Massachusetts Center for Health Information and Analysis

Hospital Inpatient Discharge Data

File Submission Guide FY 2025

Effective October 1, 2024

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 10/1/2024 – 12/31/2024 data due at CHIA on March 16, 2025 (preliminary data due January 31, 2025).

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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 for inpatient discharges must be submitted in an asterisk delimiter format. Separate files must be filed for each quarter for each hospital. Inclusion of a patient's Inpatient Discharge Data in a quarterly submission shall be based on the patient's discharge date which must fall within the quarter to be submitted.

Hospitals must submit asterisk delimited data using the following format specifications:

Field Separator: Asterisk (*)

Carriage return must be placed at the end of each record, including the final record in the file.

The number of characters between asterisks must not exceed the maximum length of a field.

A text file should be submitted in .txt format (lower case).

Asterisk Delimiter Format Example: 20XX*nnnnnnnnn**nnnnnnnnn*nnnnn

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Data Transmission Media Specifications

Data must be submitted in an asterisk delimiter format. In order to do this in a secure manner, CHIA's file encryption application (FileSecure) must be utilized. Each submitter must first download a copy of FileSecure from the CHIA web site. There is a separate installation guide for installing the FileSecure program. FileSecure will take each submission file and compress, encrypt and rename it in preparation for transmitting to CHIA. The newly created encrypted file shall be transferred to CHIA via its CHIA Submissions website. Providers should contact their CHIA liaison to submit test files. Detailed information on FileSecure and CHIA Submissions will be shared separately.

The edit specifications are incorporated into CHIA's system for receiving and editing incoming data. Edit reports are posted to CHIA Submissions 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 '_TEST' at the end of the file name. (ex: HDD_123_2001_1_TEST.txt).

Inpatient Discharge Data Record Specification

Record Specification Elements

The Inpatient Discharge Data File is made up of a series of data elements. The Record Specifications that follow provide further details:

Data Element	Definition
Field No	Sequential number for the field in the record (**Field Number**).
Field Name	Name of the Field.
Data Type	Data format required for field.
Length	Length of field.
Edit Specifications	Explanation of Conditional Requirements. List of edits to be performed on fields to test for validity of File, Batch, and Discharge.
Error Type	Errors are categorized as A or B errors. Presence of one A or two B errors will cause a discharge to be rejected.

Data Field Type

Data Type	Field Use	Definition	Example
Text	**Date**	Date fields are 8 characters. The field is formatted as follows: CCYYMMDD	February 14, 2024 would be entered as: 20240214
	Numeric (Num) A numeric field which will be used in a calculation	Numeric, whole, unsigned, integer digits. Do NOT space fill.	Birth Weight-grams (a 4 character field) might be entered as: 3968
	Currency (Curr) A numeric field which will contain a currency amount	(Unformatted) numeric, whole, unsigned integer digits. Do not include cents or decimals.	20 dollars in a 10 character field might be entered as: 20
	Char/Varchar An alphanumeric field	Alphanumeric field May be fixed length or variable length within stated field length Do NOT zero pad or space fill.	Address may contain alphanumeric data with a length up to 100 Medicaid Claim Certificate Number (New MMIS ID/ Medicaid ID) is a 12 digit fixed length field containing only numbers

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Record Type Inclusion Rules

Each inpatient data submission file must include the following record types:

Record Type	Description	Condition	Number
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.	Must be present.	One per File
Record Type '10'	*Record Type '10'* identifies the hospital whose data is provided in the file and occurs only once per submission. This is the first record of the provider's batch.	Must be present.	One per File
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.	Must be present.	One per Discharge
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.	Must be present.	One per Discharge.
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.	Must be present.	Unlimited number per Discharge.

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.	Must be present.	Unlimited number per Discharge.
Record Type '45'	*Record Type '45'* contains principal medical information such as principal 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.	Must be present.	One per Discharge.
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.	Must be present.	Unlimited number per Discharge.
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.	Must be present.	Unlimited number per Discharge.
Record Type '80'	*Record Type '80'* reports physician information for the patient. This record is provided once for each patient discharge.	Must be present.	One per Discharge.
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.	Must be present.	One per Discharge.

