.
- Only one allowed per discharge.
- Must follow RT 40.
- Must be followed by RT 60.
- Record Type = 50.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type
*1	Record Type ‘50'	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 of Injury Code	X(6)	L/B	13 18	- Must be present if principal diagnosis is ICD-9-CM codes 800-904.9 or 910-995.89 - May be present if Principal Diagnosis is ICD-9-CM codes 996-999.9 - If present, must be a valid ICD-9-CM E-code (E800-E999) excluding E849.0 - E849.9 - Principal E-code shall be recorded in designated field and not be present in Diagnoses Codes 1-9 - Associated E-codes, present in the Associated Diagnosis field, shall only be permitted when a Principal E-Code is entered.	B
4	Filler	X		19 19		
*5	Principal Diagnosis Code	X(5)	L/B	20 24	- Must be present - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A

6	Filler	X(2)		25 26		
*7	Assoc. Diagnosis Code I	X(5)	L/B	27 31	- Only permitted if a principal diagnosis is entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
8	Filler	X(2)		32 33		
*9	Assoc. Diagnosis Code II	X(5)	L/B	34 38	- May only be entered if Assoc. Diagnosis Code I is entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
10	Filler	X(2)		39 40		
*11	Assoc. Diagnosis Code III	X(5)	L/B	41 45	- May only be entered if Assoc. Diagnosis Code II is entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A

12	Filler	X(2)		46 47		
*13	Assoc. Diagnosis Code IV	X(5)	L/B	48 52	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
14	Filler	X(2)		53 54		
*15	Assoc. Diagnosis Code V	X(5)	L/B	55 59	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
16	Filler	X(2)		60 61		
*17	Assoc. Diagnosis Code VI	X(5)	L/B	62 66	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A

18	Filler	X(2)		67 68		
*19	Assoc. Diagnosis Code VII	X(5)	L/B	69 73	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
20	Filler	X(2)		74 75		
*21	Assoc. Diagnosis Code VIII	X(5)	L/B	76 80	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
22	Filler	X(2)		81 82		
*23	Assoc. Diagnosis Code IX	X(5)	L/B	83 87	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A

24	Filler	X(2)		88 89		
*25	Assoc. Diagnosis Code X	X(5)	L/B	90 94	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
26	Filler	X(2)		95 96		
*27	Assoc. Diagnosis Code XI	X(5)	L/B	97 101	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
28	Filler	X(2)		102 103		
*29	Assoc. Diagnosis Code XII	X(5)	L/B	104 108	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A

30	Filler	X(2)		109 110		
*31	Assoc. Diagnosis Code XIII	X(5)	L/B	111 115	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
32	Filler	X(2)		116 117		
*33	Assoc. Diagnosis Code XIV	X(5)	L/B	118 122	- May only be entered if the previous diagnosis fields are entered - Must be valid ICD-9-CM code in diagnosis file - Sex of patient must agree with diagnosis code for sex specific diagnosis	A
34	Filler	X(18)		123 140		
*35.	Number of ANDs	9(4)	R/Z	141 144	- Must not exceed total accommodation days	A
36.	Filler	X(3)		145 147		

*37.	Other Caregiver	X		148 148	- May be present - If present must be a valid code as specified in Inpatient Data Code Tables (4)(a)	B
*38.	Attending Physician National Provider Identifier (NPI)	X(8)	L/B	149 156	- May be present when available	
*39.	Attending Physician National Provider Identifier (NPI) Location Code	X(2)	L/B	157 158	- May be present when available	
*40.	Operating Physician National Provider Identifier (NPI)	X(8)	L/B	159 166	- May be present when available	
*41.	Operating Physician National Provider Identifier (NPI) Location Code	X(2)	L/B	167 168	- May be present when available	

*42.	Additional Caregiver National Provider Identifier (NPI)	X(8)	L/B	169 176	- May be present when available	
*43.	Additional Caregiver NPI Location Code	X(2)	L/B	177 178	- May be present when available	
*44.	Condition Present on Admission – Principal E-Code	X		179 179	- Must be present when Principal E-Code is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
*45.	Condition Present on Admission – Principal Diagnosis Code	X		180 180	-Must be present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
*46.	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
*47.	Condition Present on Admission – Assoc. Diagnosis Code II	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
*48.	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

*49.	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
*50.	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
*51.	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
*52.	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
*53.	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
*54.	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

*55.	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
*56.	Condition Present on Admission – Assoc. Diagnosis Code XI	X		191 191	-Must be present when Assoc. Diagnosis Code XI is present -Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
*57.	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
*58.	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
*59.	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
60.	Filler	X(56)		195 250		

RECORD TYPE 60 – MEDICAL PROCEDURE

- Required for each discharge.
- Only one allowed for each discharge.
- Must follow RT 50.
- Must be followed by RT 80.
- 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	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 Procedure Code	X(5)	L/B	13 17	- If entered must be valid ICD-9-CM code - Must be valid for patient sex	A
4.	Filler	X(4)		18 21		

*5.	Date of Principal Procedure (CCYYMMDD)	X(8)	L/B	22 29	- Must be present if Principal Procedure code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(d) - Must not be later than discharge date	B
*6.	Significant Procedure I	X(5)	L/B	30 34	- May only be present if Principal Procedure Code is present - Must be valid ICD-9-CM code - Must be valid for patient sex	A
7.	Filler	X(4)		35 38		
*8.	Significant Proc. I Date (CCYYMMDD)	X(8)	L/B	39 46	- Must be present if Significant Procedure Code I is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B

*9.	Significant Proc. II	X(5)	L/B	47 51	- May only be present if Significant Procedure I present - Must be valid ICD-9-CM code - Must be valid for patient sex	A
10.	Filler	X(4)		52 55		
*11.	Significant Proc. II Date (CCYYMMDD)	X(8)	L/B	56 63	- Must be present if Significant Procedure II code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*12.	Significant Proc. III	X(5)	L/B	64 68	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
13.	Filler	X(4)		69 72		

*14.	Significant Proc. III Date (CCYYMMDD)	X(8)	L/B	73 80	- Must be present if Significant Procedure III code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*15.	Significant Proc. IV	X(5)	L/B	81 85	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
16.	Filler	X(4)		86 89		
*17.	Significant Proc. IV Date (CCYYMMDD)	X(8)	L/B	90 97	- Must be present if Significant Procedure IV code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B

*18.	Significant Proc. V	X(5)	L/B	98 102	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
19.	Filler	X(4)		103 106		
*20.	Significant Proc V Date (CCYYMMDD)	X(8)	L/B	107 114	- Must be present if Significant Procedure V code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*21.	Significant Proc. VI	X(5)	L/B	115 119	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
22.	Filler	X(4)		120 123		

*23.	Significant Proc. VI Date (CCYYMMDD)	X(8)	L/B	124 131	- Must be present if Significant Procedure VI code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*24.	Significant Proc. VII	X(5)	L/B	132 136	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
25.	Filler	X(4)		137 140		
*26.	Significant Proc. VII Date (CCYYMMDD)	X(8)	L/B	141 148	- Must be present if Significant Procedure VII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B

