RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM

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STATE OF ARKANSAS
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SECTION I. AUTHORITY.

The following Rules and Regulations pertaining to the Hospital Discharge Data System are duly adopted and promulgated by the Arkansas Board of Health pursuant to the authority expressly conferred by the State of Arkansas including, without limitation, Act 670 of 1995 (the Act), as amended, the same being Ark. Code Ann. § 20-7-301 et seq. The Act established the State Health Data Clearing House within the Arkansas Department of Health. The Clearing House is mandated by the Act to acquire and disseminate health care information in order to understand patterns and trends in the availability, use and costs of health care services in the state. Subsection (h) of the Act directs the Arkansas State Board of Health to prescribe and enforce such rules and regulations as may be necessary to carry out the purpose of this Act.

SECTION II. PURPOSE.

It is the purpose of these regulations to provide direction about the required collection, submission, management and dissemination of health data.

SECTION III. DEFINITIONS.

For the purposes of these Regulations, the following words and phrases when used herein shall be construed as follows:

A. "**Act**" means the State Health Data Clearing House Act 670 of 1995, Ark. Code Ann. § 20-7-301 et seq;

B. "**Aggregate data set**" means a compilation of raw data that has been subject to a critical edit check and consists of at least a small cell count. Aggregate data sets shall not include the following data elements: hospital control number; patient control number; attending physician number, or any element which might be used to identify an individual patient;

C. "**Board" or "State Board**" means the Arkansas State Board of Health;

D. "**Confidential information**" means that information which the State Board has defined to be confidential in these regulations and procedures;

E. "**Department**" means the Arkansas Department of Health;

F. "**Director**" means the director of the Arkansas Department of Health;

G. "**Hospital**" means any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which is subject to licensure by the Arkansas Department of Health (Ark. Code Ann. § 20-9-201 et seq);

H. "**Submit,**" "**submission**" or "**submittal**" means, with respect to data, reports, surveys, statements and documents required to be filed with the Department: 1) delivery to the Arkansas Department of Health, by the close of business on the prescribed filing date, or 2) deposit with the United States Postal Service, postage prepaid, addressed to the Arkansas Department of Health, in sufficient time so that the mailed materials will arrive by the close of business on the prescribed filing date;

l. "**Guide(s)**" means the Hospital Discharge Data Submittal Guide(s) published by the Arkansas Department of Health. The Guide(s) contains technical information relating to data format, media and submittal time frames.

SECTION IV. GENDER AND NUMBER.

All terms used in any one gender or number shall be construed to include any other gender or number.

SECTION V. HOSPITAL DISCHARGE DATA SUBMITTAL.

Each Arkansas hospital shall submit patient data to the Department in a manner that complies with the provisions of the Guide(s), which includes all inpatient hospital discharges occurring on or after January 1, 1996 and all emergency department discharges on or after January 1, 2012.

SECTION VI. ADDITIONAL DATA REQUIRED TO BE SUBMITTED.

In addition to data prescribed for submission in the Guide(s), the following data must be submitted according to the schedule provided: Each hospital shall provide a complete and accurate copy of the American Hospital Association's Annual Survey to the Arkansas Department of Health or the Arkansas Hospital Association. The required submission date will be published annually with the distribution of the survey.

SECTION VII. EXTENSION OF TIME.

The State Board or the Director shall, upon a showing of good cause and if time permits, extend the time allowed for the performance of any function or duty required by the provisions of the Act or of these regulations and rules. In making any determination with regard to good cause, the Board and the Director shall give due consideration to all relevant facts and circumstances, including such considerations as the complexity of the issues or the existence of extraordinary circumstances or unforeseen events which have led to the request for an extension of time. The State Board or the Director shall act upon a request for an extension of time within thirty (30) days of receiving the written request by the hospital. Failure to act within thirty (30) days shall be deemed as a grant of the extension.

SECTION VIII. AUTHORIZED USE OF DATA.

Information reported to the Department shall not be disclosed except as authorized by the Arkansas law. See Ark. Code Ann. § 20-7-305 as amended.

SECTION IX. ACCESS TO AGGREGATE REPORTS.

All reports generated by the Department from the aggregate data set for a member of the general public are open for public inspection. The Department shall provide copies of these reports, upon request, at a cost of $.25 per page. The Department shall determine fees to be charged to cover the direct and indirect costs for providing other information requests or special compilations from aggregate data sets. The fee shall include staff time, computer time, copying costs, postage and supplies.

SECTION X. PENALTIES FOR NON-COMPLIANCE.

Ark. Code Ann. § 20-7-301 et seq. sets forth civil and criminal penalties for non-compliance with provisions of the Act and of rules and regulations adopted by the Arkansas State Board of Health to implement the Act, as follows:

A. Any person, firm, corporation, organization or institution that violates any of the provisions of Ark. Code Ann. § 20-7-301 et seq., or any rules or regulations promulgated thereunder, regarding confidentiality of information, shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not less than one hundred dollars ($100) nor more than ($500), or by imprisonment not exceeding one month, or both. Each day of violation shall constitute a separate offense.

B. Any person, firm, corporation, organization or institution knowingly violating any of the provisions of Ark. Code Ann. § 20-7-301 et seq., or any rules or regulations promulgated thereunder, shall be guilty of a misdemeanor and, upon a plea of guilty, a plea of nolo contendere or conviction, shall be fined not more than five hundred dollars ($500).

C. Every person, firm, corporation, organization or institution that violates any of the rules or regulations adopted by the Arkansas State Board of Health or that violates any provision of Act 670 may be assessed a civil penalty by the Board. The penalty shall not exceed two hundred fifty dollars ($250) for each violation. No civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-101, et seq.

SECTION XI. HEARING AND APPEAL.

Hearings and appeals will be conducted according to the Adjudication and Rule Making Sections of the Department's Administrative Procedures previously promulgated by the Department and any revisions thereto.

SECTION XII. MAINTENANCE OF REGULATIONS AND PROCEDURES.

All pages of these regulations and rules, and of the Hospital Discharge Data Submittal Guide(s), issued by the Department are dated at the bottom. As changes occur, replacement pages will be issued or replacement guide(s) will be issued. All replacement pages will be dated so that users may be certain they are referring to the most recent information.

SECTION XIII. INCORPORATION BY REFERENCE.

The following documents are hereby incorporated by reference:

A. The most recent edition of the International Classification of Diseases, Clinical Modifications. Copies are available from the National Center for Health Statistics, 3311 Toledo Road, Hyattsville, Maryland 20782 or website, www.cdc.gov/nchs/icd.htm.

B. Uniform Hospital Billing Form 2004 (UB04/CMS-1450). Copies are available from the Office of Public Affairs, Center for Medicare and Medicaid Services, Humphrey Building, Room 428-H, 200 Independence Avenue S.W., Washington, D.C. 20201 or website,

www.cms.hhs.gov/cmsforms/. All incorporated material is available for public review at the central administrative office of the Department.

SECTION XIV. SEVERABILITY.

If any provision of these Rules and Regulations or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of these Rules and Regulations which can give effect without the invalid provisions or applications, and to this end the provisions hereto are declared severable.

SECTION XV. REPEAL.

All regulations and parts of regulations in conflict herewith are hereby repealed.

CERTIFICATION

This will certify that the foregoing Rules and Regulations for the Hospital Discharge Data System were adopted by the Arkansas Board of Health at a regular session of the Board held in Little Rock Arkansas, on the 26th day of January , 2012.

_____ Secretary, Arkansas Board of Health

ARKANSAS DEPARTMENT OF HEALTH

EMERGENCY DEPARTMENT PATIENT DATABASE

HOSPITAL DISCHARGE DATA SUBMITTAL GUIDE

2012

Arkansas Department of Health (ADH)
Health Statistics Branch
Hospital Data Section
4815 West Markham Street,
Slot H19 Little Rock, AR 72205

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INTRODUCTION

A statewide Hospital Discharge Data System (HDDS) is one of the most important tools for addressing a broad range of health policy issues. Act 670 of 1995, A.C.A. 20-7-301 et seq. requires all hospitals licensed by the State of Arkansas to report health data.

In order to simplify the reporting process, the Arkansas HDDS is based on the Health Care Finance Administration (HCFA) UB-04. This Guide defines the emergency department patient data that hospitals will submit for the specific purpose of constructing the Emergency Department Patient Database (EDPD).

The ADH, Hospital Data Section can provide technical consultation and assistance. For further information, contact Lynda Lehing, Section Chief.

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1.0 DATA REPORTING SOURCE

All facilities operating and licensed as a hospital in the State of Arkansas by Arkansas Department of Health (ADH), Health Facility Services, will report patient discharge data to the ADH, Hospital Data Section for all acuity range cases performed in the emergency department. Cases already reported by the hospital in the Inpatient Data Submissions should NOT be included (e.g. those patients admitted through the emergency department). Discharge data means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single emergency department encounter. The consolidation of patient data is a patient data record and its format is defined later in this manual. A patient record is submitted for each encounter, not for each bill generated.

A hospital may submit directly to ADH, Hospital Data Section or designate a submitting intermediary. Designation of an intermediary does not relieve the hospital of its responsibility to submit and correct the information as outlined.

In order to facilitate communication and problem solving, each hospital should designate a person as contact. Please provide the office name, telephone number, job title and name of the person assigned this responsibility.

2.0 CONFIDENTIALITY OF DATA

Act 670 of 1995, A.C.A. 20-7-301 et seq. provides for the strictest confidentiality of data and severe penalties for the violation of the Act. Any information collected from hospitals which identifies a patient, provider, institution, or health plan cannot be released without promulgation of rules and regulations by the Arkansas State Board of Health in accordance with Act 670 Section (2)(g) and (h). ADH will only release data, except as allowed by law that has sufficiently masked these identities.

Since ADH needs patient specific information to complete our analyses, we will take every prudent action to ensure the confidentiality and security of the data submitted to us. Procedures include, but are not limited to, physical security and monitoring, access to the files by authorized personnel only, passwords and encryption. Not all measures taken are documented or mentioned in this Guide to further protect our data.

3.0 SUBMITTAL SCHEDULE

Patient data records will be submitted to ADH, Hospital Data Section as specified below. Each submittal should contain records for all encounters completed during the specified calendar quarter. Deadlines for data submission are 40 days after the end of the quarter for the first through third quarters and 60 days after the end of the fourth quarter.

While most hospitals will be submitting data directly to ADH, Hospital Data Section, some are utilizing third-party intermediaries. When using an intermediary, the reporting deadlines are still to be met. Refer to Section 5.7 Intermediaries for further details.

3.1 REPORTING SCHEDULE

Patients' date of discharge is:	*Discharge data must be received by:*
January 1 through March 31	QTR 1 – May 10th
April 1 through June 30	QTR 2 – August 10th
July 1 through September 30	QTR 3 – November 10th
October 1 through December 31	QTR 4 – March 1st

3.2 REQUEST FOR EXTENSION

All hospitals will submit patient data timely in a form consistent with the requirements unless an extension has been granted. Request for extension should be in writing or email and be directed to:

Arkansas Department of Health
Health Statistics Branch, Slot 19
Hospital Data Section
4815 West Markham Street
Little Rock, AR 72205
Phone (501) 661-2231
FAX (501) 661-2544
E-mail: Lynda.Lehing@arkansas.gov

The Hospital Data Section will review requests submitted to them for extensions to the reporting schedule requirement. A request for extension should be submitted at least 10 working days prior to the reporting deadline. Extensions may be granted for a maximum of 20 calendar days. Additional 20-day extensions must be requested separately. Extensions may be granted when the hospital documents that unforeseen difficulties, such as technical problems, prevent compliance.

4.0 DATA ERRORS AND CERTIFICATION

Hospitals will review the patient data records prior to submission for accuracy and completeness. Correction of invalid records and validation of aggregate tabulation are the responsibility of the hospital. All hospitals will certify the data submitted for each quarter in the manner specified.

4.1 ERROR CORRECTION

Edits that indicate a high probability of error will be highlighted for review, comment and correction when applicable. The invalid record will be printed in a simplified format providing record identification, an indication or explanation of the error, and space to record corrections. The error report will be sent by fax or email to the attention of the individual designated to receive the correspondence at the hospital. Corrected information from the hospital is to be returned within seven business days of receipt to the Hospital Data Section.

In the event one (1) percent or more of the records for a quarter are indicated as having a high probability of error, the entire submittal may be rejected. A record is in error when one or more required data elements are in error.

Notification of the rejection will accompany the error report and will be sent by fax or email to the attention of the individual designated to receive the correspondence at the hospital. After correction, the submittal is to be returned within seven business days of receipt, to the Hospital Data Section. In some situations, the Hospital Data Section staff will make corrections to the hospital's submissions, based on information obtained from hospital staff and/or internal health department databases. When this is done, notice will be given to the hospital.

5.0 DATA SUBMITTAL SPECIFICATIONS

Currently, data must be submitted via encrypted email, CD's or FTP. Alternate modes of transmission may be established by agreement with the Hospital Data Section. Data submittals not in compliance with media or format specifications will be rejected unless approval is obtained from the Hospital Data Section prior to the scheduled due date. Data submittal on physical media should be mailed to:

Arkansas Department of Health
Health Statistics Branch
Hospital Data Section
4815 West Markham Street, Slot 19
Little Rock, AR 72205

If you are submitting data for more than one hospital on one media submission, the additional specifications found in Section 5.6 Multi - Hospital Submission must be followed.

5.1 File Compression

WINZIP is the compression utility of choice by Hospital Data Section. If a compression utility other that WINZIP is used, the resulting file must be able to be unzipped by Hospital Data Section. Please contact a Hospital Data Section staff person prior to sending a file compressed with any compression software other than WINZIP.

5.2 File Encryption

Crypt-text is the freeware, encryption software that Hospital Data Section recommends. Encryption of data files sent as email attachments is required. Refer to Section 5.4 E-Mail Attachment Submissions – Secondary Submittal Format. All passwords used with encryption software will be supplied by the Hospital Data Section. Please contact a Hospital Data Section staff person for the correct password for your hospital.

5.3 File Transfer Protocol (FTP) – Primary Submittal Format (preferred)

The following specifications must be met when submitting data using the FTP:

1) The secured web site is at: http://adhftp.arkansas.gov.

B. Upload by accessing the secured web site and inputting the user name and password. (Please contact a Hospital Data Section staff person for the user name and password.)

Please note the data file name must be created in the following format, HHHHQNYYEDVN.dat, where:

(a) HHHH = Four letter identifier for the hospital,

(b) QN = Reporting quarter number,

(c) YY = Last 2 digits of the calendar year,

(d) ED = Emergency Department data,

(e) VN = Version number.

Example: HHHHQ112EDV1.dat translates as the hospital identifier HHHH, reporting quarter one or Q1, submission year 2012 or 12, data type Emergency Department or ED and version number one or V1 of data that was submitted. If you do not know the four letter identifier for the hospital, please contact a Hospital Data Section staff person for that information.

5.4 E-Mail Attachment Submissions – Secondary Submittal Format

The following specifications must be met when submitting data by email attachment via the Internet:

Hospitals must use encryption software and passwords provided by the Health Statistics Branch. Please contact a Hospital Data Section staff person for the correct password for your hospital.

1) The physical characteristics of the attached file must have the following attributes:

(a) Record Length - 239 bytes, Fixed;

(b) PC Text File (ASCII), WINZIP file or self-extracting executable file. Refer to Section 5.1 File Compression.

2) Each E-mail submission must include a general message that contains the following information:

(a) The description: 'EMERGENCY DEPARTMENT DATA' in SUBJECT field;

(b) Hospital's name;

(c) Date of submittal as MM/DD/YY;

(d) Beginning and ending dates of the reporting period (e.g., 1/1/12-3/30/12);

(e) The name and telephone number of the contact person.

3) Refer to paragraph 3), Section 5.5 CD-ROM Submittal Specifications - Server Down Submittal for 'filename.extension' naming standard for the attached file.

5.5 CD-ROM Submittal Specifications - Server Down Submittal

The following specifications must be met when submitting data on PC CD'S:

1) Hospitals will submit no more than one CD per quarter.

