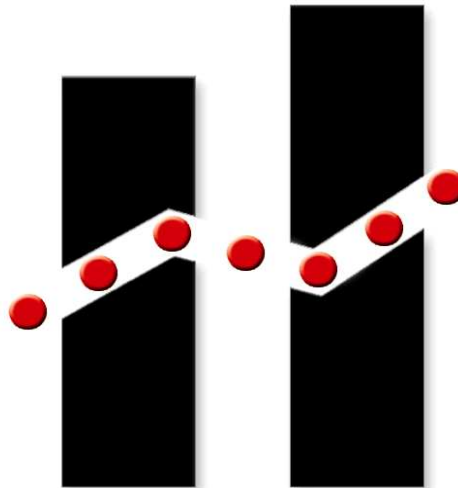


2008
V.1

Oklahoma State Department of Health

Hospital Inpatient Discharge Data

SUBMISSION MANUAL



HEALTH CARE INFORMATION

1000 NE Tenth Street
Oklahoma City, OK 73117-1299
(405) 271-6225
chsadmin@health.ok.gov

AT A GLANCE:
**Major changes made to the 2008 version
of the Hospital Inpatient Data Manual**

1. In addition to this file format, files will also be accepted in the flat file format. Beginning with data year 2009 only the XML format will be accepted.
2. Relevant changes to date associated with UB-04 are accommodated in this manual version
3. The error threshold on all critical fields listed in Table I is lowered to 2% to further improve the quality of data.
4. New edits will be implemented on existing fields such as Medical Record Number, Patient Control Number and Revenue Code Charges.
5. Admit Source has changed to Point of Origin with additional selections.
6. The option to report CMS-DRG Ver 24 or Ver 25 or other type of DRG is available under the DRG field.
7. The Present-on-Admission field has been revised to include "1" for exempt diagnosis codes.
8. The preferred method of data submission is through the website, however email and postal mail submissions are also accepted.

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For questions please call: 405-271-6225

NOTICE

This Oklahoma Inpatient Discharge Data Reporting Manual, issued in January 2008, supersedes and replaces all previous versions. Please note that there have been major changes in the submission format of this version to coincide with the implementation of the UB-04. Major changes are listed inside the front cover.

If you have any questions regarding submission of this data, please contact:

Lou Ann Sanders at (405)271-6225 or louanns@health.ok.gov. If you would like to schedule a site visit at your facility, please contact Lou Ann Sanders at (405)271-6225 and she will schedule a visit at your convenience.

Introduction

The Oklahoma Health Care Information System Act, defined in 63 O.S. (Supp. 1994) § 1-115 et seq., established the Division of Health Care Information (“Division”) in the Oklahoma State Department of Health. In accordance with the Act, the Division’s purpose is to develop and operate a system for collecting, processing and disseminating health care data. An integral component of the activities of the Division is the collection of inpatient discharge data. ***All facilities or related institutions that are licensed pursuant to Title 63 Section 1-701 et seq. of the Oklahoma Statutes are required to report information on inpatient discharge encounters.***

This manual defines the data that facilities are required by statute to submit to the Division. It specifies the technical requirements for data submission, defines the data elements to be submitted, and outlines the data editing procedure. In order to ensure the integrity of the database, data must be received in usable formats from all facilities. The Division will provide technical consultation and assistance upon request. This consultation or assistance is limited to activities that specifically enable the facility to submit data that will meet the requirements. The following sections provide a definition of the reporting source, the submission schedule, the preferred transfer method, the format and description of data elements to be transferred, and, finally, information about the editing/validation/error processing of the submitted data.

Data Confidentiality

Inpatient discharge data furnished to the Division are considered confidential under State law and are not public records as defined by the Open Records Act, Title 51 § 24A.1 et seq. Patient identifying information will not be disclosed. It will be used only for the creation and maintenance of anonymous medical case histories for statistical analysis and reports. The Division is prohibited from identifying, either directly or indirectly, any individual in its reports. The Division will not disclose individual patient identities in any manner, except as directed by a court of competent jurisdiction after an application showing good cause.

DATA REPORTING SOURCES AND DEFINITIONS

Licensed hospital facilities are the source for inpatient discharge data.

For each single inpatient hospital stay, a single discharge data record should be submitted. Each discharge record should consist of billing, medical, and personal information describing a patient, services received by the patient, and charges billed for the patient. The specific fields required are described in detail in the Data Elements Layout and Description sections of this manual. Only one discharge record should be submitted for each discharge. For a given patient, separate records for each bill generated should not be submitted, unless each bill represents a distinct hospital stay.

Discharge records should be submitted for persons discharged from all hospital beds, including acute medical/surgical care, swing, rehabilitation, psychiatric, and skilled nursing beds. Outpatient surgical care, observational care, respite, hospice and nursing home care should **NOT** be included in this submission. If a patient is discharged from one type of bed, readmitted to another, and discharged again, then a record for each discharge should be submitted; however, each record must contain information in the 'type of bill' field that accurately depicts the type of bed utilized prior to discharge.

A facility may submit inpatient discharge data to the Division or designate a submitting intermediary. Please note that each facility is responsible for the quality and completeness of its yearly submission, regardless of the utilization of a submitting intermediary. The Division will contact the facility directly for any necessary corrections or additional information. **When an intermediary is designated, the facility must still ensure the correct information is submitted in a timely manner. If a designated intermediary handles only a subset of a facility's discharges, then the facility must make separate arrangements to submit its other records (i.e., those not handled by the intermediary).**

For the purpose of communication and problem solving, each facility shall supply the Division with the name, telephone number, and job title of the person responsible for data submission and data corrections from each facility.

DATA SUBMISSION SCHEDULE

For each calendar year of data collected, the Division must receive all inpatient data records by May 1st following the close of that calendar year (e.g. calendar year 2008 data must be submitted by May 1, 2009). Facilities may submit on a monthly, quarterly, or semi-annual basis, if they prefer, as long as the Division is notified of their proposed schedule. **In all cases, data must be received by May 1st following each calendar year.**

The data elements to be submitted are based on inpatient discharges occurring in a calendar year. A patient must be discharged within the calendar year to be included in the calendar year data set.

FOLLOW-UP FOR NON-COMPLIANCE

Submitting inpatient data is required and is a condition of the facility's license as defined in Title 63 Section 1-701 et seq. Noncompliance, including incomplete reporting of required fields, will be referred to the Oklahoma State Department of Health Medical Facilities Division for follow-up and will be published as noncompliant in HCI reports.

DATA TRANSFER MEDIA

Secure Website Data Transfer

The preferred method of data submission is through the Division's secure website. The website is accessible with a login and password.

The URL is: <https://www.phin.state.ok.us/chi-data/>

Instructions for submitting files on the website can be obtained from the Division.

Alternate Data Transfer Media

Data can also be submitted by U S mail on CD-ROM or IBM compatible 3.5" disk or by email to:

**Oklahoma State Department of Health
Health Care Information Division, Room 807
1000 NE 10th Street
Oklahoma City, Oklahoma 73117-1299
chsadmin@health.ok.gov**

All data submitted must have a label containing the following information:

- A. Name of the information supplier.
- B. Date of submission as MM / DD / YYYY.
- C. The total number of records contained in the file.
- D. An unduplicated count of the patients contained in the file.
- E. The name and telephone number of an individual to contact if problems arise.
- F. If multiple diskettes are submitted, then a sequence number must indicate the processing order.
- G. The beginning and end dates of the data submitted.

The totals indicated on the label (items C and D) must balance with the detail count obtained when processed.

DATA TRANSFER

The physical characteristics of the transfer media must have the following attributes:

- a. All data fields (numeric and alphanumeric) are to be initialized with blank spaces (character code 32).
- b. The data should be ASCII code.

The Division uses PGP encryption for data security. WinZip version 9.0 can also be used for encryption. If you would like to use another type of data security method please contact the Division for technical advice on security issues:
Lou Ann Sanders (405) 271-6225.

Files submitted electronically must be HIPAA compliant.

EDITING AND VALIDATION

The Division will perform a variety of edits for quality assurance purposes and compliance with the specifications set forth in this submission manual. Data submissions not meeting a 2% error tolerance level will be rejected.

Rejected submissions will be returned to the facility for resubmit or corrections. Table I gives a list of the data fields and a tolerance level for each of field. Facilities are encouraged to review the data records for accuracy and completeness to the corresponding edit

FACILITY CONTACTS

Facilities are encouraged to provide contact information for the following individuals:

Administrator
Data submission contact
Error correction contact
Vendor contact
Corporate contact (if applicable)

For questions please call: 405-271-6225

DATA TRANSFER FORMAT

Table 1 lists the data elements and Table 2 describes the record format. The column headings used in Table 2 are:

Field Name: Data Element names listed in Tables 1 and 2.

Type: Field attribute:
A=Alphanumeric
N=Numeric

Length: Field length in bytes.

Position: Starting and ending position of the field in the records.

