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.

DISCHARGE DATA ELEMENTS FOR INPATIENTS

The discharge data set for Inpatients include the following data elements (in alphabetical order):

Admission Date
Date of Birth
Discharge Date
Disposition of Patient
Expected Source of Payment
External Cause of Injury and Present on Admission Indicator
Other Diagnoses and Present on Admission Indicator
Other Procedures and Dates
Patient Social Security Number
Prehospital Care and Resuscitation (DNR – Do Not Resuscitate)
Principal Diagnosis and Present on Admission Indicator
Principal Language Spoken
Principal Procedure and Date
Race
Sex
Source of Admission
Total Charges
Type of Admission
ZIP Code

Additional Reporting Requirements

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

The Facility Identification Number is a required part of the discharge data record. Using the reported data elements, OSHPD computes and adds to the discharge data record the appropriate Diagnosis Related Group (DRG) and Major Diagnostic Category (MDC), using the current version of the Grouper approved by the Centers for Medicare and Medicaid Services.

Type of Care is also a required part of the discharge record. Type of Care may be one of the following: Acute Care, Chemical Dependency Recovery Care, Psychiatric Care, Physical Rehabilitation Care, or Skilled Nursing/Intermediate 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 discharges occurring on or after January 1, 2006:

ABSTRACT RECORD NUMBER (Optional)

In order to identify a particular patient's record from all others in the reporting facility, 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, and apostrophe) must not be included.
- Should be reported from the left-most position of the field. Do not fill blank spaces with zeroes.

ADMISSION DATE — Section 97221

The patient's date of admission 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. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined by Subsection (x) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this 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 discharges occurring on or after January 1, 2006:

ADMISSION DATE

Month *Day* *Year (4-Digit)*

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

Four Digit Year: Hospital medical record systems are expected to be properly record the 4-digit year in the medical record system and eliminate any ambiguity of the correct century.

Reporting Requirements:

- The actual date of admission to inpatient care and the actual date of discharge must be reported, even if the length of stay is over 365 days.
- If the patient is admitted to inpatient care on May 3, 1999, the reported value is 05031999.

Discharge/Transfer:
Make certain that the date recorded represents the initial date of admission to the hospital for that episode of inpatient care. A separate episode of inpatient care (a discharge) is to be reported when a patient is transferred between hospitals or within a hospital between Types of Care (TOC). The admission date for the initial episode is when the patient is first admitted to the hospital for inpatient care, regardless of TOC. If the patient is transferred from one TOC to another (e.g., from acute care to skilled nursing/intermediate care), the admission date for the second episode would be the date the patient was transferred to "the new TOC" skilled nursing/intermediate care.

One Day Stays (Same Day):
One day stays include patients admitted and discharged on the same day. Such patients are formally admitted (expected to remain overnight or longer) but are discharged on the day of admission. A discharge data record must be reported to OSHPD.

Observation Patients:
When an observation patient is admitted to inpatient care, the admission date to be reported is the date the patient is admitted to inpatient care. See Glossary of Terms and Abbreviations (Appendix A) for definition of observation.

Ambulatory Surgery Facility and Hospital Outpatient Services:
Patients are sometimes admitted within 72 hours of procedures performed in a licensed ambulatory surgery facility or as an outpatient at a hospital. Under certain circumstances, the procedure may be reported on the discharge data record. If so, the procedure date must be reported when it actually occurred and not be changed to the admission date. OSHPD accommodates procedure dates three days prior to the admission date.

Emergency Room:
Patients are often seen in the emergency room on one day and remain until the next day and are then admitted to inpatient care. The admission date reported is the date the patient is admitted to inpatient care.

Skilled Nursing Bed Hold Days:
Skilled nursing bed hold days are **not** reported to OSHPD. A patient cannot be in two levels of care at the same time.

Length of Stay:
This is calculated by subtracting the Admission Date from the Discharge Date. A patient admitted and discharged on the same day is calculated as one day LOS. The LOS will appear in OSHPD publications for hospital utilization and outcome studies.

DATE OF BIRTH — Section 97216

The patient's birth date shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year of birth. 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. If the month and year of birth are known, and the exact day is not, the year, the month, and zeros for the day shall be reported.

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 discharges occurring on or after January 1, 2006:

DATE OF BIRTH

Month *Day* *Year (4-Digit)*

Reporting Requirements:

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 00, the day will be 00, and the given year.

Example: The patient was born in 1948. Report the date of birth as 00001948.

If the patient's month, day, and year of birth are unknown, and the patient's age is known, the patient's age at the time of admission will be subtracted from the year of admission to determine the year of birth.

Example: The patient is known to be 65 years old and the year of admission is 1997 (1997 - 65 = 1932). The date of birth will be 00001932.

If the patient's day of birth is unknown, and the month and year are known, the day will be 00.

Example: The patient was born in November 1952. The date of birth will be 11001952.

DISCHARGE DATE — Section 97224

The patient's date of discharge 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 with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after January 1, 2006:

DISCHARGE DATE

Month		*Day*		*Year (4-Digit)*			

Reporting Requirements:

- The actual date of discharge from inpatient care or transfer to another Type of Care (TOC) must be reported, even if the length of stay is over 365 days.
- If the patient is discharged on February 5, 2000, the reported value is 02052000.

Discharge/Transfer:
A separate episode of inpatient care (a discharge) is to be reported when a patient is transferred between hospitals or within a hospital between Types of Care. If the patient is transferred from one TOC to another (e.g., from acute care to skilled nursing/intermediate care), the discharge date for the first episode would be the date the patient was transferred to "the new TOC" skilled nursing/intermediate care.

One Day Stays (Same Day):
One day stays include patients admitted and discharged on the same day. Such patients are formally admitted (expected to remain overnight or longer) but are discharged on the day of admission. A discharge data record must be reported to OSHPD.

Bed Hold Days:
Bed hold days are **not** reported to OSHPD. A patient cannot be in two types of care at the same time.

Length of Stay:
This is calculated by subtracting the Admission Date from the Discharge Date. A patient admitted and discharged on the same day is calculated as one day LOS. The LOS will appear in OSHPD publications for hospital utilization and outcome studies.

DISPOSITION OF PATIENT — Section 97231

Effective with discharges on or after January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay 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 discharges occurring on or after January 1, 2006:

DISPOSITION OF PATIENT	
01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

(a) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office or a clinic shall be included. Excludes patients referred to a home health service.

DISCUSSION

See Examples 1 and 2 at the end of this subsection.

This category is used to indicate discharge to a location not licensed as a hospital by the Department of Public Health includes:

- Patients discharged to a home environment (e.g., half-way house, group home, foster care, woman's shelter).
- Patients discharged to receive outpatient services (physical therapy, lab work, x-ray, etc.) at your or another facility with the intent of going home. For services that are surgical in nature, please see **(m)** below.
- Patients discharged to an Alcoholism or Drug Abuse Recovery or Treatment Facility as licensed by the Department of Alcoholism and Drug Programs.
- Patients discharged home with hospice care which is not arranged through a home health service.
- Patients who are homeless.

(b) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit within this reporting hospital.

DISCUSSION

See Examples 3, 4, and 5 at the end of this subsection.

Consolidated Hospital Submitting One Discharge Data Report:

Includes patients discharged from a TOC 3, 4, 5, or 6 bed to a TOC 1 bed.

(c) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit within this reporting hospital.

DISCUSSION

See example 11 at the end of this subsection.

Consolidated Hospital Submitting One Discharge Data Report:

Includes patients discharged from a:

- TOC 1 bed to a TOC 4, 5, or 6 bed.
- TOC 3 bed to a TOC 4, 5, or 6 bed.
- TOC 4 bed to a TOC 5 or 6 bed.
- TOC 5 bed to a TOC 4 or 6 bed.
- TOC 6 bed to a TOC 4 or 5 bed.

(d) Skilled Nursing/Intermediate Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

DISCUSSION

See Examples 6 and 7 at the end of this subsection.

Consolidated Hospital Submitting One Discharge Data Report:

Includes patients discharged from a:

- TOC 1 bed to a TOC 3 bed.
- TOC 4 bed to a TOC 3 bed.
- TOC 5 bed to a TOC 3 bed.
- TOC 6 bed to a TOC 3 bed.

This category includes patients discharged to:

- A skilled nursing bed for the Medi-Cal Subacute Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- A skilled nursing bed for the Medi-Cal Transitional Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An acute care bed that is used to provide skilled nursing care in an approved swing bed program.
- An Institution for Mental Disease (IMD). See Glossary of Terms and Abbreviations (Appendix A) for definition.
- A skilled nursing facility for hospice care.

(e) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of another hospital.

See Example 8 at the end of this subsection.

Disposition to this category are for discharges to the licensed bed type category "Acute Care" as defined by paragraph (1) Subdivision (a) of Section 1250.1 of the Health and Safety Code. This category includes patients discharged:

- Between two facilities of a consolidated hospital that has elected to submit two or more discharge data reports to OSHPD.
- To the ED or AS of another hospital with the intent of being admitted to that facility's acute care.
- To an acute care bed at an out-of-state, federal, or foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.
- To an acute care bed for the Medi-Cal Subacute Care Program of another acute care hospital. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- To an acute care bed for the Medi-Cal Transitional Care Program of another acute care hospital. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- To an acute care bed at a Long Term Acute Care Hospital (LTACH).

(f) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment at another hospital, not of a medical/surgical nature and not skilled nursing/intermediate care.

DISCUSSION

This category includes patients discharged:

- Between a consolidated hospital that has elected to submit two discharge data reports to OSHPD.
- To an acute care bed at an out of state, federal, or foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.
- To the ED or AS of another hospital with the intent of being admitted to that facility's psychiatric, rehabilitation, or chemical dependency care.

(g) Skilled Nursing/Intermediate Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within another hospital, or to a Congregate Living Health Facility, as defined by Subsection (i) of Section 1250 of the Health and Safety Code.

DISCUSSION

See Example 9 at the end of this subsection.

This category includes patients discharged:

- Between two facilities of a consolidated hospitals that have elected to submit two or more discharge data reports to OSHPD.
- To the ED or AS of another hospital with the intent of being admitted to that facility's skilled nursing care.
- To a skilled nursing bed at an out-of-state, federal, or foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.
- To a skilled nursing bed for the Medi-Cal Subacute Care Program at another facility. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- To a skilled nursing bed for the Medi-Cal Transitional Care Program at another facility. See Glossary of Terms and Abbreviations (Appendix A) for definition.