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.	Must be present.	One per File.
Record Type '99'	*Record Type '99'* is a control record. This is the last record of the submission and occurs only once per submission.	Must be present.	One per File.

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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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '01'	Text	2	- Must be first record on file - Must be 01	A
2	Submitter EIN	Text	9	- Must be present - Must be numeric - Must not include a hyphen	Note
3	Submitter Name	Text	100	- Must be present	Note
4	Receiver Identification	Text	5	- Must be present - Must be CHIA	Note
5	Processing Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must not be later than today's date	Note
6	Reel Number (Submission Number)	Text	2	- Must be numeric - Must be present	Note

RECORD TYPE 10 - PROVIDER DATA

- Required for every file.
- Only one allowed per file.
- Must follow RT 01 and be followed by RT 20.
- Record Type = 10

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '10'	Text	2	- Must be first record following Label Record Type '01' - Must be 10	A
2	Type of Batch	Text	2	- Must be present and a valid code as specified in Inpatient Data Code Tables(5)	Note
3	Batch Number	Text	2	- Must be present - Must be numeric	Note
4	Provider Telephone No.	Text	10	- Must be present	Note
5	Provider Name	Text	100	- Must be present	A
6	Provider Address	Text	100	- Must be present	Note
7	Provider City	Text	15	- Must be present	Note

8	Provider State	Text	2	- Must be present	Note
9	Provider Zip	Text	9	- Must be present	Note
10	Period Starting Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must be the first day of the **quarter** for which data is being submitted	A
11	Period Ending Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must be later than Starting Date - Must be the last day of the **quarter** for which data is being submitted	A
12	Organization ID for Provider	Text	7	- Must be present - Must be a valid Organization ID as assigned by the Center for Health Information and Analysis (CHIA)	A

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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '20'	Text	2	- Must be first record following Provider Record Type '10' or follow Patient Control Record Type '90' - Must be 20	A
2	Medical Record Number	Text	25	- Must be present	A
3	Patient Sex at Birth	Text	8	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(a)	A
4	Patient Birthday (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must not be later than date of admission	A

5	Marital Status Code	Text	1	- If present must be a valid code as specified in Inpatient Data Code Tables(1)(b)	Note
6	Patient Employer Zip Code	Text	9	- Must be present, if applicable - Must be numeric - Must be a valid US postal zip code	Note
7	Type of Admission	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(c)	B
8	Primary Source of Admission	Text	1	- Must be present - Must be a 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
9	Secondary Source of Admission	Text	1	- Must be present, if applicable - Must be a 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	Massachusetts Transfer Hospital Organization ID (OrgID)	Text	7	- Must be a valid OrgID if Primary or Secondary Source of Admission is: ‘4’ (Transfer from an Acute Hospital) ‘5’ (Transfer from a SNF Facility) ‘6’ (Transfer from an Intermediate Care Facility) ‘7’ (Outside Hospital Emergency Room Transfer) ‘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) ‘V’ (Transfer from another facility to a Medicare-approved swing bed and the provider from which the transfer occurred is in Massachusetts) - Transfer OrgID should not be the OrgID for Provider on RT10 or the Hospital Service Site on RT20 - Must be a valid OrgID as specified in the Transfer OrgID list posted on CHIA’s website if the provider from which the transfer occurred is in Massachusetts OR - If the provider from which the transfer occurred is outside Massachusetts, the transfer OrgID must be 9999999	B
11	Admission Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format	A

12	Discharge Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - 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 Type 10	A
13	Veterans Status	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(h)	B
14	Primary Source of Payment	Text	3	- Must be present - Must be a 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
15	Patient Status	Text	2	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(e)	A
16	Billing Number	Text	25	- Must be present - First digit must not be blank - May include alpha, numeric slash (/) or dash (-), but no special characters	A

17	Primary Payer Type	Text	1	- Must be present - Must be a 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
18	Patient Social Security Number	Text	9	- Must be present - Must be a valid social security number or '000000001' if unknown	B
19	Birth Weight-grams	Text	4	- 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
20	DNR Status	Text	1	- May be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(i)	Note

