Rhode Island Hospital Discharge Data Reporting Manual

Specifications for Uniform Reporting of Financial and Statistical Data: Hospital Inpatient Discharges

June 2004

Rhode Island Department of Health, Office of Health Statistics

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July 15, 2004 (Patient Status appendix)
Dec 2, 2004 (Ecode requirement p16, Other Physician State License Number, p25, Edit and Validation section, Appendices 5 & 6)
May 19, 2005 (Patient Status appendix p44)

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Overview

Financial and statistical data on hospital inpatient stays have been collected by regulations promulgated by the Rhode Island Department of Health pursuant to its licensure authority (Rhode Island General Law Chapter 23-17, Section 17.0 of the *Rules and Regulations for Licensing of Hospitals*). Revised regulations, effective October 1, 2004 (Section 17.5) authorizes the Rhode Island Department of Health to issue data and technical specifications to be used in the uniform reporting of hospital inpatient discharge data. This manual defines the data and technical specifications with which hospitals must comply in reporting to the Rhode Island Department of Health, Office of Health Statistics, directly or though a third party, and provides information on transmission specifications, data element layout and description, and quality assurance. Please note that data and technical specifications have been modified from previous reporting requirements.

The Office of Health Statistics gives hospitals flexibility in the method they use to meet the data reporting requirement. Hospitals should consider their available data sources when selecting the most efficient method of data reporting. It is anticipated that the majority of hospitals will select to extract much of the required data from the existing billing system and this manual was developed to coincide with the data element definitions and specifications from the National Uniform Billing Committee to the extent that is possible.

Hospitals are required to report data for every hospital inpatient stay in compliance with the specifications in this manual for discharges occurring on or after October 1, 2004. Newborns are to be reported as a discharge separate from the mother's discharge and charges associated with the newborn's inpatient stay are to be reported with the newborn record and not included on the mother's record.

It is anticipated that payer-specific reporting requirements will decrease the reporting burden for hospitals under existing internal information systems. At this time, reporting requirements will be dependent upon whether the expected source of payment requires the generation of a single bill for patients receiving care across settings (e.g. emergency services, observation services, inpatient stay) during a single episode of treatment or a separate bill for each setting. All inpatient stays in which the patient does not utilize any other type of care setting must be reported as specified in this manual. While the current reporting requirements are payer-specific for patients utilizing multiple types of care, the Department of Health will work with hospital representatives to generate uniform reporting requirements that are consistent across all payers for all patients. Hospitals are advised to keep this longer-term goal in mind when making any required modifications to internal information systems to meet the current reporting requirements.

For all payers requiring the generation of a separate bill for each type of care a patient receives during a single episode of treatment, only information relating to the inpatient stay should be reported as part of the hospital discharge data system. Information relating to other type of care settings, such as emergency and observation services, should

be reported as a separate record to the emergency and observation data systems, respectively. For these payers, the charges, diagnoses and procedures reported to the hospital discharge data system should only include charges, diagnoses and procedures associated with the inpatient stay.

For all payers requiring the generation of a single bill for patients receiving care in multiple care settings, only one record should be reported for a patient per visit or stay. The patient level information should be reported to the data system corresponding to the patient's last site of care. Patients seen in the emergency room and/or observation services prior to inpatient admission should be reported with the hospital discharge data for these payers. For patients receiving care in more than one care setting, the generation of a single bill indicates that information regarding charges, diagnoses and procedures made in or related to all care settings will be included in the single record reported to the data system related to the last care setting utilized during the episode of treatment. Data element descriptions provided in the Data Element Layout and Description section of this manual indicate to only include information related to the inpatient stay. For payers requiring the generation of a single bill, it is understood that charges, diagnoses and procedures will contain information covering multiple care settings for patients utilizing more than one type of care.

Transmission Specifications

Frequency of Reporting
Hospitals shall submit financial and statistical data on a quarterly basis to the Rhode Island Department of Health, Office of Health Statistics, directly or through a third party. Each submission shall include data on every hospital inpatient stay occurring during the three (3) month periods ending on March 31, June 30, September 30, and December 31. Hospital inpatient stays with discharge dates that occur in the range of dates for the quarter must be included. The data for each three (3) month period shall be submitted no later than ninety (90) days after the end of the three (3) month period covered. See below for the submission schedule.

Calendar Year Quarter	Quarterly Data Must be Reported by:
January 1 – March 31	June 30
April 1 – June 30	September 30
July 1 – September 30	December 31
October 1 – December 31	March 31 (of subsequent calendar year)

Hospitals are given the option of reporting data for the first one-month period (October 1 through October 31, 2004) as soon as the data is available to test compliance with the revised data specifications. [Note that hospitals submitting data through a third party must obtain consent of the third party in order to do so.] The Office of Health Statistics will provide feedback to the hospitals choosing to do so in efforts to prevent hospitals from having to make a large number of corrections after the first quarterly data submission.

Data File Format
The data must be submitted in a fixed-length ASCII file format. There must be a non-blank character filler at the end of each hospital inpatient discharge record. The filler must be a one character "Z" in column 798.

Data Submission Format
The data for hospital inpatient discharges must be submitted on a 1.44MB diskette or compact disk (CD) with a total capacity of 650 megabytes. Each media must have a separate electronic label file (e.g. Readme.txt) that includes the following information:

a) Hospital name;
b) Geographic premise (if applicable);
c) Name of data supplier;
d) Submittal date;
e) Beginning and ending dates of calendar quarter contained in the file;
f) Name, telephone number and e-mail of a contact person for all matters relevant to the data submission;
g) Number of discharges reported;
h) Sequence number (if applicable). If multiple diskettes or CD-ROMs are submitted, a sequence number must indicate the processing order.

Data submissions are to be mailed to:

Rhode Island Department of Health
Office of Health Statistics
3 Capitol Hill, Room 407
Providence, RI 02908
ATTN: Hospital Discharge Processing

Hospitals shall retain copies of all data submissions and corrections submitted to the Office of Health Statistics for no less than one (1) year after the end of the three (3) month period covered.

If a hospital designates a third party to submit data on their behalf, the hospital must still provide the information on the electronic label file with hospital specific information. Hospitals are responsible for timely, complete and accurate submission of data and corrections per the timeframe given above.

Editing and Validation

The Office of Health Statistics will perform a variety of edits for quality assurance purposes and compliance with the specifications set forth in the reporting manual. Data submissions not meeting a minimum level of acceptance criteria will be rejected. The standards for accepting or rejecting data submissions will be based on the presence of Category A and B errors (defined in Date Element Layout and Description). Edits on both individual patient records and the data submission as a whole will be performed. See below for the rejection criteria for individual records and the entire data submission.

	Rejection Criteria
Individual Record	Presence of one or more Category A errors; or
	Presence of two or more Category B errors
Data Submission	Any error in Emergency Department Facility Code or Geographic Premise; or
	1% or more of discharges are rejected; or
	50 consecutive records are rejected; or
	Aggregate patterns of errors in data submission (See end of this section for description)

Rejected submissions will be returned to the hospital for correction. Hospitals will receive an error report and will have 20 working days to re-submit the corrected quarterly data after notification that corrections are required. Hospitals will have up to two (2) opportunities to correct rejected submissions.

The Office of Health Statistics will perform at least the following computer edits on each data submission. Hospitals are encouraged to review the data records for accuracy and completeness corresponding to these edits prior to submission.

