Massachusetts Center for Health Information and Analysis

Hospital Inpatient Discharge Data

File Submission Guide FY 2021

Effective October 1, 2020

CHIA.
center
for health
information
and analysis

CHIA has adopted regulation 957 CMR 8.00 to require the reporting of Hospital Inpatient Discharge Data, Outpatient Emergency Department Visit Data and Outpatient Observation Data to the Center for Health Information and Analysis. This document provides the technical and data specifications, including edit specifications required for the Hospital Inpatient Discharge Data.

This submission guide will be in effect beginning with the quarterly submission of 10/1/2020 – 12/31/2020 data due at CHIA on March 16, 2021.

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Hospital Inpatient Discharge Data Submission Overview

Data to Include in Hospital Inpatient Discharge Data Submissions

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

Definitions

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

Data File Format

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

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

Data Transmission Media Specifications

Data will be transferred to CHIA via the Internet. In order to do that in a secure manner CHIA'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 CHIA 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 CHIA. The newly created encrypted file shall be transferred to CHIA via its INET website. Providers should contact their CHIA liaison to submit test files.

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

(a) the potential of unacceptable data reaching CHIA and

(b) penalties for inadequate compliance as specified in regulation 957 CMR 8.00

File Naming Convention

In order for CHIA to correctly associate each file with the proper provider please use the following naming convention for all files:

HDD_#######_CCYY_# where

####### = Provider CHIA organization ID – do not pad with zeros

CCYY = the Fiscal Year for the data included

= the Quarter being reported.

For Test Files please include a "_TEST" at the end of the file name. (ex: ED_123_2001_1_TEST).

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.

Data Element	Definition
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 nine record types as follows:

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

e)	**Record Type '45'**	*Record Type '45'* contains principal medical information such as primary diagnosis, admitting diagnosis, principal external cause, principal procedure, physician information and ED boarding information. This record is presented once for each patient discharge in the reporting period.
f)	**Record Type '50'**	*Record Type '50'* reports associated diagnosis information pertaining to this patient's episode of care. This record may be repeated more than once per discharge if it is necessary to report the use of more than fourteen associated diagnoses within this episode of care.
g)	**Record Type '60'**	*Record Type '60'* reports procedures and additional clinical information pertaining to this patient's episode of care. This record may be repeated more than once per discharge if it is necessary to report the use of more than thirteen significant procedures within this episode of care.
h)	**Record Type '80'**	*Record Type '80'* reports physician information for the patient. This record is provided once for each patient discharge.
i)	**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.

Each submission must also contain four other types of records as follows:

a)	**Record Type '01'**	*Record Type '01'* 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.

RECORD TYPE 01 - LABEL DATA

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

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

8	Filler	X(57)		49 105		
9	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 RT 01 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 Center for Health Information and Analysis	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 Inpatient 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 valid OrgID if Primary or Secondary Source of Admission is 4- Transfer from an Acute Hospital, 7- Outside Hospital Emergency Room Transfer, 5- Transfer from an SNF Facility, 6- Intermediate Care Facility, or V- Transfer from another facility to a Medicare-approved swing bed and the provider from which the transfer occurred is in Massachusetts. If provider from which the transfer occurred is outside Massachusetts, the transfer OrgID must be 9999999. - Must be valid OrgID if Primary or Secondary Source of Admission is 9- Other (to include Level 4 Nursing Facility) and the transfer facility is a Level 4 Nursing Facility/Rest Home and the provider from which the transfer occurred is in Massachusetts. If Level 4 Nursing Facility provider from which the transfer occurred is outside Massachusetts, the transfer OrgID must be 9999999. - If the Primary or Secondary Source of Admission is 9 and the admission is from anything other than a Level 4 Nursing Facility the Transfer Organization ID must be blank.	B