- To a skilled nursing facility for hospice care at another facility.
- To an acute care bed that is being used to provide skilled nursing care in an approved swing bed program at another facility.
- To an Institute for Mental Disease (IMD). See Glossary of Terms and Abbreviations (Appendix A) for definition.

(h) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

DISCUSSION

This category includes patients discharged to:

- Various types of facilities that provide supportive and custodial care. The 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).
- Mental Health Rehabilitation Centers (MHRC). See Glossary of Terms and Abbreviations (Appendix A) for definition.

(i) Prison/Jail. A patient discharged to a correctional institution.

DISCUSSION

This category includes patients discharged to juvenile hall.

(j) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from away without leave status (AWOL) are also included in this category.

(k) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(l) Home Health Service. A patient referred to a licensed home health service program.

DISCUSSION

This category includes patients discharged home with home health services.

See Example 10 at the end of this subsection.

(m) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a freestanding, not hospital-based, inpatient hospice facility.

DISCUSSION

This category includes:

- Patients sent to another facility's Emergency Department, Ambulatory Surgery, or freestanding Ambulatory Surgery Clinic for a significant procedure with the intent of returning to your facility.
- Patients sent to another facility's Emergency Department, Ambulatory Surgery, or freestanding Ambulatory Surgery Clinic for a significant procedure with the intent of going home following the procedure.

For patients sent to another facility's Emergency Department or Ambulatory Surgery with the intent of being admitted to the facility, please report 05, 06, or 07 as applicable based on the type of care to which the patient is being discharged.

ADDITIONAL DISCUSSION FOR <u>ALL</u> CATEGORIES

- **Skilled Nursing Bed Hold Days:** Skilled nursing **bed hold days are not reported** to OSHPD. A patient cannot be reported in two levels of care at the same time.

- **Mode of Transportation:** The mode of transporting a patient from one health facility to another is irrelevant to the patient's disposition.

- **Billing Requirements:** The use of coded information has become increasingly important in the health care reimbursement systems. This impacted the reporting of disposition codes, and codes for diagnoses, procedures, and E-codes to OSHPD.

  The Inpatient Data Reporting Requirements in California Code of Regulations cannot deal effectively with every billing requirement because the variations and rules are not consistent among insurers and because they change from time to time.

  The hospital should always apply the reporting requirements as specified in the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8, regardless of which reimbursement system is involved.

EXAMPLES OF DISPOSITION OF PATIENT

ROUTINE "OUTPATIENT SERVICES"

EXAMPLE 1

1. Laura was discharged from your hospital to a dialysis clinic for further treatment as an outpatient.

Q. How was Laura's Disposition reported?

A. Laura was discharged to "Routine," this should be reported by using "01" as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	1

EXAMPLES OF DISPOSITION OF PATIENT

ROUTINE "HOSPICE CARE"

EXAMPLE 2

2. Daniel was discharged home with hospice care (not ordered through Home Health Services.)

Q. How was Daniel's Disposition reported?

A. Daniel was discharged to "Home," this should be reported by using "01" as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	1

EXAMPLES OF DISPOSITION OF PATIENT

ACUTE CARE – WITHIN THIS HOSPITAL

EXAMPLE 3

3. Lucy was discharged from skilled nursing care at your hospital to an acute care bed at your hospital.

Q. How was Lucy's Disposition reported on the skilled nursing record?

A. Lucy was discharged to "Acute Care, Within Your Hospital," this should be reported by using "02", which is reported as shown below.

01 Routine (Home)	07 SN/IC	
Within This Hospital	08 Residential Care Facility	
02 Acute Care	09 Prison Jail	
03 Other Care	10 Against Medical Advice	
04 SN/IC	11 Died	
To Another Hospital	12 Home Health Service	
05 Acute Care	13 Other	0 2
06 Other Care (Not SN/IC)		

EXAMPLES OF DISPOSITION OF PATIENT

ACUTE CARE – WITHIN THIS HOSPITAL

EXAMPLE 4

For a **CONSOLIDATED HOSPITAL** that submits discharge data on **ONE REPORT** with one Facility Identification Number:

4. Alberto was discharged from skilled nursing care at your hospital to an acute care bed at your hospital.

Q. How was Alberto's disposition reported on the skilled nursing record?

A. Alberto was discharged to "Acute Care, Within Your Hospital." *Because your data is submitted on one report*; this should be reported by using "02" as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	2

EXAMPLES OF DISPOSITION OF PATIENT

ACUTE CARE – WITHIN THIS HOSPITAL

EXAMPLE 5

5. Riley was discharged from psychiatric care at your hospital to an acute care bed at your hospital.

Q. How was Riley's disposition reported on the psychiatric care record?

A. Riley was discharged to "Acute Care" within your hospital; this should be reported by using "02" as shown below.

01 Routine (Home)	07 SN/IC	
Within This Hospital	08 Residential Care Facility	
02 Acute Care	09 Prison Jail	
03 Other Care	10 Against Medical Advice	
04 SN/IC	11 Died	
To Another Hospital	12 Home Health Service	
05 Acute Care	13 Other	0 2
06 Other Care (Not SN/IC)		

EXAMPLES OF DISPOSITION OF PATIENT

SKILLED NURSING/INTERMEDIATE CARE – WITHIN THIS HOSPTIAL

EXAMPLE 6

6. Jenna was discharged from acute care at your hospital to a skilled nursing care bed at your hospital.

Q. How was Jenna's disposition reported on the acute care record?

A. Jenna was discharged to "To SN/IC, Within This Hospital"; this should be reported by using "04" as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	4

EXAMPLES OF DISPOSITION OF PATIENT

SKILLED NURSING/INTERMEDIATE CARE – WITHIN THIS HOSPITAL "HOSPICE CARE"

EXAMPLE 7

7. Vern was discharged from acute care at your hospital to a swing bed at your hospital for hospice care.

Q. How was Vern's Disposition reported on the acute care record?

A. Vern was discharged to "SN/IC, Within Your Hospital," this should be reported by using "04" as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	4

EXAMPLE OF DISPOSITION OF PATIENT

ACUTE CARE – ANOTHER HOSPITAL

EXAMPLE 8

8. Sarah was discharged from skilled nursing at your hospital to an acute bed at a Long Term Acute Care Hospital.

Q. How was Sarah's disposition reported on the skilled nursing record?

A. Sarah was discharged to "To Another Hospital, Acute Care." This should be reported by using "05" as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	5

*This example would also apply to a consolidated hospital that submits inpatient data on **two or more reports with separate Facility Identification Numbers**.

EXAMPLES OF DISPOSITION OF PATIENT

SKILLED NURSING/INTERMEDIATE CARE – ANOTHER HOSPITAL

EXAMPLE 9

9. Charlie was transferred from acute care at your hospital to skilled nursing at another hospital with or without hospice care.

Q. How was Charlie's Disposition reported on the acute care record?

A. Charlie was discharged to "SN/IC, Another Hospital," this should be reported by using "07", as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	7

EXAMPLE OF DISPOSITION OF PATIENT

HOME HEALTH SERVICE "HOSPICE CARE"

EXAMPLE 10

10. Mary was discharged home with hospice care ordered through a home health agency.

Q. How was Mary's Disposition reported?

A. Mary was discharged to "Home Health Service," this should be reported by using "12" as shown below. Home health care has a higher level of care and takes precedence over home.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

1	2

EXAMPLE OF DISPOSITION OF PATIENT

OTHER (PSYCHIATRIC) CARE – WITHIN HOSPITAL

EXAMPLE 11

11. Aaron was discharged from acute care of your hospital to a psychiatric bed at your hospital.

Q. How was Aaron's disposition reported on the acute record?

A. Aaron was discharged to "Within This Hospital, Other Care." This should be reported by using "03" as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

0	3

EXAMPLE OF DISPOSITION OF PATIENT

OTHER – ASC

EXAMPLE 12

12. Justin was discharged from acute care of your hospital to an Ambulatory Surgery Clinic (ASC).

Q. How was Aaron's disposition reported on the acute record?

B. Aaron was discharged to "Other." This should be reported by using 13 as shown below.

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	

1	3

EXPECTED SOURCE OF PAYMENT — Section 97232

(a) Effective with discharges on or after January 1, 1999, the patient's expected source of payment shall be reported using the following:

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

EXPECTED SOURCE OF PAYMENT

PAYER CATEGORY			TYPE OF COVERAGE		NAME OF PLAN
01 Medicare 02 Medi-Cal 03 Private Coverage 04 Workers' Compensation 05 County Indigent Programs	06 Other Government 07 Other Indigent 08 Self Pay 09 Other Payer	[ ][ ]	1 Managed Care - Knox – Keene/ MCOHS 2 Managed Care - Other 3 Traditional Coverage	[ ]	[ ][ ][ ][ ] (0001-9999 Plan Code Name)

DISCUSSION:

Valid combinations for reporting Expected Source of Payment

FOR PAYER CATEGORY	SELECT TYPE OF COVERAGE	NAME OF KNOX-KEENE (HMO) PLAN OR MCOHS PLAN
01, 02, 03, 04, 05, 06	1 Knox-Keene (HMO) or MCOHS Plan	Report valid plan code number (Refer to Table 1 and Table 2)
01, 02, 03, 04, 05, 06	2 Managed Care – Other (PPO, IPO, POS, etc.)	0000
01, 02, 03, 04, 05, 06	3 Traditional Coverage (Fee for Service)	0000
07, 08, 09	0 Not applicable	0000

(1) Payer Category: The type of entity or organization, which is expected to pay or did pay the greatest share of the patient's bill.

DISCUSSION:

This data element is defined as the source of payment that is expected, at the time of admission, to pay or did pay the greatest share of the patient's bill. Hospitals may report to OSHPD the most recent source of payment for patients with stays exceeding a year.

(A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(2) Type of Coverage.***

(B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(2) Type of Coverage.***

(C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, or Shriners.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(2) Type of Coverage.***

Automobile Insurance payments are included in this Payer Category.