2) The physical characteristics of the CD Rom must have the following attributes:

   1) Record Length - 239 bytes, Fixed,

   2) ASCII, WINZIP file or self-extracting executable file.

   Note: Self-extracting executable file must run on Windows XP or higher operating system. Source and target of WINZIP or executable file must be ASCII. ASCII file must have a carriage-return (CR) and line-feed (LF) at the end of each data record.

3) All CD's must have an external label or accompanying data sheet containing the following information:

   1) The description: 'EMERGENCY DEPARTMENT DATA';

   2) Hospital's name;

   3) Date of submittal as MM/DD/YY;

   4) Reporting Quarter as QTR#,

   5) Number of records;

   6) Record format (1450);

   7) The name and telephone number of the contact person;

   8) PC extension, ASCII or ZIP or EXE (refer to paragraph D, 4);

   9) If encrypted, the description: 'ENCRYPTED' (refer to Section 5.2 - File Encryption).

   An example of the label for the case is as follows:

EMERGENCY DEPARTMENT DATA
Hospital Name:
Submission Date: mm/dd/yy
Reporting Quarter: QTR #
Total Record Count: ###### Format: ####
Contact Person _____ Phone: _____
Extension:_____
ENCRYPTED

4) Use the following 'filename.extension' file naming standard:

   1) The first two positions of the filename will be the last two digits of the calendar year,

   2) The next three characters will be 'QTR',

3) The last position must be the quarter from one through four that indicates the quarter of the calendar year of the data submitted,

4) The extension will be 'TXT' **or** 'DAT' for a PC Text file **or** 'ZIP' for a file compressed with WINZIP **or** 'EXE' for a self-extracting file.

Example: 12QTR1.TXT - ASCII data file for the first quarter of 2012

5.6 MULTI - HOSPITAL SUBMISSION

Data from more than one hospital may be submitted on one media submission as one file per hospital. Change the following items on your external label or accompanying information sheet:

1) If you are not a hospital, replace 'Hospital:' with your company name.

2) If you are a hospital or subsidiary of a hospital, replace 'Hospital:' with 'Agent:' and your hospital name.

3) If multiple files are on the submission, replace 'Total Record Count:' with 'Number of Files:'

4) The contact person and phone number should be that of the agent or company, not the hospital.

5) If multiple files are placed on a CD, the 'filename.extension' file-naming standard must change. The last two positions of the filename (follows 'QTR' and quarter number) must be the file number provided.

In addition to the above changes, a list of hospitals on the medium must be provided, with tax id, number of records, and hospital contact.

5.7 INTERMEDIARIES

Third-party intermediaries may be utilized by hospitals for the delivery of data to Hospital Data Section. To better manage data collection, intermediaries must be registered with Hospital Data Section. Additions and deletions to the intermediary's list of hospitals represented must be submitted at least 10 days prior to the reporting due date. The intermediary must specify hospitals being represented, media, formats, contacts, and length of contractual obligation.

5.7.1 Editing Intermediaries

The following additional requirements and information apply to intermediaries delivering edited data to the Hospital Data Section:

1) The data must not have an error rate greater than 1 percent.

2) Each hospital's data must be submitted in a separate file.

3) Data may be submitted on any approved media - declared at the time of registration.

4) Data may be submitted in any approved data format - declared at the time of registration.

5.7.2 Pass-Thru Intermediaries

The following additional requirements and information apply to intermediaries delivering unedited data to Hospital Data Section:

1) The data must not have an error rate greater than 1 percent.

2) Each hospital's data must be submitted in a separate file.

5.8 SUBJECT TO CHANGE

Data submission methods are always under review. If implemented, all Arkansas hospitals will receive notice of the changes to be implemented.

6.0 DATA RECORD FORMATS

The accepted data record formats are the UB-04 1450 version format. This format has altered slightly. The definition specified for each data element is in general agreement with the definition in the UB-04 Users Manual. Hospitals using data sources other than uniform billing should evaluate definitions for agreement with the definitions specified in this Guide and UB-04 Users Manual. Refer to Section 7.0 EXCEPTIONS TO 1450 FORMAT to identify possible changes to your current format. Each record must be followed by a carriage return/line feed sequence.

6.1 'UB-04-1450' RECORD SPECIFICATION

The UB-04 1450 claim "record" is made up of a series of 213-character physical records. Not all of the physical claim records are used in the Emergency Department Patient Database (EDPD), such as the Claim Request Data and Inpatient Accommodations Data. Records not specified in the EPDP will be ignored, if included in the submittal. Fields not referenced in the record formats may contain information but will not be processed by computer programs; this also includes fields reserved for national use. The exact record sequence and format of the 1450 is used for the EPDP, when possible. A complete copy of the patient's 1450 records would satisfy the requirements, with exceptions noted in Section 7.0 - EXCEPTIONS TO 1450 FORMAT. The physical records for each claim are divided into logical subsets as follows:

Subset 1	***Patient Data*** - Record Codes 20-29
Subset 2	***Third Party Data*** - Record Codes 30-39
Subset 3	***Claim Request Data*** - Record Codes 40-49
Subset 4	***Inpatient Accommodations Data*** - Record Codes 50-59
Subset 5	***Ancillary Services Data*** - Record Codes 60-69
Subset 6	***Medical Data*** - Record Codes 70-79
Subset 7	***Physician Data*** - Record Codes 80-89

The record layouts that follow will provide the following information:

1) ***Record Name***: The name of the data record.
2) ***Record Type***: Code indicating the type of record.
3) ***Record Size***: Physical length of record is a constant 213.
4) ***Required Field Annotation***: An asterisk '*' denotes the field is required and must contain data if applicable.
5) ***Field Number***: Field number as specified on the UB-04 1450 version 5 file layout. This number is not the Form Locator number found on the UB-04 1450 form.
6) ***Field Name***: Name generally used with the UB-04 1450 Form.
7) ***Picture***: This is the COBOL picture. Pic X is initialized to blanks and Pic 9 is initialized to zeroes. All money and date fields are Pic 9.
8) ***Field Specification***: Indicates how the data field is justified. L = Left justification, and R = Right justification.
9) ***Position***: From = Leftmost position in the record (high order). Thru = Rightmost position in the record (low order).
10) ***Form Locator***: Number found on the UB-04 Form and associated with the field in that location.

6.2 1450 & 1450Y2K -RECORD TYPE 10 - PROVIDER DATA

Only one type '10' record is required per hospital per submittal. Only the first type '10' record and each type '10' record following a type '95' record will be processed, all others will be

ignored. This record type will be processed as a header record and a record type '95' will be processed as a trailer record. The records encapsulated between the first type '10' and '95' will be processed using the hospital specified on the type '10' record. It is absolutely imperative that each submission includes at least one type '10' record with correct Federal Tax Number. If the Federal Tax Number is not unique to a facility or cost center, the Federal Tax Sub ID must be included.

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '10'	XX	L	1	2	
*	2	Federal Tax Number or EIN	9(10)	R	8	17	FL05
	3	Federal Tax Sub ID	X(4)	L	18	21	FL05
*	4	National Provider Identifier (Billing Provider)	X(13)	L	22	34	FL56
*	5	Medicaid Provider Number	X(13)	L	35	47	
*	6	Provider Telephone Number	9(10)	R	87	96	FL01
*	7	Provider Name	X(25)	L	97	121	FL01
*	8	Provider (Hospital) Data ID	X(4)	L	122	125	
		PROVIDER ADDRESS (FIELDS 9 – 13)			*126*	*185*	*FL01*
*	9	Address	X(25)	L	126	150	
*	10	City	X(14)	L	151	164	
*	11	State	XX	L	165	166	
*	12	Zip Code	X(9)	L	167	175	
	13	Provider Fax Number	9(10)	R	176	185	

6.3 1450-RECORD TYPE 20 - PATIENT DATA

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '20'	XX	L	1	2	
*	2	Patient Control Number	X(20)	L	5	24	FL3A
		PATIENT NAME (FIELDS 3 – 5)					*FL08*
*	3	Last Name	X(20)	L	25	44	
*	4	First Name	X(9)	L	45	53	
	5	Middle Initial	X		54	54	
		OTHER PATIENT INFORMATION (FIELDS 6 -10)					
*	6	Patient Sex	X		55	55	FL11
*	7	Patient Birth Date (mmddccyy)	9(8)	R	56	63	FL10
	8	Patient Marital Status	X		64	64	
*	9	Priority Of Admission	X		65	65	FL14
*	10	Point of Origin for Admission or Visit	X		66	66	FL15
		PATIENT ADDRESS (FIELDS 11 – 15)					*FL09*
*	11	Address Line 1	X(18)	L	67	84	
	12	Address Line 2	X(18)	L	85	102	
*	13	City	X(15)	L	103	117	
*	14	State	XX	L	118	119	
*	15	Zip Code	X(9)	L	120	128	

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
		PATIENT ADMISSION INFORMATION (FIELDS 16 – 17)					
*	16	Admission/Start of Care Date	9(6)	R	129	134	FL12
*	17	Admission Hour	XX	R	135	136	FL13
		STATEMENT COVERS PERIOD (FIELDS 18 – 19)					*FL06*
*	18	From (mmddyy)	9(6)	R	137	142	
*	19	Thru (mmddyy)	9(6)	R	143	148	
		PATIENT DISCHARGE INFORMATION (FIELDS 20 – 24)					
*	20	Patient Discharge Status	99	R	149	150	FL17
*	21	Discharge Hour	XX	R	151	152	FL16
	22	Payments Received (Patient Line)	9(8)V99S	R	153	162	FL54
	23	Estimated Amt Due (Patient Line)	9(8)V99S	R	163	167	FL55
*	24	Medical Record Number	X(17)	L	173	189	FL3B

Note: **'Admission/Start of Care Date'** should be the start of care date for this episode of care. **'Admission Hour"** should be the hour the patient was admitted to the Emergency Department. **'Statement Covers Period From'** should be the date of the first medical service of the period included on the bill related to this episode of care. **'Statement Covers Period Thru'** should be the ending service date on the bill for this episode of care or discharge date. **'Discharge Hour'** should be the hour patient was discharged from the Emergency Department. **'Payments Received'** and **'Estimated Amt Due'** should reflect a single discharge if multiple claims have been submitted.

6.4 1450Y2K-RECORD TYPE 20 - PATIENT DATA

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '20'	XX	L	1	2	
*	2	Patient Control Number	X(20)	L	5	24	FL3A
		PATIENT NAME (FIELDS 3 – 5)					*FL08*
*	3	Last Name	X(20)	L	25	44	
*	4	First Name	X(9)	L	45	53	
	5	Middle Initial	X		54	54	
		OTHER PATIENT INFORMATION (FIELDS 6 – 10)					
*	6	Patient Sex	X		55	55	FL11
*	7	Patient Birth Date (ccyymmdd)	9(8)	R	56	63	FL10
	8	Patient Marital Status	X		64	64	
*	9	Priority Of Admission	X		65	65	FL14
*	10	Point of Origin for Admission or Visit	X		66	66	FL15
		PATIENT ADDRESS (FIELDS 11 – 15)					*FL09*
*	11	Address Line 1	X(18)	L	67	84	
	12	Address Line 2	X(18)	L	85	102	
*	13	City	X(18)	L	103	120	
*	14	State	XX	L	121	122	

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	15	Zip Code	X(9)	L	123	131	
		PATIENT ADMISSION INFORMATION (FIELDS 16 -17)					
*	16	Admission Date/Start of Care Date	9(8)	R	132	139	FL12
*	17	Admission Hour	XX	R	140	141	FL13
		STATEMENT COVERS PERIOD (FIELDS 18 – 19)					*FL06*
*	18	From (ccyymmdd)	9(8)	R	142	149	
*	19	Thru (ccyymmdd)	9(8)	R	150	157	
		PATIENT DISCHARGE INFORMATION (FIELDS 20 – 24)					
*	20	Patient Status	99	R	158	159	FL17
*	21	Discharge Hour	XX	R	160	161	FL16
	22	Payments Received (Patient Line)	9(8)V99S	R	162	171	FL54
	23	Estimated Amt Due (Patient Line)	9(8)V99S	R	172	181	FL55
*	24	Medical Record Number	X(17)	L	182	198	FL3B

Note: **'Admission/Start of Care Date'** should be the start of care date for this episode of care. **Admission Hour"** should be the hour the patient was admitted to the Emergency Department. **'Statement Covers Period From'** should be the date of the first medical service of the period included on the bill related to this episode of care. **'Statement Covers Period Thru'** should be the ending service date on the bill for this episode of care or discharge date. **'Discharge Hour'** should be the hour patient was discharged from the Emergency Department. **'Payments Received'** and **'Estimated Amt Due'** should reflect a single discharge if multiple claims have been submitted.

6.5 1450 & 1450Y2K -RECORD TYPE 27 - HEALTH DEPT. SPECIFIC DATA

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '27'	XX	L	1	2	
*	2	Sequence '01'	99		3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL03
*	4	Type of Bill	X(3)	L	25	27	FL04
	5	Patient Social Security Number	9(10)	R	28	37	
*	6	Patient Race	X		38	38	
*	7	Patient Ethnicity	X		39	39	
	8	Filler (Empty Fields)			40	43	
*	9	Total Charges	9(8)V99S	R	44	53	
	10	Estimated Collection rate	999	R	54	56	
	11	Charitable / Donation rate	999	R	57	59	
	12	Trauma Band Number	X(7)	L	60	66	

6.6 1450 & 1450Y2K RECORD TYPES 30-31 - THIRD PARTY PAYER DATA

The use of these record types for the Hospital Discharge Data System is the same as the UB-04 claim. When reporting for Hospital Discharge Data System, records may need to be consolidated and amounts accumulated by payer. Below are specifications and an example as taken from UB-04.

One third party payer record packet must appear in the bill record for each payer involved in the bill. Each third party payer packet must contain a record type 30. However, each record type 30 may or may not have an associated record type 31, depending on the specific third party payer data required by the particular payer.

Example: Medicare is primary, and the secondary payer requires the insured's address.

	Record Type Code	Seq.No.
Medicare	30	01
Secondary Payer	30	02
Secondary Payer	31	02

Because the sequence number of the type 31 record for the secondary payer matches the sequence number of the secondary payer's type 30 record, it serves as a matching criterion for the specific third party payer record packet.

Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

6.6.1 1450 & 1450Y2K Record Type 30 - Third Party Payer

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '30'	XX	L	1	2	
*	2	Sequence Number	99	R	3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL03
*	4	Source of Payment Code	X		25	25	
	5	Health Plan ID	X(9)	L	26	34	FL51
*	6	Insured's Unique ID	X(19)	L	35	53	FL60
	7	Insurance Group Number	X(17)	L	80	96	FL62
	8	Insured Group Name	X(14)	L	97	110	FL61
	INSURED'S NAME (FIELDS 9-11)						FL58
	9	Last Name	X(20)	L	111	130	
	10	First Name	X(9)	L	131	139	
	11	Middle Initial	X		140	140	
	12	Insured Sex	X		141	141	
	13	Patient Relationship to Insured	99	R	144	145	FL59
	14	Employment Status Code	9		146	146	
	15	Payments Received	9(8)V99S	R	173	182	FL54
	16	Estimated Amount Due	9(8)V99S	R	183	192	FL55

Note: **'Payments Received'** and **'Estimated Amt Due'** should reflect a single discharge if multiple claims have been submitted.

6.6.2 1450 & 1450Y2K Record Type 31 - Third Party Payer

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '31'	XX	L	1	2	
*	2	Sequence Number	99	R	3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL03
		INSURED'S ADDRESS (FIELDS 4-8)					
	4	Address Line 1	X(18)	L	25	42	
	5	Address Line 2	X(18)	L	43	60	
	6	City	X(15)	L	61	75	
	7	State	XX	L	76	77	
	8	Zip Code	X(9)	L	78	86	
	9	Employer Name	X(24)	L	87	110	FL65
		EMPLOYER LOCATION (FIELDS 10-13)					
	10	Employer Address	X(18)	L	111	128	
	11	Employer City	X(15)	L	129	143	
	12	Employer State	XX	L	144	145	
	13	Employer Zip Code	X(9)	R	146	154	

6.7 1450 & 1450Y2K-RECORD TYPE 60 - ANCILLARY SERVICES DATA

The sequence number for record type 60 can go from 01 to 99; each such physical record contains up to three ancillary service codes, thus making provision for reporting up to 297 ancillary services on a single claim. Payer and related information revenue codes: codes 001 – 099. Ancillary services revenue codes: codes 220 – 99x.