					- Must be valid Organization Id as assigned by the Center for Health Information and Analysis as specified in Inpatient Data Code Tables (1)(m) if the provider from which the transfer occurred is in Massachusetts Or 9999999 if facility was outside Massachusetts. - Transfer OrgID should not be the OrgID for Provider on RT10 or the Hospital Service Site on RT20.	
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 source of payment unless Health Safety Net or Free Care is the secondary source of payment. - Medicaid may be primary with code “159” (None) as secondary.	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) - If Medicaid is one of two payers, Medicaid must be coded as the secondary payer type unless Health Safety Net or Free Care is the secondary payer type. - Medicaid may be primary with code “N” (None) in secondary.	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)	Note
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) - If Medicaid is one of two payers, Medicaid must be coded as the secondary payer type unless Health Safety Net or Free Care is the secondary payer type. - If not applicable, must be coded as “N” (None) as specified in Inpatient Data Code Tables(1)(f).	A

26	Secondary Source of Payment	X(3)	L/B	114 116	- Must be present if secondary payer type is other than "N" (None) - 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 source of payment unless Health Safety Net or Free Care is the secondary source of payment. - If not applicable, must be coded as “159” (None) as specified in Inpatient Data Code Tables(1)(g).	
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 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 valid code as specified in Inpatient Data Code Tables(1)(k)	A
34	Hospital Service Site Reference	X(7)	L/B	160 166	- Must be present if provider is approved to submit multiple campuses in one file - Must be valid Organization Id as assigned by the Center for Health Information and Analysis	A
35	Homeless Indicator	X	L/B	167 167	- Include if applicable. - Must be valid code as specified in Inpatient Data Code Tables(1)(l).	B
36	Medicaid Claim Certificate Number (New MMIS ID/ Medicaid ID)	X(12)	L/B	168 179	- Must be present if primary or secondary Payer Type Code is "4" (Medicaid) or “H” (Health Safety Net) as in Inpatient Data Code Tables(1)(f) - Must be blank if neither primary nor secondary payer is Medicaid or Health Safety Net - First position must not be blank if the field contains data - If present, must be numeric characters, length must be 12.	A

37	Patient Last Name	X (35)	L/B	180 214	Required.	A
38	Patient First Name	X(25)	L/B	215 239	Required.	A
39	Filler	X(11)	L/B	240 250		

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 '20' or follow Patient Control Record Type '30'	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 (Record 25 field 7) is 'US' - Must be valid US 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 valid US postal code for state	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
19	Health Plan Member ID	X(40)	L/B	207 246	- Must be present when Primary Payer Type Code is not: “1” (Self Pay) “2” (Worker’s Comp) “4” (Medicaid) “9” (Free Care) “H” (Health Safety Net) “T” (Auto Insurance) - Report Health Plan Subscriber ID if Member ID is unknown.	A
20	Filler	X(4)	L/B	247 250		

RECORD TYPE 30 – IP ACCOMMODATIONS

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

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

4	Filler	X(7)		15 21		
	ACCOMMODATIONS 1♦	X(33)		22 54		A
5	Revenue Code (Accommodations)	X (4)	L/B	22 25	- If present must be valid code as specified in Inpatient Data Code Tables(3)	A
6	Filler	X (4)		26 29		
7	Units 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(8)	R/Z	36 43	- 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(11)		44 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 45.
- Record Type = 40.

Field No.	Field Name	Pic-ture	Spec.	Field Position From-Through	Edit Specifications	Error Type
1	Record Type '40'	XX	L/B	1 2	- Must be first record following last occurrence of IP Accommodations Record Type '30' or following previous Record Type '40'	A
2	Sequence	99	R/Z	3 4	- Must be numeric - If first record following IP Accommodations Record Type '30' sequence must = '01' - For each subsequent occurrence of Record Type '40' sequence must be incremented by one	A
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
4	Filler	X(7)		15 21		
	ANCILLARIES 1♦	X(33)		22 54		A
5	Revenue Code (Ancillary)	X (4)	L/B	22 25	- If present must be valid code as specified in Inpatient Data Code Tables(3)	A
6	Filler	X (4)		26 29		