(D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(2) Type of Coverage.***

(E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(2) Type of Coverage.***

(F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections (a)(1)(A), (a)(1)(B), (a)(1)(D), or (a)(1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section under ***(2) Type of Coverage.***

Report funds received as Federal reimbursement of emergency health services furnished to undocumented and other specified aliens as part of the Medicare Prescription Drug Improvement and Modernization Act (MMA) in this category as Type of Coverage Traditional fee-for-service.

Reimbursement through Victims of Violent Crimes is also reported in this category.

(G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (a)(1)(E) of this section.

DISCUSSION

This category is excluded from reporting Type of Coverage and Name of Plan. The Other Indigent record will have no Type of Coverage or Name of Plan to render payment. Use of Plan Code Number 8000, “Other”, is inappropriate because the Other Indigent patient does not have Knox-Keene (HMO) coverage. Unused numeric fields may be zero-filled.

(H) Self Pay. Payment directly by the patient, personal 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 health plan.

DISCUSSION

This category is excluded from reporting Type of Coverage and Name of Plan. The Self-Pay record will have no Type of Coverage or Name of Plan to render payment. Use of Plan Code Number 8000, "Other", is inappropriate because the Self-Pay patient does not have Knox-Keene (HMO) coverage. Unused numeric fields may be zero-filled.

(I) Other Payer. Any third party payment not included in Subsections (a)(1)(A) through (a)(1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

DISCUSSION:

This category is excluded from reporting Type of Coverage and Name of Plan. No payment will be required of patients reported as Other Payer. The record will have no Type of Coverage or Name of Plan to render payment. Use of Plan Code Number 8000, "Other", is inappropriate because the Other Payer patient does not have Knox-Keene (HMO) coverage. Unused numeric fields may be zero-filled.

Live organ donors are included in this payer category.

(2) Type of Coverage. For each Payer Category, Subsections (a)(1)(A) through (a)(1)(F) of this section, select one of the following Types of Coverage:

DISCUSSION

A Type of Coverage category must be selected when reporting the following Payer Categories:

- Medicare
- Medi-Cal
- Private Coverage
- Workers' Compensation
- County Indigent Programs
- Other Government

A Type of Coverage category is **not selected** when reporting the following:

- Other Indigent
- Self Pay
- Other Payer

(A) Managed Care - Knox-Keene/Medi-Cal County Organized Health System. Healthcare service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Corporations under the Knox-Keene Healthcare Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems.

DISCUSSION:

Plans and Plan Code numbers are listed in Table 1. Medi-Cal County Organized Health Systems (MCOHS) are listed in Table 2.

(B) Managed Care - Other. Health care plans, except those in Subsection (a)(2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Exclusive Provider Organization with Point-of-Service option (POS).

DISCUSSION:

This type of coverage should be reported for all non-HMO managed care.

(C) Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

(3) Name of Plan.

(A) Applies to 2003 and prior reporting periods. See Appendix E for complete text of regulation.

(B) For discharges occurring on or after January 1, 2004, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan or the Medi-Cal County Organized Health System as shown in Table 1.

DISCUSSION

A Name of Plan/Code Number from Table 1 must be selected when reporting the Managed Care – Knox-Keene (HMO)/Medi-Cal County Organized Health System (MCOHS) category of Type of Coverage.

Plan Code Number 8000 may be used only to report Knox-Keene Licensed Plans that are not listed because they obtained licensure after the table was created. Questions regarding appropriate Plan Code Numbers for unlisted Plans may be referred to your Patient Discharge Data Analyst. Plan Code Number 8000 should not be used to report PPO, EPO or other non-HMO coverage.

If no Knox-Keene (HMO) or MCOHS Plan is to be reported, the unused numeric fields may be zero-filled or they may be left unfilled.

Please report **only** California HMO's under Type of Coverage Managed Care Knox-Keene/MCOHS (1). Inpatient care covered by an out-of-state or a non-California HMO is reported as Managed Care-Other (2). Plan code for out-of-state or a non-California HMO is reported as 0000.

Table 1. Plan Code Numbers for Knox-Keene Licensed Plans and Medi-Cal County Organized Health Systems: For use with discharges occurring on or after January 1, 2004

Plan Names and Medi-Cal County Organized Health System Names	***Plan Code Numbers***
AET Health Care Plan Of California	***0296***
Aetna Health Plans of California, Inc.	***0176***
Alameda Alliance for Health	***0328***
American Family Care	***0322***
Avante Behavioral Health Plan	***0397***
Blue Cross of California	***0303***
Blue Shield of California	***0043***
Caloptima (Orange County)	***0394***
Care 1st Health Plan	***0326***

CareMore Insurance Services, Inc	***0408***
Cedars-Sinai Provider Plan, LLC	***0366***
Central Coast Alliance For Health (Santa Cruz County / Monterey County)	***0401***
Central Health Plan	***0404***
Chinese Community Health Plan	***0278***
Cigna Behavioral Health of California	***0298***
Cigna HealthCare of California, Inc.	***0152***
Community Health Group	***0200***
Community Health Plan (County of Los Angeles)	***0248***
Contra Costa Health Plan	***0054***
HAI, Hai-Ca	***0292***
Health Net of California, Inc.	***0300***
Health Plan of America (HPA)	***0126***
Health Plan of the Redwoods	***0159***
(The) Health Plan of San Joaquin	***0338***
Health Plan of San Mateo	***0358***
Heritage Provider Network, Inc.	***0357***
HHRC, Integrated Insights	***0319***
Holman Professional Counseling Centers	***0231***
Inland Empire Health Plan (IEHP)	***0346***
Inter Valley Health Plan	***0151***
Kaiser Foundation Health Plan, Inc.	***0055***
Kern Health Systems Inc	***0335***
Lifeguard, Inc.	***0142***
LA Care Health Plan	***0355***
Managed Health Network	***0196***
Medcore HP	***0390***
Merit Behavioral Care of California, Inc. (MBC)	***0288***
Molina Healthcare of California	***0322***
One Health Plan of California Inc.	***0325***
On Lok Senior Health Services	***0385***
PacifiCare Behavioral Health of California	***0301***
PacifiCare of California	***0126***
Primecare Medical Network, Inc.	***0367***
ProMed Health Care Administrators	***0380***
Regents of the University of California	***0354***
San Francisco Health Plan	***0349***
Santa Barbara Regional Health Authority	***0400***
Santa Clara Family Health Plan	***0351***
Santa Clara Valley Med. Ctr.	***0236***
SCAN Health Plan	***0212***

Scripps Clinic Health Plan Services, Inc.	***0377***
Secure Horizons	***0126***
Sharp Health Plan	***0310***
Simnsa Health Care	***0393***
Sistemas Medicos Nacionales, S.A. De C.V.	***0393***
Smartcare Health Plan	***0212***
Solano Partnership Health Plan (Solano County)	***9048***
The Health Plan of San Joaquin	***0338***
UHP Healthcare	***0008***
Universal Care	***0209***
U.S. Behavioral Health Plan, California	***0259***
Valley Health Plan	***0236***
ValueOptions of California, Inc.	***0293***
Ventura County Health Care Plan	***0344***
Vista Behavioral Health Plan	***0102***
Western Health Advantage	***0348***
Other	***8000***

(B) For discharges occurring on or after January 1, 2005 also include the additional plans listed.

Table 1. Plan Code Numbers for Knox-Keene Licensed Plans and Medi-Cal County Organized Health Systems: For use with discharges occurring on or after January 1, 2005

Plan Names and Medi-Cal County Organized Health System Names	**Plan Code Numbers**
Blue Cross of California Partnership Plan	**0415**
Great-West Healthcare of California, Inc.	**0325**
Honored Citizens Choice Health Plan, Inc.	**0414**

EXTERNAL CAUSE OF INJURY AND PRESENT ON ADMISSION INDICATOR **Section 97227**

(a) The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the 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 for 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 additional 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 discharge 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. 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.

(b) Effective with discharges on or after July 1, 2008, whether the patient's External Cause of Injury was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to determine whether the condition was present on admission or not.

(4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present on admission or not.

(5)(blank) Exempt from present on admission reporting.

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or before June 30, 2008.

PRINCIPAL E-CODE E ___ ___ ___ . ___

OTHER E-CODE
E ___ ___ ___ . ___
E ___ ___ ___ . ___
E ___ ___ ___ . ___
E ___ ___ ___ . ___

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after July 1, 2008.

PRINCIPAL E-CODE
E ___ ___ ___ ___

PRESENT ON ADMISSION
___

OTHER E-CODES
E ___ ___ ___ ___
E ___ ___ ___ ___
E ___ ___ ___ ___
E ___ ___ ___ ___

PRESENT ON ADMISSION
___
___
___
___

Y = Yes
N = No
U = Unknown
W = Clinically Undetermined
(blank) = Exempt from POA reporting

Reporting Requirements:

- 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 External Cause of Injury code fields.

Principal E-code: The principal E-code is 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 reported for when the injury, poisoning, and/or adverse effect was **first diagnosed and/or treated**.

Other E-codes:

- Defined as additional ICD-9-CM codes from the range E800-E999 necessary to completely describe the mechanisms that contributed to or the casual events surrounding the injuries, poisonings, or adverse effects.
- Include category E849 (place of occurrence) if documented in the medical record.

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.

Number of Other E-codes: Four other E-codes in addition to the principal E-code may be reported to OSHPD.

- When multiple E-codes are required to completely classify the cause(s), the principal E-code and up to three additional E-codes need to describe **how** it happened. If the principal E-code does not include a description of **where** it happened, report the E-code for the place of occurrence (E849.x) in the remaining field.

- 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. In either case, include the E-code for the place of occurrence (E849.x).

Examples

First New Event: Injury During the Stay:
If the patient attempts suicide with a drug overdose during the stay at Hospital A, the E-code(s) needs to be reported by Hospital A.

First New Event: Drug Reaction During the Stay:
If the patient has an adverse effect of a prescribed medication during the stay at Hospital A, the E-code(s) needs to be reported by Hospital A.

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 on the ED record of Hospital A.

Treated and Transferred:
If the patient was first treated and admitted to Hospital A and then transferred to Hospital B, the E-code(s) needs to be reported by Hospital A.