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '60'	XX	L	1	2	
*	2	Sequence Number	99	R	3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL03
		ANCILLARY SERVICES DATA (OCCURS 3 TIMES)					
		ANCILLARIES 1	***X(56)***		***25***	***80***	
*	4	Revenue Code	9(4)	R	25	28	FL42
	5	HCPCS / Procedure Code	X(5)	L	29	33	
	6	Modifier 1 (HCPCS & CPT 4)	X(2)	L	34	35	
	7	Modifier 2 (HCPCS & CPT 4)	X(2)	L	36	37	
*	8	Units of Service	9(7)	R	38	44	FL46
*	9	Total charges by Revenue Code	9(8)V99S	R	45	54	FL47
	10	Non-covered Charges by Revenue Code	9(8)V99S	R	55	64	FL48
		ANCILLARIES 2	***X(56)***		***81***	***136***	
*	11	Revenue Code	9(4)	R	81	84	FL42
	12	HCPCS / Procedure Code	X(5)	L	85	89	

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
	13	Modifier 1 (HCPCS & CPT 4)	X(2)	L	90	91	
	14	Modifier 2 (HCPCS & CPT 4)	X(2)	L	92	93	
*	15	Units of Service	9(7)	R	94	100	FL46
*	16	Total Charges by Revenue Code	9(8)V99S	R	101	110	FL47
	17	Non-covered Charges by Revenue Code	9(8)V99S	R	111	120	FL48
	ANCILLARIES 3		*X(56)*		*137*	*192*	
*	18	Revenue Code	9(4)	R	137	140	FL42
	19	HCPCS / Procedure Code	X(5)	L	141	145	
	20	Modifier 1 (HCPCS & CPT 4)	X(2)	L	146	147	
	21	Modifier 2 (HCPCS & CPT 4)	X(2)	L	148	149	
*	22	Units of Service	9(7)	R	150	156	FL46
*	23	Total Charges by Revenue Code	9(8)V99S	R	157	166	FL47
	24	Non-covered Charges by Revenue Code	9(8)V99S	R	167	176	FL48

Note: Identical revenue codes should be combined and their charges added together for reporting purposes.

6.8 1450-RECORD TYPE 70 SEQUENCES 1, 2, & Y2K - MEDICAL DATA

6.8.1 Sequence 1 – 1450 &1450Y2K

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '70'	XX	L	1	2	
*	2	Sequence '01'	XX	R	3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL03
*	4	Principal Diagnosis Code	X(7)	L	25	31	FL67
*	5	Other Diagnosis Code 1	X(7)	L	32	38	FL67A
*	6	Other Diagnosis Code 2	X(7)	L	39	45	FL67B
*	7	Other Diagnosis Code 3	X(7)	L	46	52	FL67C
*	8	Other Diagnosis Code 4	X(7)	L	53	59	FL67D
*	9	Other Diagnosis Code 5	X(7)	L	60	66	FL67E
*	10	Other Diagnosis Code 6	X(7)	L	67	73	FL67F
*	11	Other Diagnosis Code 7	X(7)	L	74	80	FL67G
*	12	Other Diagnosis Code 8	X(7)	L	81	87	FL67H
*	13	Other Diagnosis Code 9	X(7)	L	88	94	FL67I
*	14	Other Diagnosis Code 10	X(7)	L	95	101	FL67J
*	15	Other Diagnosis Code 11	X(7)	L	102	108	FL67K
*	16	Other Diagnosis Code 12	X(7)	L	109	115	FL67L
*	17	Other Diagnosis Code 13	X(7)	L	116	122	FL67M
*	18	Other Diagnosis Code 14	X(7)	L	123	129	FL67N
*	19	Other Diagnosis Code 15	X(7)	L	130	136	FL67O
*	20	Other Diagnosis Code 16	X(7)	L	137	143	FL67P
*	21	Other Diagnosis Code 17	X(7)	L	144	150	FL67Q
*	22	Other Diagnosis Code 18	X(7)	L	151	157	
*	23	Other Diagnosis Code 19	X(7)	L	158	164	

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	24	Other Diagnosis Code 20	X(7)	L	165	171	
*	25	Other Diagnosis Code 21	X(7)	L	172	178	
*	26	Other Diagnosis Code 22	X(7)	L	179	185	
*	27	Other Diagnosis Code 23	X(7)	L	186	192	
*	29	Other Diagnosis Code 24	X(7)	L	193	199	
*	30	Other Diagnosis Code 25	X(7)	L	200	206	
*	31	Other Diagnosis Code 26	X(7)	L	207	213	

6.8.2 Sequence 2 - 1450

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '70'	XX	L	1	2	
*	2	Sequence '02'	XX	R	3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL3A
*	4	Principal Procedure Code	X(8)	L	25	32	FL74
*	5	Principal Procedure Code Data (mmddyy)	X(6)	L	33	38	
*	6	Other Procedure Code 1	X(8)	L	39	46	FL74A
*	7	OPC 1 – Date (mmddyy)	X(6)	R	47	52	
*	8	Other Procedure Code 2	X(8)	L	53	60	FL74B
*	9	OPC 2 – Date (mmddyy)	X(6)	R	61	66	
*	10	Other Procedure Code 3	X(8)	L	67	74	FL74C
*	11	OPC 3 – Date (mmddyy)	X(6)	R	75	80	
*	12	Other Procedure Code 4	X(8)	L	81	88	FL74D
*	13	OPC 4 – Date (mmddyy)	X(6)	R	89	94	
*	14	Other Procedure Code 5	X(8)	L	95	102	FL74E
*	15	OPC 5 – Date (mmddyy)	X(6)	R	103	108	
*	16	Other Procedure Code 6	X(8)	L	109	116	
*	17	OPC 6 – Date (mmddyy)	X(6)	R	117	122	
*	18	Other Procedure Code 7	X(8)	L	123	130	
*	19	OPC 7 – Date (mmddyy)	X(6)	R	131	136	
	20	Filler (Empty Fields)			137	153	
*	21	Reason for Visit	X(8)	L	153	160	FL70
*	22	External Cause of Injury Code 1	X(8)	L	161	168	FL72A
*	23	External Cause of Injury Code 2	X(8)	L	169	176	FL72B
*	24	External Cause of Injury Code 3	X(8)	L	177	184	FL72C
*	25	External Cause of Injury Code 4	X(8)	L	185	192	
*	27	External Cause of Injury Code 5	X(8)	L	193	200	
*	28	External Cause of Injury Code 6	X(8)	L	201	208	
*	29	Procedure Coding Method Used	9(1)		209	209	

6.8.3 Sequence 2 – 1450Y2K

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '70'	XX	L	1	2	
*	2	Sequence '02'	XX	R	3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL3A
*	4	Principal Procedure Code	X(8)	L	25	32	FL74
*	5	Principal Procedure Code Date (ccyymmdd)	X(8)	L	33	40	
*	6	Other Procedure Code 1	X(8)	L	41	48	FL74A
*	7	OPC 1 – Date (ccyymmdd)	X(8)	R	49	56	
*	8	Other Procedure Code 2	X(8)	L	57	64	FL74B
*	9	OPC 2 – Date (ccyymmdd)	X(8)	R	65	72	
*	10	Other Procedure Code 3	X(8)	L	73	80	FL74C
*	11	OPC 3 – Date (ccyymmdd)	X(8)	R	81	88	
*	12	Other Procedure Code 4	X(8)	L	89	96	FL74D
*	13	OPC 4 – Date (ccyymmdd)	X(8)	R	97	104	
*	14	Other Procedure Code 5	X(8)	L	105	112	FL74E
*	15	OPC 5 – Date (ccyymmdd)	X(8)	R	113	120	
*	16	Other Procedure Code 6	X(8)	L	121	128	
*	17	OPC 6 – Date (ccyymmdd)	X(8)	R	129	136	
*	18	Other Procedure Code 7	X(8)	L	137	144	
*	19	OPC 7 – Date (ccyymmdd)	X(8)	R	145	152	
	20	FILLER (empty fields)			153	159	
*	21	Reason for Visit Code	X(8)	L	160	167	FL70
*	21	External Cause of Injury Code 1	X(8)	L	168	175	FL72
*	22	External Cause of Injury Code 2	X(8)	L	176	183	FL72
*	23	External Cause of Injury Code 3	X(8)	L	184	191	FL72
*	25	External Cause of Injury Code 4	X(8)	L	192	199	
*	27	External Cause of Injury Code 5	X(8)	L	200	207	
*	28	External Cause of Injury Code 6	X(8)	L	208	215	
*	29	Procedure Coding Method Used	9(1)		216	216	

6.9 FOR BOTH 1450 & 1450Y2K

ICD 9 CM is required for diagnosis coding. Do not report the decimal in the code. The ICD 9 CM diagnosis codes are assigned a COBOL picture of X. Format the actual code in one of four general ways, as follows:

1) If you report 99999, it translates to 999.99.

2) If you report V9999, it translates to V99.99.

3) If you report E9999, it translates to E999.9.

4) If you report M99999, it translates to M9999/9.

To determine the location of the decimal position and the potential number of decimal positions it is necessary only to examine the high order (left most) position of the field.

6.10 1450 & 1450Y2K-RECORD TYPE 80 – 8N – PHYSICIAN DATA

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '80'	XX	L	1	2	
*	2	Sequence	99	R	3	4	
*	3	Patient Control Number	X(20)	L	5	24	FL03
	4	Filler (Empty Space)			25	26	
*	5	Attending Provider Identifier	X(16)	L	27	42	FL76
*	6	Operating Physician Identifier	X(16)	L	43	58	FL77
*	7	Other Physician Identifier	X(16)	L	59	74	FL78
*	8	Other Physician Identifier	X(16)	L	75	90	FL79
*	9	Attending Provider Name	X(25)	L	91	115	
		Last Name	X(16)	L	91	106	
		First Name	X(8)	L	107	114	
		Middle Initial	X		115	115	
	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
	10	Operating Physician Name	X(25)	L	116	140	
	11	Other Physician Name	X(25)	L	141	165	
	12	Other Physician Name	X(25)	L	166	190	

6.11 1450 & 1450Y2K-RECORD TYPE 95 -PROVIDER BATCH CONTROL

Only one type '95' is allowed per hospital per submittal. The Federal Tax Number must match the type '10' record. This record type will be processed as a trailer record. A record type '10' will be processed as a header record. The records encapsulated between the first type '10' and '95' will be processed using the hospital specified on the type '10' record.

	FIELD NO.	NAME	PICTURE	SPEC	POSITION FROM	POSITION THRU	FORM LOCATOR
*	1	Record Type '95'	XX	L	1	2	
*	2	Federal Tax Number (EIN)	9(10)	R	3	12	FL05
		Federal Tax Sub ID	X(4)	L	13	16	FL05
*	3	Number of Claims	9(6)	R	25	30	

Note: Federal Tax Sub ID must be the same as specified on the type '10' record. **'Number of Claims'** should be the number of discharges in the batch (number of type '20' records).

7.0 EXCEPTIONS TO 1450 FORMAT

In general, the submittal is identical to the current UB-04 1450 version 5 format used. The differences are minor but nevertheless important. The most notable difference is the requirement for one discharge record for one patient's episodic care, as opposed to the possibility of multiple claim records for one patient visit. For discharges with multiple claim records, they should be consolidated into a single discharge, accumulating amounts where necessary (e.g., amounts by Payer).

Only one type '10' is required per hospital per submittal. Only the first type '10' record and each type '10' record following a type '95' record will be processed; all others will be ignored. A record type '10' will be processed as a header record and a record type '95' will be processed as a trailer record. The records encapsulated between the first type '10' and '95' will be processed using the hospital specified

on the type '10' record.

In record type '20', **'Admission/Start of Care Date'** should be the start of care date for this episode of care.

In record type '20', **Admission Hour"** should be the hour the patient was admitted to the Emergency Department.

In record type '20', **'Statement Covers Period From'** should be the date of the first medical service of the period included on the bill related to this episode of care.

In record type '20', **'Statement Covers Period Thru'** should be the discharge date from the Emergency Department.

In record type '20', **'Discharge Hour'** should be the hour patient was discharged from the Emergency Department.

In record type '95', Federal Tax Sub ID must be the same as specified on the type '10' record.

'Number of Claims' in record type '95' should be the number of discharges reported in the batch, the batch should be equal to the number of type '20' records.

Record type '27' is not a record type used in the UB-04 claim. It contains data that may come from other record types, such as **'Type of Bill,'** or may be computable, such as **'Total Charges,'** or should be found in your current databases, **'Patient Social Security Number,'** for example.

8.0 USE OF MULTI-PAGE CLAIMS

All data except revenue code and charge fields should be duplicated on successive records. All available revenue and charge fields should be completely filled before using additional records. The '0001' revenue code should be the last entry on the last record for a multi-page claim. Its charge should be equal to the total charge for all pages.

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APPENDICES

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APPENDIX A
DATA DICTIONARY

The definition specified for each data element is in general agreement with the definition in the UB-04 Users Manual. Hospitals using existing UB-04 record formats should reference Section 7.0 - EXCEPTIONS TO 1450 FORMAT, for differences from the established UB-04 record formats. Hospitals using data sources other than uniform billing should evaluate their definitions for agreement with the definitions specified in this Guide and the UB-04 Users Manual.

A1 The dictionary format that follows will provide the following information:

1. ***Data Element:*** The name of the data element
2. ***Char Type:*** Character type for the data element

   N = numeric

   A = alphanumeric
3. ***Char Length:*** Character length of data element. For fields with an implied decimal point, the first number is the total length, the second number is the length after the implied decimal point (e.g., '9, 2' represents the COBOL picture clause 9(7)V99).
4. ***Data Reporting Requirement for the Data Element Level:***

   Required = must be reported

   As available = must be present, if captured in your database
5. ***Definition:*** A definition of the data element
6. ***General Comments:*** These comments help to further define or explain the data.

   Comments: elements and give permissible values for code and type data elements.
7. ***Edit:*** Minimal edits that will be performed on the data element; these edits should be performed by the hospital prior to submission.

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Table 1. Definition Breakdown

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
Admission/Start of Care Date	N	6 or 8	☒ Required ☐ As available	Record Type 20, positions (1450) 129-134, (1450Y2K) positions 132-139
DEFINITION	Admission date to the Emergency Department.			
GENERAL COMMENTS	The admission date is to be entered as month, day, and year. The format is MMDDYY for 1450 record. The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging from 01-31. The year is recorded as two digits ranging from 00 -99. Each of the three components (month, day, year) must be right justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 1992 is entered as 020792 (1450). For hospitals using the 1450 record format that began using a different date format in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 is entered 20010207. Where this change is made, all dates must use this format.			
EDIT	Admission date must be present and a valid date. The date cannot be before date of birth or be after ending date in Statement Covers Period Thru.			
Admission Hour	A	2	☒ Required ☐ As available	Record Type 20, positions (1450) 135-136, (1450Y2K) positions 140-141
DEFINITION	The hour during which the patient was admitted to the Emergency Department.			
GENERAL COMMENTS	Military time should be used to represent the hour of admission. If admitted between midnight and noon, use the values from 00 to 11; if admitted between noon and 11:59 pm, use the values from 12 to 23.			