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21	Secondary Payer Type	Text	1	- Must be present - Must be a valid code 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
22	Secondary Source of Payment	Text	3	- Must be present if secondary payer type is other than ‘N’ (None) - Must be a 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)	
23	Mother’s Social Security Number	Text	9	- Must be present for newborn or if age is less than 1 year - Must be a valid social security number or ‘000000001’ if unknown	B
24	Mother’s Medical Record Number	Text	25	- Must be present for newborns born in the hospital	A

25	Primary National Payer Identification Number	Text	10	- May be present when available	
26	Secondary National Payer Identification Number	Text	10	- May be present when available	
27	ED Flag	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(j)	A
28	Outpatient Observation Stay Flag	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(1)(k)	A
29	Hospital Service Site Reference	Text	7	- Must be present if provider is approved to submit multiple campuses in one file - Must be a valid Organization ID as assigned by CHIA	A
30	Homeless Indicator	Text	8	- If applicable, must be a valid code as specified in Inpatient Data Code Tables(1)(l)	B

31	Medicaid Claim Certificate Number (New MMIS ID/ Medicaid ID)	Text	12	- Must be present if primary or secondary Payer Type Code is '4' (Medicaid) or 'H' (Health Safety Net) as specified 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 - Must not start with a zero - If present, must be numeric characters, length must be 12	A
32	Patient Last Name	Text	35	- Must be present	A
33	Patient First Name	Text	25	- Must be present	A

RECORD TYPE 25 – PATIENT ADDRESS AND ETHNICITY DATA

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '25'	Text	2	- Must be first record following Provider Record Type '20' - Must be 25	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record number from Discharge Record Type '20'	A
3	Permanent Patient Street Address	Text	100	- Must be present when Patient Country (RT 25 Field 7) is 'US' unless Homeless Indicator is 'Y'	B
4	Permanent Patient City/Town	Text	25	- Must be present when Patient Country (RT 25 Field 7) is 'US'	B
5	Permanent Patient State	Text	2	- Must be present when Patient Country (RT 25 Field 7) is 'US' - Must be a valid US postal code for state	B

6	Permanent Patient Zip Code	Text	9	- 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 (RT 25 Field 7) is not 'US'	B
7	Permanent Patient Country	Text	2	- Must be present - Must be a valid International Standards Organization (ISO-3166) 2-digit country code	B
8	Temporary US Patient Street Address	Text	100	- Must be present when Patient Country (Record Type 25 Field 7) is not 'US'	B
9	Temporary US Patient City/Town	Text	25	- Must be present when Patient Country (Record Type 25 Field 7) is not 'US'	B
10	Temporary US Patient State	Text	2	- Must be present when Patient Country (Record Type 25 Field 7) is not 'US' - Must be a valid US postal code for state	B
11	Temporary US Patient Zip Code	Text	9	- 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	Text	8	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(2)(a)	B
13	Race 2	Text	8	- May only be entered if Race 1 is entered - If present, must be a valid code as specified in Inpatient Data Code Tables(2)(a)	B
14	Other Race	Text	15	- May only be entered if Race 1 is entered - Must be entered if Race 1 is OTH – Other Race	B
15	Hispanic Indicator	Text	8	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(2)(b)	B
16	Ethnicity 1	Text	8	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(2)(c)	B
17	Ethnicity 2	Text	8	- May only be entered if Ethnicity 1 is entered. -If present, must be a valid code as specified in Inpatient Data Code Tables(2)(c)	B
18	Other Ethnicity	Text	20	- May only be entered if Ethnicity 1 is entered	B

19	Health Plan Member ID	Text	40	- 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

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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '30'	Text	2	- Must be first record following Discharge Record Type '25' or must follow previous Record Type '30' - Must be 30	A
2	Sequence	Text	2	- 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	Text	25	- Must be present - Must equal Medical Record number from Discharge Record Type '20'	A

	Accommodations 1♦		20		A
4	Revenue Code (Accommodations)	Text	4	- If present must be a valid code as specified in Inpatient Data Code Tables(3)	A
5	Units of Service (Accom. Days)	Text	6	- Must be present if related Revenue Code is present - Must be numeric	A
6	Total Charges (Accom.)	Text	10	- Must be present if related Revenue Code is present - Must exceed one dollar - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is recorded as 151. - Accumulate Total Charges (Accom.) for balancing against Total Charges (All Charges) in Patient Control Record Type '90'	A
7	Accommodations 2++		20	- May only be present if Accommodations 1 present+ - Same as Accommodations 1	A
8	Accommodations 3++		20	- May only be present if Accommodations 2 present+ - Same as Accommodations 1	A

9	Accommodations 4++		20	- May only be present if Accommodations 3 present+ - Same as Accommodations 1	A
10	Accommodations 5++		20	- May only be present if Accommodations 4 present+ - Same as Accommodations 1	A
11	Leave of Absence Days	Numeric	3	- If present, must be less than total length of stay	A

♦ Accommodations may occur up to 5 times.