General Edit: All data elements must have the correct field type (alphanumeric or numeric). Please note that some edits are applied only to one or two of the three databases (Inpatient, Emergency and Observation). Edits are marked if they are applicable to a specific database. Edits followed with "**(W)"** will be flagged as warnings only. These flags should occur infrequently and indicate that the data should be reviewed and verified but may not indicate an actual error.

Data Element	**Edit Checks Performed**
Facility Code	Missing
	Invalid Facility Code
	Inconsistent with Geographic Premise
Patient ZIP Code	Missing
	Invalid Patient ZIP code
	Inconsistent with Patient State Code
Census Tract	Missing
	Invalid Census Tract
	Inconsistent with Patient State Code

Patient Birth Date	Missing
	Invalid Birth Date Invalid format Day inconsistent with month Month, day or year component out of valid range
	Birth Date occurring after Admission Date or Discharge Date
	Birth Date occurring after Procedure Date
	Birth Date not equal to Admission Date for hospital newborn (Principal Diagnosis = V30-V39, 4th digit 0)
Patient Gender Code	Missing
	Invalid Gender Code
	Inconsistent with Principal and Other Diagnosis (See Appendix 5. Diagnoses for details)
	Inconsistent with Principal and Other Procedures (See Appendix.6. Procedures)
Patient Race	Missing
	Invalid Race code
Admission Date	Missing
	Invalid Admission Date Invalid format Day inconsistent with month Month, day or year component out of valid range
	Admission Date occurring after Discharge Date
	Admission Date more than 2 days (OBS) or 24 hrs (ED) prior to Discharge Date [ED/ OBS] **(W)**
	Admission Date more than 100 days before Discharge Date [IP] **(W)**
Admission Type Code	Missing
	Invalid Admission Type
	Inconsistent with Admission Source Code, if newborn
Admission Source Code	Missing
	Invalid Admission Source Code
	Inconsistent with Type of Admission, if Type of Admission = Newborn
	Inconsistent with ED Charges (if Admission Source = 7 [ED], ED charges must be present if payer requires single bill)
Patient Status Code	Missing
	Invalid Patient Status code
Discharge Date	Missing
	Invalid Discharge Date Invalid format Day inconsistent with month Month, day or year component out of valid range
	Discharge Date prior to Admission Date
	Discharge Date more than 2 days (OBS) or 24 hrs (ED) after Admission Date [ED/OBS] **(W)**
	Discharge Data more than 100 days after Admission Date [IP] **(W)**

Medical Record Number	Missing
	Inconsistent with inpatient or other outpatient MRN if record indicates preceding or subsequent visit (e.g. Admission Source = 7, ED charges present,) and payer requires separate bills [Requires linking ED, OBS and IP files]
Expected Source of Coverage	Missing
	Invalid Expected Source of Coverage code
	Inconsistent with Expected Type of Coverage (See Appendix 12)
	Inconsistent with Age (If W, age must be greater than 15 years)
Expected Type of Coverage	Invalid Expected Type of Coverage code
	Inconsistent with Expected Source of Coverage (See Appendix 12)
Principal Diagnosis	Missing
	Invalid ICD-9-CM code, based on Discharge Date or 799.9
	Ecode in Principal Diagnosis field
	Inconsistent with Patient Gender Code (See Appendix 5. Diagnoses for details)
	Duplicate diagnosis code
Other Diagnosis (1-10 ED/OBS; 1-24 IP)	Invalid ICD-9-CM code, based on Discharge Date
	Presence of nonadjacent Other Diagnosis codes
	Inconsistent with Patient Gender Code (See Appendix 5. Diagnoses for details)
	Duplicate diagnosis code
Principal External Cause of Injury (Ecode)	Missing Principal Ecode when any diagnosis code is in the range of 800.00-909.2, 909.4, 909.9, 910 – 994, 995.5, 995.80 – 995.85 (Additional ecodes should be reported in the Other Diagnosis fields)
	Invalid ICD-9-CM Ecode (Out of range E800-E999, excluding E849.0-E849.9) based on Discharge Date
	Ecode blank if ecode present in Principal or Other Diagnosis field
Principal Procedure Code	Invalid ICD-9-CM code, based on Discharge Date [IP]
	Invalid HCPCS/CPT code, based on Discharge Date [ED/OBS]
	Inconsistent with Principal Procedure Date field (if either is present, both must be present)
Other Procedure Code (1-10 ED/OBS; 1-24 IP)	Invalid ICD-9-CM code, based on Discharge Date [IP]
	Invalid HCPCS/CPT code, based on Discharge Date [ED/OBS]
	Inconsistent with Other Procedure Date field (if either is present, both must be present)
	Presence of non-adjacent Other Procedure Code
Principal Procedure Date	Missing, if Principal Procedure is present
	Invalid Principal Procedure Date Invalid format Day inconsistent with month Century, month, day or year component out of valid range
	Principal Procedure Date greater than 3 days prior to admission date
	Principal Procedure Date after Discharge Date
	Inconsistent with Principal Procedure Code (if either is present, both must be present)
	Principal Procedure Date before Birth Date

Other Procedure Date (1-10 ED/OBS; 1-24 IP)	Invalid Other Procedure Date Invalid format Day inconsistent with month Month, day or year component out of valid range
	Other Procedure Date greater than 3 days prior to admission date
	Other Procedure Date after Discharge Date
	Other Procedure Date before Birth Date
	Inconsistent with Other Procedure Code (if either is present, both must be present)
Birth Weight	Missing, if newborn record (Newborn defined V30-V39 in DX1)
	Birth weight less than 0453 g or greater than 4893g
Attending Physician State License Number	Missing
	Invalid State License Number
Operating Physician State License Number	Invalid State License Number
	Missing or zero filled when Principal Procedure is present
ICU, CCU and NICU Days [IP]	Missing or zero filled when Special Care Unit Charges are present
Hospital Service [IP]	Missing
	Invalid Hospital Service Code
Diagnosis Related Group [IP]	Missing;
	Invalid DRG code, based on discharge date
Charges (All charge categories)	Missing Total Charges or Room and Board Charges [IP]
	Total Charges less than $25 [IP]
	Total Charges greater than $1,000,000 [IP] $50,000 [ED/OBS] **(W)**
	Total Charges greater less than $100 or greater than $40,000 per day of stay [IP] **(W)**
Length of Stay	Not equal to Discharge Date– Admission Date [Discharge/Admission Hour will be used for ED and OBS records]
	Length of Stay greater than 100 days [IP] **(W)**
	Length of Stay greater than 2 days [OBS] or 24 hrs [ED] **(W)**
Patient Ethnicity	Missing
	Invalid Ethnicity code
Patient State Code	Missing
	Invalid State code
	Inconsistent with Patient ZIP code
	Inconsistent with Census Tract
Patient Stated Reason for Visit [ED]; Admitting Diagnosis [OBS/IP]	Missing
	Invalid ICD-9-CM code, based on Discharge Date
	Inconsistent with Patient Gender Code (See Appendix 5. Diagnoses for details)
Other Physician State License Number	Invalid State License Number
Geographic Premise	Missing
	Invalid Geographic Premise Code
	Inconsistent with Hospital Facility Code

