DEFINITIONS OF DATA ELEMENTS

NOTE: The regulations are identified by bold and italics.

The section number located at the top right corner of the first page of each regulation refers to the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8.

DATA ELEMENTS

The data set includes the following data elements (in alphabetical order):

Date of Birth
Disposition of Patient
Ethnicity
Expected Source of Payment
Other Diagnoses
Other External Cause of Injury
Other Procedures
Patient Social Security Number
Principal Diagnosis
Principal External Cause of Injury
Principal Procedure
Race
Service Date
Sex
ZIP Code

Additional Reporting Requirements

- A facility has the option to include the Abstract Record Number for use by OSHPD and the reporting facility to identify specific records for correction. If submitted, the abstract record number is deleted prior to release of public data.

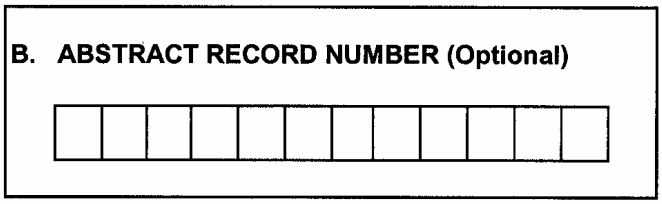
- The Facility Identification Number assigned to your facility by OSHPD is a required part of the data record.

- ED and AS Data Records must be submitted separately. There will be no separate code indicating the type of care for emergency care or ambulatory surgery care.

ABSTRACT RECORD NUMBER (Optional)

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



In order to identify a particular patient's record from all others within the data submission, a unique code consisting of not more than 12 alphanumeric characters may be reported. The abstract record number is optional.

When the abstract record number is reported, it:

- May be used by OSHPD and reporting hospital to identify specific records for correction and outcome studies.
- Will be deleted prior to release of public data.
- May be the medical record number.
- May include hyphens or slashes. Other special characters (e.g., period, comma, apostrophe) must not be included.
- Should be reported from the left-most position of the field. Do not fill blank fields with zeroes.

DATE OF BIRTH **Section 97251**

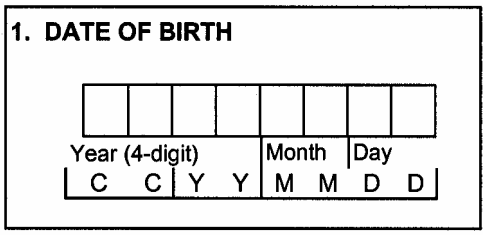
For online transmission of data reports as electronic data files, the patient's date of birth shall be reported in numeric form as follows: 4-digit year, 2-digit month, and 2-digit day. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

For online entry of individual records, the patient's date of birth shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

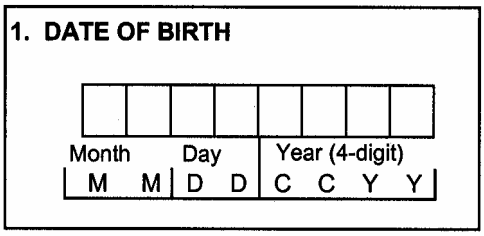
When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth shall be reported. If only the age is known, the estimated year of birth shall be reported and the month and day can be reported as 01 for month and 01 for day.

DISCUSSION
The numeric format differs depending on how it is being reported:

Specifications for reporting this data element for online data file transmission file for encounters occurring on or after January 1, 2006:



Specifications for reporting this data element with the Record Entry Form for online web entry of individual records for encounters occurring on or after January 1, 2006:



Partial Dates of Birth:

Please provide as much data as is available.

If the patient's month and day of birth are unknown, and the year is known, the month will be 01, the day will be 01, and the given year.

Example: The patient was born in 1948. Report the date of birth as:

Electronic Data File	Record Entry Form
19480101	01011948

If the patient's age is known, subtract the age from the current year to get year of birth.

Example: The patient is known to be 65 years old and the year he receives medical service is 2004 (2004 - 65 = 1939). Report the date of birth as:

Electronic Data File	Record Entry Form
19390101	01011939

If the patient's day of birth is unknown, and the month and year are known, the day will be 01.

Example: The patient was born in August 1952. Report the date of birth as:

Electronic Data File	Record Entry Form
19520801	08011952

DISPOSITION OF PATIENT — Section 97264

The patient's disposition, defined as the consequent arrangement or event ending a patient's encounter in the reporting facility, shall be reported as one of the following:

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:

14. DISPOSITION OF PATIENT

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
20	Expired
43	Discharged/transferred to a federal health care facility
50	Discharged home with hospice care
51	Discharged to a medical facility with hospice care
61	Discharged/transferred to a hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
00	Other

(a) Discharged to home or self care (routine discharge).

DISCUSSION

This category includes the following discharges or transfers:

- Patients who go home directly after treatment;
- Home environment (e.g., half-way house, group home, community care facility, foster care, woman's shelter);
- Residential care facilities[1];
- Court/law enforcement (including patients discharged to a correctional institution or law enforcement custody[1]);
- Home with non-home health or non-hospice care services, such as services by a durable medical equipment (DME) supplier or services related to home oxygen[1];
- Homeless

This category also includes various types of facilities that provide supportive and custodial care. These facilities are licensed by the California Department of Social Services and are not considered to be health facilities. The facilities are referred to by a variety of terms (e.g., board and care, residential care facilities for the elderly). This category is used to indicate discharge to a location not licensed as a medical facility by the Department of Health Services, such as Mental Health Rehabilitation Centers (MHRC).

This category **does not include** patients sent to home health care or to home with hospice care. See (f) and (j).

[1] According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes.

(b) Discharged/transferred to a short term general hospital for inpatient care.

DISCUSSION

This category includes patients discharged or transferred to inpatient hospital care.

See also (l) and (n);

This category **does not include** patients discharged or transferred to physical medicine rehabilitation facilities, or rehabilitation distinct part of a hospital, or psychiatric facilities, or psychiatric distinct part unit of a hospital. See (m) and (p).

(c) Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care.

DISCUSSION

This category includes the following discharges or transfers:

- SNF facility or skilled nursing distinct part of a hospital that provides supportive and nursing care to patients whose primary need is for skilled nursing care on an extended basis;
- SNF certified by Medicare[1];
- Rehabilitation unit in a SNF[1];
- Institute for Mental Disease (IMD), if licensed by California Department of Health Services as SNFs. If IMD is not licensed by the California Department of Health Services as SNF, this can be reported as Federal health care facility. See (i).

This category **does not include** patients discharged or transferred to facilities with a Medicare approved skilled nursing swing bed[2]. See (l).

[1] According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes.

[2] According to the information in Summary of NUBC Minutes dated May 2002.

(d) Discharged/transferred to an intermediate care facility (ICF).

DISCUSSION

This category includes the following discharges or transfers:

- Intermediate care facility or a distinct part of a hospital or SNF that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous nursing care

- Non-certified SNFs[1];

- Skilled nursing level of care in the state designated assisted living facilities[2]

(e) Discharged/Transferred to another type of institution not defined elsewhere in this code list.