*27.	Significant Proc. VIII	X(5)	L/B	149 153	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
28.	Filler	X(4)		154 157		
*29.	Significant Proc. VIII Date (CCYYMMDD)	X(8)	L/B	158 165	- Must be present if Significant Procedure VIII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*30.	Significant Proc. IX	X(5)	L/B	166 170	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
31.	Filler	X(4)		171 174		

*32.	Significant Proc. IX Date (CCYYMMDD)	X(8)	L/B	175 182	- Must be present if Significant Procedure IX code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*33.	Significant Proc. X	X(5)	L/B	183 187	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
34.	Filler	X(4)		188 191		
*35.	Significant Proc. X Date (CCYYMMDD)	X(8)	L/B	192 199	- Must be present if Significant Procedure X code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B

*36.	Significant Proc. XI	X(5)	L/B	200 204	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
37.	Filler	X(4)		205 208		
*38.	Significant Proc. XI Date (CCYYMMDD)	X(8)	L/B	209 216	- Must be present if Significant Procedure XI code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*39.	Significant Proc. XII	X(5)	L/B	217 221	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
40.	Filler	X(4)		222 225		

*41.	Significant Proc. XII Date (CCYYMMDD)	X(8)	L/B	226 233	- Must be present if Significant Procedure XII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
*42.	Significant Proc. XIII	X(5)	L/B	234 238	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
43.	Filler	X(4)		239 242		
*44.	Significant Proc. XIII Date (CCYYMMDD)	X(8)	L/B	243 250	- Must be present if Significant Procedure XIII code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B

RECORD TYPE 80 – PHYSICIAN DATA

- Required for each discharge.
- Must be preceded by RT 60.
- 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 '60'	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
*5	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 "DENSG", "PODTR", "OTHER" or "MIDWIF" as specified in Inpatient Data Elements Definitions (9) (a).	B
6	Filler	XX	L/B	21 22		

*7	Operating Physician for Principal Procedure (Board of Registration in Medicine Number)	X(6)	L/B	23 28	- Must be present if Principal Procedure Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
8	Filler	XX	L/B	29 30		
*9	Operating Physician for Significant Procedure I (Board of Registration in Medicine Number)	X(6)	L/B	31 36	- Must be present if Significant Procedure I Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
10	Filler	XX	L/B	37 38		

*11	Operating Physician for Significant Procedure II (Board of Registration in Medicine Number)	X(6)	L/B	39 44	- Must be present if Significant Procedure II Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
12	Filler	XX	L/B	45 46		
*13	Operating Physician for Significant Procedure III (Board of Registration in Medicine Number)	X(6)	L/B	47 52	- Must be present if Significant Procedure III Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
14	Filler	XX	L/B	53 54		

*15	Operating Physician for Significant Procedure IV (Board of Registration in Medicine Number)	X(6)	L/B	55 60	- Must be present if Significant Procedure IV Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
16	Filler	XX	L/B	61 62		
*17	Operating Physician for Significant Procedure V (Board of Registration in Medicine Number)	X(6)	L/B	63 68	- Must be present if Significant Procedure V Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
18	Filler	XX	L/B	69 70		

*19	Operating Physician for Significant Procedure VI (Board of Registration in Medicine Number)	X(6)	L/B	71 76	- Must be present if Significant Procedure VI Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
20	Filler	XX	L/B	77 78		
*21	Operating Physician for Significant Procedure VII (Board of Registration in Medicine Number)	X(6)	L/B	79 84	- Must be present if Significant Procedure VII Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
22	Filler	XX	L/B	85 86		

*23	Operating Physician for Significant Procedure VIII (Board of Registration in Medicine Number)	X(6)	L/B	87 92	- Must be present if Significant Procedure VIII Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
24	Filler	XX	L/B	93 94		
*25	Operating Physician for Significant Procedure IX (Board of Registration in Medicine Number)	X(6)	L/B	95 100	- Must be present if Significant Procedure IX Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
26	Filler	XX	L/B	101 102		

*27	Operating Physician for Significant Procedure X (Board of Registration in Medicine Number)	X(6)	L/B	103 108	- Must be present if Significant Procedure X Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
28	Filler	XX	L/B	109 110		
*29	Operating Physician for Significant Procedure XI (Board of Registration in Medicine Number)	X(6)	L/B	111 116	- Must be present if Significant Procedure XI Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
30	Filler	XX	L/B	117 118		

*31	Operating Physician for Significant Procedure XII (Board of Registration in Medicine Number)	X(6)	L/B	119 124	- Must be present if Significant Procedure XII Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
32	Filler	XX	L/B	125 126		
*33	Operating Physician for Significant Procedure XIII (Board of Registration in Medicine Number)	X(6)	L/B	127 132	- Must be present if Significant Procedure XIII Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
34	Filler	XX	L/B	133 134		

*35	Operating Physician for Significant Procedure XIV (Board of Registration in Medicine Number)	X(6)	L/B	135 140	- Must be present if Significant Procedure XIV Code is present. - Must be a valid and current Mass. Board of Registration in Medicine license number or - must be “DENSG”, “PODTR”, “OTHER” or “MIDWIF” as specified in Inpatient Data Elements Definitions (9) (b).	B
36	Filler	XX	L/B	141 142		
*37	Significant Proc. XIV	X(5)	L/B	143 147	- May only be present if all previous procedure fields are entered - Must be valid ICD-9-CM code - Must be valid for patient sex	A
38	Filler	X(4)		148 151		

*39	Significant Proc. XIV Date (CCYYMMDD)	X(8)	L/B	152 159	- Must be present if Significant Procedure XIV code is present - Must be valid date - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(g) - Must not be later than discharge date	B
40	Filler	X(91)		160 250		

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', '40', '50', 60 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 3x Count	99	R/Z	29 30	- Must equal number of Record Type'30' records	A
*9	Record Type 4x Count	99	R/Z	31 32	- Must equal number of Record Type'40' records	A

*10	Record Type 5x Count	99	R/Z	33 34	- Must equal number of Record Type'50' records - Must = '01'	A
*11	Record Type 6x Count	99	R/Z	35 36	- Must equal number of Record Type'60' records - Must = '01'	A
*12.	Record Type 8x Count	99	R/Z	37 38	- Must equal number of Record Type'80' records - Must = '01'	A
13	Filler	X(8)		39 46		
*14	Total Charges Spec. Services	9(8)	R/Z	47 54	- Must be numeric - Must be whole numbers, no decimals	A
*15	Total Charges Routine Services	9(8)	R/Z	55 62	- Must be numeric - Must be whole numbers, no decimals	A
16	Filler	X(8)		63 70		

*17	Total Charges Ancillaries	9(8)	R/Z	71 78	- Must equal sum of Total Charges (Services) from Ancillary Services Record Type '40' records - Must be whole numbers, no decimals	A
18	Filler	X(8)		79 86		
*19	Total Charges (All Chgs)	9(10)	R/Z	87 96	- 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 - Must be whole numbers, no decimals	A
20	Filler	X(154)		97 250		

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(4)	L/B	3 6		
3	Filler	X(4)		7 10		
*4	Type of Batch	XX	L/B	11 12	- Must be present and must be valid code as specified in Inpatient Data Code Tables(4)	Note
*5	Number of Discharges	9(5)	R/Z	13 17	- Must equal number of Patient Control Record Type '90'records	A
*6	Total Days	9(5)	R/Z	18 22	- Must equal total accommodation days from all Record Type '30' Records	Note