Code	Time – AM	Code	Time – PM
00	12:00 – 12:59 Midnight	12	12:00 – 12:59 Noon
01	01:00 – 01:59	13	01:00 – 01:59
02	02:00 – 02:59	14	02:00 – 02:59
03	03:00 – 03:59	15	03:00 – 03:59
04	04:00 – 04:59	16	04:00 – 04:59
05	05:00 – 05:59	17	05:00 – 05:59
06	06:00 – 06:59	18	06:00 – 06:59
07	07:00 – 07:59	19	07:00 – 07:59
08	08:00 – 08:59	20	08:00 – 08:59
09	09:00 – 09:59	21	09:00 – 09:59
10	10:00 – 10:59	22	10:00 – 10:59
11	11:00 – 11:59	23	11:00 – 11:59

EDIT	Valid numeric value for the hour of admission.			
Attending Provider Name	A	25	☒ Required ☐ As available	Record Type 80, positions 91-115
DEFINITION	The individual who has overall responsibility for the patient's medical care and treatment reported in this claim.			
GENERAL COMMENTS	Entered in the order of last name, first name and middle initial. Last name in positions 1-16, first name in positions 17-24 and initial in position 25.			
EDIT	None			
Attending Provider Identifier	A	16	☒ Required ☐ As available	Record Type 80, positions 27-42
DEFINITION	National Provider Identifier of the individual who has overall responsibility for the patient's medical care and treatment reported via this claim.			
GENERAL COMMENTS	This field is to be left justified with spaces to the right to complete the field.			
EDIT	This field must contain a valid National Provider Identifier (NPI).			
Charitable / Donation Rate	N	3	☐ Required ☒ As available	Record Type 27, positions 57 – 59
DEFINITION	This item identifies the 'claim' fully or partially as charitable or a donation of services. (This should not be confused with a bad debt.)			
GENERAL COMMENTS	Use the following percentage rates: 100 Fully charitable / donation			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
	1 – 99 Partially charitable, expecting some reimbursement of expenses. Estimate the percentage of total charges that will be charitable 0 Not charitable, expect collection of all or some of the charges			
EDIT	If present, must be a valid numeric value.			
Discharge Hour	A	2	☒ Required ☐ As available	Record Type 20, positions 151-152 (1450), positions 160-161 (1450Y2K)
DEFINITION	Hour that the patient was discharged.			
GENERAL COMMENTS	Military time should be used to represent the hour of discharge. If discharged between midnight and noon, use the values from 00 to 11; if discharged between noon and 11:59 pm, use the values from 12 to 23.			

Code	Time – AM	Code	Time – PM
00	12:00 – 12:59 Midnight	12	12:00 – 12:59 Noon
01	01:00 – 01:59	13	01:00 – 01:59
02	02:00 – 02:59	14	02:00 – 02:59
03	03:00 – 03:59	15	03:00 – 03:59
04	04:00 – 04:59	16	04:00 – 04:59
05	05:00 – 05:59	17	05:00 – 05:59
06	06:00 – 06:59	18	06:00 – 06:59
07	07:00 – 07:59	19	07:00 – 07:59
08	08:00 – 08:59	20	08:00 – 08:59
09	09:00 – 09:59	21	09:00 – 09:59
10	10:00 – 10:59	22	10:00 – 10:59
11	11:00 – 11:59	23	11:00 – 11:59

EDIT	Valid numeric value for the hour of discharge.			
Employer Location	A	44	☐ Required ☒ As available	Record Type 31, positions 111-154
DEFINITION	The specific location represented by the address of the employer of the individual identified by the second of two entries in employment information data field.			
GENERAL COMMENTS	This is to be the full and complete address of the employer of the individual.			
EDIT	None			
Employer Name	A	24	☐ Required ☒ As available	Record Type 31, positions 87-110
DEFINITION	The name of the employer that might or does provide health care coverage for the individual identified by the first of two entries in the employment information data fields.			
GENERAL COMMENTS	Enter the full and complete name of the employer providing health care coverage.			
EDIT	None			
Employer Zip Code	A	9	☐ Required ☒ As available	Record Type 31, positions 146-154
DEFINITION	The ZIP Code of the employer of the individual identified by the first of two entries in the employment information data fields.			
GENERAL COMMENTS	None			
EDIT	None			
Employment Status Code	A	1	☐ Required ☒ As available	Record Type 30, position 146-146
DEFINITION	A code used to define the employment status of the individual identified in the first of two employment information data fields.			
GENERAL COMMENTS	This field contains the employment status of the person described in the first of two employment information data fields. The codes to be used are as follows: 1 Employed full time. Definition: individual states that he/she is employed full time 2 Employed part time Definition: individual states that he/she is employed part time 3 Not employed Definition: individual states that he/she is not employed part			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
	time or full time			
	4 Self employed			
	5 Retired			
	6 On active military duty			
	9 Unknown Definition: individual's employment status is unknown			
EDIT	If an entry is present, it must be a valid code.			
Estimated Amounted Due	N	8,2	☐ Required ☒ As available	Record Type 30, positions 183-192; Record Type 20, positions 163-172
DEFINITION	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).			
GENERAL COMMENTS	The format of this estimate is dollars and cents. The dollar amount can be a maximum of 6 digits with 2 additional digits for cents (no decimal is entered). If the amount has no cents then the last 2 digits must be zeros. For example, an estimate of $500 is entered as 50000; an estimate of $50.55 is entered as 5055. The entry is right justified within the field.			
EDIT	None			
Estimated Collection Rate	N	3	☐ Required ☒ As available	Record Type 27, positions 54-56
DEFINITION	Collection rate (percentage) expected from all sources for this ED occurrence. This percentage could be the result of bad debt, contracted amounts or rates with insurance carriers, etc.			
GENERAL COMMENTS	The value could be for the specific patient or could be the hospital's percentage of collections against charges. The hospital collection rate should also include capitated rates against normal charges.			
EDIT	Numeric value; range 0 to 100			
External Cause of Injury Code (E-code)	A	6	☒ Required ☐ As available	Record Type 70, Sequence 2, positions 168-175, 176-183, 184-191 (1450 & 1450Y2K)
DEFINITION	The ICD-9-CM code for the external cause of injury, poisoning or adverse effect.			
GENERAL COMMENTS	Hospitals are to complete this field whenever there is a diagnosis of an injury, poisoning or adverse effect. The priorities for recording an E-code are: a. Principal diagnosis of an injury or poisoning b. Other diagnosis of an injury c. Other diagnosis with an external cause All entries are to be left justified without a decimal.			
EDIT	Must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.			
Federal Tax Number (EIN)	N	10	☒ Required ☐ As available	Record Type 10, positions 8-17; Record Type 95, positions 3-12
DEFINITION	The number assigned to the provider by the Federal government for tax report purposes, also known as a Tax Identification Number (TIN) or Employer Identification Number (EIN).			
GENERAL COMMENTS	None			
EDIT	None			
Federal Tax Sub ID	A	4	☒ Required ☐ As available *When Federal Tax Number is not unique*	Record Type 10 position 18-21; Record Type 95 position 13-16
DEFINITION	Four-position modifier to Federal Tax ID.			
GENERAL COMMENTS	Used by providers to identify their affiliated subsidiaries when the Federal Tax Number does not distinguish between separate facilities or cost centers.			
EDIT	None			
HCPCS / Procedure Code	A	5	☐ Required ☒ As available	Record Type 60, positions 29-34, 85-89, 141-145

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
DEFINITION	Procedure codes reported in record types identify services so that appropriate payment can be made. HCFA Common Procedural Coding System (HCPCS) code is required for many specific types of outpatient services and a few inpatient services. May include up to two modifiers.			
GENERAL COMMENTS	None			
EDIT	None			
Health Plan ID	A	9	☐ Required ☒ As available	Record Type 30, positions 26-34
DEFINITION	The numbers used by the health plan to identify itself.			
GENERAL COMMENTS	None			
EDIT	None			
Insured Address	A	62	☐ Required ☒ As available	Record Type 31, positions 25-86
DEFINITION	Insured's current mailing address: Address Line 1, Address Line 2, City, State, Zip.			
GENERAL COMMENTS	None			
EDIT	None			
Insured Group Name	A	14	☐ Required ☒ As available	Record Type 30, positions 97-110
DEFINITION	Name of the group or plan through which the insurance is provided to the Insured.			
GENERAL COMMENTS	Enter the complete name of the group or plan name. If the name exceeds 16 characters, truncate the excess.			
EDIT	None			
Insurance Group Number	A	17	☐ Required ☒ As available	Record Type 30, positions 80-96
DEFINITION	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.			
GENERAL COMMENTS	None			
EDIT	None			
Insured's Name	A	30	☐ Required ☒ As available	Record Type 30, positions 111-140
DEFINITION	The name of the individual in whose name the insurance is carried.			
GENERAL COMMENTS	Enter the name of the insured individual in last name, first name, middle initial order. Titles such as Sir, Mr. or Dr. should not be recorded in this data field. Record hyphenated names with the hyphen as in Smith-Jones. To record suffix of a name, write the last name, leave a space then write the suffix, for example, Snyder III or Addams Jr.			
EDIT	None			
Insured's Sex	A	1	☐ Required ☒ As available	Record Type 30, position 141-141
DEFINITION	A code indicating the sex of the insured.			
GENERAL COMMENTS	This is a one-character code. The sex is to be reported as male, female or unknown using the following coding: M = Male F = Female U = Unknown			
EDIT	If present, the code must be valid.			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
Insured's Unique ID	A	19	☒ Required ☐ As available	Record Type 30, positions 35-53
DEFINITION	Insured's unique identification number assigned by the payer organization. For Medicare purposes enter the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.			
GENERAL COMMENTS	The payer organization's assigned identification number is to be entered in this field. It should be entered exactly as printed on the Insured's proof of coverage.			
EDIT	Must be a valid code.			
Medical Record Number	A	17	☒ Required ☐ As available	Record Type 20, positions 173-189
DEFINITION	Number assigned to patient by hospital or other provider to assist in retrieval of medical records.			
GENERAL COMMENTS	This number is assigned by the hospital for each patient.			
EDIT	None			
National Provider Identifier (NPI)-Billing Provider	A	13	☒ Required ☐ As available	Record Type 10, positions 22-34
DEFINITION	The National Provider Identifier (NPI) is a ten-position identifier issued by Medicare.			
GENERAL COMMENTS	The unique identification number assigned to the billing provider by the National Plan and Provider Enumeration System.			
EDIT	The field must contain a valid NPI.			
Non Covered Charges by Revenue Code	N	10, 2	☐ Required ☒ As available	Record Type 60 position 55-64, 111-120, 167-176
DEFINITION	Charges pertaining to the related UB-04 revenue code that are not covered by the primary payer as determined by the provider.			
GENERAL COMMENTS	The total allows for an 8-digit dollar amount followed by 2 digits for cents (no decimal point). All entries are right justified. If the charge has no cents, then the last two digits must be zero. For example, a charge of $500.00 is entered as 50000; a charge of $37.50 is entered as 3750.			
EDIT	This field must be present and contain a value greater than 0 when revenue code field is greater than 0.			
Number of Claims	N	6	☒ Required ☐ As available	Record Type 95, positions 25-30
DEFINITION	The number of discharge claims submitted by a hospital for this submission. Used to verify a complete submittal, no losses of data.			
GENERAL COMMENTS	None			
EDIT	Must be the total number of discharges for the hospital in the batch (type '20'records).			
Operating Physician Name	A	25	☐ Required ☒ As available	Record Type 80, positions 116-140
DEFINITION	The name of the individual with the primary responsibility for performing the surgical procedure(s).			
GENERAL COMMENTS	Entered in the order of last name, first name and middle initial with last name in positions 1-16, first name in positions 17-24 and initial in position 25.			
EDIT	None			
Operating Physician Identifier	A	16	☒ Required ☐ As available	Record Type 80, Position 43-58
DEFINITION	National Provider Identifier of the individual with primary responsibility for performing the surgical procedure(s).			
GENERAL COMMENTS	The unique identification number assigned to the operating physician by the National Plan and Provider Enumeration System.			
EDIT	This field must contain a valid NPI and be left-justified in the field.			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
Other Diagnosis Code	A	6	☒ Required ☐ As available	Record Type 70, Sequence 1
DEFINITION	ICD-9-CM codes describing other diagnoses corresponding to additional conditions that co-exist at the time of admission or develop subsequently, and which have an effect on the treatment received or the length of stay.			
GENERAL COMMENTS	The first of twenty-five additional diagnoses. This field must contain the appropriate ICD-9-CM code without a decimal. In the ICD-9-CM codebook there are three; four; and five digit codes, plus 'V' and 'E' codes. Use of the fourth, fifth, 'V' and 'E' is not optional, but must be entered when present in the code. For example, a five-digit code is entered as '12345'; a 'V' code is entered as 'V270.' All entries are to be left justified with spaces to the right to complete the field length.			
EDIT	If other diagnoses are present, they must be valid. When diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.			
Other Physician Name	A	25	☐ Required ☒ As available	Record Type 80, positions 141-165, 166-190
DEFINITION	This is the name of a physician other than the attending physician as defined by the payer organization.			
GENERAL COMMENTS	Entered in the order of last name, first name and middle initial with last name in positions 1-16, first name in positions 17-24 and initial in position 25.			
EDIT	None			
Other Physician Identifier	A	16	☒ Required ☐ As available	Record Type 80, positions 59-74, 75-90
DEFINITION	This is the National Provider Identifier of a physician other than the attending physician as defined by the payer organization.			
GENERAL COMMENTS	The unique identification number assigned to the physician by the National Plan and Provider Enumeration System.			
EDIT	This field must contain a valid NPI and be left justified.			
Other Procedure Code	A	7	☒ Required ☐ As available	Record Type 70, Sequence 2 (1450 & 1450Y2K)
DEFINITION	The code that identifies the other procedures performed during the patient's hospital stay covered by this discharge record. This may include diagnostic or exploratory procedures.			
GENERAL COMMENTS	The coding method used must agree with the coding method used for the principal procedure. Entries must include all digits. In the ICD-9-CM there are three-digit procedure codes and four-digit codes; use of the fourth digit is NOT optional. It must be present. Enter the code left justified, without a decimal.			
EDIT	If this field is present, there must be a principal procedure entered. Codes entered must be valid. When a procedure is gender-specific, the gender code entered in the record must be consistent.			
Other Procedure Date	N	6	☒ Required ☐ As available	Record Type 70, Sequence 2 (1450 & 1450Y2K)
DEFINITION	Date that the procedure indicated by the related procedure code was performed.			
GENERAL COMMENTS	None			
EDIT	Must be a valid date.			
Patient Address	A	62	☒ Required ☐ As available	Record Type 20, positions 67-128 (1450 & 1450Y2K)
DEFINITION	The address including postal zip code of the patient, as defined by the payer organization. (Address line 1 & 2, City, State & ZIP Code)			
GENERAL COMMENTS	The order of the complete address, if provided, should be street number, apartment number, city, state and zip code, left justified, with spaces to the right to complete the field. The state must be the standard post office abbreviations (AR for Arkansas). If the nine digit zip code is used, it must be entered in the form XXXXXYYYY where X's are the five-digit zip code and Y's are the zip code extension. If Street Address is not provided, the nine-digit postal ZIP code is required for a valid address.			
EDIT	This field is edited for the presence of an address with a valid and complete postal ZIP code.			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
Patient Control Number	A	20	☒ Required ☐ As available	All Records, positions 5-24 except for Record Types 10 and 95
DEFINITION	A patient's unique alpha-numeric number assigned by the hospital to facilitate retrieval of individual discharge records, if editing or correction is required.			
GENERAL COMMENTS	This number should not be the same as the Medical Record Number. This number will be used for reference in correspondence, problem solving or edit corrections.			
EDIT	The number must be present and should be unique within a hospital.			
Patient's Date of Birth	N	8	☒ Required ☐ As available	Record Type 20, positions 56-63 (1450 & 1450Y2K)
DEFINITION	The date of birth of the patient in month day year order; year is 4 digits.			
GENERAL COMMENTS	The date of birth must be present and recorded in an eight-digit format of month day year (MMDDYYYY). The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging form 01-31. The year is recorded as four digits ranging from 1800-2100. Each of the first two components (month, day) must be right justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 1982 is entered as 02071982. If the birth date is unknown, then the field must contain '00000000'. For hospitals using the 1450 record format that began using a different date in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 format is entered 20010207. Where this change is made, all dates must use this format.			
EDIT	This field is edited for the presence of a valid date and of a date that it is not equal to the current date. Age is calculated and used in the clinic code edit to identify age/diagnosis conflicts.			
Patient's Discharge Status	N	2	☒ Required ☐ As available	Record Type 20, positions (1450) 149-150, positions (1450Y2K) 158-159
DEFINITION	A code indicating patient status at the time of the discharge. It is the arrangement or event ending a patient's stay in the Emergency Department.			
GENERAL COMMENTS	This is a two-character code. This should be the status at the time of discharge. The patient's status is coded as follows:			
	01	Definition: Discharged to Home or Self Care (Routine Discharge)-Includes discharges to home; home on oxygen if DME only; any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.		
	02	Definition: Discharged/transferred to a Short-Term General Hospital for Inpatient Care		
	03	Definition: Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care-Indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities see 04 and 64.		
	04	Definition: Discharged/transferred to a facility that provides custodial or supportive care. This includes intermediate care facilities (ICFs) if specifically designated at the state level. Also, used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.		
	05	Definition: Discharged/transferred to Designated Cancer Center or Children's Hospital		
	06	Definition: Discharged/transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care		
	07	Definition: Left Against Medical Advice or Discontinued Care		
	09	Definition: Admitted as an Inpatient to this Hospital-Use only with Medicare outpatient claims. Applies only to those Medicare outpatient services that begin more than three days prior to an admission.		
	20	Definition: Expired		
	21	Definition: Discharged/transferred to Court/Law Enforcement – includes transfers to incarceration facilities such as jails, prison or other detention facilities.		
	30	Definition: Still a Patient in the Hospital- ***not a valid code		