7	Units of Service (Ancillary)	X(5)	R/Z	30 34	- Must be present if related Revenue Code is present - Must be greater than zero if Revenue Code 762 or 769 are present	A
8	Filler	X		35 35		
9	Total Charges (Service)	9(8)	R/Z	36 43	- 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(11)		44 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 present+ - Same as Ancillaries 1	A
14	Ancillaries 5++	X(33)		154 186	- May only be present if Ancillaries 4 present+ - Same as Ancillaries 1	A

15	Filler	9(3)		187 189		
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 45 – PRINCIPAL MEDICAL INFORMATION

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

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
1	Record Type '45'	XX	L/B	1 2	- Must be first record following last occurrence of Ancillary Services Record Type '40'	A
2	Medical Record Number	X(10)	L/B	3 12	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A

3	Principal External Cause Code	X(7)	L/B	13 19	- Must be present if principal diagnosis is an ICD-10-CM S-code (S00-S99). - May be present if principal diagnosis is an ICD-10-CM T-code (T00-T88). - If present, must be a valid ICD-10-CM external cause code (V00-Y89). - Supplemental ICD-10-CM external cause codes (Y90-Y99) shall be recorded in associated diagnosis fields. - Additional ICD-10-CM external cause codes (V00-Y89) shall be recorded in associated diagnosis fields.	B
4	Filler	X		20 20		
5	Principal Diagnosis Code	X(7)	L/B	21 27	- Must be present - Must be valid ICD-10-CM code* (exclude decimal point) - Must not be ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	A
6	Filler	X(2)		28 29		

7	Admitting Diagnosis Code	X(7)	L/B	30 36	- Must be present - Must be valid ICD-10-CM code* (exclude decimal point) - Must not be ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	B
8	Filler	X(2)		37 38		
9	Discharge Diagnosis Code	X(7)	L/B	39 45	- Must be present - Must be valid ICD-10-CM code* (exclude decimal point) - Must not be ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	Note
10	Condition Present on Admission – Principal External Cause Code	X		46 46	- Must be present when Principal External Cause Code is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
11	Condition Present on Admission – Principal Diagnosis Code	X		47 47	- Must be present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
12	Principal Procedure Code	X(7)	L/B	48 54	- If entered must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A

13	Filler	X(4)		55 58		
14	Date of Principal Procedure (CCYYMMDD)	X(8)	L/B	59 66	- 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
15	ICD Indicator	X	L/B	67 67	- International Classification of Diseases version - All ICD codes must be ICD-10 - 0 for ICD-10	A
16	Other Caregiver	X	L/B	68 68	- May be present - If present must be a valid code as specified in Inpatient Data Code Tables (4)(a)	B
17	Attending Physician National Provider Identifier (NPI)	X(10)	L/B	69 78	- Must be present - Must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	B
18	Operating Physician National Provider Identifier (NPI)	X(10)	L/B	79 88	- Must be present if Principal Procedure Code is present - If present, must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	B

19	Additional Caregiver National Provider Identifier (NPI)	X(10)	L/B	89 98	- May be present - If present, must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	B
20	Number of ANDs	9(4)	R/Z	99 102	- Must not exceed total accommodation days	A
21	Number of hours in ED	9(3)	R/Z	103 105	- Must be present if Source of Admission is 'R' – Within hospital Emergency Room Transfer - Must be present if ED Flag is set to 2. - May be present if Revenue Codes 045x are used or ED Flag is set to 1.	B
22	Emergency Department Registration Date	X(8)	L/B	106 113	- Must be present if Source of Admission is 'R' – Within hospital Emergency Room Transfer. - Must be present if ED Flag is set to 2. - May be present if Revenue Codes 045x are used or ED Flag is set to 1. - Must be valid date format (CCYYMMDD). - Must be less than or equal to ED Discharge Date.	B