*7	Total Charges Accommodations	9(10)	R/Z	23 32	- Must equal sum of Total Charges Spec. Services and Total Charges Routine Services. from Patient Control Record Type '90' records - - Must be whole numbers, no decimals	A
8	Filler	X(8)		33 40		
*9	Total Charges Ancillaries	9(10)	R/Z	41 50	- Must equal sum of Total Charges Ancillaries from Patient Control Record Type '90' records - - Must be whole numbers, no decimals	A
10	Filler	X(200)		51 250		

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	Batch Type "11" Count	9(4)	R/Z	33 36	- Must equal total number of Record Type '95' records where Batch Type = 11 - Must equal zero.	Note

*8	Batch Type "22" Count	9(4)	R/Z	37 40	- Must equal total number of Record Type '95' records where Batch Type = 22 - Must equal zero.	Note
*9	Batch Type "33" Count	9(4)	R/Z	41 44	- Must equal total number of Record Type '95' records where Batch Type = 33 - Must equal zero or 1.	Note
*10	Batch Type "99" Count	9(4)	R/Z	45 48	- Must equal total number of Record Type '95' records where Batch Type = 99 - Must equal zero or 1.	Note
11	Filler	X(202)		49 250		

*** MUST PROVIDE THOSE DATA ELEMENTS WHICH ARE ASTERISKED (*)**

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. *Definitions are presented only for asterisked data elements which are the data elements required by the Division of Health Care Finance and Policy*.

(1) Record Type '01'

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

(b) Receiver Identification. A control field for insuring the correct file is being forwarded to the Division. Code this field `HCF'.

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

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

(2) Record Type '10'

(a) Type of Batch. A code indicating the type of data submission. See codes in Inpatient Data Code Tables (4).

(b) Batch Number. The sequential numbering of hospital batches included on the submission. There is only one batch allowed per file.

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

(d) DHCFP Organization ID for Provider. A unique code assigned by the Division of Health Care Finance and Policy for each healthcare 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. When exact month and day are unknown, record 9's. If exact century and year are unknown, estimate.

(c) Patient Employer's Zip Code. The U.S. Post Office (nine digit) zip code which designates the patient's employer's zip code. Until the nine digit zip code is widely used, left justify the relevant five digit code and blank fill the remaining four digits. When a patient is covered under someone else's policy, e.g., that of the patient's spouse or parent, record the U.S. Post Office (nine digit) zip code for the employer of the spouse or parent, i.e. the employer of the policy holder.

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

(e) 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". If the patient has been seen in Observation or the hospital's ER as well as has more than 2 other Admission Sources and is then admitted, use Revenue Code 762 or 450 to report charges for Observation Room or ER, respectively, and use the alternate outpatient department or transferring or referring sources for the Primary and Secondary Source of Admission. For example, if the patient is seen in the hospital's ER without contacting his physician or

health plan and is then transferred to Observation before being admitted, the Primary Source of Admission should be “M - Walk-In/Self Referral, the Secondary Source of Admission should be “R - Within Hospital Emergency Room Transfer” and charges should be reported in ancillary revenue code 762 for Observation Room.

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, T 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.	Extramural Birth	Yes	W	If no, refer to #7

7.	Transferred from Within Hospital Emergency Room (should only be used for secondary Source of Admission unless the hospital is unable to determine the originating or Primary Source of Admission)	Yes	R	If no, refer to #8
8.	Referred or transferred from Within Hospital Clinic or Ambulatory Surgery	Yes	2 or Y	If no, refer to #9.
9.	Observation Referral	Yes	X	If no, refer to #10
10.	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.**

(f) Extramural Birth. The birth of a newborn in a non-sterile environment; birth outside of the hospital.

(g) 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.

(h) Normal Newborn. A healthy infant born at 37 weeks gestation or later.

(i) Premature Newborn. An infant born after less than 37 weeks of gestation.

(j) Sick Newborn. A newborn suffering from disease or from a severe condition which requires treatment.

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

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

m) 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.

(n) 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).

(**o) 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).

(p) 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.

(**q) 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.

(r) Claim Certificate Number. This number is also referred to as the Medicaid Recipient Identification Number. If the Payer Type Code is equal to "4" (Medicaid) or "B" (Medicaid Managed Care) as specified in Inpatient Data Code Tables (1) (i), the Medicaid Recipient Identification Number must be recorded. This number is the patient's Social Security Number and one additional random number (ten characters).

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

(t) 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. The social security number for the mother of a newborn should not be reported in this field; The field Mother's Social Security Number is a separate field designated for the social security of the newborn's mother as specified in Inpatient Data Elements Definitions (3)(w). The patient's social security number will be encrypted into a Unique Health Information Number (UHlN) and the social security number will never be considered a case mix data element. Only the UHIN will be considered a data base element and only this encrypted number will be used by the Division.

(u) Birth Weight of Newborn. The specific birth weight of the newborn recorded in grams.

(v) 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.

(w) Mother's Social Security Number. The social security number of the patient's mother is to be reported for newborns or for infants less than one year old as a nine digit number. If the mother'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 mother's social security number will be encrypted into a Unique Health Information Number (UHlN) and the social security number will never be considered a case mix data element. Only the UHIN will be considered a data base element and only this encrypted number will be used by the Division.

(x) Mother's Medical Record Number. The medical record number assigned within the hospital to the newborn's mother is to be reported for the newborn. The medical record number of the newborn's mother distinguishes the patient's mother and the patient's mother's hospital record(s) from all others in that institution.

y) **Hospital Service Site Reference**. Hospital Organization ID as assigned by the Division of Health Care Finance and Policy for the site where care was given. Required if provider is approved to submit multiple campuses in one file.

(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 State's citizen.

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

(d) Patient Zip Code. The U.S. Post Office (nine digit) zip code which designates the patient's residence. Until the nine digit zip code is widely used, left justify the relevant five digit zip code, and blank fill the remaining four digits. 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)Temporary US Patient Street Address. The temporary United States street address where the patient resides while under treatment. This is required for patient's whose permanent country of residence is outside the United States. It may be used for patients whose permanent residence is outside the state of Massachusetts but are residing at a temporary address while receiving treatment.

(g) Temporary Patient City/Town. The temporary United States city/town where the patient resides while under treatment. This is required for patient's whose permanent country of residence is outside the United States. It may be used for patients whose permanent residence is outside the state of Massachusetts but are residing at a temporary address while receiving treatment.

(h) Temporary Patient State. The US Postal Service code for the state of the temporary address where the patient resides while under treatment. This is required for patient's whose permanent country of residence is outside the United States. It may be used for patients whose permanent residence is outside the state of Massachusetts but are residing at a temporary address while receiving treatment.

(i)Temporary Patient Zip Code . The US Postal Service zip code for the temporary address where the patient resides while under treatment. This is required for patient's whose permanent country of residence is outside the United States. It may be used for patients whose permanent residence is outside the state of Massachusetts but are residing at a temporary address while receiving treatment.

(5) Record Type '30'

(a) <u>Sequence</u>. 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) <u>Revenue Code</u>. A numeric code which identifies a particular routine or special care accommodation. The revenue codes are taken from the UB-92 revenue codes and correspond to specific cost centers in the DHCFP-403 cost report and HURM. Exceptions include Chronic Care and Subacute which have DHCFP assigned revenue codes versus UB-92 assigned revenue codes.