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
	40	Definition: Expired at home- (hospice claims only)		
	41	Definition: Expired in a Medical Facility-hospital, skilled nursing facility, intermediate care facility, or freestanding hospice (hospice claims only)		
	42	Definition: Expired – Place Unknown (hospice claims only)		
	43	Definition: Discharged/transferred to a Federal Health Care Facility e.g. Department of Defense hospital, a VA hospital, or a VA nursing facility		
	50	Definition: Hospice – Home		
	51	Definition: Hospice – Medical Facility		
	61	Definition: Discharged/transferred to a hospital based (Medicare approved) swing bed-For Medicare discharges; use for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.		
	62	Definition: Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital		
	63	Definition: Discharged/transferred to a Long Term Care Hospital (LTCH)		
	64	Definition: Discharged/transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare		
	65	Definition: Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a hospital		
	66	Definition: Discharged/transferred to a Critical Access Hospital (CAH)		
	67-69	Reserved for Assignment by the NUBC		
	70	Definition: Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List.		
	71-99	Reserved for Assignment by the NUBC		
EDIT	The patient status code must be present and a valid code as defined. A patient status code of 30 is not a valid code. *In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier, such as observation following outpatient surgery, which results in admission.			
Patient's Ethnicity	A	1	☒ Required ☐ As available	Record Type 27, position 39-39
DEFINITION	This item gives the ethnicity of the patient. The information is based on self-identification, and is to be obtained from the patient, a relative, or a friend. The hospital is not to categorize the patient based on observation or personal judgment.			
GENERAL COMMENTS	The patient may choose not to provide the information. If the patient chooses not to answer, the hospital should enter the code for unknown. If the hospital fails to request the information, the field should be space filled.			
	1	Hispanic origin	Definition: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.	
	2	Not of Hispanic Origin	Definition: A person who is not classified in 1.	
	6	Unknown	Definition: A person who chooses not to respond to the inquiry	
EDIT	The field will have a valid code. Verification will be requested on those coded as "Unknown."			
Patient's Marital Status	A	1	☐ Required ☒ As available	Record Type 20, position 64-64 (1450 & 1450Y2K)
DEFINITION	The marital status of the patient at date of admission, or start of care.			
GENERAL COMMENTS	The marital status of the patient is to be reported as a one character code whenever the information is recorded in the patient's hospital record. The following codes apply: S = Single M = Married			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
	X = Legally Separated D = Divorced W = Widowed U = Unknown Space = Not present in patient's record			
EDIT	This field is edited for a valid entry.			
Patient's Name	A	31	☒ Required ☐ As available	Record Type 20, positions 25-54 (1450 & 1450Y2K)
DEFINITION	The name of the patient in last, first and middle initial order.			
GENERAL COMMENTS	Titles such as Sir, Msgr., and Dr. should not be recorded. Record hyphenated names with the hyphen, as in Smith-Jones. To record a suffix of a name, write the last name, leave a space, then write the suffix, for example: Snyder III or Addams Jr.			
EDIT	The name will be edited for the presence of the last name and the first name.			
Patient's Race	A	1	☒ Required ☐ As available	Record Type 27, position 38-38
DEFINITION	This item gives the race of the patient.			
GENERAL COMMENTS	The patient may choose not to provide the information. If the patient chooses not to answer, the hospital should enter the code for unknown. If the hospital fails to request the information, the field should be space filled.			
	1 American Indian or Alaskan Native — Definition: A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.			
	2 Asian or Pacific Islander — Definition: A person having origins in any of the original oriental peoples of the Far East, Southeast Asia, the Indian Subcontinent or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.			
	3 Black — Definition: A person having origins in any of the black racial groups of Africa			
	4 White — Definition: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.			
	5 Other — Definition: Any possible options not covered in the above categories.			
	6 Unknown — Definition: A person who chooses not to answer the question.			
	Blank Space — Definition: The hospital made no effort to obtain the information.			
EDIT	None			
Patient's Relationship to Insured	N	2	☐ Required ☒ As available	Record Type 30, positions 144-145
DEFINITION	A code indicating the relationship, such as patient, spouse, child, etc., of the patient to the identified Insured person listed in the first of three Insured's Name fields.			
GENERAL COMMENTS	Enter the 2 digit code representing the patient's relationship to the individual named. All codes are to be right justified with a leading 0, if needed. The following codes apply:			
	18 Patient is named insured — Definition: Self-explanatory			
	01 Spouse — Definition: Self-explanatory			
	19 Natural child/insured financially responsible — Definition: Self-explanatory			
	43 Natural child/insured does not have financial responsibility — Definition: Self-explanatory			
	17 Step Child — Definition: Self-explanatory			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
	10	Foster Child	Definition: Self-explanatory	
	15	Ward of the Court	Definition: Patient is ward of the insured as a result of a court order	
	20	Employee	Definition: The patient is employed by the named insured.	
	21	Unknown	Definition: The patient's relationship to the named insured is unknown	
	22	Handicapped Dependent	Definition: Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage.	
	39	Organ Donor	Definition: Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.	
	40	Cadaver Donor	Definition: Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.	
	05	Grandchild	Definition: Self-explanatory	
	07	Niece or Nephew	Definition: Self-explanatory	
	41	Injured Plaintiff	Definition: Patient is claiming insurance as a result of injury covered by insured.	
	23	Sponsored Dependent	Definition: Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.	
	24	Minor Dependent of a Minor Dependent	Definition: Code is used where patient is a minor and a dependent of another minor who in turn is a dependent, although not a child of the insured.	
	32	Mother	Definition: Self-explanatory	
	33	Father	Definition: Self-explanatory	
	04	Grandparent	Definition: Self-explanatory	
	29	Significant Other		
	36	Emancipated Minor		
	53	Life Partner		
	G8	Other Relationship		
EDIT	A code must be present and valid if Insured's Name is entered.			
Patient's Sex	A	1	☒ Required ☒ As available	Record Type 20, position 55 (1450 & 1450Y2K)
DEFINITION	The gender of the patient as recorded at date of admission.			
GENERAL COMMENTS	This is a one-character code. The sex is to be reported as male, female or unknown using the following coding: M =Male F = Female U = Unknown			
EDIT	A valid code must be present. The gender of the patient is checked for consistency with diagnosis and procedure codes. The edit is to identify gender diagnosis conflicts and invalid or unknown gender.			
Patient Social Security Number	N	10	☒ Required ☒ As available	Record Type 27, positions 28-37
DEFINITION	The social security number of the patient receiving care			
GENERAL COMMENTS	For 1450 submissions, this field is to be right justified, with zeroes to the left to complete the field. The format of SSN is 0123456789 without hyphens. If the patient is a newborn, use the mother's			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
	SSN. If a patient does not have a social security number, fill with zeroes.			
EDIT	The field is edited for a valid entry.			
Payments Received	N	8, 2	☐ Required ☒ As available	Record Type 20, positions (1450) 153-162, 163-121 (1450Y2K), Record Type 30, positions 173-182
DEFINITION	The amount the hospital has received from the patient toward payment of a bill prior to the billing date.			
GENERAL COMMENTS	The format of this payment is dollar and cents. The dollar amount can be a maximum of 6 digits with 2 additional digits for cents (no decimal is entered). If the amount has no cents, then the last 2 digits must be zeros. For example, an estimate of $500 is entered as 50000 and a payment of $50.00 is entered as 5000. The entry is right justified within the field.			
EDIT	None			
Point of Origin for Admission or Visit	A	1	☒ Required ☐ As available	Record Type 20, position 66-66
DEFINITION	A code indicating the point of patient origin for this admission or visit.			

Code Structure for all Admission Types (excluding Newborns (Type 4))

1	Non-Health Care Facility Point of Origin	Definition: The patient presented to this facility for services from a non-health care origin. Examples: Includes patients coming from home or workplace.
2	Clinic	Definition: The patient presented to this facility for services from a clinic or physicians office.
3	Reserved for assignment by NUBC	
4	Transfer from a Hospital	Definition: The patient was transferred to this facility as an outpatient from an acute care facility.
5	Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	Definition: The patient was referred to this facility from a SNF or ICF where he or she was a resident.
6	Transfer from another Health Care Facility	Definition: The patient was referred this facility from another type of health care facility not defined elsewhere in this code list.
7	Reserved for assignment by NUBC	
8	Court/Law Enforcement	Definition: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9	Information not available	Definition: The means by which the patient was referred to this hospital's emergency department is not known.
D	Inpatient transfers within the same facility	Definition: The patient was transferred from a separate unit of a hospital to another unit of the same hospital which results in separate claim to the payers.
E	Transfer from Ambulatory Surgery Center	Definition: The patient was referred to this facility from an ambulatory surgery center.
F	Transfer from Hospice	Definition: The patient was referred to this facility from hospice.

Code Structure for Newborn (4)
If Type of Admission is a 4, the following codes apply:

1-4	Reserved for assignment by the NUBC.
5	Definition: A baby born inside this Hospital.
6	Definition: A baby born outside of this Hospital.
7-9	Reserved for assignment by the NUBC.

EDIT	The code must be present and valid and agree with the Type of Admission code entered.

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
Principal Diagnosis Code	A	6	☒ Required ☐ As available	Record Type 70, Sequence 1, positions 25-31
DEFINITION	The principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the patient for care. An ICD-9-CM code describes the principal disease.			
GENERAL COMMENTS	This field is to contain the appropriate ICD-9-CM code without a decimal. In the ICD-9-CM codebook there are three, four, and five digit codes plus 'V' and 'E' codes. Use of the fourth, fifth, 'V' and 'E' is not optional, but must be entered when present in the code. For example, a five-digit code is entered as '12345'; a 'V' code is entered as 'V270.' All entries are to be left justified with spaces to the right to complete the field length. An 'E' code should not be recorded as the principal diagnosis.			
EDIT	A principal diagnosis must be present and valid. When the principal diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.			
Principal Procedure Code	A	7	☒ Required ☐ As available	Record Type 70 Sequence 2 position 25-32 (1450 & 1450Y2K)
DEFINITION	The code that identifies the principal procedure performed during the ED visit covered by this discharge data record. The principal procedure is one that is performed for definitive treatment rather than for diagnostic or exploratory purposes, or is necessary as a result of complications. The principal procedure is that procedure most related to the principal diagnosis.			
GENERAL COMMENTS	The coding method used should be ICD-9. If some other coding method is used, Procedure Coding Method Used field must NOT be 9, but must indicate the code for all digits and decimal. In the ICD-9-CM, there are three-digit procedure codes and four-digit procedure codes; use of the fourth digit is NOT optional. It must be present. Enter the code left-justified without a decimal			
EDIT	This field must be present if other procedures are reported and be a valid code. When a procedure is sex-specific, the sex code entered in the record must be consistent.			
Principal Procedure Date	N	6	☒ Required ☐ As available	Record Type 70, Sequence 2, positions (1450) 33-38, positions (1450Y2K) 33-40
DEFINITION	The date on which the principal procedure described on the bill was performed.			
GENERAL COMMENTS	None			
EDIT	This must be a valid date falling between start of care and discharge dates.			
Procedure Coding Method Used	N	1	☒ Required ☐ As available	Record Type 70, Sequence 2, position 192
DEFINITION	An indicator that identifies the coding method used for procedure coding.			
GENERAL COMMENTS	The default value is 9 for ICD-9. If coding method is **NOT** ICD-9, enter appropriate code from the list: 4 CPT – 4 5 HCPCS (HCFA Common Procedure Coding Systems) 9 ICD – 9 – CM			
EDIT	This field must agree with the coding method used to code procedures.			
Priority of Admission or Visit	A	1	☒ Required ☐ As available	Record Type 20, positions 65-65
DEFINITION	A code indicating priority of the admission/visit.			
GENERAL COMMENTS	This is a one-digit code ranging from 1 – 4, or may be 9. The code structure is as follows. 1 Emergency – Definition: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. 2 Urgent – Definition: The patient requires immediate attention for the care and treatment of a physical or mental disorder 3 Elective – Definition: The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4 Newborn – Definition: Use of this code necessitates the use of special Point of Origin for Admission or Visit codes; see Point of Origin for Admission or Visit. 5 Trauma – Definition: Visit to a trauma center/hospital as licensed or designated by			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
			state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.	
	9 Information not available		Definition: Information was not collected or was not available.	
EDIT	The field must be present and be a valid code 1 - 5 or 9. If the code is entered 4 (newborn), the Point of Origin or Admission or Visit codes will be checked for consistency as well as the date of birth and diagnosis.			
Provider Address	A	50	☒ Required ☐ As available	Record Type 10, positions 126-175
DEFINITION	Complete mailing address to which the provider correspondence is to be sent for the correction and acknowledgment of discharge data. Street address or box number, city, state and ZIP code are required.			
GENERAL COMMENTS	None			
EDIT	All address fields must be present.			
Provider (Hospital) Data ID	A	4	☒ Required ☐ As available	Record Type 10, positions 122-125
DEFINITION	A four-letter hospital identification code that is assigned to each hospital.			
GENERAL COMMENTS	None			
EDIT	A Data ID must be present, valid and consistent for each hospital			
Provider FAX Number	N	10	☐ Required ☒ As available	Record Type 10, positions 176-185
DEFINITION	FAX number for provider.			
GENERAL COMMENTS	Fax number to be used for transmission of correction documents and acknowledgment of discharge data. If a FAX number does not exist, fill with zeroes.			
EDIT	This must be numeric data.			
Provider Name	A	25	☒ Required ☐ As available	Record Type 10, positions 97-121
DEFINITION	The name of the hospital submitting the record.			
GENERAL COMMENTS	The hospital's name is entered in the first 25 character positions and must be the name as it is licensed by the Department of Health.			
EDIT	The name must be present and match a name in a coding table.			
Provider Telephone Number	N	10	☒ Required ☐ As available	Record Type 10, positions 87-96
DEFINITION	Telephone number, including area code, at which the provider wishes to be contacted for correction and acknowledgment of discharge data.			
GENERAL COMMENTS	None			
EDIT	This must be present and numeric; it cannot be all zeroes.			
Record Type	N	2	☒ Required ☐ As available	All Records, positions 1-2
DEFINITION	The record format type indicator.			
GENERAL COMMENTS	This field is used to specify each type of record. Use the following numbers:			

Record Type Code	*Record Name*	*Record Type Code*	*Record Name*
01	Processor Data	20	Patient Data
02-04	Reserved for National Assignment	21	Noninsured Employment Information
05-09	Local Use	22	Unassigned State Form Locators
10	Provider Data	23-24	Reserved for National