+ Accommodations 1 - 5 are required as applicable.

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

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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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '40'	Text	2	- Must be first record following last occurrence of IP Accommodations Record Type '30' or following previous Record Type '40' - Must be 40	A
2	Sequence	Text	2	- 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	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
	Ancillaries 1♦		20		A
4	Revenue Code (Ancillary)	Text	4	- If present must be a valid code as specified in Inpatient Data Code Tables(3)	A
5	Units of Service (Ancillary)	Text	6	- Must be present if related Revenue Code is present - Must be numeric - Must be greater than zero if Revenue Code 762 or 769 are present	A
6	Total Charges (Service)	Text	10	- Must be present if related Revenue Code is present - Must exceed one dollar - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is recorded as 151. - Accumulate Total Charges (Service) for balancing against Total Charges (Ancillaries) in Patient Control Record Type '90'	A

7	Ancillaries 2⁺⁺		20	- May only be present if Ancillaries 1 is present⁺ - Same as Ancillaries 1	A
8	Ancillaries 3⁺⁺		20	- May only be present if Ancillaries 2 is present⁺ - Same as Ancillaries 1	A
9	Ancillaries 4⁺⁺		20	- May only be present if Ancillaries 3 is present⁺ - Same as Ancillaries 1	A
10	Ancillaries 5⁺⁺		20	- May only be present if Ancillaries 4 is present⁺ - Same as Ancillaries 1	A

♦ Ancillaries may occur up to 5 times.

⁺ Ancillaries 1 - 5 are required as applicable.

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

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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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '45'	Text	2	- Must be first record following last occurrence of Ancillary Services Record Type '40' - Must be 45	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
3	Principal External Cause Code	Text	7	- 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)	B

				- 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	
4	Principal Diagnosis Code	Text	7	- Must be present - Must be a valid ICD-10-CM code* (exclude decimal point) - Must not be an ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	A
5	Admitting Diagnosis Code	Text	7	- Must be present - Must be a valid ICD-10-CM code* (exclude decimal point) - Must not be an ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	B
6	Discharge Diagnosis Code	Text	7	- Must be present - Must be a valid ICD-10-CM code* (exclude decimal point) - Must not be an ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	Note

7	Condition Present on Admission – Principal External Cause Code	Text	1	- Must be present when Principal External Cause Code is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
8	Condition Present on Admission – Principal Diagnosis Code	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
9	Principal Procedure Code	Text	7	- If entered must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
10	Date of Principal Procedure (CCYYMMDD)	Text	8	- Must be present if Principal Procedure code is present - Must be valid date and format - 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	ICD Indicator	Text	1	- International Classification of Diseases version - All ICD codes must be ICD-10 - Report ‘0’ for ICD-10	A
12	Other Caregiver	Text	1	- May be present - If present must be a valid code as specified in Inpatient Data Code Tables (4)(a)	B

13	Attending Physician/Clinician National Provider Identifier (NPI)	Text	10	- Must be present - Must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	B
14	Operating Physician/Clinician National Provider Identifier (NPI)	Text	10	- 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
15	Additional Caregiver National Provider Identifier (NPI)	Text	10	- May be present - If present, must be a valid National Provider Identifier per National Plan and Provider Enumeration System (NPPES)	B
16	Number of ANDs	Text	4	- Must not exceed total accommodation days - Must be numeric	A
17	Number of hours in ED	Text	10	- Must be present if Source of Admission is ‘R’ – Within hospital Emergency Room Transfer - Must be present if ED Flag is set to 2 - Must be numeric - Include decimal point with 2 places (for example 100.25) - May be present if Revenue Codes 045x are used or ED Flag is set to 1	B