Rehabilitation Routine Accommodation. A patient's routine accommodation should be reported as 'Rehabilitation' if the patient's care requires comprehensive therapy and services necessary to improve the functional limitations resulting from the recent onset, regression or progression of an illness or disease and to obtain optimal health. Rehabilitative programs are usually well coordinated, integrated, goal oriented, evaluative and/or therapeutic and utilize an interdisciplinary approach with services such as intensive skilled rehabilitation nursing, physician therapy, occupational therapy, speech therapy, social services, prosthetic and /or orthotic fitting, psychological services, recreation therapy, dental services, special education, vocational assessment and counseling. Use Routine Accommodation Revenue Code 118 for Rehabilitation.

***Chronic Care Routine Accommodation*.** A patient's routine accommodation should be reported as 'Chronic Care' if the patient's care and treatment require frequent or daily physician visits in addition to skilled nursing and regular intervention by other therapists and technicians with an average length of stay greater than 25 days; the illness is marked by long duration, frequent occurrence and is expected to continue for an extended period. Types of chronic care services may include patients requiring 24 hour per day parenteral pain management, general palliative care, aggressive interventions for stage III and IV decubiti, hyperalimentation, long term antibiotic administration and peritoneal dialysis. Examples of chronic disease include long term endocarditis, long term osteomyelitis, chronic degenerative disease of the central nervous system, such as Alzheimer's disease, end stage chronic organ failure, end stage AIDS and end stage cancer. Use Routine Accommodation Revenue Code 192 for Chronic Care.

Subacute Care Routine Accommodation. A patient's routine accommodation should be reported as 'Subacute Care" if the patient requires short term comprehensive care and specialized resources, such as interdisciplinary teams, case managers, highly trained physicians and nurses, and specialized protocols such as critical pathways and measured outcomes, before discharge home.

Subacute care can be provided in a variety of settings, such as skilled nursing facilities (either freestanding or hospital based) or transitional care units. Use Routine Accommodation Revenue Code 196 for Subacute Care.

Transitional Care Unit Routine Accommodation (TCU). A patient's routine accommodation should be reported as TCU if the patient is admitted to this type of unit. TCU is a type of subacute unit. Use Routine Accommodation Revenue Code 197 for Transitional Care.

(c) Leave of Absence. The count in days of a patient's absence with physician approval during a hospital stay without formal discharge and readmission to the facility.

(d) 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".

(e) Total Charges (Accommodation). The full, undiscounted 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 DHCFP-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-92 revenue codes and correspond to specific cost centers in the DHCFP-403 cost report and HURM.

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. If the patient is not admitted, refer to *Outpatient Observation Data Specifications.*

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 charges summarized by a specific ancillary service revenue code(s).

(7) Record Type '50'

(a) External Cause of Injury Code (E-Code). International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes E800-E999 (E-codes) are used to categorize events and conditions describing the external cause of injuries, poisonings, and adverse effects. E-codes adequate to describe the external cause shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999) or where certain other conditions from Chapters 1 through 16 of the ICD-9-CM (001 - 799) demonstrate that an additional E-code is appropriate. The principal E-code shall describe the mechanism that caused the most severe injury, poisoning, or adverse effect. Additional E-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-9-CM diagnosis code corresponding to the condition established after study to be chiefly responsible for the admission of the patient for hospital care.

(c) Associated Diagnosis Code. The ICD-9-CM 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.

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

(e) Other Caregiver. The primary caregiver responsible for the patient's care other than the Attending Physician, Operating Room Physician or Nurse Midwife as specified in Inpatient Data Code Tables (3).

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

(8) Record Type '60'

(a) Principal Procedure Code. The ICD-9-CM 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.

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

(c) Significant Procedure Code. The ICD-9-CM procedure code usually corresponding to additional procedures which carry an operative or anesthetic risk or require highly trained personnel, special equipment or facilities.

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

(9) 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:

DENSG	for each Dental Surgeon.
PODTR	for each Podiatrist.
OTHER	for other situations where no permanent license number is assigned or if a limited license number is assigned.
MIDWIF	for each midwife.

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:

DENSG	for each Dental Surgeon.
PODTR	for each Podiatrist.
OTHER	for other situations where no permanent license number is assigned or if a limited license number is assigned.
MIDWIF	for each midwife.

(10) 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 '50'. For instance. Record Type "3X" is the count of all record types '30'.

(c) Total Charges Special Care Services. The full, undiscounted 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)(b).

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

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

(f) Total Charges (All Charges) . The full, undiscounted 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 DHCFP-403 must be included in total charges.

(11) 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.

(12) Record Type '99'

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

(b) Batch Type Count. The count of the number of each type of separate batch from “33” and “99.” 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)

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

(d)

* SRCADM CODE	* Source of Admission Definition		SRCADM CODE	FOR NEWBORN:
0	Information Not Available		0	Information not Available
1	Direct Physician Referral		1	Normal Delivery
2	Within Hospital Clinic Referral		2	Premature Delivery
3	Direct Health Plan Referral/HMO Referral		3	Sick Baby
4	Transfer from an Acute Hospital		4	Extramural Birth
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)			
L	Outside Hospital Clinic Referral			
M	Walk-In/Self Referral			
R	Within Hospital Emergency Room Transfer			
T	Transfer from Another Institution's Ambulatory Surgery			

W	Extramural Birth
X	Observation
Y	Within Hospital Ambulatory Surgery Transfer

(e)

*** PASTA CODE**	*** Patient Status Definition**
01	Discharged/transferred to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged, transferred to Skilled Nursing Facility (SNF)
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice

08	Discharged/transferred to home under care of a Home IV Drug Therapy Provider
09	Not used
10	Invalid
11	Invalid
12	Discharge Other
13	Discharge/transfer to rehab hospital
14	Discharge/transfer to rest home
15	Discharge to Shelter
20	Expired (or did not recover - Christian Science Patient)
50	Discharged to Hospice - Home

51	Discharged to Hospice Medical Facility
43	Discharged/transferred to federal healthcare facility
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital.
63	Discharge/transfer to a Medicare certified long term care hospital.
65	Discharged/transferred to psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH).