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
				Assignment
	11-14	Reserved for National Assignment	25-29	Local Use
	15-19	Local Use		
	30-31	Third Party Payer Data	40	Claim Data TAN-Occurrence
	32-33	Reserved for National Assignment	41	Claim Data Condition-Value
	34	Authorization	42-44	Reserved for National Assignment
	35-39	Local Use	45-49	Local Use
	50	IP Accommodations Data	60	IP Ancillary Services Data
	51-54	Reserved for National Assignment	61	Outpatient Procedures
	55-59	Local Use	62-64	Reserved for National Assignment
			65-69	Local Use
	70	Medical Data		
	71	Plan of Treatment and Patient Information	80	Physician Data
	72	Specific Services and Treatments	81	Pacemaker Registry Record
	73	Plan of Treatment/Medical Update Narrative	82-84	Reserved for National Assignment
	74	Patient Information	85-89	Local Use
	75-78	Reserved for National Assignment		
	79	Local Use		
	90	Claim Control Screen	95	Provider Batch Control
	91	Remarks (Overflow from RT 90)	96-98	Local Use
	92-94	Reserved for National Assignment	99	File Control

EDIT	The number must be present and valid.			
Revenue Code	N	4	☒ Required ☐ As available	Record Type 60, positions 25-28, 81-84, 137-140
DEFINITION	A four-digit code that identifies a specific accommodation, ancillary service or billing calculation.			
GENERAL COMMENTS	For every patient there must be at least one revenue service entered. There may be an entry representing the sum of all revenue services; this entry would have a revenue code of '0001.' If the summed entry ('0001') is one of the entries, the revenue amount associated must equal 'TOTAL CHARGES' found on record type 27.			
EDIT	This field must be present and contain a valid revenue code as defined in Revenue Codes and Units of Service section.			
Reason for Visit	A	8	☒ Required ☐ As available	Record 70, Sequence 2, on 1450, positions 153-160 and on 1450 Y2K, positions 160-167
DEFINITION	The ICD 9 CM diagnosis codes describing the patient's reason for seeking care.			
GENERAL COMMENTS	This is to contain the appropriate ICD-9-CM code without a decimal.			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
EDIT	Reason for Visit code must be present and valid. When the reason for visit code is sex or age dependent, the age and sex must be consistent with the code entered.			
Sequence Number	N	2	☒ Required ☐ As available	Positions 3-4, as needed
DEFINITION	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 01, 10, 90, 91, 95 and 99 do not have sequence numbers. The sequence numbers for record types 30, 31, 34, 80 and 81 are used as matching criteria to determine which type 30, type 31, type 34, type 80 and/or type 81 records are associated, like sequence numbers indicating the records are associated.			
GENERAL COMMENTS	None			
EDIT	Must be valid sequence number for record type.			
Source of Payment Code	A	1	☒ Required ☐ As available	Record Type 30, position 25-25
DEFINITION	A code indicating source of payment associated with this payer record.			
GENERAL COMMENTS	Valid codes are as follows: A Self Pay B Worker's compensation C Medicare D Medicaid E Other Federal Programs F Commercial Insurance G Blue Cross/Blue Shield, Medi-Pak, Medi-Pak Plus H CHAMPUS I Other J County or State (state or county employees) L Managed Assistance N Division of Health Services Q HMO/Managed Care S Self Insured Z Medically Indigent/Free			
EDIT	Code must be present and valid.			
Statement Covers Period From	N	6	☒ Required ☐ As available	Record Type 20, positions 137-142 on the 1450 On the 1450Y2K, positions 142-149
DEFINITION	The date of the first medical service of the period included on the bill related to this episode of care.			
GENERAL COMMENTS	The format is MMDDYY for 1450 record. The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging from 01-31. The year is recorded as two digits ranging from 00-99. Each of the three components (month, day, year) must be right justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 1992 is entered as 020792 (1450). For hospitals using the 1450 record format that began using a different date format in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 is entered 20010207. Where this change is made, all dates must use this format.			
EDIT	This date must be present and be valid.			
Statement Covers Period Thru	N	6	☒ Required ☐ As available	Record Type 20, positions 143-148 on the 1450 On the 1450 Y2K, positions 150-157
DEFINITION	The ending service date on the bill for this episode of care or discharge date			
GENERAL COMMENTS	The format is MMDDYY for 1450 record. The month is recorded as two digits ranging from 01-12. The day is recorded as two digits ranging from 01-31. The year is recorded as two digits ranging from 00-99. Each of the three components (month, day, year) must be right justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 1992 is entered			

DATA ELEMENT	CHAR TYPE	CHAR LGTH	DATA REPORTING LEVEL	LOCATION
	as 020792 (1450). For hospitals using the 1450 record format that began using a different date format in 2000, the date must be given as CCYYMMDD. In this case, February 7, 2001 is entered 20010207. Where this change is made, all dates must use this format.			
EDIT	This date must be present and be valid.			
Total Charges	N	10, 2	☒ Required ☐ As available	Record Type 27, positions 44-53
DEFINITION	Total of charges for this ED visit.			
GENERAL COMMENTS	The total allows for an 8-digit dollar amount followed by 2 digits for cents (no decimal point). All entries are right justified. If the charge has no cents, then the last two digits must be zero. For example, a charge of $500.00 is entered as 50000; a charge of $37.50 is entered as 3750.			
EDIT	This field must be present and contain a value greater than 0 when any revenue code field is greater than 0.			
Total Charges by Revenue Code	N	10, 2	☒ Required ☐ As available	Record Type 50, positions 42-51, 84-93, 126-135, 168-177 Record Type 60, positions 45-54, 101-110, 157-166
DEFINITION	Total dollars and cents amount charged for the related revenue service entered			
GENERAL COMMENTS	The total allows for an 8-digit dollar amount followed by 2 digits for cents (no decimal point). All entries are right- justified. If the charge has no cents, then the last two digits must be zero. For example, a charge of $500.00 is entered as 50000; a charge of $37.50 is entered as 3750.			
EDIT	This field must be present and contain a value greater than 0 when the associated revenue code field is greater than 0.			
Type of Bill	A	3	☒ Required ☐ As available	Record Type 27, positions 25-27
DEFINITION	A code indicating the specific type of bill (inpatient, outpatient, etc.). This three digit code requires 1 digit each, in the following sequence: 1. Type of facility, 2. Bill classification, and 3. Frequency			
GENERAL COMMENTS	All positions must be fully coded. See UB-04 guidelines for codes and definitions. This code indicates the specific type of patient billing.			
EDIT	None			
Trauma Band Number	A	7	☐ Required ☒ As available	Record Type 27, positions 60-66
DEFINITION	The trauma band number of designated trauma patient.			
GENERAL COMMENTS	None			
EDIT	None			
Units of Service	N	7	☒ Required ☐ As available *If the revenue code needs units; see Revenue Codes and Units of Service Section*	Record Type 60, positions 38-44, 94-100, 150-156
DEFINITION	A quantitative measure of services rendered, by revenue category, to the patient. It includes such items as the number of scans, number of pints, number of treatments, number of visits, number of miles or number of sessions.			
GENERAL COMMENTS	This number qualifies the revenue service. The presence of this code ensures that charges per revenue service are adjusted to a common base for comparison. Revenue Codes and Units of Service (refer to Appendix B) defines the appropriate units for each revenue code.			
EDIT	The units of service must be present for those revenue services that require a unit; see Revenue Codes and Units of Service section.			

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APPENDIX B
REVENUE CODES AND UNITS OF SERVICE

This section defines acceptable revenue codes representing services provided to a patient, and the unit of measure associated with each revenue service. Any codes not assigned are assumed to be non-applicable unless found in the NUBC's published manual or addenda to this manual.

B1 Revenue Code

Identifies a specific accommodation, ancillary service or billing calculation. Revenue Code categories are four digits with an "x" in the fourth position to dented the subcategory number. The subcategory number provides a more detailed list generally ranging from "0" through "9". When reporting the revenue code on the claim, the fourth position must include one of the numeric choices available in that category. The reporting of an "x" is not appropriate.

B2 Units of Service

A quantitative measure of services rendered by revenue category to or for the patient, to include items such as number of accommodation days, miles, pints or treatments.

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Table 2. Data Element Description Breakdown

CODE	UNIT	DEFINITION	SUBCATEGORY x
001	None	Total Charges	
01x	Reserved for Internal Payer Use		
02x	None	Health Insurance – Prospective Payment System	0 = Reserved 1 = Research 2 = Skilled Nursing Facility - PPS 3 = Home Health - PPS 4 = Inpatient Rehab Facility - PPS
03x to 09x	Reserved		
10x	Days	All inclusive rate – a flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.	0 = All inclusive room and board plus ancillary 1 = All inclusive room and board
11x	Days	Room and board – private medical or general routine services for single bed rooms	0 = General Classification 1 = Medical/surgical/GYN 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice 6 = Detoxification 7 = Oncology 8 = Rehabilitation 9 = Other
12x	Days	Room and board – semi-private (two beds) medical or general – routine service charges incurred for accommodations with two beds	0 = General classification 1 = Medical/Surgical/GYN 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice 6 = Detoxification 7 = Oncology 8 = Rehabilitation 9 = Other
13x	Days	Semi-private – three and four beds – routine service charges incurred for accommodations with three and four beds	0 = General classification 1 = Medical/Surgical/GYN 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice 6 = Detoxification 7 = Oncology 8 = Rehabilitation 9 = Other
14x	Days	Private deluxe – deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients	0 = General classification 1 = Medical/Surgical/GYN 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice 6 = Detoxification 7 = Oncology 8 = Rehabilitation 9 = Other

CODE	UNIT	DEFINITION	SUBCATEGORY "x"
15x	Days	Room and board – ward medical or general routine service charge for accommodations with five or more beds	0 = General classification 1 = Medical/Surgical/GYN 2 = OB 3 = Pediatric 4 = Psychiatric 5 = Hospice 6 = Detoxification 7 = Oncology 8 = Rehabilitation 9 = Other
16x	Days	Other room and board – any routine service charges for accommodations that cannot be included in the more specific revenue center codes	0 = General classification 4 = Sterile environment 7 = Self care 9 = Other
17x	Days	Nursery – charges for nursing care to newborn and premature infants in nurseries	0 = General classification 1 = Newborn – Level I 2 = Newborn – Level II 3 = Newborn – Level III 4 = Newborn – Level IV 9 = Other
18x	Days	Leave of absence – charges for holding a room while the patient is temporarily away from the provider	0 = General classification 1 = Reserved 2 = Patient convenience 3 = Therapeutic leave 4 = ICF/MR (any reason) 5 = Nursing home (for hospitalization) 9 = Other leave of absence
19x	Days	Subacute Care – Accommodations charges for subacute care to inpatients or skilled nursing facilities	0 = Reserved Classification 1 = Subacute Care – Level I 2 = Subacute Care – Level II 3 = Subacute Care – Level III 4 = Subacute Care – Level IV 9 = Other Subacute Care
20x	Days	Intensive care – routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit	0 = General classification 1 = Surgical 2 = Medical 3 = Pediatric 4 = Psychiatric 6 = Intermediate ICU 7 = Burn care 8 = Trauma 9 = Other intensive care
21x	Days	Coronary care – routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the more general medical care unit	0 = General classification 1 = Myocardial infarction 2 = Pulmonary care 3 = Heart transplant 4 = Intermediate ICU 9 = Other coronary care
22x	None	Special charges-charges incurred during an inpatient stay or on a daily basis for certain services	0 = General classification 1 = Admission charge 2 = Technical support charge 3 = U. R. service charge 4 = Late discharge, medically necessary 9 = Other special charges

CODE	UNIT	DEFINITION	SUBCATEGORY 'x'
23x	None	Incremental nursing charge rate – charge for nursing service assessed in addition to room and board	0 = General classification 1 = Nursery 2 = OB 3 = ICU (includes transitional care) 4 = CCU (includes transitional care) 5 = Hospice 9 = Other
24x	None	All inclusive ancillary – a flat rate charge incurred on either a daily basis or total stay basis for ancillary services only	0 = General classification 9 = Other inclusive ancillary
25x	None	Pharmacy – charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist	0 = General classification 1 = Generic drug 2 = Non-generic drug 3 = Take home drug 4 = Drugs incident to other diagnostic services 5 = Drugs incident to radiology 6 = Experimental drug 7 = Non-prescription 8 = IV solutions 9 = Other pharmacy
26x	None	IV therapy – equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment	0 = General classification 1 = Infusion pump 2 = IV therapy/pharmacy service 3 = IV therapy/drug/supply/delivery 4 = IV therapy/supplies 9 = Other IV therapy
27x	Item	Medical/surgical supplies and devices – charges for supply items required for patient care	0 = General classification 1 = Non-sterile supply 2 = Sterile supply 3 = Take home supplies 4 = Prosthetic/orthotic devices 5 = Pace maker 6 = Intraocular lens 7 = Oxygen take home 8 = Other implants 9 = Other supplies/devices
28x	None	Oncology – charges for the treatment of tumors and related diseases	0 = General classification 9 = Other oncology
29x	Item	Durable Medical Equipment (other than rental) charges for medical equipment that can withstand repeated use	0 = General classification 1 = Rental 2 = Purchase of new DME 3 = Purchase of used DME 4 = Supplies\drugs for DME effectiveness (HHA's only) 9 = Other equipment
30x	Test	Laboratory – charges for the performance of diagnostic and routine clinical laboratory tests	0 = General classification 1 = Chemistry 2 = Immunology 3 = Renal patient (home) 4 = Non-routine dialysis 5 = Hematology 6 = Bacteriology and microbiology 7 = Urology 9 = Other laboratory

CODE	UNIT	DEFINITION	SUBCATEGORY 'x'
31x	Test	Laboratory pathological – charges for diagnostic and routine lab tests on tissue and culture	0 = General classification 1 = Cytology 2 = Histology 4 = Biopsy 9 = Other
32x	Test	Radiology diagnostic – charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs	0 = General classification 1 = Angiocardiography 2 = Arthrography 3 = Arteriography 4 = Chest x-ray 9 = Other
33x	Test	Radiology therapeutic – charges for therapeutic radiology services and chemotherapy required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances	0 = General classification 1 = Chemotherapy injected 2 = Chemotherapy oral 3 = Radiation therapy 5 = Chemotherapy IV 9 = Other
34x	Test	Nuclear medicine – charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients	0 = General classification 1 = Diagnostic 2 = Therapeutic 3 = Diagnostic Radiopharmaceuticals 4 = Therapeutic Radiopharmaceuticals 9 = Other
35x	Scan	CT scan – charges for Computer Tomographic scans of the head and other parts of the body	0 = General classification 1 = Head scan 2 = Body scan 9 = Other CT scan
36x	None	Operating room services – charges for services provided by specifically trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery	0 = General classification 1 = Minor surgery 2 = Organ transplant other than kidney 7 = Kidney transplant 9 = Other operating room services
37x	None	Anesthesia – charges for anesthesia services in the hospital	0 = General classification 1 = Anesthesia incident to RAD 2 = Anesthesia incident to other diagnostic services 4 = Acupuncture 9 = Other anesthesia
38x	Pint	Blood storage and processing – charges for the storage and processing of whole blood	0 = General classification 1 = Blood administration 2 = Whole blood 3 = Plasma 4 = Platelets 5 = Leucocytes 6 = Other components 7 = Other derivatives (cryoprecipitates) 9 = Other blood and blood components
39x		Blood storage and processing – charges for the storage and processing of whole blood	0 = General classification 1 = Blood administration 2 = Processing and Storage 9 = Other blood handling
40x	Test	Other imaging services	0 = General classification 1 = Diagnostic mammography