18	Emergency Department Registration Date (CCYYMMDD)	Text	8	- 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 and format - Must be less than or equal to ED Discharge Date	B
19	Emergency Department Registration Time	Text	4	- 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 and range from 0000 to 2359	B
20	Emergency Department Discharge Date (CCYYMMDD)	Text	8	- 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 and format - Must be greater than or equal to Registration Date	B

21	Emergency Department Discharge Time	Text	4	- 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 and range from 0000 to 2359 - Must be greater than the registration time when the discharge date and registration date are equal	B

* = All ICD-10-CM codes 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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '50'	Text	2	- Must be first record following Principal Medical Information Record Type '45' - Must be 50	A
2	Sequence	Text	2	- Must be numeric - If first record following Principal Medical Information Record Type '45' sequence must = '01' - For each subsequent occurrence of Record Type '50' sequence must be incremented by one	A
3	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
4	Assoc. Diagnosis Code I	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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
5	Assoc. Diagnosis Code II	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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 III	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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	Data Type	Length	Edit Specifications	Error Type
7	Assoc. Diagnosis Code IV	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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
8	Assoc. Diagnosis Code V	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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 VI	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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	Data Type	Length	Edit Specifications	Error Type
10	Assoc. Diagnosis Code VII	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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 VIII	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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
12	Assoc. Diagnosis Code IX	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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	Data Type	Length	Edit Specifications	Error Type
13	Assoc. Diagnosis Code X	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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 XI	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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 XII	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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	Data Type	Length	Edit Specifications	Error Type
16	Assoc. Diagnosis Code XIII	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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 XIV	Text	7	- Only permitted if prior diagnosis is entered - Must be a 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	Condition Present on Admission – Assoc. Diagnosis Code I	Text	1	- Must be present when Assoc. Diagnosis Code I is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
19	Condition Present on Admission – Assoc. Diagnosis Code II	Text	1	- Must be present when Assoc. Diagnosis Code II is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
20	Condition Present on Admission – Assoc. Diagnosis Code III	Text	1	- Must be present when Assoc. Diagnosis Code III is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
21	Condition Present on Admission – Assoc. Diagnosis Code IV	Text	1	- Must be present when Assoc. Diagnosis Code IV is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
22	Condition Present on Admission – Assoc. Diagnosis Code V	Text	1	- Must be present when Assoc. Diagnosis Code V is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
23	Condition Present on Admission – Assoc. Diagnosis Code VI	Text	1	- Must be present when Assoc. Diagnosis Code VI is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
24	Condition Present on Admission – Assoc. Diagnosis Code VII	Text	1	- Must be present when Assoc. Diagnosis Code VII is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
25	Condition Present on Admission – Assoc. Diagnosis Code VIII	Text	1	- Must be present when Assoc. Diagnosis Code VIII is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
26	Condition Present on Admission – Assoc. Diagnosis Code IX	Text	1	- Must be present when Assoc. Diagnosis Code IX is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
27	Condition Present on Admission – Assoc. Diagnosis Code X	Text	1	- Must be present when Assoc. Diagnosis Code X is present - Must be valid code as specified in Inpatient Data Code Tables(4)(b)	B
28	Condition Present on Admission – Assoc. Diagnosis Code XI	Text	1	- Must be present when Assoc. Diagnosis Code XI is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
29	Condition Present on Admission – Assoc. Diagnosis Code XII	Text	1	- Must be present when Assoc. Diagnosis Code XII is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
30	Condition Present on Admission – Assoc. Diagnosis Code XIII	Text	1	- Must be present when Assoc. Diagnosis Code XIII is present - Must be a valid code as specified in Inpatient Data Code Tables(4)(b)	B
31	Condition Present on Admission – Assoc. Diagnosis Code XIV	Text	1	- Must be present when Assoc. Diagnosis Code XIV is present - Must be a valid code as specified in Inpatient Data Code Tables (4)(b)	B

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	Data Type	Length	Edit Specifications	Error Type
1	Record Type ‘60'	Text	2	- Must be first record following Medical Diagnosis Record Type '50' - Must be 60	A
2	Sequence	Text	2	- 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	
3	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A