(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
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 Plans

(g) SOURCE OF PAYMENT:

*SRCPAY CODE	* SOURCE OF PAYMENT DEFINITIONS	MATCH-ING PAYER TYPE CODE	PAYER TYPE ABBREVIATION
1	Harvard Community Health Plan	8	HMO
2	Bay State - a product of HMO Blue	C	BCBS-MC
3	Network Blue (PPO)	C	BCBS-MC
4	Fallon Community Health Plan (includes Fallon Plus, Fallon Affliates, Fallon UMass)	8	HMO
5	Invalid (replaced by #9)		
6	Invalid (replaced by #251)		
7	Tufts Associated Health Plan	8	HMO
8	Pilgrim Health Care	8	HMO
9	United Health Plan of New England (Ocean State)	8	HMO
10	Pilgrim Advantage - PPO	E	PPO
11	Blue Care Elect	C	BCBS-MC
12	Invalid (replaced by #49)		
13	Community Health Plan Options (New York)	J	POS

14	Health New England Advantage POS	J	POS
15	Invalid (replaced by #158)		
16	Invalid (replaced by #172)		
17	Prudential Healthcare POS	D	COM-MC
18	Prudential Healthcare PPO	D	COM-MC
19	Matthew Thornton	8	HMO
20	HCHP of New England (formerly RIGHA)	8	HMO
21	Commonwealth PPO	E	PPO
22	Aetna Open Choice PPO	D	COM-MC
23	Guardian Life Insurance Company PPO	D	COM-MC
24	Health New England, Inc	8	HMO
25	Pioneer Plan	8	HMO
26	Invalid (replaced by #75)		
27	First Allmerica Financial Life Insurance PPO	D	COM-MC
28	Great West Life PPO	D	COM-MC
29	Invalid (replaced by #171 and 250)		
30	CIGNA (Indemnity)	7	COM
31	One Health Plan HMO (Great West Life)	D	COM-MC
32	Invalid (replaced by #157 and 158)		
33	Mutual of Omaha PPO	D	COM-MC
34	New York Life Care PPO	D	COM-MC

35	United Healthcare Insurance Company - HMO (New for 1997)	D	COM-MC
36	United Healthcare Insurance Company - PPO (New for 1997)	D	COM-MC
37	HCHP-Pilgrim HMO (integrated product)	8	HMO
38	Health New England Select (self-funded)	8	HMO
39	Pilgrim Direct	8	HMO
40	Kaiser Foundation	8	HMO
41	Invalid (replaced by #157)		
42	ConnectiCare Of Massachusetts	8	HMO
43	MEDTAC	8	HMO
44	Community Health Plan	8	HMO
45	Health Source New Hampshire	8	HMO
46	Blue CHiP (BCBS Rhode Island)	8	HMO
47	Neighborhood Health Plan	8	HMO
48	US Healthcare	8	HMO
49	Healthsource CMHC Plus PPO	E	PPO
50	Blue Health Plan for Kids	6	BCBS
51	Aetna Life Insurance	7	COM
52	Boston Mutual Insurance	7	COM
53	Invalid (no replacement)		

54	Continental Assurance Insurance	7	COM
55	Guardian Life Insurance	7	COM
56	Hartford L&A Insurance	7	COM
57	John Hancock Life Insurance	7	COM
58	Liberty Life Insurance	7	COM
59	Lincoln National Insurance	7	COM
60	Invalid (replaced by #97)		
61	Invalid (replaced by #96)		
62	Mutual of Omaha Insurance	7	COM
63	New England Mutual Insurance	7	COM
64	New York Life Care Indemnity (New York Life Insurance)	7	COM
65	Paul Revere Life Insurance	7	COM
66	Prudential Insurance	7	COM
67	First Allmerica Financial Life Insurance	7	COM
68	Invalid (replaced by #96)		
69	Corporate Health Insurance Liberty Plan	7	COM
70	Union Labor Life Insurance	7	COM
71	ADMAR	E	PPO
72	Healthsource New Hampshire	7	COM

73	United Health and Life (subsidiary of United Health Plans of NE)	7	COM
74	United Healthcare Insurance Company	7	COM
75	Prudential Healthcare HMO	D	COM-MC
76	Invalid (replaced by #270)		
77	Options for Healthcare PPO	E	PPO
78	Phoenix Preferred PPO	D	COM-MC
79	Pioneer Health Care PPO	E	PPO
80	Tufts Total Health Plan PPO	E	PPO
81	HMO Blue	C	BCBS-MC
82	John Hancock Preferred	D	COM-MC
83	US Healthcare Quality Network Choice- PPO	E	PPO
84	Private Healthcare Systems PPO	E	PPO
85	Liberty Mutual	7	COM
86	United Health & Life PPO (Subsidiary of United Health Plans of NE)	E	PPO
87	CIGNA PPO	D	COM-MC
88	Freedom Care	E	PPO
89	Great West/NE Care	7	COM
90	Healthsource Preferred (self-funded)	E	PPO
91	New England Benefits	7	COM

92	Invalid (replaced by # 84, 166, 184)		
93	Psychological Health Plan	E	PPO
94	Time Insurance Co	7	COM
95	Pilgrim Select - PPO	E	PPO
96	Metrahealth (United Health Care of NE)	7	COM
97	UniCare	7	COM
98	Healthy Start	9	FC
99	Other POS (not listed elsewhere) ***	J	POS
100	Transport Life Insurance	7	COM
101	Quarto Claims	7	COM
102	Wausau Insurance Company	7	COM
103	Medicaid (includes MassHealth)	4	MCD
104	Medicaid Managed Care-Primary Care Clinician (PCC)	B	MCD-MC
105	Invalid (replaced by #111)		
106	Medicaid Managed Care-Central Mass Health Care	B	MCD-MC
107	Medicaid Managed Care - Community Health Plan	B	MCD-MC
108	Medicaid Managed Care - Fallon Community Health Plan	B	MCD-MC
109	Medicaid Managed Care - Harvard Community Health Plan	B	MCD-MC
110	Medicaid Managed Care - Health New England	B	MCD-MC

111	Medicaid Managed Care - HMO Blue	B	MCD-MC
112	Medicaid Managed Care - Kaiser Foundation Plan	B	MCD-MC
113	Medicaid Managed Care - Neighborhood Health Plan	B	MCD-MC
114	Medicaid Managed Care - United Health Plans of NE (Ocean State Physician's Plan)	B	MCD-MC
115	Medicaid Managed Care - Pilgrim Health Care	B	MCD-MC
116	Medicaid Managed Care-Tufts Associated Health Plan	B	MCD-MC
117	Invalid (no replacement)		
118	Medicaid Mental Health & Substance Abuse Plan - Mass Behavioral Health Partnership	B	MCD-MC
119	Medicaid Managed Care Other (not listed elsewhere) ***	B	MCD-MC
120	Out-of-State Medicaid	5	GOV
121	Medicare	3	MCR
122	Invalid (replaced by #234)		
123	Invalid (no replacement)		
124	Invalid (replaced by # 222)		
125	Medicare HMO - Fallon Senior Plan	F	MCR-MC
126	Invalid (replaced by #230)		
127	Medicare HMO - Health New England Medicare Wrap **	F	MCR-MC
128	Medicare HMO - HMO Blue for Seniors **	F	MCR-MC
129	Medicare HMO - Kaiser Medicare Plus Plan **	F	MCR-MC

130	Invalid (replaced by #232 and 233)		
131	Medicare HMO - Pilgrim Enhance 65 **	F	MCR-MC
132	Medicare HMO - Matthew Thornton Senior Plan	F	MCR-MC
133	Medicare HMO -Tufts Medicare Supplement (TMS)	F	MCR-MC
134	Medicare HMO - Other (not listed elsewhere) ***	F	MCR-MC
135	Out-of-State Medicare	3	MCR
136	BCBS Medex **	6	BCBS
137	AARP/Medigap supplement **	7	COM
138	Banker's Life and Casualty Insurance **	7	COM
139	Bankers Multiple Line **	7	COM
140	Combined Insurance Company of America **	7	COM
141	Other Medigap (not listed elsewhere) ***	7	COM
142	Blue Cross Indemnity	6	BCBS
143	Free Care	9	FC
144	Other Government	5	GOV
145	Self-Pay	1	SP
146	Worker's Compensation	2	WOR
147	Other Commercial (not listed elsewhere) ***	7	COM
148	Other HMO (not listed elsewhere) ***	8	HMO
149	PPO and Other Managed Care (not listed elsewhere) ***	E	PPO
150	Other Non-Managed Care (not listed elsewhere) ***	0	OTH