Emergency Room Professional Fees	Missing, if applicable
Emergency Room Charges	Missing, if applicable. [Must be present on all ED records; Must be present all on IP and OBS records if Admission Source = 7 if payer requires a single rolled-up bill]
Mode of Arrival	Missing, if applicable [Must be present on all ED records; Must be present all on IP and OBS records with Admission Source = 7 if payer requires a single rolled-up bill]
	Invalid Mode of Arrival code, if applicable [Required for all ED visits and on OBS/IP records when payer requires single bill]
Observation Room Charges	Inconsistent with Observation Hours (if either is present, both must be present)
Observation Hours	Inconsistent with Observation Room Charges (if either is present, both must be present)
	Observation Hours greater than 2 days **(W)**
	Not equal to Discharge Date/Hour – Admission Date/Hour
Discharge Hour [ED/OBS]	Missing
	Must be a valid Time Format code
	Must be after the Admission Hour unless on different days
Admission Hour [ED/OBS]	Missing
	Must be a valid Time Format code
	Must be before the Discharge Hour unless on different days

Data Elements Computed by Rhode Island Department of Health	
Age (in years)	Age less than 0 years
	Age greater than 100 years **(W)**
	Neonatal diagnosis inconsistent with Age (See Appendix 5. Diagnoses for details)
Length of Stay	Computed Length of Stay greater than 100 days [IP] **(W)**
	Computed Length of Stay greater than 24 hrs [ED] or 2 days [OBS] **(W)**
	Computed Length of Stay not equal to reported Length of Stay **(W)**

- **Aggregate Data Edits That Will Be Performed by HEALTH**
  Large percent of Unknown or Information Not Available (Race, Ethnicity, Zip, Gender, State, Admission Type, Admission Source, Mode of Arrival)
  Large percent of Other (Race, Expected Source of Coverage, Mode of Arrival)
  Large percent of Ungroupable DRG (DRG = 470) [IP]
  One data element consistently not coded (All coded data elements)
  All records coded in one category (All coded data elements)
  Comparison to historical data

- **Working Data Edits That Will Be Performed by HEALTH When Linking Databases**
  Demographics do not match (e.g. dates, race, ethnicity, payer, sex, census tract, zip, etc)
  Illogical source of admission and/or disposition (ED/OBS database should include admission disposition, IP/OBS database should show admission source indicative of previous encounter
  ED Charges reported on IP record when payer requires separate bills
  Flag when one record indicates that a second records should exist but one does not.

Data Element Layout and Description

This section identifies and defines the data elements to be reported in a tabular form. Comments regarding coding and editing are included as well as a reference to the coding source.

The column headings used in the Data Elements Layout and Description are defined as follows:

Data Element Name	The name of the data element.
Data Element Description	The definition of the data element.
Field Type	The abbreviation in this column indicates the data element's attribute. AN = Alphanumeric N = Numeric
Field Length	The length (in bytes) of this data element in the record.
Position	The number indicating the starting and ending position of the data element in the record.
Coding Specifications	Coding and general editing comments specific to the data element. Includes a reference to the source of available codes for coded data elements.
Error Type	The letter indicating the type of error class for this data element. See Editing and Validation section. A = Category A B = Category B

