Massachusetts Center for Health Information and Analysis

Inpatient Discharge Data from Behavioral Health Facilities

File Submission Guide FY 2025

Effective October 1, 2024

CHIA has adopted regulation 957 CMR 8.00 to require the reporting of health care data to the Center for Health Information and Analysis. This document provides the technical and data specifications, including edit specifications required for the Inpatient Discharge Data from Behavioral Health Facilities.

This submission guide will be in effect beginning with the quarterly submission of 10/1/2024 – 12/31/2024 data.

For FY 2025 only, all four quarterly Inpatient Discharge Data files will be due at the CHIA on December 14, 2025.

In subsequent years, Inpatient Discharge Data Files must be submitted quarterly to the CHIA according to the submittal schedule included in this submission guide.

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Inpatient Discharge Data Submission Overview

Data to Include in Inpatient Discharge Data Submissions

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

It is expected that the discharges reflected in the data submissions will be reflected in the Massachusetts Hospital Cost Reports submitted to CHIA.

Definitions

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

Data File Format

The data for all inpatient visits at the reporting facility must be submitted in an asterisk delimiter format using the following format specifications:

Field Separator: Asterisk (*)

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

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

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

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Data Transmission Media Specifications

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

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

(a) the potential of unacceptable data reaching CHIA and

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

File Naming Convention

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

BHID_#######_CCYY_# where:

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

CCYY = the Fiscal Year for the data included

= the Quarter being reported

For Test Files please include '_TEST' at the end of the file name (ex: BHID_123_2025_1_TEST.txt)

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Inpatient Discharge Data Record Specification

Record Specification Elements

The Inpatient Discharge Data File is made up of a series of records. The Record Specifications that follow provide the following data for each field in the record:

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

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Data Field Type

Data Type	Field Use	Definition	Example
Text	**Date**	Date fields are 8 characters. The field is formatted as follows: CCYYMMDD	February 14, 2024 would be entered as: 20240214
	Numeric (Num) A numeric field which will be used in a calculation or as a counter	Numeric, whole, unsigned, integer digits. Do NOT space fill.	Sequence might be entered as: 01
	Currency (Curr) A numeric field which will contain a currency amount	(Unformatted) numeric, whole, unsigned integer digits. Do not include cents or decimals.	$150.70 might be entered as: 151
	Char/Varchar An alphanumeric field	Alphanumeric field May be fixed length or variable length within stated field length Do NOT zero pad or space fill.	Address may contain alphanumeric data with a length up to 100 Medicaid Claim Certificate Number (New MMIS ID/ Medicaid ID) is a 12 digit fixed length field containing only numbers

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Record Type Inclusion Rules

Patient Discharge Records: Each patient discharge will be represented by ten record types as follows:

a)	**Record Type '20'**	Record Type *'20'* contains selected socio-demographic and clinical information pertaining to the discharged patient. This record is presented once for each patient discharge in the reporting period.
b)	**Record Type '25'**	*Record Type '25'* contains patient address, health plan ID, and ethnicity information. This record is presented once for each patient discharge in the reporting period.
c)	**Record Type '30'**	*Record Type '30'* summarizes the charges billed and the units of service (days) provided in routine and special care accommodations for each patient discharge. This record may be repeated more than once per discharge if it is necessary to report the use of more than five different routine and/or special care accommodations within this episode of care.
d)	**Record Type '40'**	*Record Type '40'* summarizes the charges billed and the units of service provided for prescribed ancillary revenue centers. This record may be repeated more than once per discharge if it is necessary to report the use of more than five different ancillary services within this episode of care.
e)	**Record Type '45'**	*Record Type '45'* contains principal medical information such as primary diagnosis, admitting diagnosis, principal external cause, principal procedure, and physician information. This record is presented once for each patient discharge in the reporting period.
f)	**Record Type '50'**	*Record Type '50'* reports associated diagnosis information pertaining to this patient's episode of care. This record may be repeated more than once per discharge if it is necessary to report the use of more than fourteen associated diagnoses within this episode of care.

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g)	**Record Type '60'**	*Record Type '60'* reports procedures and additional clinical information pertaining to this patient's episode of care. This record may be repeated more than once per discharge if it is necessary to report the use of more than thirteen significant ICD procedures within this episode of care. **Record Type '60' is for ICD procedure codes only.**
h)	**Record Type '65'**	*Record Type '65'* reports procedures and additional clinical information pertaining to this patient's episode of care. This record may be used to report up to eight significant HCPCS/CPT procedures within this episode of care. **Record Type '65' is for HCPCS/CPT procedure codes only.**
I)	**Record Type '80'**	*Record Type '80'* reports physician information for the patient. This record is provided once for each patient discharge.
j)	**Record Type '90'**	*Record Type '90'* is a control record which balances the counts of each of the several discharge specific records and charges. This record is provided once per patient discharge.

Submission Records: Each quarterly file submission must also contain four other types of records as follows:

a)	**Record Type '01'**	*Record Type '01'* is the first record appearing on the file and occurs only once per submission. This label record identifies the submitter which may be an individual facility or a processor submitting data for a facility.
b)	**Record Type '10'**	*Record Type '10'* identifies the facility whose data is provided on the file and occurs only once per submission.
c)	**Record Type '95'**	*Record Type '95'* is a control record which balances selected data from all patient discharges for the facility and occurs only once per submission.
d)	**Record Type '99'**	*Record Type '99'* is a control record. This is the last record of the submission and occurs only once per submission.

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RECORD TYPE 01 - LABEL DATA

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '01'	Text	2	- Must be first record on file - Must be 01	A
2	Submitter EIN	Text	9	- Must be present - Must be numeric - Must not include a hyphen	Note
3	Submitter Name	Text	100	- Must be present	Note
4	Receiver Identification	Text	5	- Must be present - Must be CHIA	Note
5	Processing Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must not be later than today's date	Note
6	Submission Number	Text	4	- Must be numeric - Must be present	Note

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RECORD TYPE 10 - PROVIDER DATA

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '10'	Text	2	- Must be first record following Label Record Type '01' - Must be 10	A
2	Provider Name	Text	100	- Must be present	A
3	Provider Address	Text	100	- Must be present	Note
4	Provider City	Text	15	- Must be present	Note
5	Provider State	Text	2	- Must be present	Note
6	Provider Zip	Text	9	- Must be present	Note
7	Period Starting Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must be the first day of the quarter for which data is being submitted	A

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8	Period Ending Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must be later than Starting Date - Must be the last day of the quarter for which data is being submitted	A
9	Organization ID for Provider	Text	7	- Must be present - Characters must be numeric - Must be valid Organization ID as assigned by the Center for Health Information and Analysis (CHIA)	A
10	National Provider Identifier (NPI) for Provider	Text	10	- May be present - If present, must be a valid National Provider Identifier per National Plan and Provider Enumeration System (NPPES) for your NPPES Entity Type 2 (Organization NPI) which is the legally recognized organization (other than an individual) that provided the health care services.	Note

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RECORD TYPE 20 – PATIENT DATA

- Required for every Discharge.
- Only one allowed per Discharge.
- Must follow either RT 10 or RT 90.
- Must be followed by RT 25.
- Record Type = 20.