Definition: The definition specified for each data element is in general agreement with the definition specified for the field entry in the UB -04 manual. Facilities using data sources other than uniform billing should evaluate definitions and coding systems for agreement with those specified in this manual.

General Comments: Used in a similar manner as the UB-04 manual to provide additional information and guidelines for the reporting of the data element. If a facility is unable to use the codes specified here, the facility must supply the Division with translation tables that read facility codes and output the Division codes.

Edit: The criteria used by the Division to determine acceptability of the information provided.

UB-04 Form: Where applicable, this line identifies the document where the data elements can be found.

Locator: The number of the UB-04 form which corresponds to the requested data element.

The data elements for each patient discharge are stored in a single record. No fillers are to be used between data fields.

Oklahoma Law (36 chapter 2 § 6581) has mandated that all hospital outpatient billing and claims submission use the UB-04 form.

**Table 1
Inpatient Discharge Data Elements**

DATA ELEMENT NAME	ERROR TOLERANCE LEVEL
<u>Patient Information</u>	
Patient name	2%
Patient street address	-
Patient city	2%
Patient state	2%
Patient address postal code	2%
Patient date of birth	2%
Patient gender	2%
Patient Social Security Number	-
Patient race	-
Patient ethnicity	-
Patient marital status	-
Patient control number	2%
Patient medical record number	-
<u>Provider Information</u>	
Medicare provider number	-
National provider identifier	-
<u>Service Information</u>	
Admission date	2%
Discharge date	2%
Point of origin	-
Type of admission	-
Patient discharge status	2%

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Table 1, Continued
Inpatient Discharge Data Elements

DATA ELEMENT NAME	ERROR TOLERANCE LEVEL
<u>Diagnosis and Treatment Information</u>	
External cause of injury I-3	-
Attending physician identifier	-
Birth weight	-
Admitting diagnosis code	-
Principal diagnosis	2%
Other diagnosis codes I-17	2%
Principal procedure code	2%
Other procedure codes I-15	2%
Principal procedure physician identifier	-
Other procedure physician identifier I-5	-
<u>Payer Information</u>	
Primary payer identifier	-
Primary payer name	
Secondary payer identifier	-
Secondary payer name	
Primary Payer classification	2%
<u>Charge Information</u>	
Total charges for this inpatient stay	2%
Total charges by revenue category	-
Units of service by revenue category	-
<u>Other</u>	
Type of Bill	2%
DRG	-

Table 2

Field Name	Type	Length	Position	
Patient name	A	30	1	- 30
Patient street address	A	70	31	- 100
Patient city	A	25	101	- 125
Patient state	A	2	126	- 127
Patient address postal code	A	10	128	- 137
Patient date of birth	N	8	138	- 145
Patient gender	A	1	146	- 146
Blank	A	5	147	- 151
Patient social security number	N	8	152	- 159
Patient race	N	1	160	- 160
Patient ethnicity	N	1	161	- 161
Patient marital status	A	1	162	- 162
Patient control number	A	17	163	- 179
Patient medical record number	A	17	180	- 196
Medicare provider number	A	6	197	- 202
National Provider Number	N	10	203	- 212
Blank	A	83	213	- 295
Admission date	N	8	296	- 303
Discharge date	N	8	304	- 311
Point of Origin	A	1	312	- 312
Type of admission	N	1	313	- 313
Patient discharge status	N	2	314	- 315
External cause of injury code (E-code)	A	8	316	323
External cause of injury code (E-code)	A	8	324	331
External cause of injury code (E-code)	A	8	332	339

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Table 2

Field Name	Type	Length	Position
Attending physician identifier	A	11	340 - 350
Birth Weight	N	4	351 - 354
Admitting diagnosis code	A	7	355 - 361
Principal diagnosis	A	8	362 - 369
Other diagnosis code 1	A	8	370 - 377
Other diagnosis code 2	A	8	378 - 385
Other diagnosis code 3	A	8	386 - 393
Other diagnosis code 4	A	8	394 - 401
Other diagnosis code 5	A	8	402 - 409
Other diagnosis code 6	A	8	410 - 417
Other diagnosis code 7	A	8	418 - 425
Other diagnosis code 8	A	8	426 - 433
Other diagnosis code 9	A	8	434 - 441
Other diagnosis code 10	A	8	442 - 449
Other diagnosis code 11	A	8	450 - 457
Other diagnosis code 12	A	8	458 - 465
Other diagnosis code 13	A	8	466 - 473
Other diagnosis code 14	A	8	474 - 481
Other diagnosis code 15	A	8	482 - 489
Other diagnosis code 16	A	8	490 - 497
Other diagnosis code 17	A	8	498 - 505
Principal procedure code	A	7	506 - 512
Other procedure code 1	A	7	513 - 519
Other procedure code 2	A	7	520 - 526
Other procedure code 3	A	7	527 - 533
Other procedure code 4	A	7	534 - 540

Table 2

Field Name	Type	Length	Position	
Other procedure code 5	A	7	541	- 547
Other procedure code 6	A	7	548	- 554
Other procedure code 7	A	7	555	- 561
Other procedure code 8	A	7	562	- 568
Other procedure code 9	A	7	569	- 575
Other procedure code 10	A	7	576	- 582
Other procedure code 11	A	7	583	- 589
Other procedure code 12	A	7	590	- 596
Other procedure code 13	A	7	597	- 603
Other procedure code 14	A	7	604	- 610
Other procedure code 15	A	7	611	- 617
Principle procedure physician identifier	A	11	618	- 628
Other procedure physician identifier 1	A	11	629	- 639
Other procedure physician identifier 2	A	11	640	- 650
Other procedure physician identifier 3	A	11	651	- 661
Other procedure physician identifier 4	A	11	662	- 672
Other procedure physician identifier 5	A	11	673	- 683
Primary payer identification	A	15	684	- 698
Primary payer name	A	25	699	- 723
Secondary payer identification	A	15	724	- 738
Secondary payer name	A	25	739	- 763
Payer classification	N	1	764	- 764
Total Charges	N	7	765	771

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Table 2

Field Name	Type	Length	Position	
Total charges-rev. code 010x	N	6	772	- 777
Total charges-rev. code 011x	N	6	778	- 783
Total charges-rev. code 012x	N	6	784	- 789
Total charges-rev. code 013x	N	6	790	- 795
Total charges-rev. code 014x	N	6	796	- 801
Total charges-rev. code 015x	N	6	802	- 807
Total charges-rev. code 016x	N	6	808	- 813
Total charges-rev. code 017x	N	6	814	- 819
Total charges-rev. code 018x	N	6	820	- 825
Total charges-rev. code 019x	N	6	826	- 831
Total charges-rev. code 020x	N	6	832	- 837
Total charges-rev. code 021x	N	6	838	- 843
Total charges-rev. code 022x	N	6	844	- 849
Total charges-rev. code 023x	N	6	850	- 855
Total charges-rev. code 024x	N	6	856	- 861
Total charges-rev. code 025x	N	6	862	- 867
Total charges-rev. code 026x	N	6	868	- 873
Total charges-rev. code 027x	N	6	874	- 879
Total charges-rev. code 028x	N	6	880	- 885
Total charges-rev. code 029x	N	6	886	- 891
Total charges-rev. code 030x	N	6	892	- 897
Total charges-rev. code 031x	N	6	898	- 903
Total charges-rev. code 032x	N	6	904	- 909
Total charges-rev. code 033x	N	6	910	- 915
Total charges-rev. code 034x	N	6	916	- 921
Total charges-rev. code 035x	N	6	922	- 927
Total charges-rev. code 036x	N	6	928	- 933

Table 2

Field Name	Type	Length	Position
Total charges-rev. code 037x	N	6	934 - 939
Total charges-rev. code 038x	N	6	940 - 945
Total charges-rev. code 039x	N	6	946 - 951
Total charges-rev. code 040x	N	6	952 - 957
Total charges-rev. code 041x	N	6	958 - 963
Total charges-rev. code 042x	N	6	964 - 969
Total charges-rev. code 043x	N	6	970 - 975
Total charges-rev. code 044x	N	6	976 - 981
Total charges-rev. code 045x	N	6	982 - 987
Total charges-rev. code 046x	N	6	988 - 993
Total charges-rev. code 047x	N	6	994 - 999
Total charges-rev. code 048x	N	6	1000 - 1005
Total charges-rev. code 049x	N	6	1006 - 1011
Total charges-rev. code 050x	N	6	1012 - 1017
Total charges-rev. code 051x	N	6	1018 - 1023
Total charges-rev. code 052x	N	6	1024 - 1029
Total charges-rev. code 053x	N	6	1030 - 1035
Total charges-rev. code 054x	N	6	1036 - 1041
Total charges-rev. code 055x	N	6	1042 - 1047
Total charges-rev. code 056x	N	6	1048 - 1053
Total charges-rev. code 057x	N	6	1054 - 1059
Total charges-rev. code 058x	N	6	1060 - 1065
Total charges-rev. code 059x	N	6	1066 - 1071
Total charges-rev. code 060x	N	6	1072 - 1077
Total charges-rev. code 061x	N	6	1078 - 1083
Total charges-rev. code 062x	N	6	1084 - 1089