DISCUSSION

A patient discharged or transferred to a health care institution not otherwise mentioned in (a)-(q).

[1] According to the information provided on the NUBC website under Frequently asked Question, updated 10/28/06, on Patient Status codes.
2 According to the information in NUBC's UB-92 Form Locator 22 for Patient Status.

(f) Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care.

DISCUSSION

This category includes the following discharges or transfers:

- Home with healthcare services provided to patients at their place of residence at a level less intensive than health facility requirements. Services under an organized home health service organization may include nursing care, respiratory/inhalation therapy, electrocardiology, physical therapy, occupational therapy, and recreational therapy;

- Home with a written home health plan of care for home health care services[1]

This category **does not include** discharges or transfers to home with hospice services[2]. See (j).

(g) Left against medical advice or discontinued care.

DISCUSSION

This category includes patients who:

- Left against medical advice (AMA);

- Discontinued care

  - If patient is seen by a provider, report as an encounter to OSHPD
  - If patient did not see a provider, do not report to OSHPD*

* According to NUBC, this category includes patients who left without being seen (LWBS)[2]. Patients who leave your facility before seeing a provider are not considered an encounter. This record should not be reported to OSHPD. See definition of a provider in Subsection (t) of Section 97212.

---

1 According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes.and NUBC's UB-92 Form Locator 22 on Patient Status, and CMS Program Memorandum Intermediaries Transmittal #A-00-71 dated 10/2/00.
2 According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes.

(h) Expired

DISCUSSION

All episodes of care that resulted in death before patient left the facility.

(i) Discharged/transferred to a Federal health care facility.

DISCUSSION

This category includes the following discharges or transfers:

- Federal government owned health care facilities such as Veterans Administration hospitals, Department of Defense hospitals, or Public Health Services hospitals[1];
- Institute for Mental Disease (IMD). If the facility is not licensed by the California Department of Health Services as SNF, it can be reported as a Federal health care facility.

(j) Discharged home with hospice care.

DISCUSSION

This category includes patients discharged or transferred to home with hospice care.

A hospice program is a centrally administered program of palliative and support services which provide psychological, social and spiritual care for dying persons and their families, focusing on pain and symptom control for the patient.

This category **does not include** discharges or transfers to home or home health services. See (a) and (f).

[1] According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes and CMS Program Memorandum Intermediaries Transmittal #A-03-032 dated 5/2/03.

(k) Discharged to a medical facility with hospice care.

DISCUSSION

This category includes patients discharged or transferred to any medical facility for hospice care only.

A hospice program is a centrally administered program of palliative and support services which provide psychological, social and spiritual care for dying persons and their families, focusing on pain and symptom control for the patient.

(l) Discharged/transferred to a hospital-based Medicare approved swing bed

DISCUSSION

This category includes patients discharged or transferred to a SNF level of care within the hospital's Medicare approved swing bed arrangement[1].

(m) Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital.

DISCUSSION

This category includes patients discharged or transferred to a rehabilitation facility or to a rehabilitation distinct part of a hospital[2].

---

[1] According to NUBC's UB-92 Form Locator 22 on Patient Status, and Medicare Hospital Manual Transmittal 771 dated 2/28/01, and CMS Program Memorandum Transmittal #A-98-31 dated 9/98.
2 According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes and CMS Program Memorandum Intermediaries Transmittals #A-01-86 dated 7/24/01 and #A-02-022 dated 3/22/02.

(n) Discharged/transferred to a Medicare certified long term care hospital (LTCH).

DISCUSSION

This category includes patients discharged or transferred to a long term care hospital that provides acute inpatient care with an average length of stay greater than 25 days[1].

This category **does not include** discharges and transfers to SNF facility certified by Medicare or ICF facility or SNF facility certified by Medicaid (Medi-Cal). See (c), (d), and (o).

(o) Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare.

DISCUSSION

This category includes the following discharges or transfers:

- SNF level of care within the hospital's non-Medicare approved swing bed arrangement[2];
- Skilled nursing bed for the Medi-Cal Subacute Care Program;
- Skilled nursing bed for the Medi-Cal Transitional Care Program;
- Skilled nursing bed in a Congregate Living Health Facility licensed by California Department of Health Services;
- Institute for Mental Disease (IMD), if licensed by California Department of Health Services as SNFs. If IMD is not licensed by the California Department of Health Services as SNF, this can be reported as federal health care facility. See (j).

[1] According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes, and CMS Program Memorandum Intermediaries Transmittals #A-01-86 dated 7/24/01 and #A-02-022 dated 3/22/02.
2 According to the information in Summaries of NUBC Meeting dated August 2000 and May 2002, and CMS Program Memorandum Transmittal #A-02-041, dated 5/17/02.

(p) Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

DISCUSSION

This category includes patients discharged or transferred to a psychiatric facility or to a psychiatric distinct part of a hospital[1].

This category has a code of 65 that was approved by the National Uniform Billing Committee and its standard use is effective April 1, 2004, regardless of payer requirements[2].

(q) Discharged/transferred to a Critical Access Hospital (CAH).

DISCUSSION

This category includes patients discharged or transferred to a hospital designated as a Critical Access Hospital.

(r) Other

DISCUSSION

This category **does not include** health care institutions which would otherwise be categorized in (e) above.

[1] According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes and CMS Program Memorandum Intermediaries Transmittal #A-03-032 dated 5/2/03.
[2] According to the information provided on the National Uniform Billing Committee's (NUBC) website's Frequently Asked Questions, updated on 10/28/06, on Patient Status codes.

EXAMPLE 1

DISPOSITION OF PATIENT TO HOME

1. John is discharged/transferred to a residential care facility. The correct disposition would be:

14. DISPOSITION OF PATIENT

0	1

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 2

DISPOSITION OF PATIENT TO HOME HEALTH SERVICES

2. John is discharged/transferred to home with respiratory therapy services. The correct disposition would be:

14. DISPOSITION OF PATIENT

0	6

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 3

DISPOSITION OF PATIENT TO HOME – HOSPICE CARE

3. John is discharged/transferred from your facility to home with hospice care. The correct disposition would be:

14. DISPOSITION OF PATIENT

5	0

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 4

DISPOSITION OF PATIENT TO SKILLED NURSING

4. Lucy is discharged/transferred to skilled nursing care at a Medicare and Medi-Cal certified facility. The correct disposition would be:

14. DISPOSITION OF PATIENT

0	3

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 5

DISPOSITION OF PATIENT TO SKILLED NURSING

5. Lucy is discharged/transferred to skilled nursing care at a Medicaid (Medi-Cal) certified facility that is not certified for Medicare. The correct disposition would be:

14. DISPOSITION OF PATIENT

6	4

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 6

DISPOSITION OF PATIENT TO A FEDERAL HEALTH FACILITY

6. Karen is discharged to a Federal hospital. The correct disposition would be:

14. DISPOSITION OF PATIENT

4	3

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
20	Expired
43	Discharged/transferred to a federal health care facility
50	Discharged home with hospice care
51	Discharged to a medical facility with hospice care
61	Discharged/transferred to a hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
00	Other