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '20'	Text	2	- Must be first record following Provider Record Type '10' or follow Patient Control Record Type '90' - Must be 20	A
2	Medical Record Number	Text	25	- Must be present	A
3	Patient Sex at Birth	Text	8	- Must be present - Must be a valid code as specified in Inpatient Data Code Table (1)(a)	A
4	Patient Birthday (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must not be later than date of admission	A
5	Marital Status Code	Text	1	- May be present - If present, must be valid code as specified in Data Code Table (1)(b)	Note

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6	Type of Admission	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Table (1)(c)	B
7	Primary Source of Admission	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Table (1)(d) - If the Source of Admission is Observation, code 'X', observation room charges must be present in the Observation Ancillary Revenue Code 762.	B
8	Secondary Source of Admission	Text	1	- Must be present, if applicable - Must be a valid code as specified in Inpatient Data Code Tables(1)(d) - If the Source of Admission is Observation, code 'X', observation room charges must be present in the Observation Ancillary Revenue Code 762.	B
9	Admission Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format	A
10	Discharge Date (CCYYMMDD)	Text	8	- Must be present - Must be valid date and format - Must be greater than or equal to admission date - Must not be earlier than Period Starting Date or later than Period Ending Date from Provider Record 10	A

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11	Veterans Status	Text	1	- May be present - If present, must be a valid code as specified in Inpatient Data Code Table (1)(h)	Note
12	Primary Source of Payment	Text	3	- Must be present - Must be a valid code as specified in Inpatient Data Code Table (1)(g) - If Medicaid is one of two payers, Medicaid must be coded as the secondary source of payment unless Health Safety Net or Free Care is the secondary source of payment - Medicaid may be primary with code '159' (None) as secondary	A
13	Patient Status	Text	2	- Must be present - Must be a valid code as specified in Inpatient Data Code Table (1)(e)	A
14	Billing Number	Text	25	- Must be present - First digit must not be blank - May include alpha, numeric slash (/) or dash (-), but no special characters	A

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15	Primary Payer Type	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Table (1)(f) - If Medicaid is one of two payers, Medicaid must be coded as the secondary payer type unless Health Safety Net or Free Care is the secondary payer type - Medicaid may be primary with code 'N' (None) in secondary	A
16	Patient Social Security Number	Text	9	- Must be present - Must be a valid social security number or '000000001' if unknown	A
17	DNR Status	Text	1	- May be present - If present, must be a valid code as specified in Inpatient Data Code Table (1)(i)	Note
18	Secondary Payer Type	Text	1	- Must be present - Must be a valid code as specified in Inpatient Data Code Table (1)(f) - If Medicaid is one of two payers, Medicaid must be coded as the secondary payer type unless Health Safety Net or Free Care is the secondary payer type - If not applicable, must be coded as "N" as specified in Inpatient Data Code Table (1)(f)	A

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19	Secondary Source of Payment	Text	3	- Must be present if secondary payer type is other than "N" (None) - If Medicaid is one of two payers, Medicaid must be coded as the secondary source of payment unless Health Safety Net or Free Care is the secondary source of payment - Must be a valid code as specified in Inpatient Data Code Table (1)(g) - If not applicable, must be coded as '159' (None) as specified in Inpatient Data Code Table (1)(g)	A
20	Hospital Service Site Reference	Text	7	- Must be present if provider is approved to submit multiple campuses in one file - Must be valid Organization ID as assigned by the Center for Health Information and Analysis	A
21	Homeless Indicator	Text	8	- Include if applicable - Must be a valid code as specified in Inpatient Data Code Table (1)(j) - Must be "Y" if Associated Diagnosis code 'Z59' is reported	B

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22	Medicaid Claim Certificate Number (New MMIS ID/ Medicaid ID)	Text	12	- Must be present if primary or secondary Payer Type Code is "4" (Medicaid) or "H" (Health Safety Net) as specified in Inpatient Data Code Table (1)(f) - Must be blank if neither primary nor secondary payer is Medicaid or Health Safety Net - First position must not be blank if the field contains data - Must not start with a zero - If present, must be numeric characters, length must be 12	A
23	Patient Last Name	Text	35	- Must be present	A
24	Patient First Name	Text	25	- Must be present	A
25	Court/Criminal Referral	Text	2	- May be present - If present, must be a valid code as specified in Inpatient Data Code Table (1)(l)	Note
26	Patient's Sexual Orientation	Text	8	- Must be present - If present, must be a valid code as specified in Inpatient Data Code Table (1)(m)	A
27	Patient's Gender Identity	Text	15	- Must be present - If present, must be a valid code as specified in Inpatient Data Code Table (1)(n)	A

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28	Transfer Hospital Organization ID (OrgID)	Text	7	Must be a valid OrgID if Primary or Secondary Source of Admission is: '4' (Transfer from an Acute Hospital) '5' (Transfer from a SNF Facility) '6' (Transfer from an Intermediate Care Facility) '7' (Outside Hospital Emergency Room Transfer) '9' (Other (to include Level 4 Nursing Facility) and the transfer facility is a Level 4 Nursing Facility/Rest Home and the provider from which the transfer occurred is in Massachusetts) 'V' (Transfer from another facility to a Medicare-approved swing bed and the provider from which the transfer occurred is in Massachusetts) - Transfer OrgID should not be the OrgID for Provider on RT10 or the Hospital Service Site on RT 20 - Must be a valid OrgID as specified in the Transfer OrgID list posted on CHIA's website if the provider from which the transfer occurred is in Massachusetts OR - If the provider from which the transfer occurred is outside Massachusetts, the transfer OrgID must be 9999999	B

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RECORD TYPE 25 – PATIENT ADDRESS AND ETHNICITY DATA

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '25'	Text	2	- Must be first record following Provider Record Type '20' - Must be 25	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
3	Permanent Patient Street Address	Text	100	- Must be present when Patient Country is 'US' unless Homeless Indicator is 'Y'	B
4	Permanent Patient City/Town	Text	25	- Must be present when Patient Country is 'US'. If patient is homeless, report city/town for last known address and indicate homeless status "Y" in the Homeless Indicator field on this record.	B
5	Permanent Patient State	Text	2	- Must be present when Patient Country is 'US' - Must be a valid US postal code for state	B

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6	Permanent Patient Zip Code	Text	5	- Must be present - Must be numeric - Must be a valid US postal zip code - If patient is homeless, report zip code for last known address and indicate homeless status "Y" in the Homeless Indicator field on this record. - Must be 0's if zip code is unknown or Patient Country (Record Type 25, field 7) is not 'US'	B
7	Permanent Patient Country	Text	2	- Must be present - Must be a valid International Standards Organization (ISO-3166) 2-digit country code	B
8	Race 1	Text	8	- Must be present - If present, must be a valid code as specified in Inpatient Data Code Table (2)(a)	A
9	Race 2	Text	8	- May only be entered if Race 1 is entered - If present, must be a valid code as specified in Inpatient Data Code Table (2)(a)	A
10	Hispanic Indicator	Text	8	- Must be present - If present, must be a valid code as specified in Inpatient Data Code Table (2)(b)	A
11	Ethnicity 1	Text	8	- Must be present - If present, must be a valid code as specified in Inpatient Data Code Table (2)(c)	A

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12	Ethnicity 2	Text	8	- May only be entered if Ethnicity 1 is entered. - If present, must be a valid code as specified in Inpatient Data Code Table (2)(c)	A
13	Health Plan Member ID	Text	40	- Must be present when Primary Payer Type Code is not: "1" (Self Pay) "2" (Worker's Comp) "4" (Medicaid) "9" (Free Care) "H" (Health Safety Net) "T" (Auto Insurance) - Report Health Plan Subscriber ID if Member ID is unknown.	A
14	Spoken Language	Text	8	The patient's self-reported Spoken Language - If present, must be a valid code as specified in Inpatient Data Code Table (2)(d)	Note

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RECORD TYPE 30 – IP ACCOMMODATIONS

- Required for every discharge. Must include at least one Accommodations.
- Must follow RT 25 or RT 30.
- Must be followed by RT 30 or RT 40.
- Record Type = 30.