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Table 2

Field Name	Type	Length	Position
Total charges-rev. code 063x	N	6	1090 - 1095
Total charges-rev. code 064x	N	6	1096 - 1101
Total charges-rev. code 065x	N	6	1102 - 1107
Total charges-rev. code 066x	N	6	1108 - 1113
Total charges-rev. code 067x	N	6	1114 - 1119
Total charges-rev. code 068x	N	6	1120 - 1125
Total charges-rev. code 069x	N	6	1126 - 1131
Total charges-rev. code 070x	N	6	1132 - 1137
Total charges-rev. code 071x	N	6	1138 - 1143
Total charges-rev. code 072x	N	6	1144 - 1149
Total charges-rev. code 073x	N	6	1150 - 1155
Total charges-rev. code 074x	N	6	1156 - 1161
Total charges-rev. code 075x	N	6	1162 - 1167
Total charges-rev. code 076x	N	6	1168 - 1173
Total charges-rev. code 077x	N	6	1174 - 1179
Total charges-rev. code 078x	N	6	1180 - 1185
Total charges-rev. code 079x	N	6	1186 - 1191
Total charges-rev. code 080x	N	6	1192 - 1197
Total charges-rev. code 081x	N	6	1198 - 1203
Total charges-rev. code 082x	N	6	1204 - 1209
Total charges-rev. code 083x	N	6	1210 - 1215
Total charges-rev. code 084x	N	6	1216 - 1221
Total charges-rev. code 085x	N	6	1222 - 1227
Total charges-rev. code 086x	N	6	1228 - 1233
Total charges-rev. code 087x	N	6	1234 - 1239
Total charges-rev. code 088x	N	6	1240 - 1245
Total charges-rev. code 089x	N	6	1246 - 1251
Total charges-rev. code 090x	N	6	1252 - 1257
Total charges-rev. code 091x	N	6	1258 - 1263

Table 2

Field Name	Type	Length	Position
Total charges-rev. code 092x	N	6	1264 - 1269
Total charges-rev. code 093x	N	6	1270 - 1275
Total charges-rev. code 094x	N	6	1276 - 1281
Total charges-rev. code 095x	N	6	1282 - 1287
Total charges-rev. code 096x	N	6	1288 - 1293
Total charges-rev. code 097x	N	6	1294 - 1299
Total charges-rev. code 098x	N	6	1300 - 1305
Total charges-rev. code 099x	N	6	1306 - 1311
Total charges-rev. code 100x	N	6	1312 - 1317
Total charges-rev. code 101x-209x	N	6	1318 - 1323
Total charges-rev. code 210x	N	6	1324 - 1329
Total charges-rev. code 211x-309x	N	6	1330 - 1335
Total charges-rev. code 310x	N	6	1336 - 1341
Total charges-rev. code 311x-999x	N	6	1342 - 1347
Units of service-rev. code 010x	N	7	1348 - 1354
Units of service-rev. code 011x	N	7	1355 - 1361
Units of service-rev. code 012x	N	7	1362 - 1368
Units of service-rev. code 013x	N	7	1369 - 1375
Units of service-rev. code 014x	N	7	1376 - 1382
Units of service-rev. code 015x	N	7	1383 - 1389
Units of service-rev. code 016x	N	7	1390 - 1396
Units of service-rev. code 017x	N	7	1397 - 1403
Units of service-rev. code 018x	N	7	1404 - 1410
Units of service-rev. code 019x	N	7	1411 - 1417
Units of service-rev. code 020x	N	7	1418 - 1424
Units of service-rev. code 021x	N	7	1425 - 1431

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Table 2

Field Name	Type	Length	Position
Units of service-rev. code 022x	N	7	1432 - 1438
Units of service-rev. code 023x	N	7	1439 - 1445
Units of service-rev. code 024x	N	7	1446 - 1452
Units of service-rev. code 025x	N	7	1453 - 1459
Units of service-rev. code 026x	N	7	1460 - 1466
Units of service-rev. code 027x	N	7	1467 - 1473
Units of service-rev. code 028x	N	7	1474 - 1480
Units of service-rev. code 029x	N	7	1481 - 1487
Units of service-rev. code 030x	N	7	1488 - 1494
Units of service-rev. code 031x	N	7	1495 - 1501
Units of service-rev. code 032x	N	7	1502 - 1508
Units of service-rev. code 033x	N	7	1509 - 1515
Units of service-rev. code 034x	N	7	1516 - 1522
Units of service-rev. code 035x	N	7	1523 - 1529
Units of service-rev. code 036x	N	7	1530 - 1536
Units of service-rev. code 037x	N	7	1537 - 1543
Units of service-rev. code 038x	N	7	1544 - 1550
Units of service-rev. code 039x	N	7	1551 - 1557
Units of service-rev. code 040x	N	7	1558 - 1564
Units of service-rev. code 041x	N	7	1565 - 1571
Units of service-rev. code 042x	N	7	1572 - 1578
Units of service-rev. code 043x	N	7	1579 - 1585
Units of service-rev. code 044x	N	7	1586 - 1592
Units of service-rev. code 045x	N	7	1593 - 1599
Units of service-rev. code 046x	N	7	1600 - 1606
Units of service-rev. code 047x	N	7	1607 - 1613

Table 2

Field Name	Type	Length	Position	
Units of service-rev. code 048x	N	7	1614	- 1620
Units of service-rev. code 049x	N	7	1621	- 1627
Units of service-rev. code 050x	N	7	1628	- 1634
Units of service-rev. code 051x	N	7	1635	- 1641
Units of service-rev. code 052x	N	7	1642	- 1648
Units of service-rev. code 053x	N	7	1649	- 1655
Units of service-rev. code 054x	N	7	1656	- 1662
Units of service-rev. code 055x	N	7	1663	- 1669
Units of service-rev. code 056x	N	7	1670	- 1676
Units of service-rev. code 057x	N	7	1677	- 1683
Units of service-rev. code 058x	N	7	1684	- 1690
Units of service-rev. code 059x	N	7	1691	- 1697
Units of service-rev. code 060x	N	7	1698	- 1704
Units of service-rev. code 061x	N	7	1705	- 1711
Units of service-rev. code 062x	N	7	1712	- 1718
Units of service-rev. code 063x	N	7	1719	- 1725
Units of service-rev. code 064x	N	7	1726	- 1732
Units of service-rev. code 065x	N	7	1733	- 1739
Units of service-rev. code 066x	N	7	1740	- 1746
Units of service-rev. code 067x	N	7	1747	- 1753
Units of service-rev. code 068x	N	7	1754	- 1760
Units of service-rev. code 069x	N	7	1761	- 1767
Units of service-rev. code 070x	N	7	1768	- 1774
Units of service-rev. code 071x	N	7	1775	- 1781
Units of service-rev. code 072x	N	7	1782	- 1788
Units of service-rev. code 073x	N	7	1789	- 1795

For questions please call: 405-271-6225

Table 2

Field Name	Type	Length	Position
Units of service-rev. code 074x	N	7	1796 - 1802
Units of service-rev. code 075x	N	7	1803 - 1809
Units of service-rev. code 076x	N	7	1810 - 1816
Units of service-rev. code 077x	N	7	1817 - 1823
Units of service-rev. code 078x	N	7	1824 - 1830
Units of service-rev. code 079x	N	7	1831 - 1837
Units of service-rev. code 080x	N	7	1838 - 1844
Units of service-rev. code 081x	N	7	1845 - 1851
Units of service-rev. code 082x	N	7	1852 - 1858
Units of service-rev. code 083x	N	7	1859 - 1865
Units of service-rev. code 084x	N	7	1866 - 1872
Units of service-rev. code 085x	N	7	1873 - 1879
Units of service-rev. code 086x	N	7	1880 - 1886
Units of service-rev. code 087x	N	7	1887 - 1893
Units of service-rev. code 088x	N	7	1894 - 1900
Units of service-rev. code 089x	N	7	1901 - 1907
Units of service-rev. code 090x	N	7	1908 - 1914
Units of service-rev. code 091x	N	7	1915 - 1921
Units of service-rev. code 092x	N	7	1922 - 1928
Units of service-rev. code 093x	N	7	1929 - 1935
Units of service-rev. code 094x	N	7	1936 - 1942
Units of service-rev. code 095x	N	7	1943 - 1949
Units of service-rev. code 096x	N	7	1950 - 1956
Units of service-rev. code 097x	N	7	1957 - 1963
Units of service-rev. code 098x	N	7	1964 - 1970
Units of service-rev. code 099x	N	7	1971 - 1977

Table 2

Field Name	Type	Length	Position
Units of service-rev. code 100x	N	7	1978 - 1984
Units of service-rev. code 101x-209x	N	7	1985 - 1991
Units of service-rev. code 210x	N	7	1992 - 1998
Units of service-rev. code 211x-309x	N	7	1999 - 2005
Units of service-rev. code 310x	N	7	2006 - 2012
Units of service-rev. code 311x-999x	N	7	2013 - 2019
Type of bill	A	4	2020 - 2023
DRG	N	4	2024 - 2027

Description of Data Elements

Field Name: Patient Name

Type: A

Position: 1— 30

Length: 30

Definition: Last name, first name, and middle initial of the patient.