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Facility Code	The facility identifier developed by the Rhode Island Department of Health.	AN	4	1-4	Must be a valid Facility Code in accordance with Appendix 1. Facility Code; Available codes are specified by the Rhode Island Department of Health; Must be right justified.	A
Patient ZIP Code	The ZIP Code assigned by the Postal Service to the patient's principal residence at the time of admission or date of service	AN	5	5-9	Must be a valid five-digit Zip Code for United States residences, including US Territories and Commonwealths, entered exactly as shown in the current edition of National Zip Code and Post Office Directory; Patients who are homeless, have unknown principal residences or have principal residences located outside of the United States must be coded using valid codes in Appendix 2. Patient Zip Code; Must be left justified and space filled.	B
Census Tract	The Census Tract assigned to the patient's principal residence at the time of admission or date of service.	AN	6	10-15	Must be a valid census tract corresponding to the patient's principal residence; If census tract coding is done manually using the Rhode Island Census Tract Coding Guide, 7th edition, a leading zero must be added to all entries shown in the Coding Guide; Census tract codes with leading zero(s) already shown in the Coding Guide, must include an additional leading zero; Most electronic coding software will automatically add the leading zero; Entries must exclude the decimal point, be left justified and space filled; If the patient's principal residence is not within the state of Rhode Island or is unknown, the codes corresponding to out-of-state residence or unknown residence as specified in the coding reference, must be used; Out-of-state census tracts, if known, will be accepted but are not required.	B
Patient Birth Date	The date of birth of the patient.	N	8	16-23	Must be a valid date in MMDDYYYY format in accordance with Appendix 3. Valid Date Format specifications; Must be right justified; Leading zeros must be retained; May not be later than the Admission Date.	A
Patient Gender Code	A code indicating the sex of the patient.	AN	1	24	Must be a valid gender code in accordance with Appendix 4. Gender; There are multiple edits between Patient Gender Code and sex-specific diagnosis and procedure codes; See Appendix 5. Diagnoses and Appendix 6. Procedures for a detailed description.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Patient Race	The code which best describes the race of the patient.	AN	1	25	Must be a valid Race code in accordance with Appendix 7. Race reported per Office of Minority Health and Office of Health Statistics, *Policy for Maintaining, Collecting, and Presenting Data on Race and Ethnicity.* Providence, RI: Rhode Island Department of Health. July 2000; Race codes allow the reporting of multiple races.	B
Admission Date	The date of the admission to the facility.	N	8	26-33	Must be a valid date in MMDDYYYYY format in accordance with Appendix 3. Valid Date Format specifications; Must be right justified; Leading zeros must be retained; Must be less than or equal to the Discharge Date.	A
Admission Type Code	A code indicating the priority of this admission.	AN	1	34	Must be a valid Admission Type code in accordance with Appendix 8. Admission Type; Available codes are specified by the National Uniform Billing Data Element Specifications.	B
Admission Source Code	A code indicating the source of this admission.	AN	1	35	Must be a valid Admission Source code in accordance with Appendix 9. Admission Source; Available codes are from the National Uniform Billing Data Element Specifications; Must be right justified and zero filled.	A
Patient Status Code	A code indicating the patient's status or destination at time of discharge.	AN	2	36-37	Must be a valid Patient Status code in accordance with Appendix 10. Patient Status Code; Available codes are applicable codes from the National Uniform Billing Data Element Specifications; Must be right justified and zero filled.	A
Discharge Date	The date when the patient was discharged or death occurred.	N	8	38-45	Must be a valid date in MMDDYYYY format in accordance with the Valid Date Format specifications in Appendix 3; Must be right justified; Leading zeros must be retained; Must be on or after Admission Date.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Medical Record Number	A unique number assigned to the patient by the provider to assist in retrieval of medical records. If the patient was seen in multiple care settings during the course of a single visit, the permanent (inpatient) MRN must be used to allow for the linking of patient records across data systems.	AN	12	46-57	Must be left justified with no embedded blanks and space filled; Must not equal zero or blanks; This number must be the 9 or 10 digit unique patient identifier; Do not include facility-specific or internal letters, numbers or strings of letters or numbers that may precede or follow the unique identifier for internal use purposes; This number must be the correct and permanent identifier that can be used to link associated records across emergency, observation and inpatient records.	A
Filler			5	58-62	Must be blank	
Expected Source of Coverage	The code indicating the expected source of payment for this claim.	AN	2	63-64	Must be a valid Expected Source of Coverage code in accordance with Appendix 11. Expected Source of Coverage. Must be left justified.	A
Expected Type of Coverage	The code indicating the expected type of payment for this claim.	N	4	65-68	Must be a valid Expected Type of Coverage code in accordance with Appendix 12. Expected Type of Coverage if Expected Source of Coverage is equal to B, H, N, O, R, or U; Must be left justified; If this field is not applicable, it must be blank filled.	A
Principal Diagnosis	An ICD-9-CM Principal Diagnosis Code identifying a diagnosed medical condition. For hospital inpatient stays, the principal diagnosis code is the diagnosis established after study to be chiefly responsible for occasioning the admission to the hospital.	AN	6	69-74	Must be a valid ICD-9-CM diagnosis code as specified in the current edition of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) based on the Discharge Date and age-specific and sex-specific diagnosis code conditions; See Appendix 5. Diagnoses for a detailed description; May not be an Ecode; Must be left justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point and space filled and including lead zeros.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Diagnosis 1	The ICD-9-CM code identifying the first additional diagnosis for this claim, not including the principal diagnosis.	AN	6	75-80	Must be a valid ICD-9-CM diagnosis code as specified in the current edition of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) based on the Discharge Date and age-specific and sex-specific diagnosis code conditions; See Appendix 5. Diagnoses for a detailed description; Must be left justified and entered as exactly as shown in the ICD-9-CM coding reference, excluding the decimal point and space filled and including leading zeros; Additional Ecodes may be used in this field if the Principal External Cause of Injury is reported; If this field is not applicable, it must contain blanks.	A
Other Diagnosis 2	The ICD-9-CM code identifying the second additional diagnosis for this claim, not including the principal diagnosis.	AN	6	81-86	See coding specifications for Other Diagnosis 1.	A
Other Diagnosis 3	The ICD-9-CM code identifying the third additional diagnosis for this claim, not including the principal diagnosis.	AN	6	87-92	See coding specifications for Other Diagnosis 1.	A
Other Diagnosis 4	The ICD-9-CM code identifying the fourth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	93-98	See coding specifications for Other Diagnosis 1.	A
Other Diagnosis 5	The ICD-9-CM code identifying the fifth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	99-104	See coding specifications for Other Diagnosis 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Diagnosis 6	The ICD-9-CM code identifying the sixth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	105-110	See coding specifications for Other Diagnosis 1.	A
Other Diagnosis 7	The ICD-9-CM code identifying the seventh additional diagnosis for this claim, not including the principal diagnosis.	AN	6	111-116	See coding specifications for Other Diagnosis 1.	A
Other Diagnosis 8	The ICD-9-CM code identifying the eighth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	117-122	See coding specifications for Other Diagnosis 1.	A
Other Diagnosis 9	The ICD-9-CM code identifying the ninth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	123-128	See coding specifications for Other Diagnosis 1.	A
Other Diagnosis 10	The ICD-9-CM code identifying the tenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	129-134	See coding specifications for Other Diagnosis 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Principal External Cause of Injury Code (Ecode)	The ICD-9-CM diagnosis code identifying the cause of the injury.	AN	6	135-140	A valid entry is required when either the Principal Diagnosis code or Other Diagnosis Code reported are in the range 800.00-909.2, 909.4, 909.9, 910 – 994, 995.5, 995.80 – 995.85; Ecodes for diagnosis codes outside this range may be reported; If Ecode is present, it must be a valid Ecode (E800-E999 excluding E849.0-E849.9) as specified in the current edition of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) based on the Discharge Date; Principal Ecode must be coded in this field and not in Other Diagnosis fields. Additional Ecodes may be reported in the Other Diagnosis fields if this principal Ecode field is reported; E849.0-E849.9 may be used as an additional Ecode only; Must be left justified including the letter "E" and all digits entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and space filled; If this field is not applicable, it must contain blanks.	A
Principal Procedure Code	The ICD-9-CM procedure code identifying the principal procedure, product or service.	AN	7	141-147	Must be a valid ICD-9-CM procedure code as specified in the current edition of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) based on the Discharge Date and age-specific and sex-specific procedure code conditions; See Appendix 6. Procedures for a detailed description; Must be left justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and space filled and including leading zeros; A significant procedure is one that is surgical in nature, carries a procedural risk, carries an anesthetic risk, or requires specialized training; Surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation; The principal procedure is one that is performed for definitive treatment rather than one performed for diagnostic purposes, or was necessary to take care of a complication; If there appears to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure; If Principal Procedure Code is reported, the corresponding Principal Procedure Date and Operating Physician State License Number must be reported; If this field is not applicable, it must contain blanks.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Code 1	The ICD-9-CM procedure code identifying the first additional procedure, product or service, other than principal.	AN	7	148-154	Must be a valid ICD-9-CM procedure code as specified in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) based on the Discharge Date and age-specific and sex-specific procedure code conditions; See Appendix 6. Procedures for a detailed description; Must be left justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and space filled and including leading zeros; A significant procedure is one that is surgical in nature, carries a procedural risk, carries an anesthetic risk, or requires specialized training; Surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation; If Other Procedure Code is reported, then Principal Procedure Code and Date and corresponding Other Procedure Date fields must also be reported. If this field is not applicable, it must contain blanks.	A
Other Procedure Code 2	The ICD-9-CM procedure code identifying the second additional procedure, product or service, other than principal.	AN	7	155-161	See specifications for Other Procedure Code 1.	A
Other Procedure Code 3	The ICD-9-CM procedure code identifying the third additional procedure, product or service, other than principal.	AN	7	162-168	See specifications for Other Procedure Code 1.	A
Other Procedure Code 4	The ICD-9-CM procedure code identifying the fourth additional procedure, product or service, other than principal.	AN	7	169-175	See specifications for Other Procedure Code 1.	A
Other Procedure Code 5	The ICD-9-CM procedure code identifying the fifth additional procedure, product or service, other than principal.	AN	7	176-182	See specifications for Other Procedure Code 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Code 6	The ICD-9-CM procedure code identifying the sixth additional procedure, product or service, other than principal.	AN	7	183-189	See specifications for Other Procedure Code 1.	A
Other Procedure Code 7	The ICD-9-CM procedure code identifying the seventh additional procedure, product or service, other than principal.	AN	7	190-196	See specifications for Other Procedure Code 1.	A
Other Procedure Code 8	The ICD-9-CM procedure code identifying the eighth additional procedure, product or service, other than principal.	AN	7	197-203	See specifications for Other Procedure Code 1.	A
Other Procedure Code 9	The ICD-9-CM procedure code identifying the ninth additional procedure, product or service, other than principal.	AN	7	204-210	See specifications for Other Procedure Code 1.	A
Other Procedure Code 10	The ICD-9-CM procedure code identifying the tenth additional procedure, product or service, other than principal.	AN	7	211-217	See specifications for Other Procedure Code 1.	A
Principal Procedure Date	The date on which the Principal Procedure was performed.	N	6	218-223	Must be a valid date in MMDDYY format in accordance with the Valid Date Format specifications in Appendix 3; Must be right justified; Leading zeros must be retained; If Principal Procedure Date is entered, Principal Procedure Code and Operating Physician State License Number must be reported; If this field is not applicable, it must be zero filled.	A
Other Procedure Date 1	The date when the health care procedure, other than principal, was performed.	N	6	224-229	Must be a valid date in MMDDYY in accordance with the Valid Date Format specifications in Appendix 3; Must be right justified; Leading zeros must be retained; If Other Procedure Date is reported, Other Procedure Code must be reported; If this field is not applicable, it must be zero filled.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Date 2	The date when the health care procedure, other than principal, was performed.	N	6	230-235	See specifications for Other Procedure Date 1.	A
Other Procedure Date 3	The date when the health care procedure, other than principal, was performed.	N	6	236-241	See specifications for Other Procedure Date 1.	A
Other Procedure Date 4	The date when the health care procedure, other than principal, was performed.	N	6	242-247	See specifications for Other Procedure Date 1.	A
Other Procedure Date 5	The date when the health care procedure, other than principal, was performed.	N	6	248-253	See specifications for Other Procedure Date 1.	A
Other Procedure Date 6	The date when the health care procedure, other than principal, was performed.	N	6	254-259	See specifications for Other Procedure Date 1.	A
Other Procedure Date 7	The date when the health care procedure, other than principal, was performed.	N	6	260-265	See specifications for Other Procedure Date 1.	A
Other Procedure Date 8	The date when the health care procedure, other than principal, was performed.	N	6	266-271	See specifications for Other Procedure Date 1.	A
Other Procedure Date 9	The date when the health care procedure, other than principal, was performed.	N	6	272-277	See specifications for Other Procedure Date 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Date 10	The date when the health care procedure, other than principal, was performed.	N	6	278-283	See specifications for Other Procedure Date 1.	A
Birth Weight	The birth weight of the newborn for a newborn hospital stay.	N	4	284-287	Must be a valid number corresponding to the newborn's birth weight in grams for newborn inpatient stays only; Do not include newborn's birth weight on the mother's inpatient record; Must be right justified and zero filled; If this field is not applicable, it must be zero filled.	B
Attending Physician State License Number	The Rhode Island state license number of the physician or other health care professional primarily responsible for the care of the patient. Attending Physician refers to the physician overseeing the care of the patient and is different than the resident physician caring for the patient who practices under the oversight of the attending physician.	AN	15	288-302	Must be a valid Rhode Island State License Number issued by Division of Professional Regulation, Rhode Island Department of Health; Must be right justified and zero filled.	B
Operating Physician State License Number	The Rhode Island state license number of the physician or other health care professional performing the principal procedure.	AN	15	303-317	Must be a valid Rhode Island State License Number issued by Division of Professional Regulation, Rhode Island Department of Health if at least one procedure was performed; Must be right justified and zero filled; If this field is not applicable, it must be zero filled.	B