Parameters for Reporting Present on Admission on or after July 1, 2008:

Follow the reporting requirements in the Appendix "Present on Admission Reporting Guidelines" in the *ICD-9-CM Official Guidelines for Coding and Reporting*.

http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf

DISCUSSION

Domestic Violence, Abuse, and Neglect using Diagnosis and E codes

Domestic violence, abuse, and neglect are considered to be underreported and underdiagnosed. Community awareness of these circumstances is growing and there is a need for data collection on its incidence. Using this data, the healthcare communities can then develop solutions in helping both the victims and the perpetrators.

If the incident of domestic violence, abuse, or neglect is documented in the patient record, the ICD-9-CM classification system provide codes for:

- diagnosis of physical abuse, mental abuse, sexual abuse, and neglects (physical, emotional, educational, medical, or social) using the 995.5 and 995.8 series,
- specific associated injuries using 001-999 series,
- external causes for the nature of these incidents and the perpetrator using the assault E codes and the E967 series,
- past history of physical or emotional abuse using the V15.4 series, and
- counseling for victims and/or perpetrators using the V61.1-V61.2 series, and/or V62.83 code.

The codes for these incidences are assigned only when the physician documents the abuse, neglect, or domestic violence. The narrative descriptions should not be interpreted as abuse without the physician's confirmation. In accordance with the Penal Code and AMA reporting policy, physicians who suspect abuse should report it to the appropriate authorities.

Coding Clinic for ICD-9-CM published the Official Guidelines for Coding and Reporting in the 2nd Quarter 2002, pages 21-71 and 4th Quarter 2002, pages 115-182, in addition to the following:

Abuse/Neglect for Diagnosis and/or E Codes:
Refer to *Coding Clinic for ICD-9-CM*: 4th Quarter 1996, pages 38-45 and 77-78; 1st Quarter 1998, page 11; 4th Quarter 1995, pages 39-40; 4th Quarter 1996, pages 77-78; 3rd Quarter 1999, pages 14-16; and 4th Quarter 2000, page 62.

Questionable or Suspected or Rule Out or Uncertain Diagnosis:
Refer to *Coding Clinic for ICD-9-CM*: May-June 1984, page 4; March-April 1985, page 3; March-April 1986, page 8; 1st Quarter 1990, page 4 and 14; 1st Quarter 1991, pages 12-13; 4th Quarter 1995, pages 40 and 45-46; 4th Quarter 1996, pages 77-78; and 3rd Quarter 2001, page 17.

Unknown or Undetermined Cause:
Refer to *Coding Clinic for ICD-9-CM*: 4th Quarter 1995, pages 33-41; and 4th Quarter 1996, pages 77-78.

Penal Codes:
Refer to California Penal Code sections 11160-11163 for reporting injuries and sections 11164-11174 for reporting child abuse and neglect.

American Medical Association:
Refer to "Diagnostic and Treatment Guidelines on Elder Abuse and Neglect", issued in 1993 or any of AMA updated policies for reporting child or elder injuries to authorities at http://www.ama-assn.org/ama/pub/article/2036-5298.html.

Consent Manual by California Healthcare Association:
Refer to release of information without patient authorization when there is suspected child abuse and neglect [42 C.F.R. section 2.12(c)(6)]. Refer to statutory reporting requirements for abuse of elders or dependent adults [California Penal Code sections 288 and 368; Welfare and Institutions Code sections 15610 and 15630-15634}.

OTHER DIAGNOSES AND PRESENT ON ADMISSION INDICATOR **Section 97226**

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. 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.

(b) Effective with discharges on or after January 1, 1996, and until and including June 30, 2008, whether the patient's other diagnoses were present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

(c) Effective with discharges on or after July 1, 2008, whether the patient's other diagnosis was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admnission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to determine if the condition was present on admission.

(4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present on admission or not.

(5)(blank). Exempt from present on admission reporting.

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 discharges occurring on or before June 30, 2008:

PRINCIPAL DIAGNOSIS **PRESENT AT ADMISSION**

CODE

Y = Yes
N = No
U = Uncertain

OTHER DIAGNOSES **PRESENT AT ADMISSION**

a.
b.
c.
d.

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after July 1, 2008:

PRINCIPAL DIAGNOSIS **PRESENT ON ADMISSION**

CODE

Y = Yes
N = No
U = Uncertain
W= Clinically Undetermined
(blank) = Exempt from POA reporting

OTHER DIAGNOSES **PRESENT ON ADMISSION**

a.
b.
c.
d.

Reporting Requirements

Other Diagnoses:

Number of Other Diagnoses: Up to twenty-four other diagnoses may be reported to OSHPD. Discharge data becomes increasingly useful and valuable for research when all diagnoses that indicate risk factors are reported. Please report all relevant diagnoses.

Psychiatric Reporting: All other diagnoses (in Axis I, II, and III) either co-exist at the time of admission, develop subsequently during the stay, or affect the treatment received, or affect the length of stay. This includes medical conditions (in Axis III). In order to comply with the State's reporting requirements to OSHPD, these medical conditions should be reported. The medical conditions are listed as ICD-9-CM codes in Appendix G of DSM-IV codebook.

While it is true that outside providers treat medical conditions, psychiatric facilities, including PHFs, also provide ongoing healthcare of patients with chronic problems, such as hypertension, diabetes, seizures, or heart conditions with medications and monitor medical conditions. Refer to Title 22 for Licensing and Certification of Acute Psychiatric Hospitals or Psychiatric Health Facilities. The medical conditions under ongoing treatment or that coexist at the time of admission or develop during the stay should be reported to OSHPD. If medication reactions due to drugs (i.e., nausea, dizziness, depression, drowsiness, rapid heartbeat, rash) occur during the stay, these reactions should be reported along with E code(s) for the drug causing the medical reactions.

Other Coding Systems:

- Morphology Codes are not accepted by OSHPD.
- SNODO codes are not accepted by OSHPD.
- DSM-IV codes are not accepted by OSHPD.

ICD-9-CM Codes:

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

Duplicate diagnosis codes on the same inpatient discharge data record will not be accepted.

Conditions should be coded that affect patient care in terms of requiring:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

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 External Causes of Injury code fields.

Parameters for Reporting Present at Admission on or before June 30, 2008:

Each principal diagnosis and all other diagnoses must have an indicator for reporting whether or not a condition is present at admission by choosing one of the following responses:

Yes

No

Uncertain

The ICD-9-CM E-codes, External Causes of Injury and Poisoning, are excluded from this reporting requirement.

If the physician states that a condition is present (Y) or not present (N) at admission or is uncertain (U) whether or not the condition was present at admission, the physician's statement takes precedence over the following parameters.

A condition is considered present at admission if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress notes, initial nursing assessment, clinic/office notes).

When a condition is present prior to or at the time of the current inpatient admission, the indicator is reported yes (Y).

When a condition develops during the current inpatient admission and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No (N).

When it is not clearly indicated that a condition is present at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain (U).

Coding professionals will need to use their best judgment to determine whether or not a condition is present at the time of the current inpatient admission. If there is doubt as to whether or not the condition is present at admission, coding professionals are encouraged to ask the physician.

Indicators for Acute and Chronic Conditions:

Chronic conditions that may not have been identified prior to or at the time of the current inpatient admission would be considered to have been present at admission. The indicator for the chronic condition is reported Yes.

Example: Lung cancer discovered during admission 162.9 Y

When there are separate ICD-9-CM codes for some conditions that are described as both acute and chronic, the indicators are reported separately as follows:

If acute and chronic conditions are both present prior to or at the time of admission, these indicators are reported Yes.

Example: Acute and chronic bronchitis 466.0 Y and 491.9 Y, respectively

If an acute exacerbation of a chronic condition is identified during the current inpatient admission, the acute condition indicator is reported no and the chronic condition indicator is reported Yes.

Example: Acute and chronic bronchitis 466.0 N and 491.9 Y, respectively

When there are no separate ICD-9-CM codes for conditions that are described as both acute and chronic, the indicator is reported as follows:

If acute and chronic conditions are both present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: COPD with acute exacerbation 491.21 Y.

If an acute exacerbation of a chronic condition developed during the current inpatient admission, the indicator is reported No.

Example: Diabetes mellitus with ketoacidosis 250.10 N.

Indicators for signs and symptoms, rule out or suspected conditions, comparative/contrasting conditions, symptoms followed by comparative/ contrasting conditions, and abnormal findings:

If a sign or symptom is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Nausea with vomiting 787.01 Y.

If a suspected condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Rule out sepsis 038.9 Y.

If two or more comparative or contrasting conditions are present prior to or at the time of the current inpatient admission, the indicators are reported Yes.

Example: Diverticulitis versus appendicitis 562.11 Y and 541 Y, respectively.

If a symptom followed by comparative or contrasting conditions is present prior to or at the time of the current inpatient admission, all indicators are reported Yes.

Example: Chills, pneumonia versus bladder infection 780.99 Y, 486 Y, and 595.9 Y, respectively

If a threatened or impending condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Threatened abortion 640.03 Y.
Impending myocardial infarction 411.1 Y.

If an abnormal finding is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Hyponatremia 276.1 Y.

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Suspected postoperative infection 998.59 N.

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported uncertain.

Example: Possible urinary tract infection was diagnosed during the stay. Patient receiving antibiotics for cholecystitis prior to admission 599.0 U.

Indicators for Obstetrical Conditions:

If an antepartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported yes.

Example: Pregnancy with fetal distress 656.33 Y.

If a chronic condition during delivery is present prior to or at the time of the current inpatient admission, the indicator is reported yes.

Example: Pregnancy with diabetes, delivered 648.01 Y.

If a postpartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Third degree perineal laceration following delivery at home 664.24 Y.

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Postpartum fever, delivered 670.02 N.

If an acute condition develops during delivery and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No.

Example: Third degree perineal laceration during delivery 664.21 N.

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Delivery and breast abscess diagnosed during stay 675.11 U.

Indicators for V Codes:

If a V code identifies a birth or an outcome of delivery at the time of the current inpatient admission, the indicator is reported Yes.

Example: Newborn V30.00 Y.
Single liveborn infant V27.0 Y.

If a V code identifies the reason for admission at the time of the current inpatient admission, the indicator is reported Yes.

Example: Admission for chemotherapy V58.1 Y.