23	Emergency Department Registration Time	9(4)	L/B	114 117	- Must be present if Source of Admission is 'R' – Within hospital Emergency Room Transfer. - Must be present if ED Flag is set to 2. - May be present if Revenue Codes 045x are used or ED Flag is set to 1. - Must be numeric. - Must range from 0000 to 2359.	B
24	Emergency Department Discharge Date	X(8)	L/B	118 125	- Must be present if Source of Admission is 'R' – Within hospital Emergency Room Transfer. - Must be present if ED Flag is set to 2. - May be present if Revenue Codes 045x are used or ED Flag is set to 1. - Must be valid date format (CCYYMMDD). - Must be greater than or equal to Registration Date.	B
25	Emergency Department Discharge Time	9(4)	L/B	126 129	- Must be present if Source of Admission is 'R' – Within hospital Emergency Room Transfer. - Must be present if ED Flag is set to 2. - May be present if Revenue Codes 045x are used or ED Flag is set to 1. - Must be numeric. - Must range from 0000 to 2359. - Must be greater than the registration time when the discharge date and registration date are equal.	B

26	Filler	X(121)		130 250		

- * = All ICD-10-CM should be reported as the exact code excluding the decimal point. Zeros contained in the code should be reported. For example, the code ‘001.0’ should be reported as ‘0010’.

RECORD TYPE 50 – MEDICAL DIAGNOSIS

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

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
1	Record Type ‘50'	XX	L/B	1 2	- Must be first record following last occurrence of Principal Medical Information Record Type '45'	A
2	Sequence	99	R/Z	3 4	- Must be numeric - If first record following Principal Medical Information Record Type '45’ sequence must = '01' - For each subsequent occurrence of Record Type '50' sequence must be incremented by one	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
4	Filler	X(12)		15 26		
5	Assoc. Diagnosis Code I	X(7)	L/B	27 33	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
6	Assoc. Diagnosis Code II	X(7)	L/B	34 40	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
7	Assoc. Diagnosis Code III	X(7)	L/B	41 47	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
8	Assoc. Diagnosis Code IV	X(7)	L/B	48 54	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
9	Assoc. Diagnosis Code V	X(7)	L/B	55 61	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
10	Assoc. Diagnosis Code VI	X(7)	L/B	62 68	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
11	Assoc. Diagnosis Code VII	X(7)	L/B	69 75	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
12	Assoc. Diagnosis Code VIII	X(7)	L/B	76 82	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
13	Assoc. Diagnosis Code IX	X(7)	L/B	83 89	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
14	Assoc. Diagnosis Code X	X(7)	L/B	90 96	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
15	Assoc. Diagnosis Code XI	X(7)	L/B	97 103	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
16	Assoc. Diagnosis Code XII	X(7)	L/B	104 110	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
17	Assoc. Diagnosis Code XIII	X(7)	L/B	111 117	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
18	Assoc. Diagnosis Code XIV	X(7)	L/B	118 124	- Only permitted if prior diagnosis is entered - Must be valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD external cause code (V00-Y99) - Must agree with ICD Indicator	A
19	Filler	X(56)		125 180		

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
20	Condition Present on Admission – Assoc. Diagnosis Code I	X		181 181	- Must be present when Assoc. Diagnosis Code I is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
21	Condition Present on Admission – Assoc. 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
22	Condition Present on Admission – Assoc. Diagnosis Code III	X		183 183	- Must be present when Assoc. Diagnosis Code III is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
23	Condition Present on Admission – Assoc. Diagnosis Code IV	X		184 184	- Must be present when Assoc. Diagnosis Code IV is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
24	Condition Present on Admission – Assoc. Diagnosis Code V	X		185 185	- Must be present when Assoc. Diagnosis Code V is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
25	Condition Present on Admission – Assoc. Diagnosis Code VI	X		186 186	- Must be present when Assoc. Diagnosis Code VI is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
26	Condition Present on Admission – Assoc. Diagnosis Code VII	X		187 187	- Must be present when Assoc. Diagnosis Code VII is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
27	Condition Present on Admission – Assoc. Diagnosis Code VIII	X		188 188	- Must be present when Assoc. Diagnosis Code VIII is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B