Comments: Use a comma and one space to separate last and first names. No space should be left between a prefix and a name (e.g. McCauley, DeClair, or VonFeldt). Titles such as Sir, Msgr., and Dr. should not be recorded. No special characters (e.g. (), *, **, /) should be included in the name. Record hyphenated names with the hyphen (e.g. Smith-Jones, Rebecca). To record a suffix of a name, write the last name, leave a space, and then write the suffix. Follow the suffix with a comma and a first name. For example: Jones II, Robert or Adams Jr., Fred. The middle initial should include only one character.

Edit: Name must have a comma and space separating the last name from the first. Comments such as 'deceased', 'test' should not be included

UB-04 FL 8

Field Name: Patient Street Address

Type: A

Position: 31—100

Length: 70

Definition: The street address of the patients residence. P.O. Boxes and Rural Routes should only be used when the physical address is not available.

Comments: Left justified with spaces to the right to complete the field. The street address where applicable should have:

- Street number
- Street direction e.g. N, NW, SW, SE etc.
- Street name
- Street type e.g. Avenue, St, Rd, Road, CT etc.

(Refer to the link for commonly used street suffixes. http://www.usps.com/ncsc/lookups/abbr_suffix.txt)

- Apartment number

Edit: Street address must be present. Comments such as 'DHS custody', 'return mail', 'deceased' should not be included.

UB-04 FL9a

Field Name: Patient City

Type: A

Position: 101—125

Length: 25

Definition: The city of the patient's street address.

Comments: Abbreviations are not accepted. City must be spelled out in full. E.g. Saint Louis, Fort Gibson etc.

Edit: Valid city must be present.

UB-04 FL9b

For questions please call: 405-271-6225

Field Name: Patient State

Type: A
Position: 126—127
Length: 2
Definition: The state of the patient's address.
Comments: Use standard Post Office state abbreviations (e.g. OK for Oklahoma, TX for Texas).
Edit: State abbreviation must be present and valid.

UB-04 FL 9c

Field Name: Patient Address Postal Code

Type: A
Position: 128— 137
Length: 10
Definition: The zip code of the patient's address.
Comments: Left justified with spaces to the right to complete the field. Nine-digit zip codes are encouraged in the form XXXXX-YYYY or XXXXXYYYY.
Edit: Postal zip code must be present and valid.
Consistent with patient's state.

UB-04 FL 9d

Field Name: Patient Date of Birth

Type: N

Position: 138— 145

Length: 8

Definition: The date of birth of the patient.

Comments: Use the eight-digit format MMDDYYYY where:

- MM is the month in two digits ranging from 01 to 12
- DD is the day in two digits ranging from 01 to 31
- YYYY is the year of birth in four digits.
- right justified. (all positions fully coded).

Edit: Date of birth must be:

- Present
- A valid date- not occurring after admit or discharge date
- Equal to admit date for hospital newborns (Principal diagnosis V30-V39 except V30.1)
- Consistent with diagnosis
- Age calculated from date of birth and discharge and must be less than 125 years

UB-04 FL 10

Field Name: Patient Gender

Type: A
Position: 146—146
Length: 1
Definition: Patient gender as recorded at the time of admission or start of care.
Comments: This is a one-character code:
M = Male
F = Female
U = Unknown
Edit: Code must be valid and consistent with diagnosis and procedure codes.

UB-04 FL 11

Field Name: Blank

Type: A
Position: 147—151
Length: 5
Definition: Previously Patient first 5 digits of Social Security Number

Field Name: Patient Social Security Number

Type: N

Position: 152—159

Length: 8

Definition: The last 4 digits of the Social Security Number of the patient receiving care.

Comments: Left justify with spaces to the right to complete the field. Do not use hyphens. If a patient does not have a Social Security Number, use the following codes:

- Mother's last 4 digits of SSN + 100 (e.g., 6789100) for a newborn who has not obtained a SSN. For multiple births, use 101 for the first baby and 102 for the second baby, etc.
- 200 for a patient who has no SSN
- 300 for a patient who chooses not to provide his/her SSN.

Edit: Entry must be a valid SSN, or 200 or 300.

Currently not a UB-04 field.

Field Name: Patient Race

Type: N

Position: 160—160

Length: 1

Definition: This item gives the race of the patient. The information is based on self-identification and is to be obtained from the patient, a relative, or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Comments: If the patient chooses not to answer, the facility should enter the code for unknown. If the facility fails to request the information the hospital should enter the code for unknown.

1 = American Indian or Alaskan Native

Definition: A person having origins in any of the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.

2 = Asian or Pacific Islander

Definition: A person having origins in any of the original oriental peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.

3 = Black

Definition: A person having origins in any of the black racial groups of Africa.

4 = White

Definition: A person having origins in any of the original Caucasian peoples of Europe, North Africa or the Middle East.

5 = Other

Definition: Any possible options not covered in the above categories.

6 = Unknown

Definition: A person who chooses not to answer the question or the hospital fails to request the information.

Edit: Code must be valid.

Currently not a UB-04 field

Field Name: Patient Ethnicity

Type: N

Position: 161—161

Length: 1

Definition: This item gives the Patient's answer to the question "Are you Hispanic?". The information is based on self-identification and is to be obtained from the patient, a relative or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Comments: If the patient chooses not to answer, the facility should enter the code for unknown. If the facility fails to request the information, the hospital should enter the code for unknown.

1 = Hispanic origin

Definition: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultural origin, regardless of race.

2 = Not of Hispanic origin

Definition: A person who is not classified in 1.

6 = Unknown

Definition: A person who chooses not to respond to the inquiry.

Edit: Code must be valid.

Currently not a UB-04 field.

Field Name: Patient Marital Status

Type: A

Position: 162—162

Length: 1

Definition: The marital status of the patient at date of admission.

Comments: One-character code, where:
S = Single
M = Married
P = Life Partner
X = Legally separated
D = Divorced
W = Widowed
U = Unknown

Edit: Code, if present, must be valid.

Currently not a UB-04 field.

Field Name: Patient Control Number

Type: A

Position: 163—179

Length: 17

Definition: A code assigned by the facility uniquely identifying individual discharge events.

Comments: This code will be used for reference in correspondence, problem solving, edit corrections and return of grouped data.

The PCN identifies a single facility visit for a patient and maybe called or defined as an account number.

The PCN is different from the medical record number which identifies an individual patient and remains the same through multiple facility visits.

Edit: PCN code must be present and should be unique within a facility.

UB-04 FL 3a**Field Name: Patient Medical Record Number**

Type: A

Position: 180—196

Length: 17

Definition: A unique identifier assigned by the facility to the patient's medical/health record at the first admission and used for all subsequent admissions.

Edit: MRN code must be present and should represent a unique patient.

UB-04 FL 3b

For questions please call: 405-271-6225

Field Name: Medicare Provider Number

Type: A
Position: 197—202
Length: 6
Definition: The six-digit number assigned to the facility by Center for Medicare and Medicaid Services.
Edit: Number must be valid.

Currently not a UB-04 field.

Field Name: National Provider Number

Type: N
Position: 203—212
Length: 10
Definition: The ten-digit number assigned to the facility as a result of HIPAA's National Provider Identifier (NPI) regulations.
Edit: Number must be valid and match the CMS national provider list.

Currently not a UB-04 field.

Field Name: Blank

Type: A
Position: 213—295
Length: 83

Field Name: Admission Date

Type: N

Position: 296—303

Length: 8

Definition: The date the patient was admitted to the facility.

Comments: Admission date has a 8 digit format MMDDYYYY where:

- MM is the month in two digits ranging from 01 to 12
- DD is the day in two digits ranging from 01 to 31
- YYYY is the year in four digits (e.g. 2008)

Each of the three components must be right justified (all positions fully coded).

Edit: Admission date must be:

- Present and valid
- No earlier than the date of birth
- No later than discharge date.

UB-04 FL 12

Field Name: Discharge Date

Type: N

Position: 304—311

Length: 8

Definition: The date the patient was discharged from the facility.

Comments: Discharge date is in an eight digit format MMDDYYYY where:

- MM is the month in two digits ranging from 01 to 12
- DD is the day in two digits ranging from 01 to 31
- YYYY is the year of discharge (e.g. 2008)

Each of the three components must be right justified (all positions fully coded).