151	CHAMPUS	5	GOV
152	Foundation	0	OTH
153	Grant	0	OTH
154	BCBS Other (Not listed elsewhere) ***	6	BCBS
155	Blue Cross Managed Care Other(Not listed elsewhere)***	C	BCBS-MC
156	Out of state BCBS	6	BCBS
157	Metrahealth - PPO (United Health Care of NE)	D	COM-MC
158	Metrahealth - HMO (United Health Care of NE)	D	COM-MC
159	None (Valid only for Secondary Source of Payment)	N	NONE
160	Blue Choice (includes Healthflex Blue) - POS	C	BCBS-MC
161	Aetna Managed Choice POS	D	COM-MC
162	Great West Life POS	D	COM-MC
163	United Healthcare Insurance Company - POS (New for 1997)	D	COM-MC
164	Healthsource CMHC Plus POS	J	POS
165	Healthsource New Hampshire POS (self-funded)	J	POS
166	Private Healthcare Systems POS	J	POS
167	Fallon POS	J	POS

168	Reserved		

169	Kaiser Added Choice	J	POS
170	US Healthcare Quality POS	J	POS
171	CIGNA POS	D	COM-MC
172	Metrahealth - POS (United Health Care of NE)	D	COM-MC

173-180	Reserved		

181	First Allmerica Financial Life Insurance EPO	D	COM-MC
182	UniCare Preferred Plus Managed Access EPO	D	COM-MC
183	Pioneer Health Care EPO	K	EPO
184	Private Healthcare Systems EPO	K	EPO

185 -198	Reserved		

199	Other EPO (not listed elsewhere) ***	K	EPO
200	Hartford Life Insurance Co **	7	COM
201	Mutual of Omaha **	7	COM
202	New York Life Insurance **	7	COM
203	Principal Financial Group (Principal Mutual Life)	7	COM
204	Christian Brothers Employee	7	COM

207	Network Health (Cambridge Health Alliance MCD Program)	B	MCD-MC
208	HealthNet (Boston Medical Center MCD Program)	B	MCD-MC

205 209	Reserved		

210	Medicare HMO - Pilgrim Preferred 65 **	F	MCR-MC
211	Medicare HMO - Neighborhood Health Plan Senior Health Plus **	F	MCR-MC
212	Medicare HMO - Healthsource CMHC Central Care Supplement **	F	MCR-MC

213 -219	Reserved		

220	Medicare HMO - Blue Care 65	F	MCR-MC
221	Medicare HMO - Harvard Community Health Plan 65	F	MCR-MC
222	Medicare HMO - Healthsource CMHC	F	MCR-MC
223	Medicare HMO - Harvard Pilgrim Health Care of New England Care Plus	F	MCR-MC
224	Medicare HMO - Tufts Secure Horizons	F	MCR-MC
225	Medicare HMO - US Healthcare	F	MCR-MC

226-229	Reserved		

230	Medicare HMO - HCHP First Seniority	F	MCR-MC
231	Medicare HMO - Pilgrim Prime	F	MCR-MC
232	Medicare HMO - Seniorcare Direct	F	MCR-MC
233	Medicare HMO - Seniorcare Plus	F	MCR-MC
234	Medicare HMO - Managed Blue for Seniors	F	MCR-MC

235-249	Reserved		

250	CIGNA HMO	D	COM -MC
251	Healthsource CMHC HMO	8	HMO

252-269	Reserved		

270	UniCare Preferred Plus PPO	D	COM - MC
271	Hillcrest HMO	8	HMO

272	Auto Insurance	T	AI
990	Free Care – co-pay, deductible, or co-insurance (when billing for free care services use #143)	9	FC

995	Health Safety Net	H	FC
300	CommCare: BMC HealthNet Plan/Commonwealth Care – General Classification (For use only when no specific level for this plan can be identified)	Q - CommCare	300
301	CommCare: BMC HealthNet Plan/Commonwealth Care – Plan Type I	Q - CommCare	301
302	CommCare: BMC HealthNet Plan/Commonwealth Care – Plan Type II	Q - CommCare	302
303	CommCare: BMC HealthNet Plan/Commonwealth Care – Plan Type III	Q - CommCare	303
304	CommCare: BMC HealthNet Plan/Commonwealth Care – Plan Type IV	Q - CommCare	304
400	CommCare: Cambridge Network Health Forward – General Classification (For use only when no specific level for this plan can be identified)	Q - CommCare	400
401	CommCare: Cambridge Network Health Forward – Plan Type I	Q - CommCare	401
402	CommCare: Cambridge Network Health Forward – Plan Type II	Q - CommCare	402

403	CommCare: Cambridge Network Health Forward – Plan Type III	Q - CommCare	403
404	CommCare: Cambridge Network Health Forward – Plan Type IV	Q - CommCare	404
500	CommCare: Fallon Community Health Care: Commonwealth Care FCHP Direct Care – General Classification (For use only when no specific level for this plan can be identified)	Q - CommCare	500
501	CommCare: Fallon Community Health Care: Commonwealth Care FCHP Direct Care – Plan 1 (Group No. 4445077)	Q - CommCare	501
502	CommCare: Fallon Community Health Care: Commonwealth Care FCHP Direct Care – Plan 2 (Group No. 4455220)	Q - CommCare	502
503	CommCare: Fallon Community Health Care: Commonwealth Care FCHP Direct Care – Plan 3 (Group No. 4455221)	Q - CommCare	503
504	CommCare: Fallon Community Health Care: Commonwealth Care FCHP Direct Care – Plan 4 (Group No. 4455222)	Q - CommCare	504
600	CommCare: Neighborhood Health Plan– General Classification (For use only when no specific level for this plan can be identified)	Q - CommCare	600

601	CommCare: Neighborhood Health Plan – NHP Commonwealth Care Plan – Plan Type I (9CC1)	Q - CommCare	601
602	CommCare: Neighborhood Health Plan – NHP Commonwealth Care Plan – Plan Type II (9CC2)	Q - CommCare	602
603	CommCare: Neighborhood Health Plan – NHP Commonwealth Care Plan – Plan Type III (9CC3)	Q - CommCare	603

** Supplemental Payer Source

*** Please list under the specific carrier when possible

SUPPLEMENTAL PAYER SOURCES

USE AS SECONDARY PAYER SOURCE ONLY:

137	AARP/Medigap Supplement	7	COM
138	Banker's Life and Casualty Insurance	7	COM
139	Bankers Multiple Line	7	COM
136	BCBS Medex	6	BCBS

140	Combined Insurance Company of America	7	COM
200	Hartford Life Insurance co.	7	COM
127	Medicare HMO -Health New England Medicare Wrap	F	MCR-MC
212	Medicare HMO - Healthsource CMHC Central Care Supplement	F	MCR-MC
128	Medicare HMO -HMO Blue for Seniors	F	MCR-MC
129	Medicare HMO-Kaiser Medicare Plus Plan	F	MCR-MC
131	Medicare HMO-Pilgrim Enhance 65	F	MCR-MC
210	Medicare HMO-Pilgrim Preferred 65	F	MCR-MC
201	Mutual of Omaha	7	COM
211	Neighborhood Health Plan Senior Health Plus	F	MCR-MC
202	New York Life Insurance Company	7	COM
141	Other Medigap (not listed elsewhere) ***	7	COM
133	Medicare HMO -Tufts Medicare Supplement (TMS)	F	MCR-MC

(h)

*** VESTA CODE**	*** VETERAN STATUS DEFINITION**
1	YES

2	NO (includes never in mililtary, 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)

ED Flag Code	Admitted ED Patient Definition
0	Not admitted from the ED, no ED visit reflected in this record
1	Not admitted from the ED, but ED visit(s) reflected in this record
2	Admitted from the ED

Example: If a patient is not admitted as an inpatient directly from the ED, but a recent ED visit is included in this record because of "payment window" rules, choose code 1.