EXAMPLE 7

DISPOSITION OF PATIENT TO A SHORT TERM CARE HOSPITAL

7. Daniel is discharged/transferred to a general hospital for inpatient care where it is presumed he will stay for 5 days. The correct disposition would be:

14. DISPOSITION OF PATIENT

0	2

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 8

DISPOSITION OF PATIENT TO A REHABILITATION FACILITY

8. Terry is discharged/transferred to an inpatient rehabilitation facility. The correct disposition would be:

14. DISPOSITION OF PATIENT

6	2

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 9

DISPOSITION OF PATIENT TO A PSYCHIATRIC FACILITY

9. Krista is discharged/transferred to a psychiatric hospital. The correct disposition would be:

14. DISPOSITION OF PATIENT

6	5

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 10

DISPOSITION OF PATIENT TO A SWING BED

10. Vern is discharged to a hospital-based Medicare approved swing bed at your hospital. The correct disposition would be:

14. DISPOSITION OF PATIENT

6	1

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
20	Expired
43	Discharged/transferred to a federal health care facility
50	Discharged home with hospice care
51	Discharged to a medical facility with hospice care
61	Discharged/transferred to a hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
00	Other

EXAMPLE 11

DISPOSITION OF PATIENT TO LONG TERM CARE

11. Betty is discharged to a Medicare certified hospital for long term care. It is presumed she will stay for longer than 25 days. The correct disposition would be:

14. DISPOSITION OF PATIENT

6	3

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 12

DISPOSITION OF PATIENT
EXPIRED

12. Frank died at your facility while receiving treatment. The correct disposition would be:

14. DISPOSITION OF PATIENT

2	0

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 13

DISPOSITION OF PATIENT
DISCONTINUED CARE

13. Carl leaves your Emergency Room after seeing a doctor but before receiving treatment. The correct disposition would be:

14. DISPOSITION OF PATIENT

0	7

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

EXAMPLE 14

DISPOSITION OF PATIENT LEFT WITHOUT BEING SEEN

14. Amy leaves your Emergency Room before being seen by a provider. The correct disposition would be: No record reported to OSHPD. No encounter took place because there was no face-to-face contact between the patient and the provider.

Note: for billing purposes, follow the national standard. According to NUBC's Frequently Asked Questions, dated 5/13/04 on Patient Status codes, code 07 includes patients who left without being seen (LWBS).

ETHNICITY Section 97254

The ethnicity shall be as self-reported by the patient or patient's guardian in cases where the patient is not capable of providing the information. The patient's ethnicity shall be reported as one choice from the following list of alternatives under ethnicity:

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:

4. ETHNICITY
E1 Hispanic or Latino
E2 Non-Hispanic or Non-Latino
99 Unknown

(a) Hispanic or Latino Ethnicity

DISCUSSION

A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin. This may include the following groups: Andalisian, Argentinian, Asturian, Belearic Islander, Bolivian, Castillian, Catalonian, Canarian, Chicano, Chilean, Columbian, Costa Rican, Criollo, Dominican, Ecuadorian, Gellego, Guatemalan, Honduran, La Raza, Latin American, Mexican American, Mexican American Indian, Mexicano, Nicaraguan, Panamanian, Paraguayan, Peruvian, Salvadorian, Spaniard, Spanish Basque, Uruguayan, Valenican, and Venezuelan.

(b) Non-Hispanic or Non-Latino Ethnicity

(c) Unknown

DISCUSSION

If the patient's ethnicity is not recorded in the patient's medical record, the patient's ethnicity should be reported as '"Unknown" (code 99). This category includes patients who cannot or refuse to declare ethnicity.

ADDITIONAL DISCUSSION FOR **ALL** CATEGORIES

Determining Ethnicity:

- Hispanic origin or descent is not to be confused with race. A person of Hispanic origin may be of any race.
- The patient's ethnicity data may be most accurately obtained directly from the patient. Self-identification may include the use of a form presenting choices.
- The quality of ethnicity data deteriorates when determination is based upon the patient's or a family member's name, physical appearance, place of birth, or primary language.
- If the patient is unable to respond, a family member may declare the patient's ethnicity.

EXPECTED SOURCE OF PAYMENT — Section 97265

The patient's expected source of payment, defined as the type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill, shall be reported using the following categories:

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:

15. EXPECTED SOURCE OF PAYMENT

09	Self Pay
11	Other Non-federal programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	CHAMPUS (TRICARE)
CI	Commercial Insurance Company
DS	Disability
HM	Health Maintenance Organization
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid (Medi-Cal)
OF	Other federal program
TV	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
00	Other

(a) Self-pay: Payment directly by the patient, guarantor, relatives or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other third party.

(b) Other Non-Federal Programs. Include any form of payment from local, county, or state government agencies. Include payment from county funds, whether from county general funds or from other funds used to support county health programs including County Indigent Programs including County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP), County Children's Health Initiative Program (C-CHIP), and Short-Doyle funds. Also include the State Children's Health Insurance Program (SCHIP), Managed Risk Medical Insurance Board (MRMIB), Health Families Program (HFP), and Access for Infants and Mothers (AIM).

DISCUSSION

This category **does not** include Title V for California Children Services (CCS) payments. See (q).

(c) Preferred Provider Organization (PPO).

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies under a PPO arrangement.

This category **does not** include Blue Cross/Blue Shield or commercial insurance companies on a Fee for Service basis. See (h) and (j).

This category **does not** include Medi-Cal patients covered under a PPO arrangement. See (o).

(d) Point of Service (POS).

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies under a POS arrangement.

This category **does not** include Blue Cross/Blue Shield or commercial insurance companies on a Fee for Service basis. See (h) and (j).

This category **does not** include Medi-Cal patients covered under a POS arrangement. See (o).

(e) Exclusive Provider Organization (EPO).

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies under an EPO arrangement.

This category **does not** include Blue Cross/Blue Shield or commercial insurance companies on a Fee for Service basis. See (h) and (j).

This category **does not** include Medi-Cal patients covered under an EPO arrangement. See (o).

(f) Health Maintenance Organization (HMO) Medicare Risk. Medicare is defined by Title XVIII of the Social Security Act (42 USC 1395 et seq.) and Title I of the Federal Medicare Act (PL 89-97). Include Medicare patients covered under an HMO arrangement.

DISCUSSION

This category includes Medicare patients covered under an HMO arrangement only.

(g) Automobile Medical: Include PPO, POS, EPO, HMO and Fee for Service or any other payment resulting from automobile coverage.

(h) ***Blue Cross/Blue Shield. Include only Fee for Service payments. Report PPO, POS, EPO, and HMO under the appropriate stated categories.***

DISCUSSION

This category includes Blue Cross/Blue Shield on a Fee for Service basis only.

This category **does not** include Blue Cross/Blue Shield under a PPO, POS, EPO, or HMO arrangement. See (c), (d), (e), and (l).