If a V code identifies a history or status at the time of the current inpatient admission, the indicator is reported Yes.

Example: Status colostomy V44.3 Y

If a V code identifies a problem that develops during the current inpatient admission, the indicator is reported No.

Example: Canceled surgery V64.1 N

If a V code identifies exposure to a communicable disease during the current inpatient admission, the indicator is reported No.

Example: Exposure to strep throat during current admission V01.89 N

If a V code identifies a situation and it is not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Family disruption V61.0 U

Parameters for Reporting Present on Admission on or after July 1, 2008:

Follow the reporting requirements in the Appendix "Present on Admission Reporting Guidelines" in the ICD-9-CM Official Guidelines for Coding and Reporting.

http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf

OTHER PROCEDURES AND DATES — Section 97229

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, or is needed for DRG assignment. Procedures shall be coded according to the ICD-9-CM. The dates shall be recorded with the corresponding other procedures and 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 with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after January 1, 2006:

PRINCIPAL PROCEDURES

CODE	DATE
	Month / Day / Year (4-Digit)

OTHER PROCEDURES

	CODE	DATE
a.		Month / Day / Year (4-Digit)
b.		
c.		
d.		

Reporting Requirements:

- A date will be reported for all other procedures reported. If the other procedure was performed on September 12, 2003, the reported value is 09122003.
- Other procedures and dates will be blank if no principal procedure is reported.

Significant Procedure: The definition of a significant procedure is one that is surgical in nature, or carries a procedural risk, carries an anesthetic risk or is needed for DRG assignment. According 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 specific definitions/guidelines should be used:

(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 should 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.

(4) **Affect DRG Assignment** - DRG Assignment (by OSHPD regulations) includes any procedure that would affect DRG assignment. The Federal Register publishes the annual changes for the DRG Grouper effective every October 1st. If a hospital has access to Appendix E of the *DRG Definitions Manual* or the Federal Register for changes to the Hospital Inpatient Prospective Payment Systems they can look for procedure codes that will impact the DRG assignment.

Some, not all Chapter 16 "Miscellaneous Diagnostic and Therapeutic" Procedures (ICD-9-CM code 87-99 range) meet the reporting requirements according to the regulations. Examples of some procedures from Chapter 16 are:

- Surgical risk would be manual rupture of joint adhesions (93.26)
- Anesthetic risk would be eye examination under anesthesia (95.04)
- Procedural risk would be insertion of endotracheal tube that can tear the tissues (96.04) or blood transfusion (99.ox series) that can introduce harmful bacterial.
- A DRG affecting procedures would be the alcohol/drug detoxification (94.6x) or mechanical ventilation (96.7x).

Other Coding Systems: HCPCS and CPT codes are not accepted by OSHPD on **inpatient** records.

Number of Other Procedures and Dates: Up to twenty other procedures and dates may be reported to OSHPD.

Ambulatory Surgery Facility and Hospital Outpatient Services: Patients are sometimes admitted within 72 hours of procedures performed in a licensed ambulatory surgery facility or as an outpatient at a hospital. Under certain circumstances, the ICD-9-CM procedure code(s) may be reported on the discharge data record. If so, the procedure date must be reported when it actually occurred and not be changed to the admission date. OSHPD accommodates procedure dates three days prior to the admission date.

PATIENT SOCIAL SECURITY NUMBER — Section 97220

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 discharges occurring on or after January 1, 2006:

PATIENT'S SOCIAL SECURITY NUMBER

(000 00 0001 if not recorded in the medical record)

Requirement for the Social Security Number (SSN) in Hospitals: Licensing and Certification of the Department of Public Health 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).

The SSN was added to the California Hospital Discharge Data Set (CHDDS) as an identifier to link episodes of care over time and across providers in order to support research addressing the quality of medical care in California hospitals. A unique personal identifier can also assist policy makers and researchers (e.g., number of patients admitted for a specific condition). OSHPD continues to consider the protection of individually identifiable medical information as the crux of its legislative mandate.

The SSN is confidential and is encrypted into a nine-digit alphanumeric identifier, the Record Linkage Number (RLN). The RLN is available only on nonpublic data sets and the SSN from which it is derived cannot be determined.

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

SSN for Patient Only:

- Mother's SSN should not be used for the newborn's SSN.
- Parent's SSN should not be used for a child's SSN.
- Husband's SSN should not be used for a wife's SSN.

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. Please refer to the current version of OSHPD's MIRCal Edit Guide for valid/invalid area identifier numbers.

Validation: Semiannually, OSHPD verifies the area (or state) digits with the local office of the Social Security Administration.

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.

Newborn Automatic Number Assignment (NANA): If parents choose to have a SSN automatically assigned to their newborn child, federal law requires the inclusion of at least one parent's SSN on the birth record. If neither parent has a SSN, the parents will be required to contact the Social Security Administration to verify this information.

PREHOSPITAL CARE AND RESUSCITATION / DNR (Do Not Resuscitate) — Section 97233

Effective with discharges on or after January 1, 1999, information about resuscitation orders in a patient's current medical record shall be reported as follows:

(a) Yes, a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital.

(b) No, a DNR order was not written at the time of or within the first 24 hours of the patient's admission to the hospital.

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 discharges occurring on or after January 1, 2006:

PREHOSPITAL CARE AND RESUSCITATION

DNR orders at admission or within 24 hrs of admission

Y = Yes
N = No

DISCUSSION

See Subsection (f) of Section 97212 of the California Code of Regulations for the definition of a DNR order.

A Do Not Resuscitate (DNR) order is a directive from a physician documented in a patient's current inpatient record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. The directive will be a physician's order, dated and signed. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following:

- cardiopulmonary resuscitation (CPR)
- intubation
- defibrillation
- cardioactive drugs
- assisted ventilation

If a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital and was then discontinued at some later time during the patient's hospital stay, report "Yes" to OSHPD. If the DNR order was written after the first 24 hours of admission, then report "No" to OSHPD.

A DNR order needs to be written for each type of care in order for it to remain in effect. A note in the medical record indicating "DNR remains in effect" is all that is required.

Example: Patient moves between two types of care on the same day.

Skilled Nursing stay	Acute Care stay	Skilled Nursing Stay
New DNR order	New DNR order	New DNR order

A DNR order needs to be noted for each type of care in order for "Yes" to be reported.

Advance Directives:
If an Advance Directive is in place but there is no DNR order, report "No" to OSHPD.

PRINCIPAL DIAGNOSIS AND PRESENT ON ADMISSION INDICATOR **Section 97225**

(a) The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-9-CM.

(b) Effective with discharges on or after January 1, 1996, and until and including June 30 2008, whether the patient's principal diagnosis was present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

(c) Effective with discharges on or after July 1, 2008, whether the patient's principal diagnosis was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admnission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to determine if the condition was present on admission.

(4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present on admission or not.

(5)(blank). Exempt from present on admission reporting.

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 discharges occurring on or before June 30, 2008:

PRINCIPAL DIAGNOSIS CODE | **PRESENT AT ADMISSION**

Y = Yes
N = No
U = Uncertain

OTHER DIAGNOSES | **PRESENT AT ADMISSION**

a.
b.
c.
d.

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after July 1, 2008:

PRINCIPAL DIAGNOSIS CODE | **PRESENT ON ADMISSION**

Y = Yes
N = No
U = Uncertain
W= Clinically Undetermined
(blank) = Exempt from POA reporting

OTHER DIAGNOSES | **PRESENT ON ADMISSION**

a.
b.
c.
d.

Principal Diagnosis:

Reporting Requirement: A principal diagnosis must be reported for every discharge data record.

Psychiatric Reporting: All psychiatric facilities are to report the principal diagnosis as the chief cause for admission for every discharge data record. The first listed diagnosis (in Axis I, II, or III) would be the principal diagnosis, if that is the reason for admission to the psychiatric facility. This includes medical conditions (in Axis III). In order to comply with the State's reporting requirements to OSHPD, these medical conditions should be reported. The medical conditions are listed as ICD-9-CM codes in Appendix G of DSM-IV codebook.

Other Coding Systems:

- Morphology Codes are not accepted by OSHPD.
- SNODO codes are not accepted by OSHPD.
- DSM-IV codes are not accepted by OSHPD.

ICD-9-CM Codes:

Refer to the official guidelines for coding and reporting the principal diagnosis 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 principal diagnosis code field. Such codes must only be reported in the External Causes of Injury code fields.

Italicized codes will never be the principal diagnosis.

Parameters for Reporting on discharges on or before June 30, 2008:

- Each principal diagnosis and all other diagnoses must have an indicator for reporting whether or not a condition is present at admission by choosing one of the following responses:

  Yes

  No

  Uncertain

- The ICD-9-CM E-codes, external causes of injury and poisoning, are excluded from this reporting requirement.

  If the physician states that a condition is present (Y) or not present (N) at admission or is uncertain (U) whether or not the condition was present at admission, the physician's statement takes precedence over the following parameters.

  A condition is considered present at admission if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes).

  When a condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes (Y).

  When a condition develops during the current inpatient admission and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No (N).

  When it is not clearly indicated that a condition is present at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain (U).

  Coding professionals will need to use their best judgment to determine whether or not a condition is present at the time of the current inpatient admission. If there is doubt as to whether or not the condition is present at admission, coding professionals are encouraged to ask the physician.

Assignment of Indicator for Principal Diagnosis:

- If the principal diagnosis indicator is blank, OSHPD will assign Yes (Y).
- If the error tolerance level for principal diagnosis indicators (invalids) is less than .1% after being corrected by the hospital, OSHPD will default the invalid indicators to Yes (Y).

Indicators for Acute and Chronic Conditions:

Chronic conditions that may not have been identified prior to or at the time of the current inpatient admission would be considered to have been present at admission. The indicator for the chronic condition is reported Yes.

Example: Lung cancer discovered during admission 162.9 Y

When there are separate ICD-9-CM codes for some conditions that are described as both acute and chronic, the indicators are reported separately as follows:

If acute and chronic conditions are both present prior to or at the time of admission, these indicators are reported Yes.

Example: Acute and chronic bronchitis 466.0 Y and 491.9 Y, respectively

If an acute exacerbation of a chronic condition develops during the current inpatient admission, the acute condition indicator is reported No and the chronic condition indicator is reported Yes.