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
ICU Days	The number of days the patient was in an intensive care unit (excluding the Neonatal Intensive Care Unit and Coronary Care Unit).	N	6	318-323	Must be a non-negative number of days associated with Intensive Care Units (Revenue code 020X - See “Note” in italics in Appendix 14. Revenue Code and Charges regarding payer-specific use); If a patient was admitted to and discharged from the Intensive Care Unit on the same day, code the number of days as 1; Must be right justified and zero filled; If this field is not applicable, it must be zero filled.	B
CCU Days	The number of days the patient was in the Coronary Care Unit.	N	6	324-329	Must be a non-negative number of days associated with the Coronary Care Unit (Revenue code 021X - See “Note” in italics in Appendix 14. Revenue Code and Charges regarding payer-specific use); If a patient was admitted to and discharged from the Coronary Care Unit on the same day, code the number of days as 1; Must be right justified and zero filled; If this field is not applicable, it must be zero filled.	B
Hospital Service	The type of service provided to the patient primarily during the hospital inpatient stay.	N	2	330-331	Must be a valid Hospital Service code in accordance with Appendix 13. Hospital Service; Must be right justified and zero filled; If a patient received multiple types of services, select the service in which the patient was primarily being cared for.	B
Diagnosis Related Group (DRG) Code	The diagnosis related group for this claim.	N	3	332-334	Must be a valid DRG code based on the principal diagnosis ICD-9-CM code and Discharge Date as specified in the current edition of the Federal Register and Health Insurance Manual; Must be right justified and zero filled.	A
Total Charges	The sum of the total charges associated only with the hospital inpatient stay.	N	10	335-344	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue code specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	A
Room and Board Subtotal Charges	The sum of the room and board charges associated only with the hospital inpatient stay.	N	10	345-354	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Hospital Room Charges	The sum of the hospital room charges (excluding special care units) associated only with the hospital inpatient stay.	N	8	335-362	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Special Care Unit Charges	The sum of the special care unit charges associated only with the hospital inpatient stay.	N	8	363-370	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Operating and Recovery Room Charges	The sum of the operating and recovery room charges related to the hospital inpatient stay.	N	8	371-378	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Anesthesia Charges	The sum of the charges associated with anesthesia charges related to the hospital inpatient stay.	N	8	379-386	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Supplies and Equipment Charges	The sum of the supplies and equipment charges related to the hospital inpatient stay.	N	8	387-394	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Laboratory Charges	The sum of the laboratory charges related to the hospital inpatient stay.	N	8	395-402	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Diagnostic Tests Charges	The sum of the diagnostic test charges related to the hospital inpatient stay.	N	8	403-410	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Therapy Charges	The sum of the therapy charges related to the hospital inpatient stay.	N	8	411-418	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Blood Charges	The sum of the blood-related charges related to the hospital inpatient stay.	N	8	419-426	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Pharmacy Charges	The sum of the pharmacy charges related to the hospital inpatient stay.	N	8	427-434	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Ancillary Charges	The sum of other ancillary charges associated only with the hospital inpatient stay.	N	8	435-442	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Patient Convenience Items Charges	The sum of the charges associated with patient convenience items related to the hospital inpatient stay.	N	8	443-450	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Length of Stay	The number of days of the patient's inpatient stay.	N	3	451-453	Must be a non-negative number of days; If the patient was admitted and discharged on the same day, record the number of days as 0; Must be right justified and zero filled.	B
Patient Ethnicity	The code which best describes the ethnic origin of the patient.	N	1	454	Must be a valid Ethnicity code in accordance with Appendix 15. Ethnicity reported per Office of Minority Health and Office of Health Statistics, *Policy for Maintaining, Collecting, and Presenting Data on Race and Ethnicity*. Providence, RI: Rhode Island Department of Health. July 2000.	B
Patient State Code	The State Code of the patient's principal residence at the time of admission or date of service.	AN	2	455-456	Must be a valid two-letter capitalized abbreviation for the state where the patient's principal residence is located on the day of admission, including US Territories, Commonwealths, as specified in current edition of Codes for the Representation of Names of Countries and Their Subdivisions; Patients with principal residences located outside of the United States must be coded using valid codes in Appendix 16. Patient State Code.	B