(i) ***CHAMPUS (TRICARE). Include any PPO, POS, EPO, HMO, Fee for Service, or other payment from the Civilian Health and Medical Program of the Uniformed Services or from TRICARE.***

(j) ***Commercial Insurance Company. Report payment from insurance carriers on a Fee for Services basis. Exclude PPO, POS, and EPO payments.***

DISCUSSION

This category includes commercial insurance companies on a Fee for Service basis only.

This category **does not** include Blue Cross/Blue Shield on a Fee for Service basis. See (h).

This category does not include commercial insurance companies, Automobile Medical, or CHAMPUS (TRICARE) under PPO, POS, or EPO arrangements. See (c), (d), (e), and (g).

(k) Disability.

DISCUSSION

This category includes payments resulting from disability coverage.

(l) Health Maintenance Organization (HMO). Report HMO payors. Include Knox-Keene licensed plans as well as out of State HMO plans. No Plan Code Number or Plan Code Name is required for ED or AS records. Report Medicare payments covered under an HMO arrangement as Health Maintenance Organization (HMO) Medicare Risk. Report Medi-Cal patients covered under an HMO arrangement as Medicaid.

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies HMOs. Both California HMOs (Knox-Keene) and out-of-state HMOs are included.

This category **does not** include Medicare or Medi-Cal under a HMO arrangement. See (m), (n), and (o).

(m) Medicare Part A: Defined by Title XVIII of the Social Security Act. Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

(n) Medicare Part B: : Defined by Title XVIII of the Social Security Act. Covers some outpatient hospital care and some home health services.

(o) Medicaid. Medicaid is called Medi-Cal in California. Defined by Title XIX of the Social Security Act and Title I of the Federal Medicare Act (PL 89-97). Report all Medi-Cal including Fee for Service, PPO, POS, EPO, and HMO.

(p) Other Federal Program: Report federal programs not covered by any other category.

(q) Title V. Defined by the Federal Medicare Act (PL 89-97) for Maternal and Child Health. Title V of the Social Security Act is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. Include a Maternal and Child Health program payment that is not covered under Medicaid (Medi-Cal). California Children Services (CCS) payment should be reported here.

(r) Veterans Affairs Plan: Include any PPO, POS, EPO, HMO, Fee for Service, or other payment resulting from Veterans Administration coverage.

(s) Workers' Compensation Health Claim. Payment from Workers' Compensation Health Claim insurance should be reported under this category.

(t) Other. Includes payments by governments of other countries. Includes payment by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners, etc. Includes payments not listed in other categories.

DISCUSSION FOR ALL CATEGORIES

The payer that is expected to pay or did pay the greatest share of the patient's bill is the primary payer. Report only the primary payer to OSHPD.

The list of payer categories are found in three implementation guides:

1) 837 Health Care Service: Data Reporting Guide,
2) 837 Health Care Claim: Institutional, and
3) 837 Health Care Claim: Professional

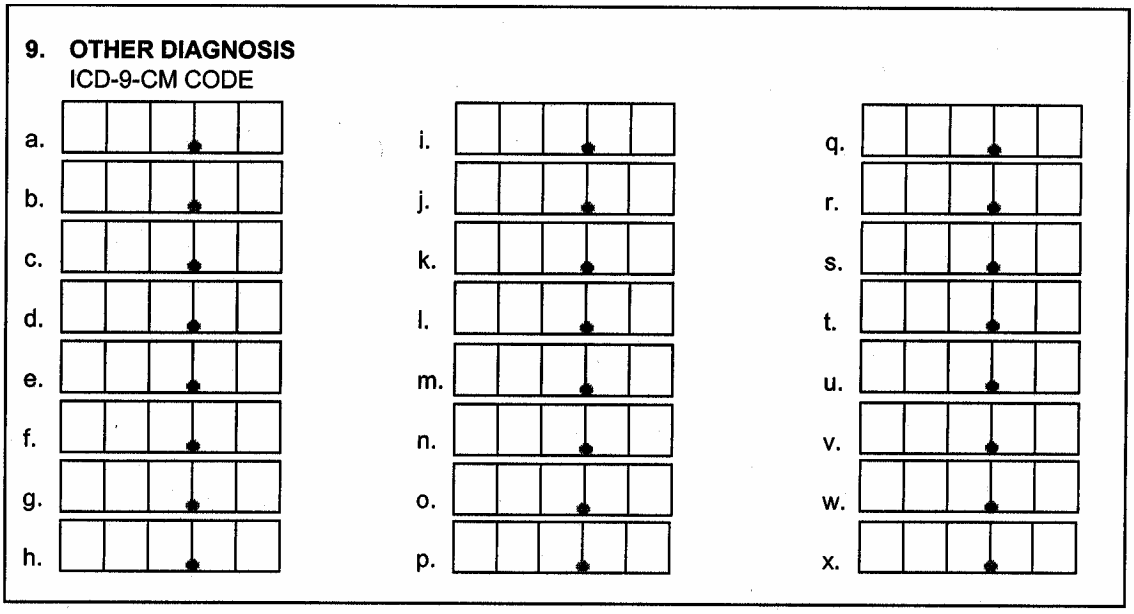
Due to lack of definitions, five payer categories were not included in this data element and are not accepted by OSHPD as valid payers. They are Central Certification, Indemnity Insurance, Liability, Liability Medical, and Mutually Defined or Unknown. If your facility uses any of these payer categories, please assign them to "Other" when reporting to OSHPD. See (t).

OTHER DIAGNOSES — Section 97259

The patient's other diagnoses are defined as all conditions that coexist at the time of the encounter for emergency or ambulatory surgery care, that develop subsequently during the encounter, or that affect the treatment received. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) and codes from Morphology of Neoplasms (M800-M997 codes) shall not be reported as other diagnoses.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



Reporting Requirement:

- Fill from the left-most position and do not skip fields.
- Diagnoses shall be coded according to the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM).
- Identical diagnosis codes must not be reported on the same encounter data record.
- Up to twenty-four Other Diagnoses, in addition to the Principal Diagnosis, may be reported to OSHPD.
- Conditions should be coded that affect patient care in terms of requiring:
    - Clinical evaluation
    - Therapeutic treatment
    - Procedures
    - Increased nursing care and/or monitoring

The following coding systems are not accepted by OSHPD:

- SNODO
- DSM-IV
- Morphology

Refer to the official guidelines on coding and reporting the diagnoses for outpatient services in *Coding Clinic for ICD-9-CM*.

Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) will never be reported in the other diagnosis code fields. Such codes must only be reported in the Principal or Other External Causes of Injury code fields.

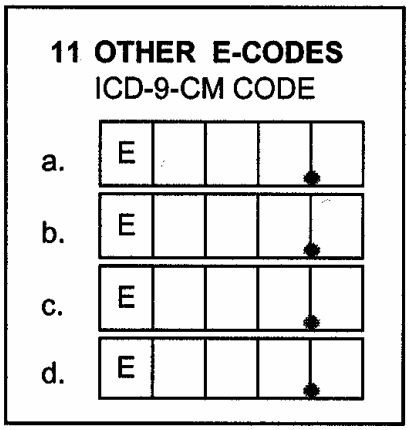
Codes from Morphology of Neoplasms (M800-M997) will never be reported in the other diagnosis code field.