Example: Acute and chronic bronchitis 466.0 N and 491.9 Y, respectively

When there are no separate ICD-9-CM codes for conditions that are described as both acute and chronic, the indicator is reported as follows:

If acute and chronic conditions are both present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: COPD with acute exacerbation 491.21 Y

If an acute exacerbation of a chronic condition developed during the current inpatient admission, the indicator is reported No.

Example: Diabetes mellitus with ketoacidosis 250.10 N

Indicators for signs and symptoms, rule out or suspected conditions, comparative/contrasting conditions, symptoms followed by comparative/contrasting conditions, and abnormal findings:

If a sign or symptom is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Nausea with vomiting 787.01 Y

If a suspected condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Rule out sepsis 038.9 Y

If two or more comparative or contrasting conditions are present prior to or at the time of the current inpatient admission, the indicators are reported Yes.

Example: Diverticulitis versus appendicitis 562.11 Y and 541 Y, respectively.

If a symptom followed by comparative or contrasting conditions is present prior to or at the time of the current inpatient admission, all indicators are reported Yes.

Example: Chills, pneumonia vs. bladder infection 780.99 Y, 486 Y, and 595.9 Y, respectively.

If a threatened or impending condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Threatened abortion 640.03 Y
Impending myocardial infarction 411.1 Y

If an abnormal finding is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Hyponatremia 276.1 Y

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Suspected postoperative infection 998.59 N

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Possible urinary tract infection was diagnosed during the stay. Patient receiving antibiotics for cholecystitis prior to admission 599.0 U

Indicators for Obstetrical Conditions:

If an antepartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Pregnancy with fetal distress 656.33 Y

If a chronic condition during delivery is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Pregnancy with diabetes, delivered 648.01 Y

If a postpartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Third degree perineal laceration following delivery at home 664.24 Y

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Postpartum fever, delivered 670.02 N

If an acute condition develops during delivery and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No.

Example: Third degree perineal laceration during delivery 664.21 N

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported uncertain.

Example: Delivery and breast abscess diagnosed during stay 675.11 U

Indicators for V Codes:

If a V code identifies a birth or an outcome of delivery at the time of the current inpatient admission, the indicator is reported Yes.

Example: Newborn V30.00 Y
Single liveborn infant V27.0 Y

If a V code identifies the reason for admission at the time of the current inpatient admission, the indicator is reported Yes.

Example: Admission for chemotherapy V58.1 Y

If a V code identifies a history or status at the time of the current inpatient admission, the indicator is reported Yes.

Example: Status colostomy V44.3 Y

If a V code identifies a problem that develops during the current inpatient admission, the indicator is reported No.

Example: Canceled surgery V64.1 N

If a V code identifies exposure to a communicable disease during the current inpatient admission, the indicator is reported No.

Example: Exposure to strep throat during current admission V01.89 N

If a V code identifies a situation and it is not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Family disruption V61.0 U

Parameters for Reporting Present on Admission on or after July 1, 2008:

Follow the reporting requirements in the Appendix "Present on Admission Reporting Guidelines" in the ICD-9-CM Official Guidelines for Coding and Reporting.

http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf

PRINCIPAL LANGUAGE SPOKEN — Section 97234

Effective with discharges occurring on or after January 1, 2009, the patient's principal language spoken shall be reporting using one of the following three alternatives:

(a) If the patient's principal language spoken is known and is included in the following list of alternatives, report the three letter code from the list:
See list below:

(b) Other. If the principal language spoken is known but is not listed in subsection (a), report the full name of the language.

(c) If the principal language spoken is unknown, report the three digit code 999.

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, 2009**:

PRINCIPAL LANGUAGE SPOKEN

ENG	English	HIN	Hindi	POL	Polish
ARA	Arabic	HUN	Hungarian	POR	Portuguese
ARM	Armenian	ITA	Italian	RUS	Russian
CHI	Chinese	JPN	Japanese	SCR	Serbo-Croatian
FRE	French	KOR	Korean	SPA	Spanish
CPF	French Creole	LAO	Laotian	TGL	Tagalog
GER	German	HMN	Miao, Hmong	THA	Thai
GRE	Greek	KHM	Mon-Khmer, Cambodian	URD	Urdu
GUJ	Guarathi	NAV	Navajo	VIE	Vietnamese
HEB	Hebrew	PER	Persian	YID	Yiddish
				999	Unknown

Reporting Requirements:

- Enter only **one** 3-digit value.
- You may use up to 24 alpha characters to report the full name of languages not already listed.
- Indicating more than one language designations is not allowed.

DISCUSSION

Principal Language would be the language the patient primarily uses in communicating with those in the health care community.

A child's language can be the language of the parent or caretaker used for communicating with the physician on the child's behalf.

PRINCIPAL PROCEDURE AND DATE — Section 97228

The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. The date the principal procedure was performed 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 with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after January 1, 2006:

PRINCIPAL PROCEDURE

CODE				**DATE**							
				Month		*Day*		*Year (4-Digit)*			

Reporting Requirement: The date of the principal procedure will be reported. If the principal procedure was performed on June 6, 2003, the reported value is 06062003.

Significant Procedure: The definition of a significant procedure is one that is surgical in nature, or carries a procedural risk, carries an anesthetic risk or is needed for DRG assignment. According 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 specific definitions/guidelines should be used:

(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 should 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.

(4) **Affect DRG Assignment** - DRG Assignment (by OSHPD regulations) includes any procedure that would affect MS-DRG assignment. The Federal Register publishes the annual changes for the DRG Grouper effective every October 1st. If a hospital has access to Appendix E of the *MS-DRG Definitions Manual* or the Federal Register for changes to the Hospital Inpatient Prospective Payment Systems they can look for procedure codes that will impact the MS-DRG assignment.

Some of the codes in Chapter 16 "Miscellaneous Diagnostic and Therapeutic" Procedures (ICD-9-CM code 87-99 range) meet the reporting requirements according to the regulations. Examples of some procedures from Chapter 16 are:

- Surgical risk would be manual rupture of joint adhesions (93.26)
- Anesthetic risk would be eye examination under anesthesia (95.04)
- Procedural risk would be insertion of endotracheal tube that can tear the tissues (96.04) or blood transfusion (99.ox series) that can introduce harmful bacterial.
- A MS-DRG affecting procedures would be the alcohol/drug detoxification (64.6x) or mechanical ventilation (96.7x).

Other Coding Systems: HCPCS and CPT codes are not accepted by OSHPD on **inpatient** records.

Ambulatory Surgery Facility and Hospital Outpatient Services: Patients are sometimes admitted within 72 hours of procedures performed in a licensed ambulatory surgery facility or as an outpatient at a hospital. Under certain circumstances, the ICD-9-CM procedure code may be reported on the discharge data record. If so, the procedure date must be reported when it actually occurred and not be changed to the admission date. OSHPD accommodates procedure dates three days prior to the admission date.

RACE **Section 97218**

Effective with discharges on January 1, 1995, the patient's ethnic and racial background shall be reported as one choice from the following list of alternatives under ethnicity and 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 discharges occurring on or after January 1, 2006:

RACE

ETHNICITY		RACE		
1 Hispanic		1 White	4 Asian/Pacific Islander	
2 Non-Hispanic		2 Black	5 Other	
3 Unknown		3 Native American/ Eskimo/Aleut	6 Unknown	

Race/Ethnicity data is most accurate when the patients are asked to identify their own race and ethnicity. Self-identification may include the use of a form displaying race/ethnicity choices. Data quality deteriorates when assumptions based on the patient's or a family member's name, physical appearance, place of birth, or primary language are the basis for the determination of race and ethnicity data.

(a) Ethnicity:

(1) Hispanic. A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

(2) Non-Hispanic.

(3) Unknown.

DISCUSSION

This category includes patients who cannot or refuse to declare ethnicity.

If the patient's ethnicity is not recorded in the patient's medical record, the patient's ethnicity should be reported as Unknown.

(b) Race:

(1) White. A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East.

(2) Black. A person having origins in or who identifies with any of the black racial groups of Africa.

(3) Native American/Eskimo/Aleut. A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

(4) Asian/Pacific Islander. A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

DISCUSSION

To bridge the gap between geography and specific names that may be used to describe Asians, the following is a list of Asian and Pacific Islander groups reported in the 2000 U.S. Census:

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian."

Asian Indian. Includes people who indicated their race as "Asian Indian" or identified themselves as Bengalese, Bharat, Dravidian, East Indian, or Goanese.

Chinese*.* Includes people who indicate their race as "Chinese" or who identify themselves as Cantonese, or Chinese American. In some census tabulations, written entries of Taiwanese are included with Chinese while in others they are shown separately.

Filipino*.* Includes people who indicate their race as "Filipino" or who report entries such as Philipino, Philipine, or Filipino American.

Japanese*.* Includes people who indicate their race as "Japanese" or who report entries such as Nipponese or Japanese American.

Korean*.* Includes people who indicate their race as "Korean" or who provide a response of Korean American.

Vietnamese*.* Includes people who indicate their race as "Vietnamese" or who provide a response of Vietnamese American.

Cambodian*.* Includes people who provide a response such as Cambodian or Cambodia.

Hmong*.* Includes people who provide a response such as Hmong, Laohmong, or Mong.

Laotian*.* Includes people who provide a response such as Laotian, Laos, or Lao.

Thai*.* Includes people who provide a response such as Thai, Thailand, or Siamese.

Other Asian*.* Includes people who provide a response of Bangladeshi, Bhutanese, Burmese, Indochinese, Indonesian, Iwo Jiman, Madagascar, Malaysian, Maldivian, Nepalese, Okinawan, Pakistani, Singaporean, Sri Lankan, or Other Asian specified and Other Asian, not specified.

Native Hawaiian and Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," and "Other Pacific Islander."

Native Hawaiian*.* Includes people who indicate their race as "Native Hawaiian" or who identify themselves as "Part Hawaiian" or "Hawaiian."

Guamanian or **Chamorro***.* Includes people who indicate their race as such, including written entries of Chamorro or Guam.

Samoan*.* Includes people who indicate their race as "Samoan" or who identify themselves as American Samoan or Western Samoan.