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '30'	Text	2	- Must be first record following Discharge Record Type '25' or must follow previous Record Type '30' - Must be 30.	A
2	Sequence	Text	2	- Must be numeric - If first record following Discharge Record Type '25' sequence must ='01' - For each subsequent occurrence of Record Type '30' sequence must be incremented by one - Accumulate count for balancing against Record Type 3x Count field in Patient Control Record Type '90'	A
3	Medical Record Number	Text	25	- Must be present - Must equal Medical Record number from Discharge Record Type '20'	A

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

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10	Accommodations 5[++]	Text	20	- May only be present if Accommodations 4 present[+] - Same as Accommodations 1	A

[♦] Accommodations may occur up to 5 times.

[+] Accommodations 1 is required.

[++] Accommodations 2 - 5 are required as applicable and must be the same format as Accommodations 1.

RT 30 may be repeated more than once per discharge if it is necessary to report the use of more than five different routine and/or special care accommodations.

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RECORD TYPE 40 – ANCILLARY SERVICES

- Required for every discharge. Must include at least one Ancillary Services.
- Must follow RT 30 or RT 40.
- Must be followed by RT 40 or RT 45.
- Record Type = 40.

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '40'	Text	2	- Must be first record following last occurrence of IP Accommodations Record Type '30' or follow a previous Record Type '40' - Must be 40.	A
2	Sequence	Text	2	- Must be numeric - If first record following IP Accommodations Record Type '30' sequence must = '01' - For each subsequent occurrence of Record Type '40' sequence must be incremented by one	A
3	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A

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	ANCILLARIES 1♦	Text	20	- Must be present	A
4	Revenue Code (Ancillary)	Text	4	- Must be a valid code as specified in Inpatient Data Code Table (3)	A
5	Units of Service (Ancillary)	Text	6	- Must be present if related Revenue Code is present - Must be numeric - Must be greater than zero if Revenue Code 762 or 769 are present	A
6	Total Charges (Service)	Text	10	- Must be present if related Revenue Code is present - Must exceed one dollar - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is reported as 151 - Accumulate Total Charges (Service) for balancing against Total Charges (Ancillaries) in Patient Control Record Type '90'	A
7	Ancillaries 2++	Text	20	- May only be present if Ancillaries 1 is present+ - Same as Ancillaries 1	A
8	Ancillaries 3++	Text	20	- May only be present if Ancillaries 2 is present+ - Same as Ancillaries 1	A
9	Ancillaries 4++	Text	20	- May only be present if Ancillaries 3 is present+ - Same as Ancillaries 1	A

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10	Ancillaries 5[++]	Text	20	- May only be present if Ancillaries 4 is present[+] - Same as Ancillaries 1	A

[◆] Ancillaries may occur up to 5 times.

[+] Ancillaries 1 is required.

[++] Ancillaries 2 - 5 are required as applicable and must be the same format as Ancillaries 1. RT 40 may be repeated more than once per discharge if it is necessary to report the use of more than five different ancillary services.

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RECORD TYPE 45 – PRINCIPAL MEDICAL INFORMATION

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '45'	Text	2	- Must be first record following last occurrence of Ancillary Services Record Type '40' - Must be 45	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
3	Principal External Cause Code	Text	7	- Must be present if principal diagnosis is an ICD-10-CM S-code (S00-S99), - May be present if principal diagnosis is an ICD-10-CM T-code (T00-T88)- If present, must be a valid ICD-10-CM External Cause code (V00-Y89) - Must agree with ICD Indicator - Principal External Cause Code shall be recorded in the designated field and not be present in Diagnosis Codes.	B

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Must be present if principal diagnosis is one of the following ICD-10-CM T-codes:¶
(T07) unspecified multiple injuries ¶
(T14) injury of unspecified body region ¶
(T20-T32) burns and corrosions ¶
(T33-T34) frostbite ¶
(T66) radiation sickness ¶
(T67) effects of heat/light ¶
(T68) heatstroke/sunstroke ¶
(T69) other effects of reduced temperatures ¶
(T70) effects of air pressure and water pressure ¶
(T74) confirmed cases of abuse/neglect¶

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				- Supplemental ICD-10-CM external cause codes (Y90-Y99) shall be recorded in associated diagnosis fields - Additional ICD-10-CM external cause codes (V00-Y89) shall be recorded in associated diagnosis fields	
4	Principal Diagnosis Code	Text	7	- Must be present - Must be valid ICD-10-CM code* (exclude decimal point) - Must not be ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	A
5	Admitting Diagnosis Code	Text	7	- Must be present - Must be valid ICD-10-CM code* (exclude decimal point) - Must not be ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	B
6	Discharge Diagnosis Code	Text	7	- Must be present - Must be valid ICD-10-CM code* (exclude decimal point) - Must not be ICD-10-CM external cause code - Sex of patient must agree with diagnosis code for sex specific diagnosis - Must agree with ICD Indicator	Note

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7	Condition Present on Admission – Principal External Cause Code	Text	1	- May be present when Principal External Cause Code is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
8	Condition Present on Admission – Principal Diagnosis Code	Text	1	- May be present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
9	Principal ICD Procedure Code	Text	7	- If present, must be valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
10	Date of Principal ICD Procedure (CCYYMMDD)	Text	8	- Must be present if Principal ICD Procedure code is present - Must be valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
11	ICD Indicator	Text	1	- International Classification of Diseases version - All ICD codes must be ICD-10 - Must be 0 for ICD-10	A
12	Other Caregiver	Text	1	- May be present - If present must be a valid code as specified in Inpatient Data Code Table (4)(a)	B

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13	Attending Physician/Clinician National Provider Identifier (NPI)	Text	10	- Must be present - Must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	A
14	Operating Physician/Clinician for Principal ICD Procedure National Provider Identifier (NPI)	Text	10	- Must be present if Principal ICD Procedure Code is present - If present, must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	A
15	Additional Caregiver National Provider Identifier (NPI)	Text	10	- May be present - If present, must be a valid National Physician Identifier per National Plan and Provider Enumeration System (NPPES)	A
16	Number of ANDs	Text	4	- May be present - If present: - Must be numeric - Must not exceed total accommodation days	Note
17	Discharge Facility National Provider Identifier (NPI)	Text	10	- May be present - If present, must be a valid National Provider Identifier per National Plan and Provider Enumeration System (NPPES)	Note

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RECORD TYPE 50 – MEDICAL DIAGNOSIS

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '50'	Text	2	- Must be first record following last occurrence of Principal Medical Information Record Type '45' - Must be 50	A
2	Sequence	Text	2	- Must be numeric	A

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
				- If first record following Principal Medical Information Record Type '45' sequence must = '01' - For each subsequent occurrence of Record Type '50' sequence must be incremented by one	
3	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
4	Assoc. Diagnosis Code I	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A
5	Assoc. Diagnosis Code II	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point)	A

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
				- Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	
6	Assoc. Diagnosis Code III	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A
7	Assoc. Diagnosis Code IV	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
8	Assoc. Diagnosis Code V	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A
9	Assoc. Diagnosis Code VI	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A
10	Assoc. Diagnosis Code VII	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point)	A