Field No.	Field Name	Pic-ture	Spec.	From-Through	Edit Specifications	Error Type
28	Condition Present on Admission – Assoc. Diagnosis Code IX	X		189 189	- Must be present when Assoc. Diagnosis Code IX is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
29	Condition Present on Admission – Assoc. Diagnosis Code X	X		190 190	- Must be present when Assoc. Diagnosis Code X is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
30	Condition Present on 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
31	Condition Present on Admission – Assoc. Diagnosis Code XII	X		192 192	- Must be present when Assoc. Diagnosis Code XII is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B

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

RECORD TYPE 60 – MEDICAL PROCEDURE

- Required for each discharge.
- Must follow RT 50 or RT 60.
- Must be followed by RT 60 or 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	Sequence	99	R/Z	3 4	- Must be numeric - If first record following Medical Diagnosis Record Type '50' sequence must = '01' - For each subsequent occurrence of Record Type '60' sequence must be incremented by one	A
3	Medical Record Number	X(10)	L/B	5 14	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
4	Filler	X(15)		15 29		
5	Significant Procedure I	X(7)	L/B	30 36	- May only be present if Principal Procedure Code is present - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
6	Filler	X(2)		37 38		

7	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)(d) - Must not be later than discharge date	B
8	Significant Proc. II	X(7)	L/B	47 53	- May only be present if Significant Procedure I present - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
9	Filler	X(2)		54 55		
10	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)(d) - Must not be later than discharge date	B

11	Significant Proc. III	X(7)	L/B	64 70	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
12	Filler	X(2)		71 72		
13	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)(d) - Must not be later than discharge date	B
14	Significant Proc. IV	X(7)	L/B	81 87	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
15	Filler	X(2)		88 89		

16	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)(d) - Must not be later than discharge date	B
17	Significant Proc. V	X(7)	L/B	98 104	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
18	Filler	X(2)		105 106		
19	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)(d) - Must not be later than discharge date	B

20	Significant Proc. VI	X(7)	L/B	115 121	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
21	Filler	X(2)		122 123		
22	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)(d) - Must not be later than discharge date	B
23	Significant Proc. VII	X(7)	L/B	132 138	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
24	Filler	X(2)		139 140		

25	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)(d) - Must not be later than discharge date	B
26	Significant Proc. VIII	X(7)	L/B	149 155	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
27	Filler	X(2)		156 157		
28	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)(d) - Must not be later than discharge date	B

29	Significant Proc. IX	X(7)	L/B	166 172	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
30	Filler	X(2)		173 174		
31	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)(d) - Must not be later than discharge date	B
32	Significant Proc. X	X(7)	L/B	183 189	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
33	Filler	X(2)		190 191		

34	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)(d) - Must not be later than discharge date	B
35	Significant Proc. XI	X(7)	L/B	200 206	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
36	Filler	X(2)		207 208		
37	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)(d) - Must not be later than discharge date	B

38	Significant Proc. XII	X(7)	L/B	217 223	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
39	Filler	X(2)		224 225		
40	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)(d) - Must not be later than discharge date	B
41	Significant Proc. XIII	X(7)	L/B	234 240	- May only be present if all previous procedure fields are entered - Must be valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
42	Filler	X(2)		241 242		

43	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)(d) - 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
4	Attending Physician License Number (Board of Registration in Medicine Number)	X(6)	L/B	15 20	- Must be present - Must be a valid and current Mass. Board of Registration in Medicine license number or - Must be “DENSG”, “PODTR”, “OTHER”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(a).	B
5	Filler	XX	L/B	21 22		
6	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
7	Filler	XX	L/B	29 30		

8	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
9	Filler	XX	L/B	37 38		
10	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
11	Filler	XX	L/B	45 46		

12	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
13	Filler	XX	L/B	53 54		
14	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
15	Filler	XX	L/B	61 62		

16	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
17	Filler	XX	L/B	69 70		
18	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
19	Filler	XX	L/B	77 78		

20	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
21	Filler	XX	L/B	85 86		
22	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
23	Filler	XX	L/B	93 94		

24	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
25	Filler	XX	L/B	101 102		
26	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
27	Filler	XX	L/B	109 110		