4	Significant Procedure I	Text	7	- May only be present if Principal Procedure Code is present - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
5	Significant Proc. I Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure I code is present - Must be valid date and format - Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in Inpatient Data Code Tables(1)(d) - Must not be later than discharge date	B
6	Significant Proc. II	Text	7	- May only be present if Significant Procedure I code is present - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
7	Significant Proc. II Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure II code is present - Must be valid date and format - 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. III	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
9	Significant Proc. III Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure III code is present - Must be valid date and format - 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
10	Significant Proc. IV	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
11	Significant Proc. IV Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure IV code is present - Must be valid date and format - 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

12	Significant Proc. V	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
13	Significant Proc V Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure V code is present - Must be valid date and format - 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. VI	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
15	Significant Proc. VI Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure VI code is present - Must be valid date and format - 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

16	Significant Proc. VII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
17	Significant Proc. VII Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure VII code is present - Must be valid date and format - 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
18	Significant Proc. VIII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
19	Significant Proc. VIII Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure VIII code is present - Must be valid date and format - 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. IX	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
21	Significant Proc. IX Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure IX code is present - Must be valid date and format - 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
22	Significant Proc. X	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
23	Significant Proc. X Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure X code is present - Must be valid date and format - 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

24	Significant Proc. XI	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
25	Significant Proc. XI Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure XI code is present - Must be valid date and format - 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. XII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
27	Significant Proc. XII Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure XII code is present - Must be valid date and format - 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

28	Significant Proc. XIII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code - Must be valid for patient sex - Must agree with ICD Indicator	A
29	Significant Proc. XIII Date (CCYYMMDD)	Text	8	- Must be present if Significant Procedure XIII code is present - Must be valid date and format - 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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '80'	Text	2	- Must be first record following Medical Procedure Record Type ‘60’ - Must be 80	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Patient Record Type '20'	A
3	Attending Physician License Number (Board of Registration in Medicine Number)	Text	25	- 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

4	Operating Physician for Principal Procedure (Board of Registration in Medicine Number)	Text	25	- 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
5	Operating Physician for Significant Procedure I (Board of Registration in Medicine Number)	Text	25	- 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
6	Operating Physician for Significant Procedure II (Board of Registration in Medicine Number)	Text	25	- 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
7	Operating Physician for Significant Procedure III (Board of Registration in Medicine Number)	Text	25	- 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

8	Operating Physician for Significant Procedure IV (Board of Registration in Medicine Number)	Text	25	- 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
9	Operating Physician for Significant Procedure V (Board of Registration in Medicine Number)	Text	25	- 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
10	Operating Physician for Significant Procedure VI (Board of Registration in Medicine Number)	Text	25	- 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
11	Operating Physician for Significant Procedure VII (Board of Registration in Medicine Number)	Text	25	- 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

12	Operating Physician for Significant Procedure VIII (Board of Registration in Medicine Number)	Text	25	- 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
13	Operating Physician for Significant Procedure IX (Board of Registration in Medicine Number)	Text	25	- 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
14	Operating Physician for Significant Procedure X (Board of Registration in Medicine Number)	Text	25	- 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
15	Operating Physician for Significant Procedure XI (Board of Registration in Medicine Number)	Text	25	- 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

16	Operating Physician for Significant Procedure XII (Board of Registration in Medicine Number)	Text	25	- 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
17	Operating Physician for Significant Procedure XIII (Board of Registration in Medicine Number)	Text	25	- 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
18	Operating Physician for Significant Procedure XIV (Board of Registration in Medicine Number)	Text	25	- 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

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	Data Type	Length	Edit Specifications	Error Type
1	Record Type '90'	Text	2	- Must be first record following Physician Data Record Type ‘80’	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Patient Record Type '20'	A
3	Physical Record Count	Text	3	- Must equal total number of all Records Type '20', ‘25’, '30', ‘40’, '45', '50', ‘60’ and ‘80’ - Must be numeric	A
4	Record Type 20 Count	Text	2	- Must equal number of Record Type '20' records - Must = '01’ - Must be numeric	A