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
				- Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	
11	Assoc. Diagnosis Code VIII	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A
12	Assoc. Diagnosis Code IX	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
13	Assoc. Diagnosis Code X	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A
14	Assoc. Diagnosis Code XI	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT45) - Must agree with ICD Indicator	A
15	Assoc. Diagnosis Code XII	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point)	A

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
				- Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	
16	Assoc. Diagnosis Code XIII	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A
17	Assoc. Diagnosis Code XIV	Text	7	- Only permitted if prior diagnosis is entered - Must be a valid ICD-10-CM code* (exclude decimal point) - Sex of patient must agree with diagnosis code for sex specific diagnosis - May be an ICD External Cause Code (V00-Y99) - If reporting an External Cause Code, the Principal External Cause Code must be present (RT 45) - Must agree with ICD Indicator	A

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
18	Condition Present on Admission – Assoc. Diagnosis Code I	Text	1	- May be present when Assoc. Diagnosis Code I is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
19	Condition Present on Admission – Assoc. Diagnosis Code II	Text	1	- May be present when Assoc. Diagnosis Code II is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
20	Condition Present on Admission – Assoc. Diagnosis Code III	Text	1	- May be present when Assoc. Diagnosis Code III is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
21	Condition Present on Admission – Assoc. Diagnosis Code IV	Text	1	- May be present when Assoc. Diagnosis Code IV is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
22	Condition Present on Admission – Assoc. Diagnosis Code V	Text	1	- May be present when Assoc. Diagnosis Code V is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
23	Condition Present on Admission – Assoc. Diagnosis Code VI	Text	1	- May be present when Assoc. Diagnosis Code VI is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
24	Condition Present on Admission – Assoc. Diagnosis Code VII	Text	1	- May be present when Assoc. Diagnosis Code VII is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
25	Condition Present on Admission – Assoc. Diagnosis Code VIII	Text	1	- May be present when Assoc. Diagnosis Code VIII is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
26	Condition Present on Admission – Assoc. Diagnosis Code IX	Text	1	- May be present when Assoc. Diagnosis Code IX is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
27	Condition Present on Admission – Assoc. Diagnosis Code X	Text	1	- May be present when Assoc. Diagnosis Code X is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
28	Condition Present on Admission – Assoc. Diagnosis Code XI	Text	1	- May be present when Assoc. Diagnosis Code XI is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
29	Condition Present on Admission – Assoc. Diagnosis Code XII	Text	1	- May be present when Assoc. Diagnosis Code XII is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B

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Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
30	Condition Present on Admission – Assoc. Diagnosis Code XIII	Text	1	- May be present when Assoc. Diagnosis Code XIII is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B
31	Condition Present on Admission – Assoc. Diagnosis Code XIV	Text	1	- May be present when Assoc. Diagnosis Code XIV is present - If present, must be a valid code as specified in Inpatient Data Code Table (4)(b)	B

RECORD TYPE 60 – MEDICAL PROCEDURE (ICD Codes)

- Required for each discharge.
- Must follow RT 50 or RT 60.
- Must be followed by RT 60 or RT 65.
- Record Type = 60.

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '60'	Text	2	- Must be first record following Medical Diagnosis Record Type '50' - Must be 60	A

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2	Sequence	Text	2	- Must be numeric - If first record following Medical Diagnosis Record Type '50' sequence must = '01' - For each subsequent occurrence of Record Type '60' sequence must be incremented by one	A
3	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
4	Significant ICD Procedure I	Text	7	- May only be present if Principal ICD Procedure Code is present (RT 45, field 9) - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
5	Significant ICD Procedure I Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure Code I is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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6	Significant ICD Procedure II	Text	7	- May only be present if Significant ICD Procedure I is present - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
7	Significant ICD Procedure II Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure II code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
8	Significant ICD Procedure III	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
9	Significant ICD Procedure III Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure III code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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10	Significant ICD Procedure IV	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
11	Significant ICD Procedure IV Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure IV code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
12	Significant ICD Procedure V	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
13	Significant ICD Procedure V Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure V code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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14	Significant ICD Procedure VI	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
15	Significant ICD Procedure VI Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure VI code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
16	Significant ICD Procedure VII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
17	Significant ICD Procedure VII Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure VII code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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18	Significant ICD Procedure VIII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
19	Significant ICD Procedure VIII Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure VIII code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
20	Significant ICD Procedure IX	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
21	Significant ICD Procedure IX Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure IX code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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22	Significant ICD Procedure X	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
23	Significant ICD Procedure X Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure X code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
24	Significant ICD Procedure XI	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
25	Significant ICD Procedure XI Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure XI code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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26	Significant ICD Procedure XII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
27	Significant ICD Procedure XII Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure XII code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
28	Significant ICD Procedure XIII	Text	7	- May only be present if all previous procedure fields are entered - Must be a valid ICD-10-PCS code* (exclude decimal point) - Must be valid for patient sex - Must agree with ICD Indicator	A
29	Significant ICD Procedure XIII Date (CCYYMMDD)	Text	8	- Must be present if Significant ICD Procedure XIII code is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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RECORD TYPE 65 – MEDICAL PROCEDURE (HCPCS/CPT Codes)

- Required for each discharge.
- Only one allowed per Discharge.
- Must follow RT 60
- Must be followed by RT 80.
- Record Type = 65.

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '65'	Text	2	- Must be first record following Medical Procedure (ICD Codes) Record Type '60' - Must be 65.	A

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2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Discharge Record Type '20'	A
3	Significant HCPCS/CPT Procedure I	Text	10	- Must be a valid HCPCS/CPT code - Must be valid for patient sex	A
4	Procedure Code Type for Significant HCPCS/CPT Procedure I	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code I is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A
5	First Modifier for Significant HCPCS/CPT Procedure I	Text	2	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be a valid HCPCS/CPT code modifier	B
6	Second Modifier for Significant HCPCS/CPT Procedure I	Text	2	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be a valid HCPCS/CPT code modifier	B
7	Third Modifier for Significant HCPCS/CPT Procedure I	Text	2	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be a valid HCPCS/CPT code modifier	B
8	Fourth Modifier for Significant HCPCS/CPT Procedure I	Text	2	- May be present if Significant HCPCS/CPT Procedure Code I is present - Must be a valid HCPCS/CPT code modifier	B

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9	Significant HCPCS/CPT Procedure I Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code I is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
10	Significant HCPCS/CPT Procedure II	Text	10	- May only be present if Significant HCPCS/CPT Procedure Code I is present - Must be a valid HCPCS/CPT code - Must be valid for patient sex	A
11	Procedure Code Type for Significant HCPCS/CPT Procedure II	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code II is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A
12	First Modifier for Significant HCPCS/CPT Procedure II	Text	2	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be a valid HCPCS/CPT code modifier	B
13	Second Modifier for Significant HCPCS/CPT Procedure II	Text	2	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be a valid HCPCS/CPT code modifier	B
14	Third Modifier for Significant HCPCS/CPT Procedure II	Text	2	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be a valid HCPCS/CPT code modifier	B

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15	Fourth Modifier for Significant HCPCS/CPT Procedure II	Text	2	- May be present if Significant HCPCS/CPT Procedure Code II is present - Must be a valid HCPCS/CPT code modifier	B
16	Significant HCPCS/CPT Procedure II Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code II is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
17	Significant HCPCS/CPT Procedure III	Text	10	- May only be present if Significant HCPCS/CPT Procedure Code II is present - Must be a valid HCPCS/CPT code - Must be valid for patient sex	A
18	Procedure Code Type for Significant HCPCS/CPT Procedure III	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code III is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A
19	First Modifier for Significant HCPCS/CPT Procedure III	Text	2	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be a valid HCPCS/CPT code modifier	B
20	Second Modifier for Significant HCPCS/CPT Procedure III	Text	2	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be a valid HCPCS/CPT code modifier	B