28	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
29	Filler	XX	L/B	117 118		
30	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
31	Filler	XX	L/B	125 126		

32	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
33	Filler	XX	L/B	133 134		
34	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”, “MIDWIF”, “NURSEP” or “PHYAST” as specified in Inpatient Data Elements Definitions (10)(b).	B
35	Filler	110	L/B	141 250		

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’, '45', '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 30 Count	99	R/Z	29 30	- Must equal number of Record Type '30' records	A
9	Record Type 40 Count	99	R/Z	31 32	- Must equal number of Record Type '40' records	A
10	Record Type 45 Count	99	R/Z	33 34	- Must equal number of Record Type '45' records - Must = '01'	A
11	Record Type 5x Count	99	R/Z	35 36	- Must equal number of Record Type '50' records - Must = '01'	A
12	Record Type 6x Count	99	R/Z	37 38	- Must equal number of Record Type '60' records - Must = '01'	A
13	Record Type 8x Count	99	R/Z	39 40	- Must equal number of Record Type '80' records - Must = '01'	A

14	Filler	X(6)		41 46		
15	Total Charges Spec. Services	9(10)	R/Z	47 56	- Must be numeric - Must be whole numbers, no decimals	A
16	Total Charges Routine Services	9(10)	R/Z	57 66	- Must be numeric - Must be whole numbers, no decimals	A
17	Filler	X(4)		67 70		
18	Total Charges Ancillaries	9(10)	R/Z	71 80	- Must equal sum of Total Charges (Services) from Ancillary Services Record Type '40' records - Must be whole numbers, no decimals	A
19	Filler	X(6)		81 86		

20	Total Charges (All Chgs)	9(12)	R/Z	87 98	- 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
21	Filler	X(152)		99 250		

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(5)	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(12)	R/Z	23 34	- 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(6)		35 40		
9	Total Charges Ancillaries	9(12)	R/Z	41 52	- Must equal sum of Total Charges Ancillaries from Patient Control Record Type '90' records - Must be whole numbers, no decimals	A
10	Filler	X(198)		53 250		

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		

Inpatient Data Element Definitions

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

(1) Record Type '01'

(a) Submitter Name. The name of the organization submitting the file which may be an individual 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 CHIA. Code this field `CHIA'.

(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 (5).

(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) CHIA Organization ID for Provider. A unique code assigned by the Center for Health Information and Analysis 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, 6 or V	If no, refer to #2.
2.	Referred or transferred from Outside Hospital Clinic or Outside Ambulatory Surgery	Yes	L, or T	If no, refer to #3
3.	Transferred from Outside Hospital Emergency Room	Yes	7	If no, refer to #4
4.	Referred or transferred from Court/Law Enforcement	Yes	8	If no, refer to #5
5.	Direct Physician Referral, Direct Health Plan/HMO Referral or Walk-In/Self-Referral	Yes	1, 3, or M	If no, refer to #6
6.	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 New MMIS ID or MassHealth ID. If the Payer Type Code is equal to "4" (Medicaid) or “H” (Health Safety Net) as specified in Inpatient Data Code Tables(1)(f), the New MMIS ID must be recorded.

(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 used to create a surrogate key called the Unique Health Information Number (UHIN).

(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 used to create a surrogate key called the Unique Health Information Number (UHIN).

(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 Center for Health Information and Analysis for the site where care was given. Required if provider is approved to submit multiple campuses in one file.

(4) Record Type '25'

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

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

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

(d) Patient Zip Code. The U.S. Post Office (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.

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

(5) Record Type '30'

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

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

(c) 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 CHIA-403 must be included in the total charges.

(6) Record Type '40'

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

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

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 '45'

(a) External Cause Code. International Classification of Diseases, 10th Revision, Clinical Modification (ICD) V-codes, W-codes, X-codes, and Y-codes (V00-Y89) are used to categorize events and conditions describing the external cause of injuries, poisonings, and adverse effects. The Principal External Cause code shall describe the mechanism that caused the most severe injury, poisoning, or adverse effect. Additional external cause codes to report place of occurrence, activity, work status and other causal circumstances, including any external cause code (V00-Y89) and supplemental codes (Y90-Y99) should be reported in the Associated Diagnosis Code section.