Edit: Discharge date must be:

- Present
- Valid
- No earlier than admission date
- No earlier than date of birth

UB-04 FL 6

Field Name: Point of Origin (Previously Source of Admission)

Type: A

Position: 312—312

Length: 1

Definition: A code indicating the patient origin of admission.Comments: This single digit code depends on the code entered for Type of Admission. If Type of Admission is 1 (emergency), 2 (urgent) 3 (elective) or 5 (trauma center), Point of Origin codes have different meanings than when Type of Admission is 4, (newborn).**Point of Origin codes for Priority Type of Admission=
Emergency (1), Urgent (2), Elective (3) Trauma Center (5):****1 = Nonhealthcare Facility Point of Origin**

Definition: The patient was admitted to this facility upon the order of a personal physician.

2 = Clinic

Definition: The patient was admitted to this facility as a transfer from a free-standing or non-free-standing clinic.

4= Transfer from a hospital

Definition: The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient or outpatient.

5= Transfer from a skilled nursing facility or Intermediate care facility

Definition: The patient was admitted to this facility as a transfer from a skilled nursing facility or ICF where he or she was an inpatient.

6= Transfer from another health care facility

Definition: The patient was admitted to this facility as a transfer from another type of health care facility other than an acute care facility or skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.

7= Emergency Room

Definition: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.

8= Court/Law enforcement

For questions please call: 405-271-6225

Definition: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.

9= Information not available

Definition: The means by which the patient was admitted to this hospital is not known.

B = Transfer from another Home Health Agency

Definition: The patient was admitted to this home health agency as a transfer from another home health agency.

C = Readmission to Same Home Health Agency

Definition: The patient was readmitted to this home health agency within the existing 60-day payment

D = Transfer From One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer.

Definition: The patient received outpatient services in this facility as a transfer from within this facility resulting in a separate claim to the payer.

E = Transfer from Ambulatory Surgery Center

Definition: The patient was referred to this facility for out patient or referenced diagnostic services from an ambulatory surgery center.

F = Transfer From Hospice and is Under a Hospice Plan of care or Enrolled in a Hospice Program

Definition: The patient was referred to this facility for out patient or referenced diagnostic services from a hospice

Point of origin codes for Type of Admission = Newborn (4)

5 = Born inside this hospital

6 = Born outside of this hospital

Edit: The code must be present, valid, and in agreement with the Type of Admission code:
When Type of Admission code = 1, 2,3, or 5, valid Point of origin codes = 1 to 9 or B through F.
When Type of Admission code = 4, valid Point of origin codes = 5 and 6.

UB-04 FL 15

Field Name: Type (Priority) of Admission
Type: N
Position: 313—313
Length: 1
Definition: A code indicating the priority of the admission.
Comments: This code is a one-digit code between 1 and 5, or 9

1= Emergency

Definition: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.

2= Urgent

Definition: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.

3= Elective

Definition: The patient condition permits adequate time to schedule the availability of a suitable accommodation. An elective admission can be delayed without substantial risk to the health of the individual.

4= Newborn

Definition: Generally, the child is born within the facility.

5= Trauma center

Definition: This code is for a visit to a trauma center/hospital as licensed or designated by the state or local government authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

9= Information is not available

Edit: The field must be:

- Present and valid
- Between 1 through 5, or 9

If Type of Admission = 4 (newborn):

- Point of origin codes must be 5 or 6
- Date of Birth must equal date of admission
- Diagnosis must be consistent with newborn

UB-04 FL 14

For questions please call: 405-271-6225

Field Name: Patient Discharge Status

Type: N

Position: 314—315

Length: 2

Definition: A code indicating patient status as of the discharge date.

Comments: Codes for this two-digit field are:

- 01= Discharged to home or self-care (routine discharge)
- 02= Discharged/transferred to another short-term general hospital for inpatient care
- 03= Discharged/transferred to skilled nursing facility (SNF) with Medicare Certification in Anticipation of Skilled Care
- 04= Discharged/transferred to an intermediate care facility (ICF)
- 05= Discharged/transferred to another type of health care institution not defined elsewhere in this code list. **Effective April 1, 2008 this code will change to Discharge/Transferred to a designated cancer center or children's hospital**
- 06= Discharged/transferred to home under care of organized home health service organization
- 07= Left against medical advice or discontinued care
- 20= Expired
- 43= Discharged/transferred to a federal health care facility.
- 50= Discharged to Hospice—home
- 51= Discharged to Hospice—medical facility
- 61= Discharged/transferred to a hospital-based Medicare approved swing bed.
- 62= Discharged/transferred to an inpatient rehabilitation facility (IRF) including distinct part units of a hospital.
- 63= Discharged/transferred to a long term care hospital (LTCH).
- 64= Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
- 65= Discharged/transferred to a Psychiatric hospital or Psychiatric Distinct Part Unit of a Hospital.
- 66= Discharged/transferred to a Critical Access Hospital (CAH)
- 70= Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this Code List. **Effective 10/01/07. For discharges prior to 10/01/07 use code 05.**

Edit: Discharge status code must be present and valid.

UB-04 FL 17

Field Name: External Cause of Injury Code (E-code I-3)

Type: A

Position: 316—339

Length: 24 (3 fields, 8 positions each)

Definition: The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

Comments: Required whenever there is any diagnosis (primary, secondary) of an injury, poisoning, or adverse effect (ICD-9-CM codes 800-999) and it is the initial treatment for that condition.

Present on admission should be reported for all E-codes that occurred prior to inpatient admission but not those that occurred during an inpatient hospitalization. See PRINCIPAL Diagnosis for definition and further description of the Present on Admission Indicator.

The priorities for recording an E-code are:

- Initial treatment of the injury or poisoning.
- Principal diagnosis of an injury or poisoning.
- Other diagnosis of an injury, poisoning or adverse effect directly related to the principal diagnosis.
- Other diagnosis with an external cause.
- Place of occurrence is not required.

Entries:

- Are left justified
- Are without a decimal. If a decimal is included, the fifth digit is lost, which will result in an inaccurate E-code.
- Start with an uppercase E

Edit: If any diagnosis is ICD-9-CM code from 800 through 999 excluding 995.9x, there must be a valid E-Code, between E800 to E999.

UB-04 FL 72a-c

For questions please call: 405-271-6225

Field Name: Attending Physician Identifier

Type: A
Position: 340—350
Length: 11
Definition: The ten-digit National Provider Identifier Number (NPI) of the physician who certified and re-certified the medical necessity of the service rendered or who has primary responsibility for the patient's medical care and treatment.
Comments: Left justify with spaces to the right to complete the field.
Edit: Entry must be a valid NPI number.

UB-04 FL 76

Field Name: Birth Weight

Type: N
Position: 351—354
Length: 4
Definition: Newborn weight in grams and is obtained from the amount field of Value Code 54.
Comments: Actual birth weight or weight at time of admission for an extramural birth.
Edit: Required on all claims with Type of Admission of 4 and on other claims as required by state law. The field should be right justified.

UB-04 FL 39-41

Field Name: Admitting diagnosis Code

Type: A

Position: 355—361

Length: 7

Definition: The ICD-9-CM code describing the patient's diagnosis at the time of admission.

Comments: The admitting diagnosis must:

- Use an ICD-9-CM code without a decimal point.
- Enter all three, four, and 5 digits or to the highest level of specificity.
- **Left justify with spaces to the right to complete the field length.**

Edit: Admitting diagnosis must be:

- Present
- Valid
- Consistent with sex and age

UB-04 FL 69

Field Name: Principal Diagnosis

Type: A

Position: 362—369

Length: 8

Definition: **Principal Diagnosis:**
The ICD-9-CM code describing the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

Definition: **Present on Admission Indicator:**
Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during a outpatient encounter, including emergency department, are considered as present on admission. **The POA Indicator is to be entered in the eighth position of the field.**

For questions please call: 405-271-6225

- Comments: The principal diagnosis must:
- Use an ICD-9-CM code without decimal point in first 7 positions.
 - Enter all three, four, and 5 digits or to the highest level of specificity.
 - Enter the “V” prefix as appropriate (newborns).
 - **Left justify with spaces to the right to complete the field length**
- Comments: The Present on Admission Indicator:
- Should be included at the 8th position of the diagnosis code.
 - Is based not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place.
 - Is applied to the principal diagnosis as well as all secondary diagnoses that are reported.
 - Applies to the diagnosis codes for claims involving inpatient admissions to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting.
- Edit: A principal diagnosis must be:
- Present
 - Valid
 - Consistent with sex and age
 - Consistent with a valid DRG
 - **An “E” code should NOT be entered as the principal diagnosis.**
- Edit: Present on Admission Indicator must be:
- Y-Yes (present at the time of inpatient admission)
 - N – No (not present at the time of inpatient admission)
 - U- Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)
 - W - Clinically Undetermined
 - 1 – Unreported/Not used – Exempt from POA reporting

Field Name: Other Diagnosis Code (I - I7)

Type:	A
Position:	370—505
Length:	136 (17 fields, 8 positions each)
Definition:	The ICD-9-CM codes describing other diagnoses corresponding to additional conditions that co-exist at the time of admission or develop subsequently, and which have an effect on the treatment received or the length of stay.
Comments:	Up to 17 secondary diagnoses may be recorded in the first 7 positions of each secondary diagnosis. Enter the present on admission indicator in the 8 th position of the secondary diagnosis fields. See comments for the principal diagnosis for definition and further description of POA Indicator. Additional “E” codes may be entered as ‘other diagnosis codes’ after the E-code fields have been completed. All codes must be entered without decimal points.
Edit:	If other diagnoses are present they must be valid. When diagnosis is age or sex dependent, the age and sex must be consistent with the code entered. If the diagnosis code is ICD-9-CM 800 through 999 there must be a valid E-Code entered in the External Cause of Injury Code (E-Code) field if it is the initial treatment for the condition reported. Present-on-admission indication must be valid.