CODE	UNIT	DEFINITION	SUBCATEGORY 'x'
			2 = Ultrasound 3 = Screening mammography 4 = Positron Emission Tomography 9 = Other imaging services
41x	Treatment	Respiratory services – charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy, through measurement of inhaled and exhaled gases and analysis of blood, and evaluation of the patient's ability to exchange oxygen and other gases	0 = General classification 2 = Inhalation services 3 = Hyper baric oxygen therapy 9 = Other respiratory services
42x	Treatment	Physical therapy – charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities	0 = General classification 1 = Visit 2 = Hourly 3 = Group 4 = Evaluation or re-evaluation 9 = Other physical therapy
43x	Treatment	Occupational therapy – charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients	0 = General classification 1 = Visit 2 = Hourly 3 = Group 4 = Evaluation or re-evaluation 9 = Other occupational therapy
44x	Treatment	Speech language pathology – charges for services provided to persons with impaired functional communications skills	0 = General classification 1 = Visit 2 = Hourly 3 = Group 4 = Evaluation or re-evaluation 9 = Other speech therapy
45x	Visit	Emergency room – charges for emergency room treatment to those ill and injured persons who require immediate unscheduled medical or surgical care	0 = General classification 1 = EMTALA emergency medical screening services 2 = ER beyond EMTALA screening 6 = Urgent care 9 = Other emergency room
46x	Test	Pulmonary function – charges for tests that measure inhaled and exhaled gases and analysis of blood, and for tests that evaluate the patient's ability to exchange other gases	0 = General classification 9 = Other pulmonary function
47x	Test	Audiology – charges for the detection and management of communication handicaps centering in whole or in part on the hearing function	0 = General classification 1 = Diagnostic 2 = Treatment 9 = Other audiology
48x	Test	Cardiology – charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization and exercise stress test.	0 = General classification 1 = Cardiac cath lab 2 = Stress test 3 = Echo cardiology 9 = Other cardiology
49x	None	Ambulatory surgical care – charges for ambulatory surgery that are not covered by other categories	0 = General classification 9 = Other ambulatory surgical

CODE	UNIT	DEFINITION	SUBCATEGORY 'X'
50x	None	Outpatient service- charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service.	0 = General classification 9 = Other outpatient
51x	Visit	Clinic – charges for providing diagnostic, preventive, curative, rehabilitative and education services on a scheduled basis to an ambulatory patient	0 = General classification 1 = Chronic pain center 2 = Dental clinic 3 = Psychiatric clinic 4 = OB-GYN clinic 5 = Pediatric clinic 6 = Urgent care clinic 7 = Family practice 9 = Other clinic
52x	Clinic Visit	Freestanding Clinic provides a breakdown of some clinics that hospitals or third party payers may require	0 = General classification 1 = Rural health – clinic 2 = Rural health – home 3 = Family practice clinic 4 = Visit Rural Health Practitioner to a member in a covered Part A stay at SNF 5 = Visit Rural Health Clinic Practitioner to a member in a SNF 6 = Urgent care clinic 7 = Visiting Nurse Service 8 = Visit by Rural Health Clinic Practitioner to other non Rural Health Clinic Site 9 = Other free standing clinic
53x	Visit	Osteopathic services – charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy	0 = General classification 1 = Osteopathic therapy 9 = Other osteopathic services
54x	Mile/Item/Unit	Ambulance – charges for ambulance service, usually on an unscheduled basis, to the ill and injured who require immediate medical attention	0 = General classification 1 = Supplies 2 = Medical transport 3 = Heart mobile 4 = Oxygen 5 = Air ambulance 6 = Neonatal ambulance services 7 = Pharmacy 8 = EKG transmission 9 = Other ambulance
55x	Skilled Nursing	Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.	0 = General classification 1 = Visit charge 2 = Hourly charge 9 = Other skilled nursing
56x	Visit/Hour	Medical social services such as counseling patients, intervening on behalf of patients, and interpreting problems of social situation rendered to patients on any basis.	0 = General classification 1 = Visit charge 2 = Hourly charge 9 = Other medical social services
57x	Home Health Aide/Visit/Hour	Charges made by an HHA for personnel who are primarily responsible for the personal care of the patient	0 = General classification 1 = Visit charge 2 = Hourly charge 9 = Other home health aide

CODE	UNIT	DEFINITION	SUBCATEGORY 'x'
58x	Other Visit/Hour /Assess	Code indicates the charge by an HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.	0 = General classification 1 = Visit charge 2 = Hourly charge 3 = Assessment 9 = Other home health visits
59x	Unit	This revenue code is used by an HHA that bills (Home Health) on the basis of units of service.	0 = General classification
60x	Oxygen	Code indicates the charges by an HHA for (Home Health) oxygen equipment supplies or contents, excluding purchased equipment. If a beneficiary purchased a stationary oxygen system, and oxygen concentrator or portable equipment, current revenue code 292 or 293 applies. DME (other than oxygen systems) is billed under current revenue codes 291, 292 or 293.	0 = General classification 1 = Oxygen – state/equip/supply/ or content 2 = Oxygen – state/equip/supply under 1 LPM 3 = Oxygen – state/equip/ over 4 LPM 4 = Oxygen – portable add-on 9 = Oxygen – other
61x	Test	MRI – charges for Magnetic Resonance Imaging of the brain and other parts of the body.	0 = General classification 1 = MRI – Brain/Brainstem 2 = MRI/Spinal Cord/Spine 4 = MRI Other 5 = MRA – Head and Neck 6 = MRA – Lower Extremities 8 = MRA – Other 9 = Other MRT
62x	Days	Medicare/Surgical supplies – charges for supply items required for patient care. The category is an extension of code 27x for reporting additional breakdown where needed. Sub code 1 is for providers that cannot bill supplies used for radiology procedures under radiology.	1 = Supplies incident to radiology 2 = Supplies incident to other diagnostic services 3 = Surgical dressing 4 = Investigational device
63x	Drugs Requiring Specific Identification		0 = General classification 1 = Single source drug 2 = Multiple source drug 3 = Restrictive prescription 4 = Erytropepoetin (EPO) - less than 10,000 units 5 = Erytropepoetin (EPO) - 10,000 or more units 6 = Drugs requiring detailed coding 7 = Self-administrable Drug
64x	Home Therapy Services	Charge for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment, and all types of covered therapy.	0 = General classification 1 = Non-routine nursing, Central Line 2 = IV site care, central line 3 = IV start/change peripheral line 4 = Non-routine nursing, peripheral line 5 = Training patient/caregiver, central line 6 = Training, disabled patient, central line 7 = Training patient/caregiver, peripheral line 8 = Training, disabled patient, peripheral line 9 = Other IV therapy services
65x	Day	Hospice service – charges for hospice care	0 = General classification

CODE	UNIT	DEFINITION	SUBCATEGORY 'x'
		services for a terminally ill patient if he/she elects these services in lieu of other services for the terminal condition	1 = Routine home care 2 = Continuous home care 3 = Reserved 4 = Reserved 5 = Inpatient respite care 6 = General non-respite inpatient care 7 = Physician services 8 = Hospice Room and Board Nursing Facility 9 = Other hospice service
68x	Activation	Trauma Response – charges representing the activation of the trauma team	0 = No Used 1 = Level I Trauma 2 = Level II Trauma 3 = Level III Trauma 4 = Level IV Trauma 9 = Other Trauma Response
70x	None	Cast room – charges for services related to the application, maintenance and removal of casts	0= General classification
71x	None	Recovery room	0 = General classification
72x	Labor Room / Delivery Room	Labor room and delivery – charges Delivery Room for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecological procedures if they are performed in the delivery suite.	0 = General classification 1 = Labor 2 = Delivery 3 = Circumcision 4 = Birthing center (unit is days) 9 = Other labor room and delivery
73x	Test	EKG/ECG (electrocardiogram) – charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for diagnosis of heart ailments	0 = General classification 1 = Halter monitor 2 = Telemetry 9 = Other EKG/ECG
74x	Test	EEG (electroencephalogram) – charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders	0 = General classification
75x	Test	Gastrointestinal services – procedure room charges for endoscopic procedures not performed in the operating room.	0 = General classification
76x	None	Treatment or observation room – charges for minor procedures performed outside the operating room	0 = General classification 1 = Treatment room 2 = Observation room 9 = Other Specialty Services
77x	Preventative Care Services	Charges for the administration of vaccines	0 = General classification 1 = Vaccine administration 9 = Other
78x	None	Telemedicine	0 = General Classification
79x	None	Lithotripsy – charges for the use of lithotripsy	0 = General classification

CODE	UNIT	DEFINITION	SUBCATEGORY 'x'
		in the treatment of kidney stones	
80x	Session	Inpatient renal dialysis – a waste removal process performed in an inpatient setting that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the abdominal covering and the tissue (peritoneal dialysis).	0 = General classification 1 = Inpatient hemodialysis 2 = Inpatient peritoneal 3 = Inpatient continuous ambulatory peritoneal dialysis 4 = Inpatient continuous cycling peritoneal dialysis 9 = Other inpatient dialysis
81x	None	Organ acquisition and storage	0 = General classification 1 = Living donor 2 = Cadaver donor 3 = Unknown donor 4 = Unsuccessful organ search – Donor Bank Charges 9 = Other organ acquisition
82x	Hemodialysis Outpatient or Home Dialysis	A waste removal performed in an outpatient or home setting necessary when the body's own kidneys have failed. Waste is removed directly from the blood.	0 = General classification 1 = Hemodialysis/composite or other rate 2 = Home Supplies 3 = Home Equipment 4 = Home Mainenance 5 = Support services 9 = Other hemodialysis outpatient
83x	Peritoneal Dialysis Outpatient or Home	A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.	0 = General classification 1 = Peritoneal/composite or other rate 2 = Home Supplies 3 = Home Equipment 4 = Maintenance 5 = Support services 9 = Other peritoneal dialysis
84x	Continuous Ambulatory Peritoneal Dialysis (CAPD) Outpatient	A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.	0 = General classification 1 = CAPD/composite or other rate 2 = Home Supplies 3 = Home Equipment 4 = Maintenance 5 = Support services 9 = Other CAPD dialysis
85x	Continuous Cycling Peritoneal Dialysis (CCPD) Outpatient	A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.	0 = General classification 1 = CCPD/composite or other rate 2 = Home Supplies 3 = Home Equipment 4 = Maintenance 5 = Support services 9 = Other CCPD dialysis
86x	Tests	Magneto encephalography (MEG) – Charges for operation of specialized medical equipment to measure the magnetic fields generated by brain activity	0 = General Classification 1 = MEG
87x	Reserved		
88x	Session	Miscellaneous dialysis – charges for dialysis services not identified elsewhere	0 = General classification 1 = Ultrafiltration 2 = Home Dialysis Aid Visit 9 = Other miscellaneous dialysis

CODE	UNIT	DEFINITION	SUBCATEGORY
89x	Reserved		
90x	Visit	Behavioral Health Treatments / Services	0 = General classification 1 = Electroshock treatment 2 = Milieu therapy 3 = Play therapy 4 = Activity therapy 5 = Intensive Outpatient Services – Psychiatric 6 = Intensive Outpatient Services - Clinical Dependency 7 = Community Behavioral Health Program 9 = Other 6 = Family therapy
91x	Visit	Behavioral Health Treatments/Services	1 = Rehabilitation 2 = Partial hospitalization – Less Intensive 3 = Partial Hospitalization - Intensive 4 = Individual therapy 5 = Group therapy 6 = Family therapy 7 = Biofeedback 8 = Testing 9 = Other Behavioral Health Treatments
92x	Test	Other diagnostic services	0 = General classification 1 = Peripheral vascular lab. 2 = Electromyelogram 3 = Pap smear 4 = Allergy test 5 = Pregnancy test 9 = Other diagnostic service
94x	Visit	Other therapeutic services – charges for other therapeutic services not otherwise categorized	0 = General classification 1 = Recreational therapy 2 = Education or training 3 = Cardiac rehabilitation 4 = Drug rehabilitation 5 = Alcohol rehabilitation 6 = Routine complex medical equipment 7 = Ancillary complex medical equipment 8 = Pulmonary rehabilitation 9 = Other therapeutic services
96x	None	Professional fees – charges for medical professionals that the hospitals or third party payers require to be separately identified on the billing form	0 = General classification 1 = Psychiatric 2 = Ophthalmology 3 = MD anesthesiologist 4 = CRNA anesthetist 9 = Other professional fees
97x	None	Professional fees – continued	1 = Laboratory 2 = Radiology – diagnostic 3 = Radiology – therapeutic 4 = Radiology – nuclear medicine 5 = Operating room 6 = Respiratory therapy 7 = Physical therapy 8 = Occupational therapy 9 = Speech pathology
98x	None	Professional fees – continued	1 = Emergency room

CODE	UNIT	DEFINITION	SUBCATEGORY X
			2 = Outpatient services 3 = Clinic 4 = Medical social services 5 = EKG 6 = EEG 7 = Hospital visit 8 = Consultation 9 = Private duty nurse
99x	None	Patient convenience items – charges for items that are generally considered by the third party payer to be strictly convenience items and as such, are not covered	0 = General classification 1 = Cafeteria/guest tray 2 = Private linen service 3 = Telephone/telegraph 4 = TV/radio 5 = Non-patient room rentals 6 = Late discharge charge 7 = Admission kits 8 = Beauty shop/barber 9 = Other convenience items
100x	None	Behavioral health Accommodations – charges for routine recommendations at specific health facilities	0 = General Classification 1 = Residential Treatment – Psychiatric 2 = Residential Treatment – Clinical Dependency 3 = Supervised Living 4 = Halfway House 5 = Group Home

APPENDIX C
ACRONYM LISTING

ACRONYM	DESCRIPTION
ADH	Arkansas Department of Health
ASCII	PC Text File
CAH	Critical Access Hospital
CAPD	Continuous Ambulatory Peritoneal Dialysis
CCPD	Continuous Cycling Peritoneal Dialysis
CD	Compact Disk
COBOL	Common Business Oriented Language
CPT	Current Procedural Technology
CR	Carriage-return
CT	Computer Tomographic
DAT	PC Text File
DCN	Document Control Number
DME	Durable Medical Equipment
DRG	Diagnosis Related Group
EEG	Electroencephalogram
EIN	Employer Identification Number
EKG/ECG	Electrocardiogram
EPO	Erythropoetin alpha or Darbepoetin alpha
FTP	File Transfer Protocol
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedural Coding System
HDDS	Hospital Discharge Data System
HH	Home Health
HHA	Home Health Agency
HIPPA	Health Insurance Portability and Accountability Act of 1996
ICD	International Classification of Diseases
ICF	Intermediate Care Facility
IRF	Inpatient Rehabilitation Facility
LF	Line-feed
LTCH	Long Term Care Hospital
MDC	Major Diagnostic Categories
MRI	Magnetic Resonance Imaging
NPI	National Provider Identifier
NUBC	National Uniform Billing Committee
PPS	Prospective Payment System
QTR	Quarter
RTC	Residential Treatment Center
SNF	Skilled Nursing Facility

TIN	Tax Identification Number
TOB	Type of Bill
TXT	Text
UB	Uniform Billing
UPIN	Universal Physician Identification Number
ZIP	Compressed file

APPENDIX D
REFERENCES

D1 RESOURCE LIST

D2 RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM

D3 ARKANSAS CODE – "STATE HEALTH DATA CLEARING HOUSE ACT"

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D1. RESOURCE LIST

Current Procedural Terminology

Published by the American Medical Association; ISBN 3-89970-792-0.

May be purchased from:

Order Department
Reference OP054194HA
American Medical Association
PO Box 10950
Chicago, IL 60610
(800) 621-8335

National Uniform Billing Committee (NUBC)

Official UB-04 Data Specifications Manual 2011, Version 5.00, July 2010

Uniform Billing (UB-04)

CMS Manual System, Pub100-04 Medicare Claims Processing, Transmittal 1104, November 3, 2006, Department of Health and Human Services, Centers for Medicare & Medicaid Services or www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf

HCFA Common Procedural Coding System (HCPCS)

Published by the Centers for Medicare and Medicaid Service, (formerly HCFA)

International Classification of Diseases, Ninth Edition (ICD-9)

Published by the Centers for Medicare and Medicaid Service, and the National Center for Health Statistics.