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

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

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

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

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

(g) ICD Indicator. The ICD codes on the discharge must be ICD-10 Codes.

(h) 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 (4)(a).

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

(8) Record Type '50'

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

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

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

(9) Record Type '60'

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

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

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

(10) 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.
MIDWIF	for each Midwife.
NURSEP	for each Nurse Practitioner
PHYAST	for each Physician Assistant
OTHER	for other situations where no permanent license number is assigned or if a limited license number is assigned.

(**b) <u>Procedure/Operating Physician License Number</u>**. 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.
MIDWIF	for each Midwife.
NURSEP	for each Nurse Practitioner
PHYAST	for each Physician Assistant
OTHER	for other situations where no permanent license number is assigned or if a limited license number is assigned.

(11) 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).

(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).

(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).

(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 CHIA-403 must be included in total charges.

(12) 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.

(13) 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	Common Law Married
P	Domestic Partnership
U	Unknown

(c)

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

(d)

* SRCADM CODE	* Source of Admission Definition		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)			
F	Transfer from a Hospice Facility			
J	Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer			

K	Transfer from a Designated Disaster Alternative Care Site
L	Outside Hospital Clinic Referral
M	Walk-In/Self-Referral
R	Within Hospital Emergency Room Transfer
T	Transfer from Another Institution's Ambulatory Surgery
U	Transfer from hospital inpatient in the same facility to a Medicare – approved swing bed
V	Transfer from another facility to a Medicare – approved swing bed
W	Extramural Birth
X	Observation
Y	Within Hospital Ambulatory Surgery Transfer

(e)

NOTE: Codes must be as specified in this table. Example: "1" may not be used in place of "01".

* 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 a Designated Cancer Center or Children's Hospital
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice
08	Discharged/transferred to home under care of a Home IV Drug Therapy Provider

* PASTA CODE	* Patient Status Definition
09	Not allowed in the MA Hospital Inpatient Discharge Data
12	Discharged Other
13	Discharged/transferred to rehab hospital
14	Discharged/transferred to rest home
15	Discharged to Shelter
20	Expired (or did not recover - Christian Science Patient)
50	Discharged to Hospice - Home
51	Discharged to Hospice - Medical Facility
41	Expired in a Medical Facility (e.g. hospital, SNF, ICF, or free standing hospice)

* PASTA CODE	* Patient Status Definition
43	Discharged/transferred to federal healthcare facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
69	Discharged/transferred to a Designated Disaster Alternative Care Site
70	Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this Code List

* PASTA CODE	* Patient Status Definition
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission
82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission

* PASTA CODE	* Patient Status Definition
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission
93	Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission

(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 (includes Medicare Advantage)
4	MCD	Medicaid
B	MCD-MC	Medicaid Managed Care/MCO
5	GOV	Other Government Payment
7	COM	Other Commercial Insurance not listed elsewhere
D	COM-MC	Commercial Managed Care
8	HMO	HMO
9	FC	Free Care
0	OTH	Other Non-Managed Care Plans
E	PPO	PPO and Other Managed Care Plans Not Elsewhere Classified
H	HSN	Health Safety Net
J	POS	Point-of-Service Plan
K	EPO	Exclusive Provider Organization

* PAYER TYPE CODE	PAYER TYPE ABBREVIATION	* PAYER TYPE DEFINITION
T	AI	Auto Insurance
N	None	None (Valid only for Secondary Payer)
Q	CommCare	Commonwealth Care/ConnectorCare Plans
Z	DEN	Dental Plans
S	SCO/ICO	Senior Care Options/Integrated Care Organization
A	MCD-ACO	Medicaid Accountable Care Organization
C	COM-ACO	Commercial Accountable Care Organization

(g) SOURCE OF PAYMENT: See CHIA website for full listing. http://www.chiamass.gov/hospital-data-specification-manuals/