(k)

Observa-tion Stay Flag Code	Admitted Observation Patient Flag
Y	Admitted from outpatient observation stay
N	Not admitted from outpatient observation stay

Example: If a patient has an ED visit, then is held for outpatient observation, and then is admitted as an inpatient from observation, use ED flag code 1 as well as Observation Stay Flag code Y.

(l)

Patient Homeless Indicator	
Valid Entries	**Definition**
Y	Patient is known to be homeless.

N	Patient is not known to be homeless.

(m)

ORG ID	**CURRENT ORGANIZATION NAME**
1	**Anna Jaques Hospital**
2	**Athol Memorial Hospital**
6	**Baystate Mary Lane Hospital**
4	**Baystate Medical Center**
7	**Berkshire Medical Center - Berkshire Campus**
9	***Berkshire Medical Center - Hillcrest Campus***
53	**Beth Israel Deaconess Hospital - Needham**
10	**Beth Israel Deaconess Medical Center - East Campus**
16	**Boston Medical Center - Harrison Avenue Campus**
144	***Boston Medical Center - East Newton Campus***
22	**Brigham and Women's Hospital**
25	**Brockton Hospital**
27	**Cambridge Health Alliance - Cambridge Campus**
143	***Cambridge Health Alliance - Somerville Campus***
142	***Cambridge Health Alliance - Whidden Memorial Campus***
39	**Cape Cod Hospital**
42	**Caritas Carney Hospital**
62	**Caritas Good Samaritan Medical Center - Brockton Campus**
4460	**Caritas Good Samaritan Medical Center - Norcap Lodge Campus**

75	**Caritas Holy Family Hospital and Medical Center**
41	**Caritas Norwood Hospital**
126	**Caritas St. Elizabeth's Medical Center**
46	**Children's Hospital Boston**
132	**Clinton Hospital**
50	**Cooley Dickinson Hospital**
51	**Dana-Farber Cancer Institute**
57	**Emerson Hospital**
8	**Fairview Hospital**
40	**Falmouth Hospital**
59	**Faulkner Hospital**
5	**Franklin Medical Center**
66	**Hallmark Health System - Lawrence Memorial Hospital Campus**
141	**Hallmark Health System - Melrose-Wakefield Hospital Campus**
68	**Harrington Memorial Hospital**
71	**Health Alliance Hospitals, Inc.**
8548	***Health Alliance Hospital -- Burbank Campus***
8509	***Health Alliance Hospital -- Leominster Campus***
73	**Heywood Hospital**
77	**Holyoke Medical Center**
78	**Hubbard Regional Hospital**
79	**Jordan Hospital**
136	**Kindred Hospital Boston**

135	**Kindred Hospital Boston North Shore**
81	**Lahey Clinic -- Burlington Campus**
4448	***Lahey Clinic Northshore***
83	**Lawrence General Hospital**
85	**Lowell General Hospital**
133	**Marlborough Hospital**
88	**Martha's Vineyard Hospital**
89	**Massachusetts Eye and Ear Infirmary**
91	**Massachusetts General Hospital**
118	**Mercy Medical Center - Providence Behavioral Health Hospital Campus**
119	**Mercy Medical Center - Springfield Campus**
70	**Merrimack Valley Hospital**
49	**MetroWest Medical Center - Framingham Campus**
457	***MetroWest Medical Center - Leonard Morse Campus***
97	**Milford Regional Medical Center**
98	**Milton Hospital**
99	**Morton Hospital and Medical Center**
100	**Mount Auburn Hospital**
101	**Nantucket Cottage Hospital**
52	**Nashoba Valley Medical Center**
103	**New England Baptist Hospital**
105	**Newton-Wellesley Hospital**
106	**Noble Hospital**

107	**North Adams Regional Hospital**
116	**North Shore Medical Center, Inc. - Salem Campus**
3	***North Shore Medical Center, Inc. - Union Campus***
109	**Northeast Health System - Addison Gilbert Campus**
110	**Northeast Health System - Beverly Campus**
112	**Quincy Medical Center**
114	**Saint Anne's Hospital**
127	**Saint Vincent Hospital**
115	**Saints Memorial Medical Center**
122	**South Shore Hospital**
123	**Southcoast Hospitals Group - Charlton Memorial Campus**
124	**Southcoast Hospitals Group - St. Luke's Campus**
145	**Southcoast Hospitals Group - Tobey Hospital Campus**
129	**Sturdy Memorial Hospital**
104	**Tufts-New England Medical Center**
131	**UMass Memorial Medical Center - University Campus**
130	***UMass Memorial Medical Center - Memorial Campus***
138	**Winchester Hospital**
139	**Wing Memorial Hospital and Medical Centers**

(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 Code	Ethnicity Definition

2182-4	Cuban
2184-0	Dominican
2148-5	Mexican, Mexican American, Chicano
2180-8	Puerto Rican
2161-8	Salvadoran
2155-0	Central American (not otherwise specified)
2165-9	South American (not otherwise specified)
2060-2	African
2058-6	African American
AMERCN	American
2028-9	Asian
2029-7	Asian Indian
BRAZIL	Brazilian
2033-9	Cambodian
CVERDN	Cape Verdean
CARIBI	Caribbean Island
2034-7	Chinese
2169-1	Columbian
2108-9	European
2036-2	Filipino
2157-6	Guatemalan

2071-9	Haitian
2158-4	Honduran
2039-6	Japanese
2040-4	Korean
2041-2	Laotian
2118-8	Middle Eastern
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOW	Unknown/not specified

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

(a) Routine Accommodations: **(b) Special Care Accommodations:**

Revenue Center	Revenue Code	Units of Service		Revenue Center	Revenue Code	Units of Service

1.	Medical/Surgical	0111 (Includes codes: 0111, 0121,0131, 0141, 0151.)	Days		1.	Neo-natal ICU	0175 (Includes codes: 0173 & 0174.)	Days
2.	Obstetrics	0112 (Includes codes: 0112, 0122,0132, 0142, 0152.	Days		2.	Medical/Surgical ICU	0200 (Includes codes: 0201 & 0202.)	Days
3.	Pediatrics	0113 (Includes codes: 0113, 0123, 0133, 0143, 0153.)	Days		3.	Pediatric ICU	0203	Days
4.	Psychiatric	0114 (Includes codes: 0114, 0124, 0134, 0144, 0154.)	Days		4.	Psychiatric ICU	0204	Days
5.	Hospice	0115 (Includes codes: 0115, 0125, 0135, 0145, 0155.)	Days		5.	Intermediate ICU	0206	Days