UB-04 FL 67 A-Q

For questions please call: 405-271-6225

Field Name: Principal Procedure ICD-9 Code

Type: A

Position: 506— 512

Length: 7

Definition: The ICD-9-CM code that identifies the principal procedure performed during the inpatient hospital stay covered by this discharge data record. The principal procedure is one that is performed for definitive treatment rather than for diagnostic or exploratory purposes, or is necessary as a result of complications. The principal procedure is that procedure most related to the principal diagnosis.

Comments: The coding method used should be ICD9-CM. Entries must include all digits and should be left justified without a decimal.

Edit: Principal Procedure field if provided must be:

- Present if other procedures are present
- Valid
- Without decimals
- Consistent with patient's sex and age
- Consistent with a valid DRG

UB-04 FL 74

Field Name: Other Procedure ICD9 Code (1 - 15)

Type: A

Position: 513—617

Length: 105 (15 fields, 7 positions each)

Definition: The ICD-9-CM code(s) that identifies all significant procedures other than the principal procedure performed during the patient's inpatient hospital stay covered by this discharge record. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Comments: Enter codes in descending order of importance.

To code other Procedure codes:

- Enter all digits
- Do not enter a decimal
- Left justify the field

Edit: Other Procedure field, if provided, must be:

- Present only if a principal procedure is present
- Valid
- Consistent with patient's sex and age
- Consistent with valid DRG

UB-04 FL 74 a-e

Field Name: Principal Procedure—Physician Identifier

Type: A

Position: 618—628

Length: 11

Definition: The ten-digit National Provider Identifier (NPI) of the physician performing the principal procedure.

Comments: Left justify with spaces to the right to complete the field.

Edit: Field must contain a valid NPI.

UB-04 FL 77

Field Name: Other Procedure—Physician Identifier (1-5)

Type: A

Position: 629—683

Length: 55 (5 fields, 11 positions each)

Definition: The ten-digit National Provider Identifier (NPI) of the physician performing the principal procedure.

Comments: Left justify with spaces to the right to complete the field.

Edit: Field must contain a valid NPI.

UB-04 FL 78 and 79

Field Name: Primary Payer Identifier

Type: A

Position: 684—698

Length: 15

Definition: National Health Plan Identifier identifying the primary payer for this bill.

Comments: This field is to contain the National Health Plan Identifier of the primary payer organization.

Edit: The identifier must be that of a licensed health insurer or self-pay.

UB-04 FL 51a

Field Name: Primary Payer Name

Type: A

Position: 699—723

Length: 25

Definition: Payer name identifying the primary payer for this bill.

Comments: This field is to contain the name of the primary payer, spelled out as completely as space allows. If a name has more than 25 characters, use abbreviations that can be used to uniquely identify the payer. If the patient paid for or was responsible for the hospital stay, primary payer should indicate self-pay.

Edit: The name must be present and health insurer or self-pay

UB-04 FL 50A

Field Name: Secondary Payer Identifier

Type: A

Position: 724—738
Length: 15

Definition: National Health Plan Identifier identifying the secondary payer for this bill.

Comments: This field is to contain the National Health Plan Identifier of the secondary payer organization.

Edit: The field must be present.

UB-04 FL 51B

Field Name: Secondary Payer Name

Type: A

Position: 739—763
Length: 25

Definition: Payer name identifying the secondary payer for this bill.

Comments: This field is to contain the name of the secondary payer, spelled out as completely as space allows. If a name has more than 25 characters, use abbreviations that can be used to uniquely identify the payer. If the patient paid for or was responsible for part of the hospital stay, secondary payer should indicate self-pay.

Edit: The name must be that of a licensed health insurer or self-pay

UB-04 FL 50B

Field Name: Payer Classification

Type: N

Position: 764—764

Length: 1

Definition: This field indicates the payer group.

Comments: The payer group should be classified as:

1. **Commercial** - Includes HMO, PPO, POS, Indemnity, BCBS, Aetna, HealthChoice etc.
2. **Medicare** - Including HMO and insurance managed Medicare
3. **Medicaid** - Including Medicaid pending
4. **Veterans affairs / Military** - Includes Champus, ChampVA and Tricare.
5. **Workers Compensation**
6. **Uninsured/ Self-pay**
7. **Others** - Payers not in any of the above groups and including charity, Indian Health, auto-liability, DOC inmate.

Edit: The code must be present and valid.

Currently not a UB-04 field.

Field Name: Total Charges

Type: N

Position: 765—771

Length: 7

Definition: The total charges for all revenue codes associated with the inpatient stay.

Comments: This entry is:

- Rounded to nearest whole dollar
- A maximum of six digits
- Right justified within the field.

Edit: This field must be present and valid. The field should equal the sum of subtotals of charges by revenue code fields.

UB-04 FL 47; Rev Code 0001

Field Name: Total Charges (by Revenue Code) 0001-0999

Type: N

Position: 772—1347

Length:: 576 (96 fields, 6 positions each)

Definition: Dollars charged, subtotaled for each revenue service code.

All valid revenue categories are defined in:

- Table 3-Revenue Codes and Units of Service

The revenue code for this charge subtotal is determined by the position of this item within the computer record specified in:

- Table 2-Record Format and Description

The four-digit revenue code:

- Identifies a specific accommodation, ancillary service or billing calculation
- Indicates a major category (the only level reported) with the first two digits
- Has "0" for its fourth digit of the four-digits, indicating the general classification for the major category.

Comments: The total allows for a six-digit dollar amount (no cents or decimal point). All entries are right justified. The charge should be rounded to the nearest whole dollar.

Edit: The sum of all charge subtotals should equal the total charges.

UB-04 FL 42

Field Name: Units of Service (by Revenue Code) 0001-0999

Type: N

Position: 1348—2019

Length: 672 (96 fields, 7 positions each)

Definition: The number of units of service rendered for each revenue code.

Comments: Like subtotal of charges, the revenue code which this unit of service describes, is determined by the position of this item within the computer record specified in:

- Table 2 – Data Elements Layout and Description

Units of service for each revenue code are defined in:

- Table 3 – Revenue Codes and Units of Service

Edit: The units of service must be present:

- If the revenue code requires a unit, and the total charges for the revenue code are greater than zero (0).

UB-04 FL 46

Field Name:	Type of Bill
Type:	A
Position:	2020—2023
Length:	4
Definition:	A code indicating the specific type of bill. The first digit is a leading zero and the fourth digit defines the frequency of the bill.
Comments:	The leading zero is not included on electronic claims. The field is left justified. Even though all bill types are included in the table below only inpatient bill types should be reported for inpatient data.

<u>Type of bill</u>	<u>Description</u>	<u>IP/OP</u>
0000-010x	Reserved for Assignment by NUBC	
011x	Hospital Inpatient including Medicare Part A	IP
012x	Hospital Inpatient Medicare Part B only	OP
013x	Hospital outpatient	OP
014x	Hospital – Laboratory Services Provided to Non-patients	OP
015x-017x	Reserved for Assignment by NUBC	
018x	Hospital – Swing Beds	IP
019x-020x	Reserved for Assignment by NUBC	
021x	Skilled Nursing – Inpatient including Medicare Part A	IP
022x	Skilled Nursing – Inpatient including Medicare Part B	OP
023x	Skilled Nursing – Outpatient	OP
024x-027x	Reserved for Assignment by NUBC	
028x	Skilled Nursing – Swing Beds	IP
029x-031x	Reserved for Assignment by NUBC	
032x	Home Health – Inpatient Medicare Part B only	OP
033x	Home Health – Outpatient Medicare Part A including DME under Part A	OP
034x	Home Health – Other	OP

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<u>Type of bill</u>	<u>Description</u>	<u>IP/OP</u>
035x-040x	Reserved for Assignment by NUBC	
041x	Religious Non-Medical Health Care Institutions	IP
042x	Reserved for Assignment by NUBC	
043x	Religious Non-Medical Health Care Institutions – Out-patient Services	OP
044x-064x	Reserved for Assignment by NUBC	
065x	Intermediate Care – Level I	IP
066x	Intermediate Care – Level II	IP
067x-070x	Reserved for Assignment by NUBC	
071x	Clinic – Rural Health	OP
072x	Clinic – Hospital Based or Independent Renal Dialysis Center	OP
073x	Clinic – Freestanding	OP
074x	Clinic – Outpatient Rehabilitation Facility (ORF)	OP
075x	Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF)	OP
076x	Clinic – Community Mental Health Center	OP
077x-078x	Reserved for Assignment by NUBC	
079x	Clinic – Other	OP
080x	Reserved for Assignment by NUBC	
081x	Special Facility – Hospice (non-hospital based)	OP
082x	Special Facility – Hospice (hospital based)	OP
083x	Special Facility – Ambulatory Surgery Center	OP
084x	Special Facility – Free Standing Birthing Center	IP
085x	Special Facility – Critical Access Hospital	OP
086x	Special Facility – Residential Facility	IP
087x-088x	Reserved for Assignment by NUBC	
089x	Special Facility – Other	IP
090x-9999	Reserved for Assignment by NUBC	

Frequency – 4th Digit

- 0 = Non-payment / zero claim
- 1 = Admit through discharge claim
- 2 = Interim – 1st claim
- 3 = Interim – Continuing claim
- 4 = Interim – Last claim
- 5 = Late charges
- 6 = Adjustment of prior claim
- 7 = Replacement of prior claim
- 8 = Voiding/cancellation of prior claim

Edit: Type of Bill Code must be present and valid.