(h)

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

(i)

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

(j)

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)

Observation 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	Organization Name
1	**Anna Jaques Hospital**
2	**Athol Memorial Hospital**
5	**Baystate Franklin Medical Center**
4	**Baystate Medical Center**
106	**Baystate Noble Hospital**
139	**Baystate Wing Memorial Hospital**
7	**Berkshire Medical Center - Berkshire Campus**
98	**Beth Israel Deaconess Hospital – Milton**
53	**Beth Israel Deaconess Hospital - Needham**
79	**Beth Israel Deaconess Hospital – Plymouth**
10	**Beth Israel Deaconess Medical Center - East Campus**
46	**Boston Children's Hospital**

Org Id	Organization Name
16	Boston Medical Center - Menino Pavilion Campus
59	Brigham and Women's Faulkner Hospital
22	Brigham and Women's Hospital
27	Cambridge Health Alliance - Cambridge Hospital Campus
142	Cambridge Health Alliance - Everett Hospital Campus (formerly Whidden)
39	Cape Cod Hospital
50	Cooley Dickinson Hospital
51	Dana-Farber Cancer Institute
57	Emerson Hospital
8	Fairview Hospital
40	Falmouth Hospital
68	Harrington Memorial Hospital
71	Health Alliance Hospitals, Inc. - Leominster Campus
132	Health Alliance - Clinton Hospital Campus
73	Heywood Hospital
77	Holyoke Medical Center
81	Lahey Hospital & Medical Center - Burlington
4448	Lahey Medical Center - Peabody
109	Lahey Health - Addison Gilbert Hospital
110	Lahey Health - Beverly Hospital
138	Lahey Health - Winchester Hospital
83	Lawrence General Hospital

Org Id	Organization Name
66	Lawrence Memorial Hospital Campus - MelroseWakefield Healthcare
85	Lowell General Hospital
115	Lowell General Hospital – Saints Campus
133	Marlborough Hospital
88	Martha's Vineyard Hospital
89	Massachusetts Eye and Ear Infirmary
91	Massachusetts General Hospital
141	MelroseWakefield Hospital Campus - MelroseWakefield Healthcare
118	Mercy Medical Center - Providence Behavioral Health Hospital Campus
119	Mercy Medical Center - Springfield Campus
49	MetroWest Medical Center - Framingham Campus
457	MetroWest Medical Center - Leonard Morse Campus
97	Milford Regional Medical Center
99	Morton Hospital and Medical Center, A Steward Family Hospital
100	Mount Auburn Hospital
101	Nantucket Cottage Hospital
11467	Nashoba Valley Medical Center, A Steward Family Hospital
103	New England Baptist Hospital
105	Newton-Wellesley Hospital
116	North Shore Medical Center, Inc. - Salem Campus
3	North Shore Medical Center, Inc. - Union Campus
127	Saint Vincent Hospital

Org Id	Organization Name
6963	Shriners Hospitals for Children – Boston
11718	Shriners Hospitals for Children – Springfield
25	Signature Healthcare Brockton Hospital
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
42	Steward Carney Hospital
62	Steward Good Samaritan Medical Center - Brockton Campus
4460	Steward Good Samaritan Medical Center - Norcap Lodge Campus
75	Steward Holy Family Hospital and Medical Center
11466	Steward Holy Family at Merrimack Valley
41	Steward Norwood Hospital
114	Saint Anne's Hospital
126	Steward St. Elizabeth's Medical Center
129	Sturdy Memorial Hospital
104	Tufts-New England Medical Center
131	UMass Memorial Medical Center - University Campus
130	UMass Memorial Medical Center - Memorial Campus

(2) Record Type '25'

(a)

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

(b)

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

(c)

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

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

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

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

Standard Facility Billing Elements: National Uniform Billing Committee (NUBC) http://www.nubc.org/

(4) Record Type '45'

(a)

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

(b)

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

(5) Record Type ‘10’ and '95'

* 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 CHIA according to the following schedule:

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