OTHER EXTERNAL CAUSE OF INJURY — Section 97261

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported on records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



Reporting Requirements

- The external cause of injury, poisoning, or adverse effect shall be coded to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), using the E-codes.
- Reporting medical/surgical misadventure and abnormal reaction codes (categories E870-E879) is optional.
- Duplicate E-codes will not be accepted on the same data record. This is consistent with the guidelines for E-codes in Coding Clinic for ICD-9-CM.
- If more than one drug or substance caused a poisoning or adverse effect, report all E-codes necessary to describe all substances.
- Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the Principal or Other External Cause of Injury code fields.
- An E-code is to be reported on the record during which the injury, poisoning, or adverse effect was first diagnosed and/or treated. If a patient was first diagnosed in a doctor's office and then sent to an ED or AS facility, the E-code is to be reported on the ED or AS record. OSHPD does not collect data from physician's offices.

FREESTANDING AMBULATORY CLINICS

If the injury or poisoning or adverse effect was first diagnosed and/or treated during the AS encounter, then report the E-Code on the AS encounter record.

HOSPITALS

If the injury or poisoning or adverse effect was first diagnosed and/or treated during the ED or AS encounter, then report the E-Code on the ED or AS encounter record.

However, if the ED or AS encounter resulted in a same-hospital admission and your hospital combines the ED or AS record with the inpatient record, then the E-code would be reported on the inpatient record.

Other E-codes:

- Defined as additional ICD-9-CM codes from the range E800-E999 necessary to completely describe the mechanisms that contributed to the causal events surrounding the injury, poisoning, or adverse effect.
- Four other E-codes in addition to the principal E-code may be reported to OSHPD.
- If your reporting format limits the number of E-codes that can be used in reporting to OSHPD, refer to the Coding Clinic for ICD-9-CM for coding multiple E-codes in the same three-digit categories or different three-digit categories.
- If none of the reported E-codes describe the place of occurrence, then include a place of occurrence E-code as one of the four Other E-codes.

Place of occurrence codes (category E849) are:

- Invalid as the principal E-code.
- Reported to OSHPD if the principal E-code does not specify the place of occurrence.
- Reported to OSHPD as unspecified (E849.9) when the place of occurrence is not specified in the medical record.
- If none of the reported E-codes describe the place of occurrence, then include a place of occurrence E-code as one of the four Other E-codes.

Refer to Section 97260, Principal External Cause of Injury, for more information and examples on reporting E-codes.

OTHER PROCEDURES — Section 97263

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. Procedures shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:

13. OTHER PROCEDURES
CPT-4 CODE

a.		k.	
b.		l.	
c.		m.	
d.		n.	
e.		o.	
f.		p.	
g.		q.	
h.		r.	
i.		s.	
j.		t.	

Reporting Requirements:

- Fill from the left-most position and do not skip fields.
- The full range of CPT-4 codes should be used to report ambulatory surgery procedures performed. Category II CPT-4 codes are optional and not accepted by OSHPD. Modifiers are not accepted by OSHPD.
- Up to twenty Other Procedures may be reported to OSHPD

Healthcare Common Procedure Coding System (HCPCS)			
Level I	**Terminology**	**Codes**	**For OSHPD**
	"CPT"		
	Category I	00001-99999	Report
	Category II	0001F-9999F	Do not report*
	Category III	0001T-9999T	Report
	Modifiers	-00 thru -99	Do not report*
Level II	**Terminology**	**Codes**	**For OSHPD**
	"National Codes" or "HCPCS"	A0000-V9999	Do Not Report*
	Modifiers	-AA thru -ZZ, -A thru -Z, and -A1 thru -Z9	Do Not Report*

* "Do Not Report" will cause an error, if reported to OSHPD.

Three categories within HCPCS Level 1 CPT-4 codes are:

1. Category I CPT-4 codes, established by the CPT Editorial panel, are required for reporting services and procedures performed to OSHPD.

2. Category II CPT-4 codes (0001F—0011F), as a set of supplemental tracking codes for performance measurements, are optional and are not accepted by OSHPD.

3. Category III CPT-4 codes (0001T—0074T), as a set of temporary codes for emergency technology, services and procedures, are required to be used instead of Category I unlisted codes when reporting to OSHPD.

Note: Other procedures will be blank if no principal procedure is reported.

The following procedural codes are **not accepted** by OSHPD for reporting ED and AS records:

- CPT-4 codes, Category II (0001F-0011F)
- ICD-9-CM

Criteria for Reporting:

For Ambulatory Surgery Data :

A procedure should be reported to OSHPD if the following criteria are met:

1. the procedure is performed on an outpatient basis, and
2. the procedure is performed in one of these areas: general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or freestanding ambulatory surgery clinic (Section 128700 of California Health and Safety Code), and
3. the procedure is surgical in nature, carries a procedural risk, or carries an anesthetic risk

If **all** criteria apply, then report procedure on the record to OSHPD

For Emergency Department Data:

Report the procedure if it is performed in the Emergency Department and if the procedure is surgical in nature, carries a procedural risk, or carries an anesthetic risk.

Note: Not all ED records will have a procedure. All ED records are to be reported to OSHPD regardless of whether a procedure was performed.

Surgery, Procedural Risk, Anesthetic Risk

The definition of a significant procedure is one that is surgical in nature, or carries a procedural risk or carries an anesthetic risk. [With reference to the *Coding Clinic Guidelines for ICD-9-CM*, July – August 1985 and Fourth Quarter 1990, and the UHDDS published in the Federal Register, Volume 50, Number 147, July 31, 1985,] the following definitions are provided:

(1) **Surgery** includes incision, excision, amputation, introduction, endoscopy repair, destruction, suture and manipulation.

(2) **Procedural risk** – This term refers to a professionally recognized risk that a given procedure may induce some functional impairment, injury, morbidity, or even death. This risk may arise from direct trauma, physiologic disturbances, interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

Traumatic procedures are those that are invasive, including nonsurgical procedures that utilize cutdowns, that cause tissue damage (e.g., irradiation), or introduce some toxic or noxious substance (e.g., caustic test reagents).

Physiologic risk is associated with the use of virtually any pharmacologic or physical agent that can affect homeostasis (e.g., those that alter fluid distribution, electrolyte balance, blood pressure levels, and stress or tolerance tests).

Any procedure in which it is obligatory (or usual) to utilize pre- or postmedications that are associated with physiologic or pharmacologic risk may be considered as having a “procedural risk,” for example, those that require heavy sedation or drugs selected for their systemic effects such as alteration of metabolism, blood pressure or cardiac function. Some of the procedures that include harmful exposures are those that can introduce bacteria into the bloodstream (e.g., cardiac catheterization), those capable of suppressing the immune system, those that can precipitate idiosyncratic reactions such as anaphylaxia after the use of contrast materials, and those involving substances with known systemic toxicity.