UB-04 FL 04

Field Name: **DRG (Diagnosis Related Group)**

Type: N

Position: 2024—2027

Length: 4

Definition: The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. This represents an inpatient classification scheme to categorize patients that are medically related with respect to diagnosis and treatment and who are statistically similar in their lengths of stay.

Comments: To accommodate other types of DRGs, prefix the the DRG with “M” to indicate MS-DRG (Ver 25), “C” to indicate CMS_DRG (Ver 24) and “O” to indicate other types of DRGs such as Champus, Medicaid DRG etc. When DRG is unknown or not available use 9999.

Edit: A DRG must be:

- Present
- Valid
- Consistent with sex and age

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Table 3 - Revenue Codes and Units of Service

This section defines valid revenue codes representing services provided to a patient, and the unit of measure associated with each revenue service. Only these codes are valid. The source of the codes and definitions is the published manual of the National Uniform Billing Committee.

Revenue Code: The revenue code is a four-digit code and identifies a specific accommodation, ancillary service or billing calculation.

Subcategory: The fourth digit denotes a subcategory number. The subcategory number provides a more detailed list generally ranging from 0 – 9. When reporting the revenue code the fourth position must include one of the numeric choices available in that category.

Units of Service: The units used to measure the patient services in each revenue category, such as number of accommodation days, miles, pints, or treatments.

DESCRIPTION OF REVENUE CATEGORIES

Code	Unit	Description	Subcategory
0001		Total Charges – The total for all revenue codes associated with a patient stay.	
001x		Reserved	
002x		Health Insurance - Prospective Payment System (HIPPS)- This revenue code is used to denote that a HIPPS rate code is being reported in FL44	2-4
0020-0021		Reserved	
0022		Skilled nursing facility prospective payment system	
0023		Home health prospective payment system	
0024		Inpatient rehabilitation facility prospective payment system	
0025-0029		Reserved	
003x - 009x		Reserved	
010x	Days	All-inclusive rate—a flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.	0-1
011x	Days	Room and board - Private - One bed. Routine service charges for accommodations in a private room.	0-9

<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
012x	Days	Room and board - Semi-private - two beds. Routine service charges for accommodations in a semi-private room.	0-9
013x	Days	Room and Board - Three and Four Beds. Routine service charges for rooms with three or four beds.	0-9
014x	Days	Room and Board - Deluxe Private - Deluxe accommodations substantially in excess of private room services.	0-9
015x	Days	Room and board - Ward. Routine service charges for accommodations with five or more beds.	0-9
016x	Days	Room and board, other - Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.	0,4,7,9
017x	Days	Nursery - Accommodation charges for nursing care to newborns and premature infants in nurseries.	0-4, 9
018x	Days	Leave of absence - charges for holding a room while the patient is temporarily away from the provider.	0-3, 5, 9
019x	Days	Subacute care - Accommodations charges for subacute care to inpatients or skilled nursing facilities.	0-4, 9
020x	Days	Intensive care - routine service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.	0-4, 6-9
021x	Days	Coronary care - routine service charges for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.	0-4, 9
022x	None	Special charges - charges incurred during an inpatient stay or on a daily basis for certain services.	0-4, 9
023x	Hours	Incremental nursing charge - Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unit.	0-5, 9
024x	None	All-inclusive ancillary - A flat-rate charge that is applied on a daily basis or on a total stay basis for ancillary services only.	0-3, 9
025x	None	Pharmacy (also see 063x, and extension of 025x) - Charges for medications produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.	0-9

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<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>	<u>Code</u>	<u>Unit</u>
026x	None	IV therapy - equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment.	0-4, 9	041x	Treatment
027x	None	Medical/surgical supplies and devices (See also 062x, and extension of 027x) - Charges for supply items required for patient care.	0-9	042x	HCPCS
028x	None	Oncology - charges for the treatment of tumors and related diseases.	0, 9		
029x	None	Durable medical equipment (other than renal) - charges for medical equipment that can withstand repeated use.	0-4, 9	043x	HCPCS
030x	Tests	Laboratory - Charges for the performance of diagnostic and routine clinical laboratory tests.	0-7, 9		
031x	Tests	Laboratory pathology - charges for diagnostic and routine laboratory tests on tissues and cultures.	0-2, 4, 9		
032x	Tests	Radiology - Diagnostic - Charges for diagnostic radiology services including interpretation of radiographs and fluorographs.	0-4, 9	044x	HCPCS
033x	Tests	Radiology - Therapeutic - Charges for therapeutic radiology services and chemotherapy administration to care and treat patients. Includes therapy by injection or ingestion of radioactive substances. Excludes charges for chemotherapy drugs.	0-3, 5, 9	045x	Visit
034x	Tests	Nuclear medicine - Charges for procedures, tests and radiopharmaceuticals performed by a department handling radioactive materials as required for diagnosis and treatment of patients.	0-4, 9	046x	Tests
035x	Tests	CT scan - charges for computed tomographic scans of the head and other parts of the body.	0-2, 9	047x	Tests
036x	None	Operating room services - charges for services provided to patients by specifically trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.	0-2, 7, 9	048x	Tests
				049x	HCPCS
				050x	Tests
037x	None	Anesthesia - charges for anesthesia services.	0-2,4,9		
038x	Pints	Blood and blood components.	0-7, 9		
039x	Pints	Administration, Processing and Storage for Blood and Blood components - Charges for administration, processing and storage of whole blood, red blood cells, platelets and other blood components.	0-1, 9	051x	Visit
				052x	Visit
040x	Tests	Other imaging services	0-4, 9		

<u>Description</u>	<u>Subcategory</u>
Respiratory services - charges for respiratory services including administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy.	0, 2-3, 9
Physical therapy - charges for therapeutic exercises, massage and utilization of effective date properties of light, heat, cold, water, electricity, and assisting devices for diagnosis and rehabilitation of patients whom have neuromuscular, orthopedic and other disabilities.	0-4, 9
Occupational therapy - charges for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance, of activities of daily living and work, including, therapeutic activities, therapeutic exercises, sensorimotor processing, psychosocial skills training, cognitive retraining, fabrication and application of orthotic devices, and training in the use of orthotic and prosthetic devices, adaptation of environments, and applications of physical agent modalities.	0-4, 9
Speech Therapy - charges for services related to impaired functional communications skills.	0-4, 9
Emergency room - charges for emergency treatment to those ill and injured persons who require immediate and unscheduled medical or surgical care.	0-2, 6, 9
Pulmonary function - charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other exhaled gases.	0,9
Audiology - charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.	0-2, 9
Cardiology - charges for cardiac procedures.	0-3, 9
Ambulatory surgical care - charges for ambulatory surgery that is not covered by other categories.	0,9
Outpatient services - Charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. Medicare no longer requires this revenue code.	0,9
Clinic - charges for providing diagnostic, preventative, curative, rehabilitative, and education services to ambulatory patients.	0-7, 9
Free-standing clinic	0-9

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<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>	<u>Code</u>	<u>Unit</u>
053x	Visit	Osteopathic services - charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.	0-1, 9	064x	Hours
054x	Mile/ Item/ Unit	Ambulance - Charges for ambulance service necessary for the transport to the ill and injured who require medical attention at a healthcare facility.	0-9	065x	Hours/ Days/ HPCP
055x	Visit/ Hour	Home Health - Skilled Nursing - Charges for nursing services provided under the direct supervision of a home health licensed nurse.	0-2, 9	066x	Hours/ Days
056x	Visit/ Hour	Home Health - Medical social services - Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.	0-2, 9	067x	Days
057x	Visit/ Hour	Home Health - Aide - Home Health charges for personnel (aides) that are primarily responsible for the personal care of the patient.	0-2, 9	068x	Activa- tion
058x	Visit/ Hour	Home Health - Other Visits - Home Health agency charges for the visits other than physical therapy, occupational therapy or speech therapy, requiring specific identification.	0-2, 9	069x	
059x	Unit	Home Health - Units of Service - Home Health charges for services billed according to the units of service provided.	0	070x	None
060x	Ft/ Lbs/ Mos	Home Health - Oxygen - Home Health agency charges for oxygen equipment, supplies or contents, excluding purchased equipment.	0-4, 9	071x	None
061x	Tests	Magnetic Resonance Technology (MRT) - Charges for Magnetic Resonance Imaging and Magnetic Resonance Angiography.	0-2, 4-6, 8-9	072x	Days/ Each
062x	HCP CS	Medicare/Surgical supplies - Extension of 027x - Charges for supply items required for patient care. The category is an extension of code 27x for reporting additional breakdown where needed. Subcategory code 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcategory code 2 is for providers that cannot bill supplies used for other diagnostic procedures.	1-4	073x	Tests
063x	HCP CS	Pharmacy - Extension of 025x - Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist. The category is an extension of 025x for reporting additional breakdown where needed.	1-7	074x	Tests
				075x	Tests
				076x	None