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21	Third Modifier for Significant HCPCS/CPT Procedure III	Text	2	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be a valid HCPCS/CPT code modifier	B
22	Fourth Modifier for Significant HCPCS/CPT Procedure III	Text	2	- May be present if Significant HCPCS/CPT Procedure Code III is present - Must be a valid HCPCS/CPT code modifier	B
23	Significant HCPCS/CPT Procedure III Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code III is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
24	Significant HCPCS/CPT Procedure IV	Text	10	- May only be present if Significant HCPCS/CPT Procedure Code III is present - Must be a valid HCPCS/CPT code - Must be valid for patient sex	A
25	Procedure Code Type for Significant HCPCS/CPT Procedure IV	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A
26	First Modifier for Significant HCPCS/CPT Procedure IV	Text	2	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be a valid HCPCS/CPT code modifier	B

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27	Second Modifier for Significant HCPCS/CPT Procedure IV	Text	2	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be a valid HCPCS/CPT code modifier	B
28	Third Modifier for Significant HCPCS/CPT Procedure IV	Text	2	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be a valid HCPCS/CPT code modifier	B
29	Fourth Modifier for Significant HCPCS/CPT Procedure IV	Text	2	- May be present if Significant HCPCS/CPT Procedure Code IV is present - Must be a valid HCPCS/CPT code modifier	B
30	Significant HCPCS/CPT Procedure IV Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code IV is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
31	Significant HCPCS/CPT Procedure V	Text	10	- May only be present if Significant HCPCS/CPT Procedure Code IV is present - Must be a valid HCPCS/CPT code - Must be valid for patient sex	A
32	Procedure Code Type for Significant HCPCS/CPT Procedure V	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code V is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A

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33	First Modifier for Significant HCPCS/CPT Procedure V	Text	2	- May be present if Significant HCPCS/CPT Procedure Code V is present - Must be a valid HCPCS/CPT code modifier	B
34	Second Modifier for Significant HCPCS/CPT Procedure V	Text	2	- May be present if Significant HCPCS/CPT Procedure Code V is present - Must be a valid HCPCS/CPT code modifier	B
35	Third Modifier for Significant HCPCS/CPT Procedure V	Text	2	- May be present if Significant HCPCS/CPT Procedure Code V is present - Must be a valid HCPCS/CPT code modifier	B
36	Fourth Modifier for Significant HCPCS/CPT Procedure V	Text	2	- May be present if Significant HCPCS/CPT Procedure Code V is present - Must be a valid HCPCS/CPT code modifier	B
37	Significant HCPCS/CPT Procedure V Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code V is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
38	Significant HCPCS/CPT Procedure VI	Text	10	- May only be present if Significant HCPCS/CPT Procedure Code V is present - Must be a valid HCPCS/CPT code - Must be valid for patient sex	A

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39	Procedure Code Type for Significant HCPCS/CPT Procedure VI	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code VI is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A
40	First Modifier for Significant HCPCS/CPT Procedure VI	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VI is present - Must be a valid HCPCS/CPT code modifier	B
41	Second Modifier for Significant HCPCS/CPT Procedure VI	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VI is present - Must be a valid HCPCS/CPT code modifier	B
42	Third Modifier for Significant HCPCS/CPT Procedure VI	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VI is present - Must be a valid HCPCS/CPT code modifier	B
43	Fourth Modifier for Significant HCPCS/CPT Procedure VI	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VI is present - Must be a valid HCPCS/CPT code modifier	B
44	Significant HCPCS/CPT Procedure VI Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code VI is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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45	Significant HCPCS/CPT Procedure VII	Text	10	- May only be present if Significant HCPCS/CPT Procedure Code VI is present - Must be a valid HCPCS/CPT code - Must be valid for patient sex	A
46	Procedure Code Type for Significant HCPCS/CPT Procedure VII	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A
47	First Modifier for Significant HCPCS/CPT Procedure VII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid HCPCS/CPT code modifier	B
48	Second Modifier for Significant HCPCS/CPT Procedure VII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid HCPCS/CPT code modifier	B
49	Third Modifier for Significant HCPCS/CPT Procedure VII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid HCPCS/CPT code modifier	B
50	Fourth Modifier for Significant HCPCS/CPT Procedure VII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid HCPCS/CPT code modifier	B

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51	Significant HCPCS/CPT Procedure VII Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B
52	Significant HCPCS/CPT Procedure VIII	Text	10	- May only be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid HCPCS/CPT code - Must be valid for patient sex	A
53	Procedure Code Type for Significant HCPCS/CPT Procedure VIII	Text	1	- Must be present if Significant HCPCS/CPT Procedure Code VIII is present - Must be a valid code as specified in Inpatient Data Code Table (1)(o)	A
54	First Modifier for Significant HCPCS/CPT Procedure VIII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VIII is present - Must be a valid HCPCS/CPT code modifier	B
55	Second Modifier for Significant HCPCS/CPT Procedure VIII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VIII is present - Must be a valid HCPCS/CPT code modifier	B
56	Third Modifier for Significant HCPCS/CPT Procedure VIII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VIII is present - Must be a valid HCPCS/CPT code modifier	B

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57	Fourth Modifier for Significant HCPCS/CPT Procedure VIII	Text	2	- May be present if Significant HCPCS/CPT Procedure Code VIII is present - Must be a valid HCPCS/CPT code modifier	B
58	Significant HCPCS/CPT Procedure VIII Date (CCYYMMDD)	Text	8	- Must be present if Significant HCPCS/CPT Procedure Code VII is present - Must be a valid date and format - Must not be earlier than 3 days prior to date of admission - Must not be later than discharge date	B

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RECORD TYPE 80 – PHYSICIAN DATA

- Required for each discharge.
- Must be preceded by RT 65.
- Must be followed by RT 90.
- Record Type = 80.

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '80'	Text	2	- Must be first record following Medical Procedure Record Type '65' - Must be 80.	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Patient Record Type '20'	A
3	Attending Physician License Number (Board of Registration in Medicine Number)	Text	25	- Must be present - Must be a valid and current Mass. Board of Registration in Medicine (BORIM) license number or - Must be NURSEP, PHYAST or OTHER, as specified in Inpatient Data Elements Definitions (11)(a)	B

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4	Operating Physician for Principal ICD Procedure (Board of Registration in Medicine Number)	Text	25	- Must be present if Principal ICD Procedure Code is present in Record Type 45, field 9. - Must be a valid and current Mass. Board of Registration in Medicine (BORIM) license number or - Must be NURSEP, PHYAST or OTHER as specified in Inpatient Data Elements Definitions (11)(b)	Note
5	Operating Physician for Significant HCPCS/CPT Procedure I (Board of Registration in Medicine Number)	Text	25	- Must be present if Significant HCPCS/CPT Procedure I Code is present. - Must be a valid and current Mass. Board of Registration in Medicine (BORIM) license number or - Must be NURSEP, PHYAST or OTHER as specified in Inpatient Data Elements Definitions (11)(b)	Note
6	Operating Physician/Clinician for Significant HCPCS/CPT Procedure I National Provider Identifier (NPI)	Text	10	- Must be present if Significant HCPCS/CPT Procedure I Code is present. - Must be a valid National Physician/Clinician Identifier per National Plan and Provider Enumeration System (NPPES).	**B**

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RECORD TYPE 90 – PATIENT CONTROL

- Required for each discharge.
- Must be preceded by RT 80.
- May be followed by RT 20 or RT 95.
- Record Type = 90.