5	Record Type 25 Count	Text	2	- Must equal number of Record Type '25' records - Must = '01' - Must be numeric	A
6	Record Type 30 Count	Text	2	- Must equal number of Record Type '30' records - Must be numeric	A
7	Record Type 40 Count	Text	2	- Must equal number of Record Type '40' records - Must be numeric	A
8	Record Type 45 Count	Text	2	- Must equal number of Record Type '45' records - Must be numeric - Must = '01'	A
9	Record Type 5x Count	Text	2	- Must equal number of Record Type '50' records - Must be numeric - Must = '01'	A
10	Record Type 6x Count	Text	2	- Must equal number of Record Type '60' records - Must be numeric - Must = '01'	A
11	Record Type 8x Count	Text	2	- Must equal number of Record Type '80' records - Must be numeric - Must = '01'	A

12	Total Charges Special Services	Text	10	- Must be numeric - Must be whole numbers, no decimals	A
13	Total Charges Routine Services	Text	10	- Must be numeric - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is recorded as 151.	A
14	Total Charges Ancillaries	Text	10	- Must equal sum of Total Charges (Services) from Ancillary Services Record Type '40' records - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is recorded as 151.	A
15	Total Charges (All Chgs)	Text	12	- 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 EXAMPLE: 150.00 is reported as 150; 150.70 is recorded as 151.	A

RECORD TYPE 95 – PROVIDER BATCH CONTROL

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '95'	Text	2	- Must follow Patient Control Record Type '90'	A
2	Type of Batch	Text	2	- Must be present and must be valid code as specified in Inpatient Data Code Tables(5)	Note
3	Number of Discharges	Text	6	- Must equal number of Patient Control Record Type '90' records - Must be numeric	A
4	Total Days	Text	10	- Must equal total accommodation days from all Record Type '30’ records - Must be numeric	Note

5	Total Charges Accommodations	Text	12	- 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 EXAMPLE: 150.00 is reported as 150; 150.70 is recorded as 151.	A
6	Total Charges Ancillaries	Text	12	- Must equal sum of Total Charges Ancillaries from Patient Control Record Type '90' records - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is recorded as 151.	A

RECORD TYPE 99 – FILE CONTROL

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '99'	Text	2	- Must follow Provider Batch Control Record Type '95'	A
2	Submitter EIN	Text	9	- Must equal Submitter EIN from Label Record Type '01' record	Note
3	No. of Providers on File	Text	1	- Must equal number of Provider Record Type '10' records - Must be numeric - Must = ‘1’	Note
4	Count of Batches	Text	1	- Must equal number of Provider Batch Control Record Type '95' records - Must be numeric - Must = ‘1’	Note

5	Batch Type ‘11’ Count	Text	1	- Must equal total number of Record Type '95' records where Batch Type = 11 - Must be numeric - Must = ’0’	Note
6	Batch Type ‘22’ Count	Text	1	- Must equal total number of Record Type '95' records where Batch Type = 22 - Must be numeric - Must = ‘0’	Note
7	Batch Type ‘33’ Count	Text	1	- Must equal total number of Record Type '95' records where Batch Type = 33 - Must be numeric - Must = ‘0’ or ‘1’	Note
8	Batch Type ‘99’ Count	Text	1	- Must equal total number of Record Type '95' records where Batch Type = 99 - Must be numeric - Must = ‘0’ or ‘1’	Note

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 ensuring 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 in 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 which encompasses the data 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. If date is 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. 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 '2 - 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 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, Transferred from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer or Ambulatory Surgery	Yes	2, J 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 (i.e., 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 before 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. The code for 'Not applicable' should be used for patients who have not turned 18 years old.

(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 spouse 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 MEID.

(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 MEID.

(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 (CHIA) 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. If the patient is homeless and does not have a ZIP Code or City, provide the ZIP Code or City of their last temporary or permanent residence.

(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. If the patient's residence is outside of the United States, or if the zip code is unknown record 0's. If the patient is homeless and does not have a ZIP Code or City, provide the ZIP Code or City of their last temporary or permanent residence.

(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.

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(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 Massachusetts Hospital Cost Report submitted to CHIA.

(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 in the Massachusetts Hospital Cost Report submitted to CHIA 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 Massachusetts Hospital Cost Report submitted to CHIA.