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Admitting Diagnosis	The ICD-9-CM diagnosis code describing the patient's diagnosis at the time of admission.	AN	6	457-462	Must be a valid ICD-9-CM code (001-V82.9) representing the patient's diagnosis at the time of admission as specified in the current edition of International Classification of Diseases, 9th Revision, Clinical Modification based on the Discharge Date and age-specific and sex-specific diagnosis code conditions; See Appendix 5. Diagnoses for a detailed description; Must be left justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and space filled and including leading zeros.	A
Ancillaries Subtotal Charges	The ancillary subtotal of the charges associated only with the hospital inpatient stay.	N	8	463-470	Must be the sum of all charges associated with the hospital inpatient stay in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	B
Other Physician State License Number	The Rhode Island state license number of the licensed physician or other health care professional other than the attending physician who was involved in the care or treatment of the patient (e.g. resident practicing under the oversight of the attending physician coded above).	AN	15	471-485	Must be a valid Rhode Island State License Number issued by Division of Professional Regulation, Rhode Island Department of Health if there was more than one physician or health care professional responsible for the care of this patient; Must be right justified and zero filled; If this field is not applicable, it must be zero filled; If provider does not have a RI license, this field must be 8 filled.	B
Geographic Premise	A code indicating the geographic location of the hospital.	AN	1	486	Must be a valid Geographic Premise code in accordance with Appendix 17. Geographic Premise.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Emergency Room Professional Fees	The sum of the charges associated with emergency room professional fees for the emergency department encounter.	N	8	487-494	[Required only for payers requiring a single bill for patients seen in multiple care settings during a single visit/stay.] Must be the sum of all charges associated with the emergency department encounter in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	A
Emergency Room Charges	The sum of the charges associated with emergency room services for the emergency department encounter.	N	8	495-502	[Required only for payers requiring a single bill for patients seen in multiple care settings during a single visit/stay.] Must be the sum of all charges associated with the emergency department encounter in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	A
Mode of Arrival	A code indicating the patient's mode of transportation to the emergency department.	AN	1	503	[Required for payers requiring a single bill for patients seen in multiple care settings during a single visit/stay.] Must be a valid Mode of Arrival code in accordance with Appendix 18. Mode of Arrival. If this field is not applicable, it must be zero filled.	A
Observation Room Charges	The sum of the observation room charges.	N	8	504-511	[Required only for payers requiring a single bill for patients seen in multiple care settings during a single visit/stay.] Must be the sum of all charges associated with the observation service encounter in accordance with the revenue code specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	A
Observation Hours	The number of hours the patient was in observation status.	N	6	512-517	[Required only for payers requiring a single bill for patients seen in multiple care settings during a single visit/stay.] Must be a non-negative number; Must be right justified and zero filled; Observation is defined in Appendix 14. Revenue Codes and Charges ; If this field is not applicable, it must contain zeros.	A
Behavioral Health Charges	The sum of the behavioral health treatments/services charges associated only with the inpatient stay.	N	8	518-525	Must be the sum of all charges associated with the encounter in accordance with the revenue codes specified in Appendix 14. Revenue Codes and Charges for this charge category; Must be rounded to the nearest dollar; Must be a non-negative value; Must be right justified and zero filled.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
NICU Days	The number of days the patient was in the Neonatal Intensive Care Unit.	N	6	526-531	Must be a non-negative number of days associated with the Neonatal Intensive Care unit (Revenue code 0174-See “Note” in italics in Appendix 14. Revenue Code and Charges regarding payer-specific use); If a patient was admitted to and discharged from the Neonatal Intensive Care unit on the same day, code the number of days as 1; Must be right justified and zero filled; If this field is not applicable, it must be zero filled.	B
Other Diagnosis 11	The ICD-9-CM code identifying the eleventh additional diagnosis for this claim, not including the principal diagnosis.	AN	6	532-537	See specifications for Other Diagnosis 1.	A
Other Diagnosis 12	The ICD-9-CM code identifying the twelfth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	538-543	See specifications for Other Diagnosis 1.	A
Other Diagnosis 13	The ICD-9-CM code identifying the thirteenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	544-549	See specifications for Other Diagnosis 1.	A
Other Diagnosis 14	The ICD-9-CM code identifying the fourteenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	550-555	See specifications for Other Diagnosis 1.	A
Other Diagnosis 15	The ICD-9-CM code identifying the fifteenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	556-561	See specifications for Other Diagnosis 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Diagnosis 16	The ICD-9-CM code identifying the sixteenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	562-567	See specifications for Other Diagnosis 1.	A
Other Diagnosis 17	The ICD-9-CM code identifying the seventeenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	568-573	See specifications for Other Diagnosis 1.	A
Other Diagnosis 18	The ICD-9-CM code identifying the eighteenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	574-579	See specifications for Other Diagnosis 1.	A
Other Diagnosis 19	The ICD-9-CM code identifying the nineteenth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	580-585	See specifications for Other Diagnosis 1.	A
Other Diagnosis 20	The ICD-9-CM code identifying the twentieth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	586-591	See specifications for Other Diagnosis 1.	A
Other Diagnosis 21	The ICD-9-CM code identifying the twenty-first additional diagnosis for this claim, not including the principal diagnosis.	AN	6	592-597	See specifications for Other Diagnosis 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Diagnosis 22	The ICD-9-CM code identifying the twenty-second additional diagnosis for this claim, not including the principal diagnosis.	AN	6	598-603	See specifications for Other Diagnosis 1.	A
Other Diagnosis 23	The ICD-9-CM code identifying the twenty-third additional diagnosis for this claim, not including the principal diagnosis.	AN	6	604-609	See specifications for Other Diagnosis 1.	A
Other Diagnosis 24	The ICD-9-CM code identifying the twenty-fourth additional diagnosis for this claim, not including the principal diagnosis.	AN	6	610-615	See specifications for Other Diagnosis 1.	A
Other Procedure Code 11	The ICD-9-CM procedure code identifying the eleventh additional procedure, product or service, other than principal.	AN	7	616-622	See specifications for Other Procedure Code 1.	A
Other Procedure Code 12	The ICD-9-CM procedure code identifying the twelfth additional procedure, product or service, other than principal.	AN	7	623-629	See specifications for Other Procedure Code 1.	A
Other Procedure Code 13	The ICD-9-CM procedure code identifying the thirteenth additional procedure, product or service, other than principal.	AN	7	630-636	See specifications for Other Procedure Code 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Code 14	The ICD-9-CM procedure code identifying the fourteenth additional procedure, product or service, other than principal.	AN	7	637-643	See specifications for Other Procedure Code 1.	A
Other Procedure Code 15	The ICD-9-CM procedure code identifying the fifteenth additional procedure, product or service, other than principal.	AN	7	644-650	See specifications for Other Procedure Code 1.	A
Other Procedure Code 16	The ICD-9-CM procedure code identifying the sixteenth additional procedure, product or service, other than principal.	AN	7	651-657	See specifications for Other Procedure Code 1.	A
Other Procedure Code 17	The ICD-9-CM procedure code identifying the seventeenth additional procedure, product or service, other than principal.	AN	7	658-664	See specifications for Other Procedure Code 1.	A
Other Procedure Code 18	The ICD-9-CM procedure code identifying the eighteenth additional procedure, product or service, other than principal.	AN	7	665-671	See specifications for Other Procedure Code 1.	A
Other Procedure Code 19	The ICD-9-CM procedure code identifying the nineteenth additional procedure, product or service, other than principal.	AN	7	672-678	See specifications for Other Procedure Code 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Code 20	The ICD-9-CM procedure code identifying the twentieth additional procedure, product or service, other than principal.	AN	7	679-685	See specifications for Other Procedure Code 1.	A
Other Procedure Code 21	The ICD-9-CM procedure code identifying the twenty-first additional procedure, product or service, other than principal.	AN	7	686-692	See specifications for Other Procedure Code 1.	A
Other Procedure Code 22	The ICD-9-CM procedure code identifying the twenty-second additional procedure, product or service, other than principal.	AN	7	693-699	See specifications for Other Procedure Code 1.	A
Other Procedure Code 23	The ICD-9-CM procedure code identifying the twenty-third additional procedure, product or service, other than principal.	AN	7	700-706	See specifications for Other Procedure Code 1.	A
Other Procedure Code 24	The ICD-9-CM procedure code identifying the twenty-fourth additional procedure, product or service, other than principal.	AN	7	707-713	See specifications for Other Procedure Code 1.	A
Other Procedure Date 11	The date when the corresponding health care procedure, other than principal, was performed.	N	6	714-719	See specifications for Other Procedure Date 1.	A
Other Procedure Date 12	The date when the corresponding health care procedure, other than principal, was performed.	N	6	720-725	See specifications for Other Procedure Date 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Date 13	The date when the corresponding health care procedure, other than principal, was performed.	N	6	726-731	See specifications for Other Procedure Date 1.	A
Other Procedure Date 14	The date when the corresponding health care procedure, other than principal, was performed.	N	6	732-737	See specifications for Other Procedure Date 1.	A
Other Procedure Date 15	The date when the corresponding health care procedure, other than principal, was performed.	N	6	738-743	See specifications for Other Procedure Date 1.	A
Other Procedure Date 16	The date when the corresponding health care procedure, other than principal, was performed.	N	6	744-749	See specifications for Other Procedure Date 1.	A
Other Procedure Date 17	The date when the corresponding health care procedure, other than principal, was performed.	N	6	750-755	See specifications for Other Procedure Date 1.	A
Other Procedure Date 18	The date when the corresponding health care procedure, other than principal, was performed.	N	6	756-761	See specifications for Other Procedure Date 1.	A
Other Procedure Date 19	The date when the corresponding health care procedure, other than principal, was performed.	N	6	762-767	See specifications for Other Procedure Date 1.	A
Other Procedure Date 20	The date when the corresponding health care procedure, other than principal, was performed.	N	6	768-773	See specifications for Other Procedure Date 1.	A