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '90'	Text	2	- Must be first record following Physician Data Record Type '80' - Must be 90	A
2	Medical Record Number	Text	25	- Must be present - Must equal Medical Record Number from Patient Record Type '20'	A
3	Physical Record Count	Text	3	- Must be numeric - Must equal total number of all Records Type '20', '25', '30', '40', '45', '50', '60', '65' and '80'	A
4	Record Type 20 Count	Text	2	- Must be numeric - Must equal number of Record Type '20' records - Must = '01'	A

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5	Record Type 25 Count	Text	2	- Must be numeric - Must equal number of Record Type '25' records - Must = '01'	A
6	Record Type 30 Count	Text	2	- Must be numeric - Must equal number of Record Type '30' records	A
7	Record Type 40 Count	Text	2	- Must be numeric - Must equal number of Record Type '40' records	A
8	Record Type 45 Count	Text	2	- Must be numeric - Must equal number of Record Type '45' records - Must = '01'	A
9	Record Type 50 Count	Text	2	- Must be numeric - Must equal number of Record Type '50' records	A
10	Record Type 60 Count	Text	2	- Must be numeric - Must equal number of Record Type '60' records	A
11	Record Type 65 Count	Text	2	- Must be numeric - Must equal number of Record Type '65' records - Must = '01'	A

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12	Record Type 80 Count	Text	2	- Must be numeric - Must equal number of Record Type '80' records - Must = '01'	A
13	Total Charges Spec. Services	Text	12	- Must be numeric - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is reported as 151	A
14	Total Charges Routine Services	Text	12	- Must be numeric- Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is reported as 151	A
15	Total Charges Ancillaries	Text	12	- Must equal sum of Total Charges (Services) from Ancillary Services Record Type '40' records - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is reported as 151	A

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16	Total Charges (All Chgs)	Text	14	- Must equal sum of Total Charges Special Services, Total Charges Routine Services, and Total Charges Ancillaries from Patient Control Record Type '90' record - Must equal sum of Total Charges Accommodations from IP Accommodations Record Type '30' records and Total Charges (Services) from Ancillary Services Record Type '40' records - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is reported as 151	A

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RECORD TYPE 95 – PROVIDER BATCH CONTROL

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

Field No.	Field Name	Data Type	Length	Edit Specifications	Error Type
1	Record Type '95'	Text	2	- Must follow Patient Control Record Type '90' - Must be 95.	A
2	Number of Discharges	Text	6	- Must be numeric. - Must equal number of Patient Control Record Type '90' records	A
3	Total Days	Text	10	- Must be numeric. - Must equal total accommodation days from all Record Type '30' records	Note
4	Total Charges Accommodations	Text	14	- Must be numeric. - Must equal sum of Total Charges Spec. Services and Total Charges Routine Services from Patient Control Record Type '90' records - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is reported as 151	A

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5	Total Charges Ancillaries	Text	14	- Must be numeric. - Must equal sum of Total Charges Ancillaries from Patient Control Record Type '90' records - Must be whole numbers, no decimals EXAMPLE: 150.00 is reported as 150; 150.70 is reported as 151	A

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RECORD TYPE 99 – FILE CONTROL

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

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

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Inpatient Data Element Definitions

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

(1) Record Type '01'

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

(b) Receiver Identification: A control field for ensuring the correct file is being forwarded to CHIA. Code this field `CHIA'.

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

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

(2) Record Type '10'

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

(b) Organization ID for Provider: A unique code assigned by the Center for Health Information and Analysis (CHIA) for each health care organization providing data.

(3) Record Type '20'

(a) Medical Record Number: The unique number assigned to each patient within the hospital that distinguishes the patient and the patient's hospital record(s) from all others in that institution.

(b) Patient Birth Date: The date of birth of the patient. Record two digits for century, two digits for year, two digits for month, and two digits for day. If date is unknown, estimate.

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

(d) Source of Admission: A code indicating the source referring or transferring this patient to inpatient status in the hospital. The Primary Source of Admission should be the originating referring or transferring facility or primary referral source causing the patient to enter the hospital's care. The Secondary Source of Admission should be the secondary referring or transferring source for the patient. If the patient has been transferred from a SNF to the hospital's Clinic and is then admitted, report the Primary Source of Admission as "5 - Transfer from SNF" and report the Secondary Source of Admission as "Within Hospital Clinic Referral".

The method for determining the Primary Source of Admission to report for each discharge should be based on the following Source of Admission hierarchy:

	Primary Source of Admission Hierarchy		**Source of Admission Codes***	
1.	Transferred from another facility	Yes	4, 5, or 6	If no, refer to #2.
2.	Referred or transferred from Outside Hospital Clinic or Outside Ambulatory Surgery	Yes	L or T	If no, refer to #3.
3.	Transferred from Outside Hospital Emergency Room	Yes	7	If no, refer to #4
4.	Referred or transferred from Court/Law Enforcement	Yes	8	If no, refer to #5
5.	Direct Physician Referral, Direct Health Plan/HMO Referral or Walk-In/Self-Referral	Yes	1, 3, or M	If no, refer to #6
6.	Referred or transferred from Within Hospital Clinic or Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer or Ambulatory Surgery	Yes	2, J, or Y	If no, refer to #7.
7.	Observation Referral	Yes	X	If no, refer to #8.
8.	Other or information not available	Yes	9 or 0	

*** Note: Refer to Inpatient Data Code Table (1)(d) for detailed listing of Source of Admission codes and definitions.**

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(e) Observation: If the Observation Source of Admission (code 'X') is reported, related observation room charges must also be reported for the Observation Ancillary Revenue Code 762. However, if the patient has been seen in Observation as well as another outpatient department and is then admitted, use Revenue Code 762 to report observation room charges and use the alternate outpatient department as the Source of Admission.

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

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

(**h) Patient Status:** A code indicating the patient's status upon discharge and/or the destination to which the patient was referred or transferred upon discharge.

(i) Intermediate Care Facility (ICF): An ICF is a facility that provides routine services or periodic availability of skilled nursing, restorative and other therapeutic services, in addition to the minimum basic care and services required for patients whose condition is stabilized to the point that they need only supportive nursing care, supervision and observation. A facility is an ICF if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR, 150.001(B)(3): Supportive Nursing Care Facilities (Level III).

(**j) Rest Home:** A Rest Home is a facility that provides or arranges to provide a supervised supportive and protective living environment and support services incident to old age for residents having difficulty in caring for themselves. This facility's services and programs seek to foster personal well-being, independence, an optimal level of psychosocial functioning, and integration of residents into community living. A facility is a Rest Home if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR 150.001(B)(4): Resident Care Facilities (Level IV).

(k) Skilled Nursing Facility (SNF): A SNF is a facility that provides continuous skilled nursing care and meaningful availability of restorative services and other therapeutic services in addition to the minimum basic care and services required for patients who show potential for improvement or restoration to a stabilized condition or who have a deteriorating condition requiring skilled care. A facility is a SNF if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR, 150.001(B)(2): Skilled Nursing Care Facilities (Level II). Use Routine Accommodation Revenue Code 198 for SNF.

(**l) Billing number:** The unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution. Newborns must have their own billing number separate from that of their mother.