The materials published by the Centers for Medicare and Medicaid Service may be purchased from:

Government Printing Office
U.S. Government Bookstore
710 North Capitol Street N.W.
Washinton, DC
http://bookstore.gpo.gov/

Health Research and Educational Trust Disparities Toolkit

Authored by Hasnain-Wynia,R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter,j. (2007). hretdisparities.org.

Some materials may also be purchased from large commercial bookstores and from medical office supply firms. These documents are also available for use by the general public at the Arkansas State Library and may be available from your local library by an interlibrary loan.

Arkansas State Library
Documents Service
One Capitol Mall
Little Rock, AR 72201
(501) 682-2326

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D2. RULES AND REGULATIONS PERTAINING TO HOSPITAL DISCHARGE DATA SYSTEM (HDDS)

SECTION I. AUTHORITY.

The following Rules and Regulations pertaining to the Hospital Discharge Data System are duly adopted and promulgated by the Arkansas Board of Health pursuant to the authority expressly conferred by the State of Arkansas including, without limitation, Act 670 of 1995 (the Act), as amended, the same being Ark. Code Ann. § 20-7-301 et seq. The Act established the State Health Data Clearing House within the Arkansas Department of Health. The Clearing House is mandated by the Act to acquire and disseminate health care information in order to understand patterns and trends in the availability, use and costs of health care services in the state. Subsection (h) of the Act directs the Arkansas State Board of Health to prescribe and enforce such rules and regulations as may be necessary to carry out the purpose of this Act.

SECTION II. PURPOSE.

It is the purpose of these regulations to provide direction about the required collection, submission, management and dissemination of health data.

SECTION III. DEFINITIONS.

For the purposes of these Regulations, the following words and phrases when used herein shall be construed as follows:

A. "**Act**" means the State Health Data Clearing House Act 670 of 1995, Ark. Code Ann. § 20-7-301 et seq;

B. "**Aggregate data set**" means a compilation of raw data that has been subject to a critical edit check and consists of at least a small cell count. Aggregate data sets shall not include the following data elements: hospital control number; patient control number; attending physician number, or any element which might be used to identify an individual patient;

C. "**Board" or "State Board**" means the Arkansas State Board of Health;

D. "**Confidential information**" means that information which the State Board has defined to be confidential in these regulations and procedures;

E. "**Department**" means the Arkansas Department of Health;

F. "**Director**" means the director of the Arkansas Department of Health;

G. "**Hospital**" means any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which is subject to licensure by the Arkansas Department of Health (Ark. Code Ann. § 20-9-201 et seq);

H. "**Submit,**" "**submission**" or "**submittal**" means, with respect to data, reports, surveys, statements and documents required to be filed with the Department: 1) delivery to the Arkansas

Department of Health, by the close of business on the prescribed filing date, or 2) deposit with the United States Postal Service, postage prepaid, addressed to the Arkansas Department of Health, in sufficient time so that the mailed materials will arrive by the close of business on the prescribed filing date;

I. "**Guide(s)**" means the Hospital Discharge Data Submittal Guide(s) published by the Arkansas Department of Health. The Guide(s) contains technical information relating to data format, media and submittal time frames.

SECTION IV. GENDER AND NUMBER.

All terms used in any one gender or number shall be construed to include any other gender or number.

SECTION V. HOSPITAL DISCHARGE DATA SUBMITTAL.

Each Arkansas hospital shall submit patient data to the Department in a manner that complies with the provisions of the Guide(s), which includes all inpatient hospital discharges occurring on or after January 1, 1996, and all emergency department discharges on or after January 1, 2012.

SECTION VI. ADDITIONAL DATA REQUIRED TO BE SUBMITTED.

In addition to data prescribed for submission in the Guide(s), the following data must be submitted according to the schedule provided: Each hospital shall provide a complete and accurate copy of the American Hospital Association's Annual Survey to the Arkansas Department of Health or the Arkansas Hospital Association. The required submission date will be published annually with the distribution of the survey.

SECTION VII. EXTENSION OF TIME.

The State Board or the Director shall, upon a showing of good cause and if time permits, extend the time allowed for the performance of any function or duty required by the provisions of the Act or of these regulations and rules. In making any determination with regard to good cause, the Board and the Director shall give due consideration to all relevant facts and circumstances, including such considerations as the complexity of the issues or the existence of extraordinary circumstances or unforeseen events which have led to the request for an extension of time. The State Board or the Director shall act upon a request for an extension of time within thirty (30) days of receiving the written request by the hospital. Failure to act within thirty (30) days shall be deemed as a grant of the extension.

SECTION VIII. AUTHORIZED USE OF DATA.

Information reported to the Department shall not be disclosed except as authorized by the Arkansas law. See Ark. Code Ann. § 20-7-305 as amended.

SECTION IX. ACCESS TO AGGREGATE REPORTS.

All reports generated by the Department from the aggregate data set for a member of the general public are open for public inspection. The Department shall provide copies of these reports, upon

request, at a cost of $.25 per page. The Department shall determine fees to be charged to cover the direct and indirect costs for providing other information requests or special compilations from aggregate data sets. The fee shall include staff time, computer time, copying costs, postage and supplies.

SECTION X. PENALTIES FOR NON-COMPLIANCE.

Ark. Code Ann. § 20-7-301 et seq. sets forth civil and criminal penalties for non-compliance with provisions of the Act and of rules and regulations adopted by the Arkansas State Board of Health to implement the Act, as follows:

A. Any person, firm, corporation, organization or institution that violates any of the provisions of Ark. Code Ann. § 20-7-301 et seq., or any rules or regulations promulgated thereunder, regarding confidentiality of information, shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not less than one hundred dollars ($100) nor more than ($500), or by imprisonment not exceeding one month, or both. Each day of violation shall constitute a separate offense.

B. Any person, firm, corporation, organization or institution knowingly violating any of the provisions of Ark. Code Ann. § 20-7-301 et seq., or any rules or regulations promulgated thereunder, shall be guilty of a misdemeanor and, upon a plea of guilty, a plea of nolo contendere or conviction, shall be fined not more than five hundred dollars ($500).

C. Every person, firm, corporation, organization or institution that violates any of the rules or regulations adopted by the Arkansas State Board of Health or that violates any provision of Act 670 may be assessed a civil penalty by the Board. The penalty shall not exceed two hundred fifty dollars ($250) for each violation. No civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-101, et seq.

SECTION XI. HEARING AND APPEAL.

Hearings and appeals will be conducted according to the Adjudication and Rule Making Sections of the Department's Administrative Procedures previously promulgated by the Department and any revisions thereto.

SECTION XII. MAINTENANCE OF REGULATIONS AND PROCEDURES.

All pages of these regulations and rules, and of the Hospital Discharge Data Submittal Guide(s), issued by the Department are dated at the bottom. As changes occur, replacement pages will be issued or replacement guide(s) will be issued. All replacement pages or replacement guides will be dated so that users may be certain they are referring to the most recent information.

SECTION XIII. INCORPORATION BY REFERENCE.

The following documents are hereby incorporated by reference:

A. The most recent edition of the International Classification of Diseases, Clinical Modifications. Copies are available from the National Center for Health Statistics, 3311 Toledo Road, Hyattsville, Maryland 20782 or website, www.cdc.gov/nchs/icd.htm.

B. Uniform Hospital Billing Form 2004 (UB04/CMS-1450). Copies are available from the Office of Public Affairs, Center for Medicare and Medicaid Services, Humphrey Building, Room 428-H, 200 Independence Avenue S.W., Washington, D.C. 20201 or website, www.cms.hhs.gov/cmsforms/. All incorporated material is available for public review at the central administrative office of the Department.

SECTION XIV. SEVERABILITY.

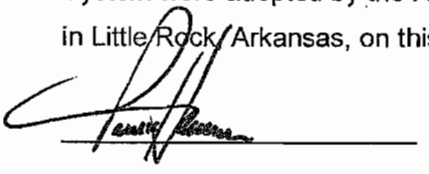
If any provision of these Rules and Regulations or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of these Rules and Regulations which can give effect without the invalid provisions or applications, and to this end the provisions hereto are declared severable.

SECTION XV. REPEAL.

All regulations and parts of regulations in conflict herewith are hereby repealed.

CERTIFICATION

This will certify that the foregoing Rules and Regulations for the Hospital Discharge Data System were adopted by the Arkansas Board of Health at a regular session of the Board held in Little Rock, Arkansas, on this 26th day of January, 2012.



_____ Secretary, Arkansas Board of Health

D3. ARKANSAS CODE – "STATE HEALTH DATA CLEARING HOUSE ACT"

20-7-301. Title.

This subchapter shall be entitled the "State Health Data Clearinghouse Act".

HISTORY: Acts 1995, No. 670, § 1.

20-7-302. Purpose.

The General Assembly finds that as a result of rising health care costs, the shortage of health professionals and health care services in many areas of the state, and the concerns expressed by care providers, consumers, third-party payors, and others involved with planning for the provision of health care, there is an urgent need to understand patterns and trends in the availability, use, and costs of these services. Therefore, to establish an information base for patients, health professionals, and hospitals, to improve the appropriate and efficient usage of health care services, and to provide for appropriate protection for confidentiality and privacy, the Division of Health of the Department of Health and Human Services shall act as a state health data clearinghouse for the acquisition and dissemination of data from state agencies and other appropriate sources to carry out this subchapter.

HISTORY: Acts 1995, No. 670, § 2.

20-7-303. Collection and dissemination of health data.

(a) With the approval of the State Board of Health, the Director of the Division of Health of the Department of Health and Human Services shall compile and disseminate health data collected by the Division of Health of the Department of Health and Human Services.

(b) (1) In consultation with advisory groups appointed by the director with representation from hospitals, outpatient surgery centers, health profession licensing boards, and other state agencies, the division should:

(A) Identify the most practical methods to collect, transmit, and share required health data as described in § 20-7-304;

(B) Utilize, wherever practical, existing administrative databases and modalities of data collection to provide the required data;

(C) Develop standards of accuracy, timeliness, economy, and efficiency for the provision of the data; and

(D) Ensure confidentiality of data by enforcing appropriate rules and regulations.

(2) To maximize limited resources and to prevent duplication of effort, the division may consider, when appropriate, contracting with private entities for the collection of data as set forth in this section subject to this subchapter.

(c) (1) All state agencies, including health profession licensing, certification, or registration boards and commissions, which collect, maintain, or distribute health data, including data relating to the Medicaid program, shall make available to the division such data as are necessary for the division to carry out its responsibilities under this subchapter or such rules and regulations as may be adopted as provided in § 20-7-305.

(2) If health data are already reported to another organization or governmental agency in the same manner, form, and content or in a manner, form, and content acceptable to the division, the director may obtain a copy of the data from the organization or agency, and no duplicative report need be submitted by the organization.

(3) All hospitals and outpatient surgery centers licensed by the state shall submit information in a form and

manner as prescribed by rules and regulations by the board pursuant to § 20-7-305. However, if the same information is being collected by another state agency, the division shall obtain the data from the other state agency.

HISTORY: Acts 1995, No. 670, § 2.

20-7-304. Release of health data.

The Director of the Division of Health of the Department of Health and Human Services may release data collected under this subchapter, except that data released shall not include any information which identifies or could be used to identify any individual patient, provider, institution, or health plan except as provided in § 20-7-305.

HISTORY: Acts 1995, No. 670, § 2.

20-7-305. State Board of Health to prescribe rules and regulations -- Data collected not subject to discovery.

(a) The State Board of Health shall prescribe and enforce such rules and regulations as may be necessary to carry out this subchapter, including the manner in which data are collected, maintained, compiled, and disseminated, and including such rules as may be necessary to promote and protect the confidentiality of data reported under this subchapter.

(b) Data provided, collected, or disseminated under this subchapter which identifies, or could be used to identify, any individual patient, provider, institution, or health plan shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(c) (1) (A) The Department of Human Services may provide data only for purposes of research and aggregate statistical reporting to the Arkansas Center for Health Improvement, the Agency for Healthcare Research and Quality for its Healthcare Cost and Utilization Project, or other researchers for research projects approved by the Department of Health to rules promulgated by the State Board of Health that provide for appropriate security and confidentiality protections for the data.

(B) The Department of Human Services also shall provide data to the Arkansas Hospital Association for its price transparency and consumer-driven health care project that will make price and quality information about Arkansas hospitals available to the general public.

(2) The data shall be treated in a manner consistent with all state and federal privacy requirements, including, without limitation, the federal Health Insurance Portability and Accountability Act of 1996 privacy rule, specifically 45 C.F.R. § 164.512(i).

(3) Any identifiable data provided, collected, or disseminated under this subsection shall not be subject to discovery pursuant to the Arkansas Rules of Civil Procedure or the Freedom of Information Act of 1967, § 25-19-101 et seq.

(d) It shall be unlawful for the center to release any patient-identifying information to any nongovernmental third party.

HISTORY: Acts 1995, No. 670, § 2; 2005, No. 1434, § 1; 2007, No. 616, § 1.

20-7-306. Reports -- Assistance.

(a) The Director of the Department of Health shall prepare and submit a biennial report to the Governor and the House Interim Committee on Public Health, Welfare, and Labor and the Senate Interim Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof.

(b) The Department of Health shall provide assistance to the House Interim Committee on Public Health,

Welfare, and Labor and the Senate Interim Committee on Public Health, Welfare, and Labor or appropriate subcommittees thereof in the development of information necessary in the examination of health care issues.

(c) (1) (A) With regard to §§ 6-18-702(d), 6-60-504(b), and 20-78-206(a)(2)(B), the department shall report every six (6) months to the committees regarding:

(i) The geographic patterns of exemptions, vaccination rates, and exemptions in those areas as well as the rest of the state; and

(ii) Disease incidence of vaccine-preventable diseases collected by the division.

(B) The collection of exemption information shall begin January 4, 2004.

(C) Reports shall begin at the first interim meeting of the committees.

(2) [Repealed.]

(3) [Repealed.]

HISTORY: Acts 1995, No. 670, § 2; 1997, No. 179, § 22; 2003, No. 999, § 4; 2007, No. 827, § 148.

20-7-307. Penalties.

(a) (1) Any person, firm, corporation, organization, or institution that violates any of the provisions of this subchapter or any rules and regulations promulgated under this subchapter regarding confidentiality of information shall be guilty of a Class C misdemeanor.

(2) Each day of violation shall constitute a separate offense.

(b) Any person, firm, corporation, organization, or institution knowingly violating any of the provisions of this subchapter or any rules and regulations promulgated under this subchapter shall be guilty of a violation and upon conviction shall be punished by a fine of not more than five hundred dollars ($500).

(c) (1) Every person, firm, corporation, organization, or institution that violates any of the rules and regulations adopted by the State Board of Health or that violates any provision of this subchapter may be assessed a civil penalty by the board.

(2) The civil penalty shall not exceed two hundred fifty dollars ($250) for each violation.

(3) However, no civil penalty may be assessed until the person charged with the violation has been given the opportunity for a hearing on the violation pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

HISTORY: Acts 1995, No. 670, § 3; 2005, No. 1994, § 243.

20-7-308. Repealer.

All laws and parts of laws in conflict with this subchapter are repealed, except that nothing in this subchapter shall be interpreted to repeal any provision which authorizes the Health Services Permit Agency to gather such data as may be necessary to conduct permit-of-approval activities.

HISTORY: Acts 1995, No. 670, § 6.

20-7-309. List of substances used to alter samples in drug or alcohol screening tests.

The Division of Health of the Department of Health and Human Services shall maintain and update as part of its database under this subchapter a list of substances that may be used to adulterate urine or other bodily fluids

that may be used in or used to interfere with a drug or alcohol screening test.

HISTORY: Acts 2003, No. 750, § 1.

20-7-310. Construction with other laws.

Nothing in this act shall be construed to encourage, conflict, or otherwise interfere with the preemption of state and local laws under any federal laws or United States Department of Transportation regulations related to drug testing procedures and confidentiality.

HISTORY: Acts 2003, No. 750, § 2.

APPENDIX E
UB-04 CLAIM FORM