Other Pacific Islander*.* Includes people who provide a write-in response of a Pacific Islander group such as Carolinian, Chuukese (Trukese), Fijian, Kosraean, Melanesian, Micronesian, Northern Mariana Islander, Palauan, Papua New Guinean, Pohnpeian, Polynesian, Solomon Islander, Tahitian, Tokelauan, Tongan, Yapese, or Pacific Islander, not specified.

(5) Other. Any possible options not covered in the above categories.

DISCUSSION

This category includes patients who cite more than one race.

(6) Unknown.

DISCUSSION

This category includes patients who cannot or refuse to declare race.

If the patient's race is not recorded in the patient's medical record, the patient's race should be reported as Unknown.

ADDITIONAL DISCUSSION FOR ALL CATEGORIES

Determining Ethnicity and Race:

- 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 and race data may be most accurately obtained directly from the patient. Self-identification may include the use of a form presenting choices. A sample of a Race/Ethnicity form can be found in Appendix F of this Manual. Please note that the sample form is not required by OSHPD.
- The quality of ethnicity and 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 ethnicity and race.

Ethnicity and Race of a Newborn: The parent(s) declares the ethnicity and race of a newborn. If the parent(s) is unable or unwilling to declare the newborn's race, it is appropriate to report the ethnicity and race of the mother for that of the newborn.

Multiracial Persons:

If a patient identifies with more than one of OSHPD's race categories:

- 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."

Legality of Inquiring of patient's Race and/or Ethnicity:

There is no known law stating that it is illegal to ask patients for information on thier race and/or ethnicity. Section 97218 of the California Code of Regulations states "***the patient's ethnic and racial background shall be reported.***"

SEX — Section 97217

The patient's gender shall be reported as male, female, other, or unknown. "Other" includes sex changes, undetermined sex, and live births with congenital abnormalities that obscure sex identification. "Unknown" indicates that the patient's sex was 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 discharges occurring on or after January 1, 2006:

SEX

1 Male	3 Other	
2 Female	4 Unknown	

DISCUSSION

In general, whenever a diagnosis or procedure is sex specific, the reported sex needs to be consistent with the reported ICD-9-CM code.

Use "Other" when a patient is admitted for any procedure related to a sex change operation.

SOURCE OF ADMISSION — Section 97222

Effective with discharges on or after January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

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 discharges occurring on or after January 1, 2006:

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home	6 Other Inpatient Hospital Care		1 This Hospital		1 Your ER	
2 Residential Care Facility	7 Newborn		2 Another Hospital		2. Not Your ER (or no ER)	
3 Ambulatory Surgery	8 Prison/Jail		3 Not a Hospital			
4 SN/IC	9 Other					
5 Acute Inpatient Hospital Care						

(a) The site from which the patient was admitted.

(1) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

DISCUSSION

See Examples 1, 2, 3, 14, 15, 16, and 24 at the end of this section.

This category includes:

- Patients admitted from a home environment (e.g., half-way house, group home, foster care, women's shelter).
- Patients admitted from an Alcoholism or Drug Abuse Recovery or Treatment Facility as licensed by the Department of Alcoholism and Drug Programs.
- A mother who delivers at home and the baby born at home.

- Patients admitted from a site of involvement in an activity, apart from and to include their customary place of residence.

- Homeless persons, who by definition lack a residence, may appropriately be reported in this category.

- Psychiatric Emergency order (5150).

  When any person, as a result of mental disorder, is a danger to others, or to himself/herself, or gravely disabled, a peace officer, member of the attending staff, of an evaluation facility designated by the county, designated members of a mobile crisis team, or other professional person designated by the county may, upon probable cause, take the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. Staff who are authorized to write a psychiatric hold order (5150) can admit a patient without the patient's agreement.

  Refer to Section 5150 of the California Welfare and Institutions Code.

2) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

DISCUSSION

See Example 25 at the end of this section.

This category includes patients admitted from:

- Various types of facilities that provide supportive and custodial care. The facilities that 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).
- Mental Health Rehabilitation Centers (**MHRC**). Licensed by the California Department of Mental Health (**DMH**). The California DMH equates this designation to the California Department of Social Services designation of residential care facilities.

3) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

DISCUSSION

See Examples 17 and 18 at the end of the section.

This category includes patients admitted from an out-of-state, federal, or foreign licensed ambulatory surgical facility.

4) Skilled Nursing/Intermediate Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility, as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

DISCUSSION

See Examples 9, 10, 11, 12, and 13 at the end of the section.

This category includes patients admitted from:

- A skilled nursing bed for the Medi-Cal Subacute Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- A skilled nursing bed for the Medi-Cal Transitional Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An acute care bed that is used to provide skilled nursing care in an approved swing bed program.
- A California Department of Corrections (prison) skilled nursing facility.
- An out-of-state, federal, or foreign SNF/IC.
- An Institute for Mental Disease (IMD). See Glossary of Terms and Abbreviations (Appendix A) for definition.

5) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of a hospital.

DISCUSSION

See Examples 19 and 20 at the end of the section.

This category includes patients admitted from:

- A California Department of Corrections (prison) hospital.
- A Long Term Acute Care Hospital (LTACH).
- An acute care bed for the Medi-Cal Subacute Care Program at another hospital only. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An acute care bed for the Medi-Cal Transitional Care Program at another hospital only. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An out-of-state, federal, or foreign acute hospital.

6) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

DISCUSSION

See Examples 21, 22, and 23 at the end the section.

This category includes patients admitted from an out-of-state, federal, or foreign hospital providing non-acute care services.

7) Newborn. A baby born alive in this hospital.

DISCUSSION

See Example 8 at the end of the section.

This category includes newborns born in your hospital with a principal diagnosis code of V30-V39 with the fourth digit of 0.

This category excludes infants born before admission to hospital. See discussion under Source of Admission “Other”.

8) Prison/Jail. A patient admitted from a correctional institution.

DISCUSSION

This category includes patients admitted from juvenile hall.

This category excludes patients admitted from Department of Corrections (prison) hospitals. See discussion under Source of Admission Skilled Nursing and Acute Hospital Care.

9) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from a freestanding, not hospital-based, inpatient hospice facility.

DISCUSSION

See Examples 4, 5, 6, and 7 at the end of the section.

This category includes patients admitted directly from another hospital's Emergency Department.

This category also includes some infants born before admission to the hospital.

Born before admission to hospital includes, but is not limited to, an infant born at the following sites:

Automobile	<u>Your or another hospital's:</u>
Taxicab	* Emergency room
Ambulance	* Waiting room
Alternative Birthing Clinic	* Elevator
Physician's office	* Lobby
Retail store	
Outpatient clinic	

This category excludes infants born at home. See discussion under Source of Admission "Home" above.

(b) Licensure of the site.

DISCUSSION

The categories refer to whether the place from where the patient was admitted is included on the admitting hospital's license, some other hospital's license, or is not included in the license of any hospital.

If your facility's licensure is unknown, contact OSHPD.

If a site's licensure is unknown, ask someone at the site whether it is licensed as part of another hospital or whether it is freestanding.

A consolidated hospital that submits one report with one facility identification number would report "This Hospital" (1) when transferring to different types of care between facilities. See Example 12.

A consolidated hospital that submits under separate facility numbers would report Another Hospital (2) when transferring between consolidated facilities. See Example 13.

(1) This Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

DISCUSSION

See Examples 4, 8, 10, 12, 18, 19, 21, and 22 for licensure of site at the end of this section.

This category also includes babies born in your hospital's ER before admission to hospital. See Example 4.

This category includes patients admitted from a consolidated hospital that has elected to submit one discharge data report to OSHPD. Admitted from a:

- TOC 1 bed to a TOC 3, 4, 5, or 6 bed.
- TOC 3 bed to a TOC 1, 4, 5, or 6 bed.
- TOC 4 bed to a TOC 1, 3, 5, or 6 bed.
- TOC 5 bed to a TOC 1, 3, 4, or 6 bed.
- TOC 6 bed to a TOC 1, 2, 3, or 5 bed.

(2) Another Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

DISCUSSION

See Examples 6, 9, 13, 20, and 23 for licensure of site at the end of this section.

This category includes:

- Patients admitted from a consolidated hospital that has elected to submit separate discharge data reports to OSHPD for each facility. See Example 13.
- Babies born in another hospital's ED before admission to your hospital. See Example 6.
- Patients admitted directly from another hospital's Emergency Department or Ambulatory Surgery.
- Patients admitted from another state, a federal, or a foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.

(3) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Skilled Nursing/Intermediate Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

DISCUSSION

See Examples 1, 2, 3, 5, 7, 11, 14, 15, 16, 17, 24, and 25 for licensure of site at the end of the section.

This category includes patients admitted from:

Home
Street
Residential Care Facility
Freestanding nursing home
Freestanding licensed ambulatory surgery facility
ABCs or other outpatient clinic
Automobile
Taxicab
Ambulance
Retail Store
Physician's Office
Prison/Jail

Your or another hospital's:
Waiting room
Elevator
Lobby
Parking lot

(c) Route of admission.

(1) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of another hospital.

DISCUSSION

See Examples 1, 2, 4, 7, 9, 14, 15, and 17 for route of admission at the end of the section.

(2) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

DISCUSSION

See Examples 3, 5, 6, 8, 10, 11, 12, 13, 16, 18, 19, 20, 21, 22, 23, 24, and 25 for route of admission at the end of the section.

EXAMPLES OF SOURCE OF ADMISSION (SOA)

OTHER HOSPITAL'S EMERGENCY ROOM

1. Jane arrives at Hospital A and was seen in the ER. She was referred to your hospital, was seen in Your ER, and admitted. What was Jane's Source of Admission at your hospital?

   Since Jane was first seen in another hospital's ER, Report "Other" (9), "Another Hospital" (2), and "Your ER" (1)

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	9	1 This Hospital 2 Another Hospital 3 Not a Hospital	2	1 Your ER 2. Not Your ER (or no ER)	1

2. John was a homeless man who arrived at Hospital A and was seen in the Emergency Room (ER). Hospital A arranged for John to be admitted to your hospital. He was sent to your hospital by ambulance and directly admitted. What was John's Source of Admission at your hospital?