Data Element Name	Data Element Description	Field Type	Field Length	Position	Coding Specifications	Error Type
Other Procedure Date 21	The date when the corresponding health care procedure, other than principal, was performed.	N	6	774-779	See specifications for Other Procedure Date 1.	A
Other Procedure Date 22	The date when the corresponding health care procedure, other than principal, was performed.	N	6	780-785	See specifications for Other Procedure Date 1.	A
Other Procedure Date 23	The date when the corresponding health care procedure, other than principal, was performed.	N	6	786-791	See specifications for Other Procedure Date 1.	A
Other Procedure Date 24	The date when the corresponding health care procedure, other than principal, was performed.	N	6	792-797	See specifications for Other Procedure Date 1.	A
Filler	Filler to identify end of record.	AN	1	798	Must be a non-blank filler (Z) to signify end of the record.	A

Appendices

Appendix 1. Facility Code

Valid Entries	Definition
7201	Newport Hospital
7202	St. Joseph Health Services of Rhode Island
7203	Memorial Hospital of Rhode Island
7204	Miriam Hospital
7205	Rhode Island Hospital
7206	Roger Williams Medical Center
7209	South County Hospital
7210	Kent County Memorial Hospital
7211	Westerly Hospital
7212	Rehabilitation Hospital
7213	Landmark Medical Center
7214	Women and Infants Hospital of Rhode Island
7215	Emma Pendleton Bradley Hospital
7216	Butler Hospital

Appendix 2. Patient ZIP Code

Refer to coding reference: Current edition of National ZIP Code and Post Office Directory. See below for additional valid entries.

Note: Definitions in italics indicate codes developed by the Rhode Island Department of Health, not included in the coding reference.

Valid Entries	Definition
XXXXX	*Unknown/No address given (e.g. homeless, shelter)*
YYYYY	*Foreign Country*

Appendix 3. Valid Date Formats

Note: Leading zeros must be retained.

For use with data elements: Patient Birth Date, Admission Date, Discharge Date

Date Format	Components	Valid Entries
MMDDYYYY	MM	01 to 12
	DD	01 to 31
	YYYY	Four digit year

For use with data elements: Principal Procedure Date, Other Procedure Dates (1-24)

Date Format	Components	Valid Entries
MMDDYY	MM	01 to 12
	DD	01 to 31
	YY	Two digit year (Last two digits)

Appendix 4. Patient Gender Code

Valid Entries	Definition
M	Male
F	Female
U	Unknown

Appendix 5. Diagnoses

Age-Specific Diagnoses	
Maternal Diagnoses	630-677; 796.5; V220 - V242; V270 - V279; V2381 - V2389
Neonatal Diagnoses	277.01; 762.0 - 770.6; 770.8 - 778.5; 778.7 - 779.9; V29.0 - V29.9; V30.00 - V39.2
Sex-Specific Diagnoses	
Male Diagnoses	016.40 – 016.56; 054.13; 072.0; 098.12 – 098.14; 098.32 – 098.34; 131.03; 175.0 – 175.9; 185 – 187.9; 214.4; 222.0 – 222.9; 233.4 – 233.6; 236.4 – 236.6; 257.0 – 257.9; 302.74 – 302.75; 456.4; 600.00 - 608.9; 752.51 - 752.52; 752.61 - 752.69; 752.81; 752.89; 758.7; 788.32; 790.93; 792.2; 878.0 – 878.3; 939.3; 959.13; V10.45 - V10.49; V13.61; V26.52; V50.2; V76.44 -V76.45; V84.03
Female Diagnoses	016.60 – 016.76; 054.11 – 054.12; 098.15 – 098.17; 098.35 – 098.37; 112.1; 131.01; 174.0 – 174.9; 179 – 184.9; 198.6; 218.0 – 221.9; 233.1 – 233.3; 236.0 – 236.3; 256.0 – 256.9; 302.73; 302.76; 306.51 – 306.52; 456.6; 611.5 – 611.6; 614.0 - 677; 716.30 – 716.39; 752.0 – 752.49; 792.3; 795.0; 796.5; 867.4 – 867.5; 878.4 – 878.7; 902.55 – 902.56; 902.81 – 902.82; 939.1 – 939.2; 947.4; 996.32; V07.4; V10.40 - V10.44; V13.1; V13.21; V13.29; V22.0 - V25.01; V25.03; V25.1; V25.3; V25.41 - V25.43; V25.5; V26.1; V26.51; V27.0 - V28.9; V45.51- V45.52; V49.81; V50.42; V52.4; V61.6; V61.7; V65.11; V67.01; V72.3 - V72.4; V76.11; V76.2; V76.46-V76.47; V84.02; V84.04

Appendix 6. Procedures

Age-Specific Procedures	
Maternal Procedures	72.0-75.99
Sex-Specific Procedures	
Male Procedures	60.0 – 64.99; 87.91 – 87.9; 98.24; 99.94 – 99.96
Female Procedures	65.01 - 75.99; 87.81 - 87.89; 88.46; 88.78; 89.26; 91.41 - 91.49; 92.17; 96.14 - 96.18; 96.44; 97.24 - 97.26; 97.71 - 97.75; 98.16 - 98.17; 98.23; 99.98

Appendix 7. Patient Race

Valid Entries	Definition
A	White
B	Black or African American
C	Asian
D	American Indian or Alaskan Native
E	Native Hawaiian or Other Pacific Islander
F	White and Black/African American
G	White and Asian
H	White and American Indian/Alaskan Native
I	White and Native Hawaiian/Other Pacific Islander
J	Black/African American and Asian
K	Black/African American and American Indian/Alaskan Native
L	Black/African American and Native Hawaiian/Other Pacific Islander
M	Asian and American Indian/Alaskan Native
N	Asian and Native Hawaiian/Other Pacific Islander
O	American Indian/Alaskan Native and Native Hawaiian/Other Pacific Islander
P	All Other Combinations of Race
Q	Information Not Available

Appendix 8. Admission Type

Note: For further definition of codes, please see the National Uniform Billing Data Element Specifications.