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(m) Claim Certificate Number: This number is also referred to as the new MMIS ID or MassHealth ID. If the Payer Type Code is equal to "4" (Medicaid) or "H" (Health Safety Net) as specified in Inpatient Data Code Table (1)(f), the new MMIS ID must be recorded.

(n) Veteran Status: A code indicating the patient's status as a United States veteran. The code for 'Not applicable' should be used for patients who have not turned 18 years old.

(o) Patient Social Security Number: The patient's social security number is to be reported as a nine digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record", by reporting the social security number as "000000001". The number to be reported for the patient's social security number is the patient's social security number, not the social security number of some other person, such as the husband or wife of the patient.

(p) Do Not Resuscitate (DNR) Status: A status indicating that the patient had a physician order not to resuscitate or the patient had a status of receiving palliative care only. Do not resuscitate status means not to revive from potential or apparent death or that a patient was being treated with comfort measures only.

(q) Hospital Service Site Reference: Hospital Organization ID as assigned by the Center for Health Information and Analysis for the site where care was given. Required if provider is approved to submit multiple campuses in one file.

(r) Patient's Sexual Orientation: The patient's self-reported sexual orientation as specified in Inpatient Data Code Table (1)(m).

(s) Patient's Gender Identity: The patient's self-reported gender identity as specified in Inpatient Data Code Table (1)(n).

(4) Record Type '25'

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

(b) Permanent Patient City/Town: The city/town where the patient resides. This is required if the patient is a United States citizen. If the patient is homeless and does not have a ZIP Code or City, provide the ZIP Code or City of their last temporary or permanent residence.

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

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(d) Patient Zip Code: The U.S. Post Office (five digit) zip code which designates the patient's residence. If the patient's residence is outside of the United States, or if the zip code is unknown record 0's. If the patient is homeless and does not have a ZIP Code or City, provide the ZIP Code or City of their last temporary or permanent residence.

(e) Patient Country: The International Standards Organization (ISO-3166) code for the country where the patient resides. This is their permanent country of residence. This is required for all patients.

(f) Patient's Race 1 and Race 2: The patient's self-reported Race 1 and Race 2 as specified in Inpatient Data Code Table (2)(a).

(g) Patient's Hispanic Indicator: The patient's self-reported response as specified in Inpatient Data Code Table (2)(b).

(h) Patient's Ethnicity 1 and Ethnicity 2: The patient's self-reported Ethnicity 1 and Ethnicity 2 as specified in Inpatient Data Code Table (2)(c).

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

(j) Patient's Spoken Language: The patient's self-reported Spoken Language as specified in Inpatient Data Code Table (2)(d).

(5) Record Type '30'

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

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

(c) Units of Service: A quantitative measure of utilization of specific hospital services corresponding to prescribed revenue codes. For routine and special care accommodations the units of service are "days".

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(d) Total Charges (Accommodation): The full, undiscounted, usual and customary charges summarized by specific accommodation revenue code(s). Total charges should not include charges for telephone service, television or private duty nurses. Any charges for a leave of absence period are to be included in the routine accommodation charges for the appropriate service (medical/surgical, psychiatry) from which the patient took the leave of absence. Any other routine admission charges or daily charges under which expenses are allocated to the routine or special care reporting centers on the CHIA cost report must be included in the total charges.

(6) Record Type '40'

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

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

For Observation Treatment the expected revenue codes are:

1. Revenue Center 760 - General Observation/Treatment Room: This ancillary revenue center is designated for any other charges associated with “observation” or “Treatment Room” that are not captured in revenue centers 761, 762, or 769.

2. Revenue Center 762 - Observation Room: This ancillary revenue center is designated for Observation Room charges only. Charges should be reported under revenue center code 762 for any patient that uses an Observation Room and is admitted

3. Revenue Center 769 - Other Treatment/Observation Room: This ancillary revenue center is designated for other atypical inpatient Observation Room charges only. An example of atypical inpatient Observation Room charges might be room charges for a patient held for observation purposes before being discharged that is not categorized as “observation status” or not placed in an observation bed.

(c) Units of Service: For the majority of ancillary services, the units of service are not specified. The Units of Service for Ancillary Services is required for Revenue Center 762 - Observation Room and 769 - Other Observation Room. The required units of service for Observation Room is hours. For hospitals that collect this information in a range, report the information using the end point and round up

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to the highest whole number. For example, if the range is 0 - 4 hours, then '4' should be reported. Hospitals that collect this unit as days will need to convert it to an hour equivalent. For example, 1 day should be reported as '24' (for 24 hours).

(d) Total Charges (Ancillary Services): The full, undiscounted, usual and customary charges summarized by a specific ancillary service revenue code(s).

(7) Record Type '45'

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

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

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

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

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

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

(g) ICD Indicator: Code to indicate the version of the ICD coding system on the diagnosis codes. Only one ICD coding system is allowed per patient discharge.

(h) Other Caregiver: The primary caregiver responsible for the patient's care other than the Attending Physician, Operating Room Physician as specified in Inpatient Data Code Tables 4(a).

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

(8) Record Type '50'

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

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

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

(9) Record Type '60'

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

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

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

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(10) Record Type '65'

(a) Significant HCPCS / CPT Procedure Code: The HCPCS / CPT procedure code usually corresponding to additional procedures which carry an operative or anesthetic risk or require highly trained personnel, special equipment or facilities.

(b) Significant HCPCS / CPT Procedure Code Modifiers: Report up to four modifiers related to each Significant HCPCS /CPT Procedure code.

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

(11) Record Type '80'

(a) Attending Physician License Number: The Massachusetts Board of Registration in Medicine license number of the clinician of record at discharge who is responsible for the discharge summary, who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode. If the attending physician does not have a license number from the Massachusetts Board of Registration in Medicine, use the following codes in the indicated circumstances:

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

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(b) Procedure/Operating Physician License Number: The Massachusetts Board of Registration in Medicine license number for the clinician who performed each procedure. If the operating physician does not have a license number from the Massachusetts Board of Registration in Medicine, use the following codes in the indicated circumstances:

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

(12) Record Type '90'

(a) Physical Record Count: The count of the total number of records provided for this particular patient discharge excluding Record Type '90'.

(b) Record Type Count: The count of the number of each type of separate records from record '20' through '80'. For instance. Record Type "30" is the count of all record types '30'.

(c) Total Charges Special Care Services: The full, undiscounted, usual and customary charges for patient care summarized by prescribed revenue code for accommodation services in those special care units which provide patient care of a more intensive nature than that provided in the general medical care units, as specified in Inpatient Data Code Table (3).

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

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

(f) Total Charges (All Charges: The full, undiscounted, usual and customary charges for patient care summarized by prescribed revenue code for special care, routine accommodation, and ancillary services. Total charges should not include charges for telephone service, television or private duty nurses. Any charges for a leave of absence are to be included in the routine accommodation charges

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for the appropriate service from which the patient took the leave of absence. Any other routine admission charges or daily charges under which expenses are allocated to the reporting centers on the CHIA-403 must be included in total charges.

(13) Record Type '95'

(a) Total Days: The total number of patient days represented by discharges in this quarter net of any leave of absence days.

(14) Record Type '99'

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

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Inpatient Data Code Tables

The following are the code tables for all data elements requiring codes not otherwise specified. They are listed in order of Record Type.