<u>Description</u>	<u>Subcategory</u>
Home IV Therapy Services - Charge for intravenous therapy services performed in the patient's residence. For Home IV providers enter the HCPCS code for all equipment, and all types of covered therapy.	0-9
Hospices service - charges for hospice care services for a terminally ill patient if he elects these services in lieu of other medical services for the terminal condition.	0-2, 5-9
Respite Care - Charge for non-hospice respite care.	0-3,9
Outpatient Special Residence Charges - Residence arrangements for patients requiring continuous outpatient care.	0-2,9
Trauma Response - Charges representing the activation of the trauma team.	1-4, 9
Reserved	
Cast room - charges for services related to the application, maintenance and removal of casts.	0
Recovery room	0
Labor room and delivery - charges for labor and delivery room services provided by specially trained nursing personnel to patients including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecological procedures if they are performed in the delivery suite.	0-4, 9
EKG/ECG (Electrocardiogram) - charges for operation of specialized equipment to record variations in actions of the heart muscle for diagnosis of heart ailments.	0-2, 9
EEG (Electroencephalogram) - charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.	0
Gastrointestinal services - Charges for gastrointestinal procedures not performed in the operating room.	0
Specialty Room - Treatment/observation room - Charges for the use of a specialty room such as a treatment or observation room.	0-2, 9

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<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>	<u>Code</u>	<u>Unit</u>
077x	None	Preventive Care Services - Revenue Code used to capture preventive care services established by payers.	0-1	090x	Visit
078x	None	Telemedicine - Facility charges related to the use of telemedicine services.	0		
079x	None	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) - Charges related to Extra-Corporeal Shock Wave Therapy.	0	091x	Visit
080x	Sessions	Inpatient Renal Dialysis - Charges for the use of equipment designed to remove waste when the body's own kidneys have failed.	0-4, 9	092x	Tests
081x	None	Acquisition of Body Components - the acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.	0-4,9	093x	Hours
082x	Sessions	Hemodialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed.	0-5,9	094x	Visit
083x	Sessions	Peritoneal Dialysis - Outpatient or Home - Charges for a waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed.	0-5, 9	095x	Visit
084x	Days	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home - Charges for continuous dialysis process performed in an outpatient or home setting which uses the patient peritoneal membrane as a dialyzer.	0-5, 9		
085x	Days	Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home - Charges for continuous dialysis process performed in an outpatient or home setting which uses a machine to make automatic exchanges at night.	0-5, 9	097x	None
				098x	None
086x		Reserved			
087x		Reserved			
088x	Sessions	Miscellaneous Dialysis - Charges for dialysis services not identified elsewhere.	0-2, 9	099x	None
089x		Reserved			

<u>Description</u>	<u>Subcategory</u>
Behavioral Health Treatment/Services (see also 091x, and extension of 090x) - Charges for prevention, intervention and treatment services in the areas of mental health, substance abuse, developmental disabilities, and sexuality. Behavioral Health Care services are individualized, holistic, and culturally competent and may include on-going care and support and non-traditional services.	0-7
Behavioral Health Treatment/Services - Extension of 090x - See Revenue code 090x	1-9
Other diagnostic services - Charges for various diagnostic services specific to common screenings for disease, illness or medical condition.	0-5, 9
Medical Rehabilitation Day Program - Medical rehabilitation services as contracted with a payer and /or certified by the state. Services may include physical therapy, occupational therapy, and speech therapy	1-2
Other therapeutic services (see also 095x, and extension of 094x) - charges for other therapeutic services not otherwise categorized.	0-7, 9
Other Therapeutic services - (Extension of 094x) - See Revenue Code 094x	1-2
Professional fees (see also 097x and 098x) - Charges for medical professionals that the institutional health care provider along with the third party payer require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by Critical Access Hospitals that bill both the technical and professional component on the UB.	0-4, 9
Professional fees (Extension of 096x) - See Revenue Code 096x.	1-9
Professional fees (Extension of 096x and 097x) - Charges for medical professionals that the institutional health care provider along with the third-party payer require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by critical access hospitals.	1-9
Patient convenience items - charges for items that are generally considered by the third party payers to be strictly convenience items and therefore are not covered by many health plans.	0-9

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<u>Code</u>	<u>Unit</u>	<u>Description</u>	<u>Subcategory</u>
100x	Days	Behavioral Health Accommodations - Charges for routine accommodations at specified behavioral health facilities.	0-5
101x - 209x		Reserved	
210x	Ses- sions	Alternative Therapy Services - Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042x, 043x, 044x, 091x, 094x, 095x) or services such as anesthesia or clinic (0374, 0511)	0-6, 9
211x - 309x		Reserved	
310x	Hour/ Day	Adult Care - Charges for person, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADL).	1-5, 9
311x - 999x		Reserved	

CLINICAL CLAIMS EDITOR

Clinical claims editing (CCE) will be applied to the hospital's discharge records submitted. The edit process checks for potential problems in a record identifying highly improbable clinical situations, which in most cases, prove to be in error. The CCE will flag records when any of the following conditions are detected.

Clinically unreasonable length-of-stay (high or low) - From a clinical perspective, it is highly improbable that patients with certain diagnoses and procedures could legitimately have length-of-stays less than or greater than a specific number of days. Such clinically unreasonable high and low length-of-stays are identified by the CCE for specific diagnoses and procedures.

Age conflict - The CCE detects inconsistencies between a patient's age and any diagnosis on the patient's claim. Examples of such conflicts are a 5-year-old patient with benign prostatic hypertrophy, or a 78 year old delivery. In such cases either the diagnosis or the age is presumed to be incorrect.

Sex conflict - The CCE detects inconsistencies between a patient's sex and any diagnosis or procedure on the patient's record. Examples of such conflicts are a male patient with cervical cancer, or a male patient with a hysterectomy. In such case either the patient's diagnosis, procedure or sex is incorrect.

E-Code as principal diagnosis - E-codes describe the circumstances that caused an injury, not the nature of the injury. An E-code should not be used as a principal diagnosis.

Manifestation code as principal diagnosis - Manifestation codes describe the manifestation of an underlying disease, not the disease itself. A manifestation code should not be used as a principal diagnosis.

Unacceptable principal diagnosis - Selected "V" codes describe a circumstances which influences an individual's health status but is not a current illness or injury. These V codes are considered

unacceptable as a principal diagnosis. For example, a family history of ischemic heart disease (V173) would be an unacceptable principal diagnosis.

Duplicate of principal diagnosis - Whenever a secondary diagnosis is coded the same as the principal diagnosis, the secondary diagnosis is identified by the CCE as a duplicate of the principal diagnosis.

Invalid diagnosis or procedure code - The CCE checks each diagnosis and procedure code entered in the record against a table of valid ICD-9-CM codes. If a code is not found in the table the record is flagged as in error.

Invalid 4th or 5th digit - The CCE identifies any diagnosis or procedure code that requires a 4th or 5th digit. The code entered may have the 4th or 5th digit missing or not be valid for the code in question.

Duplicate code - When the CCE detects the same ICD-9-CM diagnosis or procedure code more than once in a record, the record is flagged as a possible error.

Maternal and fetal/newborn edit - A maternal diagnosis code and a fetal/newborn diagnosis code should not appear on the same discharge record. When the CCE detects a maternal diagnosis code and a fetal/newborn diagnosis code the record is flagged as an error.

Invalid or unknown age - CCE allows entry of patient age from 0 through 124 years. Any other entry is considered an error.

NOTES:

NOTES:

For questions please call: 405-271-6225

**Health Care Information Staff and Contact Information
(405) 271-6225**

LouAnn Sanders*, RHIT, LPN ...Record Coding Specialist.....louanns@health.ok.gov
Mary Piscitello, MS.....Facility Coordinatormary@health.ok.gov
Binitha Kunnel, MSProject Coordinatorbinithak@health.ok.gov
Jeffrey CarlisleITjeffreyc@health.ok.gov
Kelly Baker, MPHDirectorkellyb@health.ok.gov

*Primary Contact



Oklahoma State Department of Health