Long-life radioisotopes pose a special kind of exposure risk to other persons as well as to the patient. Thus, these substances require special precautionary measures and the procedures using them carry procedural risk.

(3) **Anesthetic risk** – Any procedure that either requires or is regularly performed under general anesthesia carries anesthetic risk, as do procedures under local, regional, or other forms of anesthesia that induce sufficient functional impairment necessitating special precautions to protect the patient from harm.

Cancelled Procedures:

If a procedure is begun but cannot be completed (similar to the description in CPT modifier 74), report the record to OSHPD showing the CPT procedure code. Code one of the V codes (V64) as Other Diagnosis to explain the reason for the incomplete procedure.

If a procedure has not begun (similar to the description in CPT modifier 73), do not report the record to OSHPD.

PATIENT SOCIAL SECURITY NUMBER — Section 97256

The patient's social security number is to be reported as a 9-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 is to be the patient's social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital's bill is to be submitted.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:

6. PATIENT'S SOCIAL SECURITY NUMBER

Report 000000001(Unknown) if not recorded in the patient's medical record

Reporting Requirements

- Fill from the left-most position and do not skip fields.
- Use the full 9-digit social security number (SSN) including zeros
- Do not use hyphens
- Enter 000000001 as "unknown" if the patient's SSN is not recorded in the medical record

Only Use Patient's SSN:

- Mother's SSN is not the newborn's SSN.
- Parent's SSN is not a child's SSN.
- Husband's SSN is not a wife's SSN
- Medicare issued numbers are not used as a patient's SSN

Non-US Numbers: Even if a non-US number resembles a SSN, do not report it to OSHPD.

Valid/Invalid SSNs: SSNs consist of nine digits divided into three parts. The first three digits denote the area (or state) where the application was filed. The middle two digits denote a group number ranging from 01 to 99. The last four digits are the serial number. Because of the way the SSN is constructed, it is possible to say that a particular SSN is invalid if it starts with three digits not approved by the Social Security Administration for use as an area identifier or if it has 00 in the group number area. On a semi-annual basis, OSHPD updates the SSN ranges to the most current. Please refer to the MIRCal ED and AS Edit Flag Description Guide for a list of invalid SSN ranges.

Medicare Numbers: The Medicare program is a federal health insurance program for individuals 65 years and older and certain disabled individuals. The number issued for Medicare coverage is a Health Insurance Benefit/Claim (HIB/HIC) number. The HIB/HIC number usually has nine digits and one or two letters, and there may also be another number after the letter(s). There are no dashes or spaces in the HIB/HIC number. SSNs and HIB/HIC numbers are not interchangeable. The first nine digits of the HIB/HIC number may be, but are not always, the same as the nine digits of the SSN.

Confidentiality: The SSN is confidential and is encrypted into a nine-digit alphanumeric number referred to as the Record Linkage Number (RLN). The RLN is used to link episodes of care over time and across facilities in order to support research addressing the quality of medical care in California healthcare facilities. OSHPD continues to consider the protection of individually identifiable medical information as the crux of its legislative mandate. By law, the patient's right of confidentiality shall not be violated, and no one reporting data shall be liable for damages in any action based on the use or misuse of this data. See Sections 128736 (ED) and 128737 (AS) of the Health and Safety Code for patient confidentiality requirements.

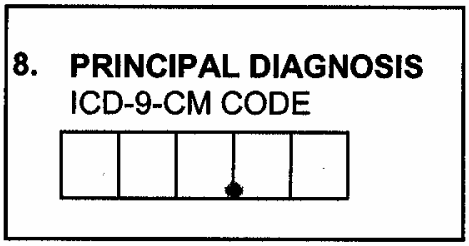
Requirement for the Social Security Number (SSN) in Hospitals: Licensing and Certification of the Department of Health Services requires that the patient's SSN, if available, be recorded as part of the content of the medical record (Section 70749, Title 22, California Code of Regulations).

PRINCIPAL DIAGNOSIS — Section 97258

The patient's principal diagnosis, defined as the condition, problem, or other reason established to be the chief cause of the encounter for care shall be coded according to the ICD-9-CM.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



Reporting Requirement:

- A principal diagnosis must be reported for every encounter record.
- Fill from the left-most position and do not skip fields.
- Diagnoses shall be coded according to the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM).
- Duplicate diagnosis codes will not be accepted on the same encounter data record.
- Conditions should be coded that affect patient care in terms of requiring:
    - Clinical evaluation
    - Therapeutic treatment
    - Procedures
    - Increased nursing care and/or monitoring

The following coding systems are not accepted by OSHPD:

- SNODO
- DSM-IV
- Morphology

Refer to the official guidelines on coding and reporting the Principal Diagnoses for outpatient services in *Coding Clinic for ICD-9-CM*.

Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) will never be reported in the Other Diagnosis code fields. Such codes must only be reported in the Principal or Other External Causes of Injury code fields.

Codes from Morphology of Neoplasms (M800-M997) will never be reported in the other diagnosis code field.

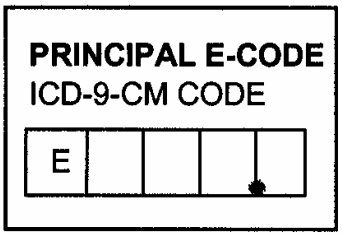
Italicized codes will never be the principal diagnosis.

PRINCIPAL EXTERNAL CAUSE OF INJURY — Section 97260

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported on records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



Reporting Requirements

- The external cause of injury, poisoning, or adverse effect shall be coded to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), using the E-codes.
- Reporting medical/surgical misadventure and abnormal reaction codes (categories E870-E879) is optional.

- Duplicate E-codes will not be accepted on the same data record. This is consistent with the guidelines for E-codes in Coding Clinic for ICD-9-CM.
- If more than one drug or substance caused a poisoning or adverse effect, report all E-codes necessary to describe all substances.
- Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the Principal or Other External Cause of Injury code fields.

Principal E-code:

- Defined as the external cause of injury or poisoning or adverse effects which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect.
- If sequencing the external cause of the most severe injury as the principal E-code is contradictory to the guidelines given in ICD-9-CM, OSHPD reporting requirements take precedence.

- An E-code is to be included for the first **reported** encounter during which the injury, poisoning, or adverse effect was first diagnosed and/or treated. If a patient was first diagnosed in a doctor's office and then sent to an ED or AS facility, the E-code is to be reported on the ED or AS record. OSHPD does not collect data from physician's offices.

FREESTANDING AMBULATORY CLINICS
If the injury or poisoning or adverse effect was first diagnosed and/or treated during the AS encounter, then report the E-Code on the AS encounter record.

HOSPITALS
If the injury or poisoning or adverse effect was first diagnosed and/or treated during the ED or AS encounter, then report the E-Code on the ED or AS encounter record.

However, if the ED or AS encounter resulted in a same-hospital admission and your hospital combines the ED or AS record with the inpatient record, then the E-code would be reported on the inpatient record.