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 Units of Service for Ancillary Services is required for Revenue Center 762 - Observation Room and 769 - Other Observation Room. The required units 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.

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(g) ICD Indicator. The ICD codes reported 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) <u>Attending Physician License Number</u>. 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 Massachusetts Hospital Cost Report submitted to CHIA 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. They are listed in order of record type.

(1) Record Type '20'

(a)

* PATIENT SEX at BIRTH CODE	* Patient Sex at Birth Definition
M	Male
F	Female
UNK	Unknown
DONTKNOW	Don’t know
ASKU	Choose not to answer
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

(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
6	Trauma

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* SRCADM CODE	* Source of Admission Definition
0	Information Not Available
1	Direct Physician Referral
2	Within Hospital Clinic Referral
3	Direct Health Plan Referral/HMO Referral
4	Transfer from an Acute Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from Intermediate Care Facility
7	Outside Hospital Emergency Room Transfer
8	Court/Law Enforcement
9	Other (to include level 4 Nursing Facility)
F	Transfer from a Hospice Facility
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

SRCADM CODE	FOR NEWBORN:
0	Information not Available
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

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 reported 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

* PASTA CODE	* Patient Status Definition
08	Discharged/transferred to home under care of a Home IV Drug Therapy Provider
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

* PASTA CODE	* Patient Status Definition
41	Expired in a Medical Facility (e.g., hospital, SNF, ICF, or free standing hospice)
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

* PASTA CODE	* Patient Status Definition
70	Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this Code List
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

* PASTA CODE	* Patient Status Definition
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
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: See CHIA website for full Payer Codes list: http://www.chiamass.gov/hospital-data-specification-manuals/

(g) SOURCE OF PAYMENT: See CHIA website for full Payer Codes list: 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 (The code for 'Not applicable' should be used for patients who have not turned 18 years old.)
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 Flag 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 Definition
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)

Homeless Indicator Code	**Homeless Indicator Definition**
Y	Patient is known to be homeless.
N	Patient is not known to be homeless.
UNK	Unknown
DONTKNOW	Don’t know
ASKU	Choose not to answer
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

(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
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

Org Id	Organization Name
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
11466	Holy Family Hospital at Merrimack Valley, A Steward Family Hospital, Inc.
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
66	Lawrence Memorial Hospital Campus – MelroseWakefield Healthcare
85	Lowell General Hospital

Org Id	Organization Name
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
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, 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
21965	North Adams Regional Hospital
116	North Shore Medical Center, Inc. – Salem Campus
127	Saint Vincent Hospital

Org Id	Organization Name
6963	Shriners Hospitals for Children – Boston
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
75	Steward Holy Family Hospital
41	Steward Norwood Hospital
114	Steward 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
1002-5	American Indian/Alaska Native
2028-9	Asian
2054-5	Black/African American
2076-8	Native Hawaiian or other Pacific Islander
2106-3	White
OTH	Other Race
DONTKNOW	Don’t know
ASKU	Choose not to answer
UNK	Unknown
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

(b)

Hispanic Indicator Code	**Hispanic Indicator Definition**
2135-2	Patient is Hispanic
2186-5	Patient is not Hispanic
DONTKNOW	Don’t know
ASKU	Choose not to answer
UNK	Unknown
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

(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
AMER	American
BRAZ	Brazilian
CANADA	Canadian
CAPE-V	Cape Verdean
CARIB	Caribbean Islander
E-EUR	Eastern European
PORT	Portuguese
RUSSN	Russian
OTH	Other
UNK	Unknown
DONTKNOW	Don't know
ASKU	Choose not to answer
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

(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 Definition**
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)

Hospital Inpatient Discharge Data Quality Standards

(1) The data will be edited for compliance with the edit specifications set forth in the Inpatient Discharge 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 errors 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 to the CHIA according to the following schedule.

Final, complete quarterly files are due 75 days following the end of the reporting period.

Quarter	Quarter Begin & End Dates	Due Date for Preliminary File > 30 days following the close of the quarter:	Due Date for Final File > 75 days following the close of the quarter:
1	10/1 – 12/31	1/31	3/16
2	1/1 – 3/31	4/30	6/14
3	4/1 – 6/30	7/31	9/13
4	7/1 – 9/30	10/31	12/14