(1) Record Type '20'

(a)

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

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(b)

* MARSTA CODE	* MARITAL STATUS DEFINITION
S	Never Married
M	Married
X	Legally Separated
D	Divorced
W	Widowed
C	Common Law Married
P	Domestic Partnership
U	Unknown

(c)

* TYPADM CODE	* TYPE OF ADMISSION DEFINITION
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Information Unavailable
6	Trauma

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(d)

* SRCADM CODE	* SOURCE OF ADMISSION DEFINITION
0	Information Not Available
1	Direct Physician Referral
2	Within Hospital Clinic Referral
3	Direct Health Plan Referral/HMO Referral
4	Transfer from an Acute Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from Intermediate Care Facility
7	Outside Hospital Emergency Room Transfer
8	Court/Law Enforcement
9	Other (to include level 4 Nursing Facility)
F	Transfer from a Hospice Facility
J	Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer
L	Outside Hospital Clinic Referral
M	Walk-In/Self-Referral
T	Transfer from Another Institution's Ambulatory Surgery
X	Observation
Y	Within Hospital Ambulatory Surgery Transfer

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(e) PATIENT STATUS:

For Patient Status reporting, use the codes found in Standard Facility Billing Elements: National Uniform Billing Committee (NUBC)

http://www.nubc.org/

(f) PAYER TYPE:

For Payer Type codes, refer to the Payer Code list on CHIA's website:

Behavioral Health Facilities Case Mix Data (chiamass.gov)

(g) SOURCE OF PAYMENT:

For Source of Payment codes, refer to the Payer Code list on CHIA's website:

Behavioral Health Facilities Case Mix Data (chiamass.gov)

(h)

* VESTA CODE	* VETERAN STATUS DEFINITION
1	YES
2	NO (includes never in military, currently in active duty, national guard or reservist with 6 months or less active duty)
3	Not applicable (The code for 'Not applicable' should be used for patients who have not turned 18 years old.)
4	Not Determined (unable to obtain information)

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(i)

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

(j)

HOMELESS INDICATOR CODE	HOMELESS INDICATOR DEFINITION
Y	Patient is known to be homeless.
N	Patient is not known to be homeless.
DONTKNOW	Don't know
ASKU	Choose not to answer
UNK	Unknown
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

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(k) TRANSFER ORG IDs:

For a list of Transfer Organization IDs (ORG ID), refer to CHIA's website:
https://www.chiamass.gov/behavioral-health-facilities-case-mix-data/

(l)

COURT / CRIMINAL REFERRAL INDICATOR CODE	COURT/CRIMINAL REFERRAL INDICATOR DEFINITION
1	State/Federal Court
2	Other court
3	Probation/Parole
4	Other Recognized Legal Entity
5	Diversionary Program
6	Prison
7	DUI/DWI
8	Other
9	Not applicable
10	Unknown

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(m)

PATIENT'S SEXUAL ORIENTATION CODE	PATIENT'S SEXUAL ORIENTATION DEFINITION
20430005	Straight or Heterosexual
38628009	Gay or Lesbian
42035005	Bisexual
QUEER	Queer, Pansexual, and/or Questioning
OTH	Something Else
DONTKNOW	Don't Know
ASKU	Choose not to Answer
UNK	Unknown
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

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(n)

PATIENT'S GENDER IDENTITY CODE	PATIENT'S GENDER IDENTITY DEFINITION
446151000124109	Male
446141000124107	Female
407376001	Transgender man/trans man
407377005	Transgender woman/trans woman
446131000124102	Genderqueer / gender nonconforming / non-binary, neither exclusively Male nor Female
OTH	Additional gender category or other
DONTKNOW	Don't Know
ASKU	Choose not to answer
UNK	Unknown
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

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(o)

PROCEDURE CODE TYPE IDENTIFIER CODE	PROCEDURE CODE TYPE IDENTIFIER DEFINITION
1	CPT or HCPCS Level 1 Code
2	HCPCS Level II Code
3	HCPCS Level III Code (State Medicare code).
4	American Dental Association (ADA) Procedure Code (Also referred to as CDT code.)
5	State defined Procedure Code
6	CPT Category II
7	CPT Category III Code

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(2) Record Type '25'

(a)

RACE CODE	RACE DEFINITION
1002-5	American Indian/Alaska Native
2028-9	Asian
2054-5	Black/African American
2076-8	Native Hawaiian or other Pacific Islander
2106-3	White
OTH	Other Race
DONTKNOW	Don't know
ASKU	Choose not to answer
UNK	Unknown
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

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(b)

HISPANIC INDICATOR CODE	HISPANIC INDICATOR DEFINITION
2135-2	Hispanic
2186-5	Not Hispanic
DONTKNOW	Don't know
ASKU	Choose not to answer
UNK	Unknown
UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond

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(c)

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

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

(d)

Acceptable Spoken Language Codes are detailed in *BHID Spoken Language Codes* available on CHIA's website: https://www.chiamass.gov/behavioral-health-facilities-case-mix-data/

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

For Routine Accommodations, Special Care Accommodations, and Ancillary Services, please use the revenue codes found in: Standard Facility Billing Elements: National Uniform Billing Committee (NUBC)http://www.nubc.org/

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(4) Record Types '45' and '50'

(a)

OTHER CAREGIVER CODE	OTHER CAREGIVER DEFINITION
1	Resident
2	Intern
3	Nurse Practitioner
5	Physician Assistant

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(b)

CONDITION PRESENT ON ADMISSION FLAG CODE	CONDITION PRESENT ON ADMISSION FLAG DEFINITION
Y	Yes
N	No
U	Unknown
W	Clinically undetermined
1	Not applicable (only valid for NCHS official published list of not applicable ICD codes for POA flag.)
Blank field	Not applicable (only valid for NCHS official published list of not applicable ICD codes for POA flag.)

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Inpatient Data Code Definitions

The following definitions apply to codes provided for Homeless Indicator, Race, Hispanic Indicator, Ethnicity, Sexual Orientation and Gender Identity.

Description	Code	Definition
Choose not to answer	ASKU	Patient was asked to provide an answer, and the patient actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Patient was asked to provide an answer, and the patient actively selected or indicated that they did not know the answer.
Unable to collect this information on patient due to lack of clinical capacity of patient to respond	UTC	Unable to collect this information on patient due to lack of clinical capacity of patient to respond. (e.g., clinical condition that alters consciousness)
Unknown	UNK	The response of the patient is unknown since either: (a) the patient was not asked to provide a response, or (b) the patient was asked to provide a response, and a response was not given. Note that a patient actively selecting or indicating the response "choose not to answer" is a valid response and should be assigned the value of ASKU instead of UNK.

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Inpatient Data Quality Standards

(1) The data will be edited for compliance with the edit specifications set forth in the Inpatient Data Record Specifications. The standards to be employed for rejecting data submissions from facilities will be based upon the presence of errors in data elements categorized as A or B errors in the Error Type column of the Record Table Specifications above.

(2) All errors will be recorded for each patient discharge. A patient discharge will be rejected under the following conditions:

(a) Presence of one or more errors for Category A elements.

(b) Presence of two or more errors for Category B elements.

(3) An entire file will be rejected and returned to submitter if:

(a) Any Category A elements of Provider Record (Record Type 10) or Provider Batch Control Record (Record Type = 95) are in error or

(b) Any Category A errors on Label Record (Record Type = 01).

(c) Any Category A errors on file Control Record (Record Type = 99).

(d) Any required record types are missing or out of order.

(e) If 1% or more of discharges are rejected or

(f) If 50 consecutive records are rejected.

(4) Acceptance of data files under the edit check procedures shall not be deemed acceptance of the factual accuracy of the data contained therein.

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Submittal Schedule

Inpatient Discharge Data Files must be submitted quarterly to the CHIA according to the following schedule:

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

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