Examples:

Drug reaction during the encounter:
Occasionally a patient may experience a reaction to a drug given at your facility. The reaction (hives, arrhythmia, lethargy, etc.) would be coded as a diagnosis, an E-code for the name of the therapeutic drug would be reported, and another E-code would be reported for the place of occurrence.

Fall from bed:
If the patient fell from a bed at your facility and an injury (e.g. bruise) occurred, the injury would be coded as an Other Diagnosis, and an E-code for the fall from the bed would be reported. Another E-code would be reported for the place of occurrence.

Treated in ED at Same Facility:
If the patient was first treated in the ED of Hospital A and is then admitted as an inpatient to Hospital A, the E code(s) needs to be reported on the inpatient record.

Treated in ED and Transferred:
If the patient was first diagnosed and treated in the ED of Hospital A and then transferred to the Hospital B, the E code(s) needs to be reported only on the ED record of Hospital A. Hospital B does not report the E-code.

Treated at Freestanding ASC and Transferred to Hospital:
If the patient was first treated in a freestanding Ambulatory Surgery facility and then transferred to Hospital A, the E code(s) needs to be reported on the AS record by the freestanding ASC. Hospital A does not report the E-code.

First diagnosed/treated in physician's office:
If a patient with an injury was first seen by his physician and then sent to your AS facility, the E-code would be reported on the AS record because the AS encounter would be the first reported treatment to OSHPD.

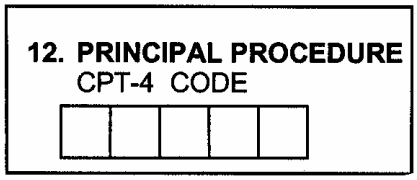
Multiple ambulatory surgeries related to the same injury
If the initial AS visit is the first reported treatment of the injury to OSHPD, report the E-code on the AS record. Subsequent AS visits related to the same injury do not require an E-code.

PRINCIPAL PROCEDURE — Section 97262

The patient's principal procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. The procedure related to the principal diagnosis, as the chief reason for the encounter, shall be selected as the principal procedure. The procedure shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



Reporting Requirements:

Ambulatory surgery procedures means those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic. (Section 128700 of California Health and Safety Code)

- A Principal Procedure must be reported on each Ambulatory Surgery record.
- Fill from the left-most position and do not skip fields.
- The full range of CPT-4 codes should be used to report ambulatory surgery procedures performed. Category II CPT-4 codes are optional and are not accepted by OSHPD. Modifiers are not accepted by OSHPD.
- Other Procedures will be blank if no Principal Procedure is reported.

Healthcare Common Procedure Coding System (HCPCS)			
Level I	**Terminology**	**Codes**	**For OSHPD**
	"CPT"		
	Category I	00001-99999	Report
	Category II	0001F-9999F	Do not report*
	Category III	0001T-9999T	Report
	Modifiers	-00 thru -99	Do not report*
Level II	**Terminology**	**Codes**	**For OSHPD**
	"National Codes" or "HCPCS"	A0000-V9999	Do Not Report*
	Modifiers	-AA thru -ZZ, -A thru -Z, and -A1 thru -Z9	Do Not Report*

* "Do Not Report" will cause an error, if reported to OSHPD.

Three categories within HCPCS Level 1 CPT-4 codes are:

1. Category I CPT-4 codes, established by the CPT Editorial panel, are required for reporting services and procedures performed to OSHPD.

2. Category II CPT-4 codes (0001F—0011F), as a set of supplemental tracking codes for performance measurements, are optional and **not accepted** by OSHPD.

3. Category III CPT-4 codes (0001T—0074T), as a set of temporary codes for emergency technology, services and procedures, are required to be used instead of Category I unlisted codes when reporting to OSHPD.

The following procedural codes are **not accepted** by OSHPD for reporting ED and AS records:

- CPT-4 codes, Category II (0001F-0011F)
- ICD-9-CM

Criteria for Reporting

For Ambulatory Surgery Data Record

Two criteria must be met:

1. Procedure is performed on an outpatient basis, and
2. Procedure is performed in one of these areas of a hospital or freestanding ambulatory surgery clinic: general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories.

If both criteria are met, then determine if the procedure is surgical in nature, carries a procedural risk, or carries an anesthetic risk. See **Determining Surgery, Procedural Risk, Anesthetic Risk** section below.

For Emergency Care Data Record:

If the procedure is performed in the Emergency Department, determine if the procedure is surgical in nature, carries a procedural risk, or carries an anesthetic risk. See **Determining Surgery, Procedural Risk, Anesthetic Risk** section below.

For ED and AS:
Determining Surgery, Procedural Risk, Anesthetic Risk

The definition of a significant procedure is one that is surgical in nature, or carries a procedural risk or carries an anesthetic risk. [With reference to the *Coding Clinic Guidelines for ICD-9-CM*, July – August 1985 and Fourth Quarter 1990, and the UHDDS published in the Federal Register, Volume 50, Number 147, July 31, 1985,] the following definitions are provided:

(1) **Surgery** includes incision, excision, amputation, introduction, endoscopy repair, destruction, suture and manipulation.

(2) **Procedural risk** – This term refers to a professionally recognized risk that a given procedure may induce some functional impairment, injury, morbidity, or even death. This risk may arise from direct trauma, physiologic disturbances, interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

Traumatic procedures are those that are invasive, including nonsurgical procedures that utilize cutdowns; cause tissue damage (e.g., irradiation); or introduce some toxic or noxious substance (e.g., caustic test reagents).

Physiologic risk is associated with the use of virtually any pharmacologic or physical agent that can affect homeostasis (e.g., those that alter fluid distribution, electrolyte balance, blood pressure levels, and stress or tolerance tests).

Any procedure in which it is obligatory (or usual) to utilize pre- or postmedications that are associated with physiologic or pharmacologic risk may be considered as having a "procedural risk," for example, those that require heavy sedation or drugs selected for their systemic effects such as alteration of metabolism, blood pressure or cardiac function. Some of the procedures that include harmful exposures are those that can introduce bacteria into the bloodstream (e.g., cardiac catheterization), those capable of suppressing the immune system, those that can precipitate idiosyncratic reactions such as anaphylaxia after the use of contrast materials, and those involving substances with known systemic toxicity.

Long-life radioisotopes pose a special kind of exposure risk to other persons as well as to the patient. Thus, these substances require special precautionary measures and the procedures using them carry procedural risk.

(3) **Anesthetic risk** – Any procedure that either requires or is regularly performed under general anesthesia carries anesthetic risk, as do procedures under local, regional, or other forms of anesthesia that induce sufficient functional impairment necessitating special precautions to protect the patient from harm.

Cancelled Procedures:

If a procedure is begun but cannot be completed (similar to the description in CPT modifier 74), report the record to OSHPD showing the CPT procedure code. Code one of the V codes (V64) as Other Diagnosis to explain the reason for the incomplete procedure.

If a procedure has not begun (similar to the description in CPT modifier 73), do not report the record to OSHPD.