6.	Detoxification	0116 (Includes codes: 0116, 0126, 0136, 0146, 0156.)	Days		6.	Burn Unit	0207	Days
7.	Oncology	0117 (Includes codes: 0117, 0127, 0137, 0147, 0157.)	Days		7.	Trauma ICU	0208	Days
8.	Rehabilitation	0118 (Includes codes: 0118, 0128, 0138, 0148, 0158.)	Days		8.	Other ICU	0209	Days
9.	Other	0119 (Includes codes: 0119, 0129, 0139, 0149, 0159.)	Days		9.	Coronary Care Unit	0210	Days
10.	Nursery	0170 (Includes codes: 0170, 0171, 0172, 0179.)	Days		10.	Myocardial Infarction	0211	Days

11.	Chronic	0192	Days		11.	Pulmonary Care	0212	Days
12.	Subacute	0196	Days		12.	Heart Transplant	0213	Days
13.	TCU	0197	Days		13.	Post Coronary Care	0214	Days
14.	SNF	0198	Days		14.	Other Coronary Care	0219	Days

(c) Ancillary Services:

Revenue Center		**Revenue Code**	**Units of Service**
1.	Special Charges	0220	Zeros
2.	Incremental Nursing Charge Rate	0230	Zeros
3.	All Inclusive Ancillary	0240	Zeros
4.	Pharmacy	0250	Zeros
5.	IV Therapy	0260	Zeros

6.	Medical/Surgical Supplies and Devices	0270	Zeros
7.	Oncology	0280	Zeros
8.	Durable Medical Equipment	0290	Zeros
9.	Laboratory	0300	Zeros
10.	Laboratory Pathological	0310	Zeros
11.	Diagnostic Radiology	0320	Zeros
12.	Therapeutic Radiology	0330	Zeros
13.	Nuclear Medicine	0340	Zeros
14.	CT Scan	0350	Zeros
15.	Operating Room Services	0360	Zeros
16.	Anesthesia	0370	Zeros
17.	Blood	0380	Zeros
18.	Blood and Blood Component Administration, Processing and Storage	0390	Zeros
19.	Other Imaging Services	0400	Zeros
20.	Respiratory Services	0410	Zeros
21	Physical Therapy	0420	Zeros
22.	Occupational Therapy	0430	Zeros
23.	Speech-Language Pathology	0440	Zeros
24.	Emergency Room	0450	Zeros

25.	Pulmonary Function	0460	Zeros
26.	Audiology	0470	Zeros
27.	Cardiology	0480	Zeros
28.	Ambulatory Surgical Care	0490	Zeros
29.	Outpatient Services	0500	Zeros
30.	Clinics	0510	Zeros
31.	Free-Standing Clinic	0520	Zeros
32.	Osteopathic Services	0530	Zeros
33.	Ambulance	0540	Zeros
34.	Skilled Nursing	0550	Zeros
35.	Medical Social Services	0560	Zeros
36.	Home Health Aide (Home Health)	0570	Zeros
37.	Other Visits (Home Health)	0580	Zeros
38.	Units of Service (Home Health)	0590	Zeros
39.	Oxygen (Home Health)	0600	Zeros
40.	Magnetic Resonance Technology (MRT)	0610	Zeros
41.	Medical/Surgical Supplies - Extension of 270	0620	Zeros

42.	Pharmacy – Extension of 0250	0630	Zeros
43.	Home IV Therapy Services	0640	Zeros
44.	Hospice Service	0650	Zeros
45.	Respite Care	0660	Zeros
46.	Outpatient Special Residence Charges	0670	Zeros
47.	Trauma Response	0680	Zeros
48.	Not Assigned	0690	
49.	Cast Room	0700	Zeros
50.	Recovery Room	0710	Zeros
51.	Labor Room/Delivery	0720	Zeros
52.	EKG/ECG (Electrocardiogram)	0730	Zeros
53.	EEG (Electroencephalogram)	0740	Zeros
54.	Gastro-Intestinal Services	0750	Zeros
55.	General Treatment or Observation Room	0760	Zeros
56.	Treatment Room	0761	Zeros
57.	Observation Room	0762	Hours
58.	Other Observation Room	0769	Hours
59.	Preventative Care Services	0770	Zeros

60.	Telemedicine	0780	Zeros
61.	Extra-corporeal Shock Wave Treatment (formerly Lithotripsy)	0790	Zeros
62.	Inpatient Renal Dialysis	0800	Zeros
63.	Acquisition of Body Components	0810	Zeros
64.	Hemodialysis - Outpatient or Home	0820	Zeros
65.	Peritoneal Dialysis - Outpatient or Home	0830	Zeros
66.	Continuous Ambulatory Peritoneal Dialysis - Outpatient or Home	0840	Zeros
67.	Continuous Cycling Peritoneal Dialysis - Outpatient or Home	0850	Zeros
68.	Invalid (Reserved for Dialysis - National Assignment)	0860	
69.	Invalid (Reserved for Dialysis - National Assignment)	0870	
70.	Miscellaneous Dialysis	0880	Zeros
71.	Reserved for National Assignment	0890	Zeros

72.	Behavioral Health Treatments/Services	0900	Zeros
73.	Behavioral Health Treatments/Services	0910	Zeros
74.	Other Diagnostic Services	0920	Zeros
75.	Medical Rehabilitation Day Program	0930	
76.	Other Therapeutic Services	0940	Zeros
77.	Other Therapeutic Services – Extension of 0940	0950	Zeros
78.	Professional Fees	0960 (Includes codes:0960, 0961, 0962, 0963, 0964, 0969.)	Zeros
79.	Professional Fees	0970 (Includes codes: 0970, 0971, 0972, 0973, 0974, 0975, 0976, 0977, 0978, 0979.)	Zeros

80.	Professional Fees	0980 (Includes codes: 0980, 0981, 0982, 0983, 0984, 0985, 0986, 0987, 0988, 0989.)	Zeros
81.	Patient Convenience Items	0990	Zeros
82.	Behavioral Health Accommodations	1000	Zeros
83.	Reserved for National Assignment	1010 - 2090	
84.	Alternative Therapy Services	2100	Zeros
85.	Reserved for National Assignment	2110 - 3090	
86.	Adult Care	3100	Zeros
87.	Reserved for National Assignment	3110 - 9990	

(4) Record Type '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
A	Not applicable (only valid for NCHS official published list of not applicable ICD-9-CM codes for POA flag.)
E	Not applicable (only valid for NCHS official published list of not applicable ICD-9-CM codes for POA flag.)

1	Not applicable (only valid for NCHS official published list of not applicable ICD-9-CM codes for POA flag.)
Blank field	Not applicable (only valid for NCHS official published list of not applicable ICD-9-CM codes for POA flag.)

(5) Record Type ‘10’ and '99'

*** TYBA CODE**	*** Type of Batch Definition**
33	Replacement of an entire quarter's data, (additions)
99	Submission of an entire quarter's data (deletions/additions).

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 hospitals 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

Hospital Inpatient Discharge Data Files must be submitted quarterly to the DHCFP 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