Valid Entries	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma
9	Information Not Available

Appendix 9. Admission Source

Note: For further definition of codes, please see the applicable National Uniform Billing Data Element Specifications

Valid Entries	Definition
1	Physician Referral
2	Within Hospital Clinic Referral
3	HMO Referral
4	Transfer from an Acute Care Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital
Type of Admission Must Equal 4 (Newborn)	
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth
9	Information Not Available

Appendix 10. Patient Status Code

Note: For further definition of codes, please see the National Uniform Billing Data Element Specifications

Patient Status Code	Valid Entries
01	Discharged to Home or Self Care (Routine Discharge)
02	Discharged/Transferred to Short Term General Hospital for Inpatient Care
03	Discharged/Transferred to Skilled Nursing Facility with Medicare Certification in anticipation of covered skilled care
04	Discharged/Transferred to an Intermediate Care Facility
05	Discharged/Transferred to another type of institution not defined elsewhere in this code list
06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in anticipation of covered skilled care
07	Left Against Medical Advice or Discontinued Care
08	Discharged/Transferred to Home Under Care of a Home IV Provider
09	Admitted as an Inpatient to This Hospital (For use only on Medicare outpatient claims.)
20	Expired
41	Expired in a medical facility
43	Discharged/Transferred to a Federal Health Care Facility
50	Discharged/Transferred Home with Hospice Care
51	Discharged/Transferred to a Medical Facility with Hospice Care
61	Discharged/Transferred to Hospital-Based Medicare Approved Swing Bed
62	Discharged/Transferred to an inpatient rehabilitation facility include rehabilitation distinct part units of a hospital
63	Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged/Transferred to a Nursing Facility Certified Under Medicaid But Not Certified Under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

Appendix 11. Expected Source of Coverage

Valid Entries	Definition
B	Out of State Blue Cross
C	CHAMPUS
D	Medicaid Fee for Service
H	Coordinated Health Partners
M	Medicare Fee for Service
N	Neighborhood Health Plan
O	Other
P	Self Pay
R	Rhode Island Blue Cross
U	United HealthCare
W	Worker Compensation

Appendix 12. Expected Type of Coverage

Required data element if Expected Source of Coverage is equal to B, H, N, O, R, U (See Appendix 11. Expected Source of Coverage)

Valid Entries	Definition
2000	Commercial Insurance Plan
3000	Medicaid [managed care]
4000	Medicare [managed care]

Allowed combinations between Expected Source of Coverage and Expected Type of Coverage are as follows:

Expected Source of Coverage	Expected Type of Coverage
B, H, N, O, R, U	2000
B, H, N, O, U	3000
B, H, O, U	4000

Appendix 13. Hospital Service

Valid Entries	Definition (Note: Include subcategories of these groupings)
02	Pediatrics
10	Medicine
22	Cardiology
38	Psychiatry
40	Surgery
48	Ophthalmology
50	ENT
54	Oral Surgery
58	Orthopedics
62	Urology
70	Gynecology
75	Abortion
76	OB – Not Delivered
77	OB – Delivered
80	Newborn
98	Rehabilitation

Appendix 14. Revenue Codes and Charges

The sum of the charges associated with the revenue codes listed in the second column is to be reported for the data element listed in the first column. Only charges associated with the hospital inpatient stay are to be included in the sum for patients with payers requiring separate bills by site of care for a single episode of treatment. For patients with payers requiring a single bill for an episode of treatment, all charges incurred during the episode of care should be reported by charge category and must include emergency and observation related charges, if appropriate.

Note: The data elements below are defined based on the UB-92 manual definition of revenue codes. It is the responsibility of each hospital to account for all differences resulting from the arrangement of payer-specific and/or hospital-specific use of revenue codes. Where such arrangements have been made to use the revenue codes listed below in a manner not corresponding to the data element indicated or to use other revenue codes in place of the one(s) listed below for a specific data element, it is the responsibility of each hospital to make necessary adjustments to the definitions below such that the each revenue code is included in the most appropriate data element grouping. Adjustments may necessitate the addition of revenue codes not listed below.

Data Element	**Revenue Codes**
Total Charges	0001
Room and Board Subtotal Charges	010X* – 018X, 020X – 023X
Hospital Room Charges	011X – 018X (Excluding 0174)
Special Care Units Charges	020X – 021X, 0174
Ancillaries Subtotal Charges	0240 plus subcategories below
Operating and Recovery Room Charges	036X, 071X, 072X
Anesthesia Charges	037X
Supplies and Equipment Charges	027X, 029X, 062X
Laboratory Charges	030X, 031X
Diagnostic Tests Charges	032X, 0341, 0343, 035X, 040X, 046X, 0470, 0471, 0479, 048X, 061X, 073X, 074X, 075X, 092X
Therapy Charges	026X, 028X, 033X, 0340, 0342, 0344, 0349, 041X, 042X, 043X, 044X, 0472, 053X, 070X, 0760, 0761, 077X, 079X, 080X, 081X, 088X, 094X, 095X, 210X
Blood Charges	038X, 039X
Pharmacy Charges	025X, 063X
Other Ancillary Charges	050X, 054X, 096X, 097X, 098X (Excluding 0981)
Behavioral Health Charges	90X, 91X
Emergency Room Professional Fees	0981
Emergency Room Charges	045X
Patient Convenience Items Charges	099X
Observation Room Charges	0762

* X refers to any digit in the indicated position that conforms to an allowed UB-92 revenue code.

Appendix 15. Patient Ethnicity

Valid Entries	Definition
1	Hispanic or Latino
2	Not Hispanic or Latino
9	Information Not Available

Appendix 16. Patient State Code

Refer to coding reference: Current edition of Codes for the Representation of Names of Countries and Their Subdivisions. See below for additional valid entries.

Note: Definitions in italics indicate codes developed by the Rhode Island Department of Health, not included in the coding reference.

Valid Entries	Definition
XX	*Unknown/No address given (e.g. homeless, shelter)*
FC	*Not Applicable (Patient's principal residence is outside the United States)*

Appendix 17. Geographic Premise

Valid Entries	Definition
0	Hospitals Has Only One Premise
1	St. Joseph Health Services of Rhode Island – Our Lady of Fatima Hospital
2	St. Joseph Health Services of Rhode Island – St. Joseph Hospital for Specialty Care
3	Rhode Island Hospital - Adult
4	Rhode Island Hospital - Hasbro

Appendix 18. Mode of Arrival

Valid Entries	Definition
0	Not Applicable – (This code may not be used with ED patients who are treated and released and is to be used only in the following circumstances: If the payer requires a single bill for multiple care settings, this field is not applicable because the patient did not have an emergency department visit; If the payer requires a separate bill for each care setting utilized, this field is not applicable because this data is reported to the ED data system.)
1	Rescue Service/Ambulance
2	Helicopter
3	Law Enforcement or Social Services Agency (Other than rescue service/ambulance, e.g. Police, DYCF)
4	Personal or Public Transportation, e.g. Walk-In, Private Vehicle, Bus
5	Other
9	Information Not Available