RACE **Section 97253**

The race shall be as self-reported by the patient or patient's guardian in cases where the patient is not capable of providing the information. The patient's race shall be reported as one choice from the following list of alternatives under race:

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:

3. RACE
R1 American Indian or Alaska Native
R2 Asian
R3 Black or African American
R4 Native Hawaiian or Other Pacific Islander
R5 White
R9 Other Race
99 Unknown

(a) American Indian or Alaska Native

DISCUSSION

A person having origins in or who identifies with any of the original peoples of North and South America, and who maintains cultural identification through tribal affiliation or community recognition.

(b) Asian

DISCUSSION

A person having origins in or who identifies with Asian Indian, Bangladeshi, Bhutanese, Burmese, Cambodian, Chinese, Filipino, Hmong, Indonesian, Iwo Jiman, Japanese, Korean, Laotian, Madagascar, Malaysian, Maldivian, Nepalese, Okinawan, Pakistani, Singaporean, Sri Lankan, Taiwanese, Thai, and Vietnamese.

(c) Black or African American

DISCUSSION

A person having origins in or who identifies with any of the black racial groups of Africa including Botswanan, Ethiopian, Liberian, Namibian, Nigerian, Zairean, Barbadian, Dominican, Haitian, Jamaican, Tobagoan, Trinidadian, and West Indian.

(d) Native Hawaiian or Other Pacific Islander

DISCUSSION

A person having origins in or who identifies with the following groups: Native Hawaiian, Carolinian, Chamorro, Chuukese (Trukese), Fijian, Guamanian, Kiribati, Kosraean, Marshailese, Melanesian, Micronesian, Mariana Islander, New Hebrides, Palauan, Papua New Guinean, Pohnpeian, Polynesian, Saipanese, Samoan, Solomon Islander, Tahitian, Tokelauan, Tongan, and Yapese.

(e) White

DISCUSSION

A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East. This may include the following groups: Armenian, English, French, German, Irish, Italian, Polish, Scottish, Middle Eastern, North African, Assyrian, Egyptian, Iranian, Iraqi, Lebanese, Palestinian, Syrian, Afghanistani, Israeili, and Arab.

(f) Other Race

DISCUSSION

Any possible options not covered in the above categories. This category includes patients who cite more than one race.

(g) Unknown

DISCUSSION
If the patient's race is not recorded in the patient's medical record, the race should be reported as "Unknown" with a race code of 99. This category includes patients who cannot or refuse to declare race.

ADDITIONAL DISCUSSION FOR **ALL** CATEGORIES

Determining Race:

- The patient's race data may be most accurately obtained directly from the patient. Self-identification may include the use of a form presenting choices.
- The quality of race data deteriorates when determination is based upon the patient's or a family member's name, physical appearance, place of birth, or primary language.
- If the patient is unable to respond, a family member may declare the patient's race.

Multiracial Persons:

If a patient identifies with more than one race category:

- At this time, OSHPD allows one choice for Race although the national standards allow up to ten choices.
- It may be appropriate for the patient to choose any one of the categories that is at least partially accurate.
- It may be appropriate for the patient to choose "Other Race."

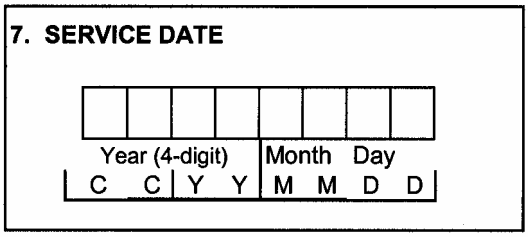
SERVICE DATE **Section 97257**

(a) For online transmission of data reports as electronic data files, the patient's service date shall be reported in numeric form as follows: 4-digit year, 2-digit month, and 2-digit day. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

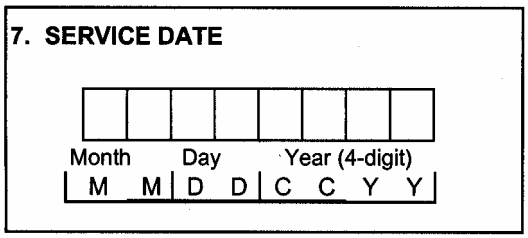
(b) For online entry of individual records, the patient's service date shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

DISCUSSION

Specifications for reporting this data element for online data file transmission file for encounters occurring on or after January 1, 2006:



Specifications for reporting this data element with the Record Entry Form for online web entry of individual records for encounters occurring on or after January 1, 2006:



Critical Data Element: If the reported service date is blank or invalid (such as February 31) and is not corrected by the facility after it is identified by OSHPD as an error, **the entire encounter data record will be deleted**.

Reporting Requirements:

- If the patient received service on May 3, 2004, the reported value would be:

Electronic Data File	Record Entry Form
20040503	05032004

- The actual date of service must be reported.
- The Service Date is the start of care date, also known as “From Date” or “Begin Date”.

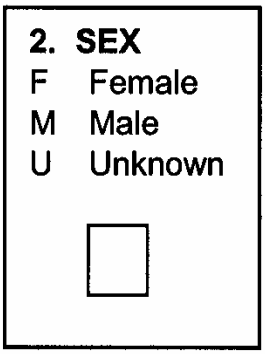
For all observation services provided to an outpatient who was diagnosed and treated for emergency care and/or ambulatory surgery, the service date is the start of care date provided in the emergency department or ambulatory surgery, whichever occurred first.

SEX **Section 97252**

The patient's gender shall be reported as male, female, or unknown. Unknown indicates that the patient's sex was undetermined or not available from the medical record.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



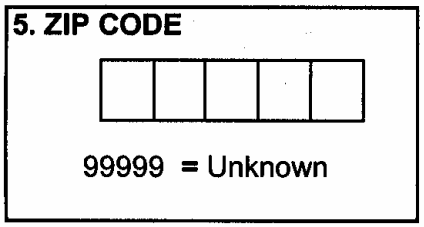
"Unknown" should be used in the case of undetermined sex, congenital abnormalities that obscure sex identification, and sex change operations, including any procedure related to a sex change operation (e.g. hysterectomy, mastectomy, etc.).

ZIP CODE — Section 97255

The "ZIP Code," a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient's usual residence shall be reported for each record. If the patient has a 9-digit ZIP Code, only the first five digits shall be reported. Do not report the ZIP Code of the hospital, third party payer, or billing address if it is different from the usual residence of the patient. If the patient's ZIP Code is not recorded in the patient's medical record, the patient's ZIP Code shall be reported as "not in medical record," by reporting the unknown ZIP Code as "99999."

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



Reporting Requirements:

- The ZIP Code of the usual residence of the patient must be reported.
- Report an unknown residence, homeless, and other countries as 99999.
- If the patient reports a 9-digit zip code, only the first five digits should be reported
- Do not report the ZIP Code of the hospital, third party payer, or billing address if it is different from the usual residence of the patient.
- ZIP Codes may be verified by calling 1-800-ASK-USPS (1-800-275-8777)
- The web address for the United States Postal Service is www.USPS.com.