   Since Jane was first seen in another hospital's ER and then directly admitted, Report "Other" (9), "Another Hospital" (2), and "Not Your ER" (2)

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	9	1 This Hospital 2 Another Hospital 3 Not a Hospital	2	1 Your ER 2. Not Your ER (or no ER)	2

EXAMPLES OF SOURCE OF ADMISSION (SOA)

INFANT BORN AT HOME

3. Alex was born at home. Alexis and his mother were taken by ambulance to your hospital and admitted.

   Q. What was Alex's Source of Admission at your hospital?

   A. Alex's SITE would be "Home" (1). "Home" is an unlicensed location so the LICENSURE OF SITE would be "Not a Hospital" (3). Alex was not seen in your ER so ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	2

EXAMPLES OF SOURCE OF ADMISSION (SOA)

INFANT BORN EN ROUTE BEFORE ADMISSION

4. Sue was born in the ER at your hospital before her mother is admitted. Sue was admitted to the nursery.

   Q. What was Sue's Source of Admission at your hospital?

   A. Her SITE would be "Other" (9) because Sue was born within the hospital but before admission (refer to the definition of "Other"). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Your ER" (1), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	9	1 This Hospital 2 Another Hospital 3 Not a Hospital	1	1 Your ER 2. Not Your ER (or no ER)	1

5. Jacob was born in a taxicab. He is seen in your ER and admitted to your hospital.

   Q. What was Jacob's Source of Admission at your hospital?

   A. His SITE would be "Other" (9) because Jacob was born before admission to the hospital (refer to the definition of "Other"). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	9	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

EXAMPLES OF SOURCE OF ADMISSION (SOA)

INFANT BORN EN ROUTE BEFORE ADMISSION

6. Carol was born in the ER of Hospital A which does not have a perinatal unit. Carol was transferred to your hospital and admitted directly to the nursery.

   Q. What was Carol's Source of Admission at your hospital?

   A. Her SITE would be "Other" (9) because Carol was born before admission to the hospital (refer to the definition of "Other"). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	9	1 This Hospital 2 Another Hospital 3 Not a Hospital	2	1 Your ER 2. Not Your ER (or no ER)	2

7. Nathan was born in his parents' automobile on the way to the hospital. He was seen in your ER and admitted.

   Q. What was Nathan's SOA at your hospital?

   A. His SITE would be "Other" (9) because Nathan was born before admission to the hospital (refer to the definition of "Other"). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	9	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

EXAMPLES OF SOURCE OF ADMISSION (SOA)

NEWBORN, BORN IN HOSPITAL

8. Jessica was admitted to your hospital and delivered twins by C-section.

   Q. What was the SOA for each newborn twin at your hospital?

   A. Each twin's SITE would be "Newborn" (7) after the mother was admitted. The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care 6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	**7**	1 This Hospital 2 Another Hospital 3 Not a Hospital	**1**	1 Your ER 2. Not Your ER (or no ER)	**2**

SKILLED NURSING / INTERMEDIATE CARE

9. June was an inpatient in a nearby skilled nursing facility. She complains of abdominal pain. She was taken to your hospital, examined in the ER, and admitted to acute care.

   Q. What was June's Source of Admission at your hospital?

   A. June's SITE would be "SN/IC" (4). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Your ER" (1), as shown below.

SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care 6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	**4**	1 This Hospital 2 Another Hospital 3 Not a Hospital	**3**	1 Your ER 2. Not Your ER (or no ER)	**1**

EXAMPLES OF SOURCE OF ADMISSION (SOA)

SKILLED NURSING / INTERMEDIATE CARE

10. Julie was an inpatient in the skilled nursing of your hospital. She complains of pain and was transferred to acute care at your hospital.

Q. What was Julie's Source of Admission for her acute care record at your hospital?

A. Julie's SITE would be "SN/IC" (4). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	4	1 This Hospital 2 Another Hospital 3 Not a Hospital	1	1 Your ER 2. Not Your ER (or no ER)	2

11. Roger was an inpatient in a freestanding nursing home. He was taken to Hospital A and seen in the ER. Roger should be admitted but Hospital A is full and is transferred to your hospital. At your hospital, Roger was admitted directly to acute care.

Q. What was Roger's Source of Admission for his acute care record at your hospital?

A. Roger's SITE would be "SN/IC" (4). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), as shown below. (Roger was not admitted to Hospital A, so his SITE would be the nursing home. His ER visit at Hospital A cannot be reported as ER at your hospital).

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	4	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	2

EXAMPLES OF SOURCE OF ADMISSION (SOA)

SKILLED NURSING / INTERMEDIATE CARE – CONSOLIDATED, ONE REPORT

A **CONSOLIDATED HOSPITAL** that submits **ONE REPORT** with one Facility Identification Number:

12. Isabel was an inpatient in the skilled nursing facility of your hospital. She was transferred to acute care at your hospital.

Q. What was Isabel's Source of Admission for her acute care record at your hospital?

A. Isabel's SITE would be "SN/IC" (4). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	4	1 This Hospital 2 Another Hospital 3 Not a Hospital	1	1 Your ER 2. Not Your ER (or no ER)	2

SKILLED NURSING / INTERMEDIATE CARE – CONSOLIDATED, TWO REPORTS

For a CONSOLIDATED HOSPITAL that submits TWO OR MORE REPORTS with separate Facility Identification Numbers:

13. Jason was an inpatient in the skilled nursing facility of your hospital. He was transferred to acute care at your hospital.

Q. What was Jason's Source of Admission for his acute care record at your hospital?

A. Jason's SITE would be "SN/IC" (4). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	4	1 This Hospital 2 Another Hospital 3 Not a Hospital	2	1 Your ER 2. Not Your ER (or no ER)	2

EXAMPLES OF SOURCE OF ADMISSION (SOA)

HOME

14. Shantelle had outpatient surgery at a free-standing licensed Ambulatory Surgery Center (**ASC**) and returned home. Later she arrived in your ER and was admitted. What was Shantelle's Source of Admission at your hospital?

    A. Shantelle's SITE would be "Home" (1). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), as shown below.

    The prior visit to the ASC would not be reported on inpatient record at your hospital.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

15. Ray was an inpatient at Hospital A and was discharged home. Later Ray was seen in your ER and is admitted as an inpatient. What was Ray's Source of Admission at your hospital?

    A. Ray's SITE would be "Home" (1). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

EXAMPLES OF SOURCE OF ADMISSION (SOA)

OBSERVATION

16. Tonya was an outpatient in the observation unit of your hospital. Later she was admitted to acute care at your hospital. What was Tonya's Source of Admission at your hospital?

    A. Tonya's SITE would be "Home" (1). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	2

AMBULATORY SURGERY

17. During Chelsea's surgery at a licensed Ambulatory Surgery Center where complications developed, she was transported to the ER of your hospital, and was admitted. What was Chelsea's Source of Admission at your hospital?

    A. Chelsea's SITE would be "Ambulatory Surgery" (3). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	3	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

EXAMPLES OF SOURCE OF ADMISSION (SOA)

AMBULATORY SURGERY

18. During surgery at Hospital A's licensed Ambulatory Surgery facility, Sara had an adverse reaction and was admitted to the Intensive Care Unit at your hospital.

Q. What was Sara's Source of Admission at your hospital?

A. Sara's SITE would be "Ambulatory Surgery" (3). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care 6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	3	1 This Hospital 2 Another Hospital 3 Not a Hospital	1 Your ER 2. Not Your ER (or no ER)
		2	2

ACUTE INPATIENT HOSPITAL CARE

19. Jacob, an inpatient in your acute care, was transferred to the skilled nursing distinct part of your hospital.

Q. What was the Source of Admission on Jacob's skilled nursing record at your hospital?

A. Jacob's SITE would be "Acute Inpatient Hospital Care" (5). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care 6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	5	1 This Hospital 2 Another Hospital 3 Not a Hospital	1 Your ER 2. Not Your ER (or no ER)
		1	2

EXAMPLES OF SOURCE OF ADMISSION (SOA)

ACUTE INPATIENT / LTACH

20. Thomas was transferred from acute care at a Long Term Acute Care Hospital to your hospital.

Q. What was Thomas's Source of Admission at your hospital?

A. Thomas's SITE would be "Acute Inpatient Hospital Care" (5). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	5	1 This Hospital 2 Another Hospital 3 Not a Hospital	2	1 Your ER 2. Not Your ER (or no ER)	2

REHABILITATION / OTHER INPATIENT HOSPITAL CARE

21. Sally was receiving inpatient physical rehabilitation care in your hospital. She is transferred to acute care at your hospital.

Q. What was the Source of Admission on Sally's acute care record at your hospital?

A. Sally's SITE would be "Other Inpatient Hospital Care" (6). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	6	1 This Hospital 2 Another Hospital 3 Not a Hospital	1	1 Your ER 2. Not Your ER (or no ER)	2

EXAMPLES OF SOURCE OF ADMISSION (SOA)

PSYCHIATRIC / OTHER INPATIENT HOSPITAL CARE

22. Jack was receiving psychiatric care at your hospital. He was transferred to acute care at your hospital.

    Q. What was the Source of Admission on Jack's acute care record at your hospital?

    A. Jack's SITE would be "Other Inpatient Hospital Care" (6). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care 6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	**6**	1 This Hospital 2 Another Hospital 3 Not a Hospital	**1**	1 Your ER 2. Not Your ER (or no ER)	**2**

23. A Psychiatric Hospital transferred Ralph to your hospital, where he was admitted to acute care. What was the Source of Admission on Ralph's acute care record at your hospital?

    A. Ralph's SITE would be "Other Inpatient Hospital Care" (6). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care 6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	**6**	1 This Hospital 2 Another Hospital 3 Not a Hospital	**2**	1 Your ER 2. Not Your ER (or no ER)	**2**

EXAMPLES OF SOURCE OF ADMISSION (SOA)

PSYCHIATRIC / EMERGENCY ORDER (5150)

24. Steve was admitted to your hospital for psychiatric emergency treatment (5150) after being brought in by law enforcement.

Q. What was Steve's Source of Admission at your hospital?

A. Steve's SITE would be "Home" (1). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	2

RESIDENTIAL CARE FACILITY

25. Bailey lived in a Residential Care Facility. He was admitted to inpatient care at your hospital.

Q. What was the Source of Admission on Bailey's inpatient record at your hospital?

A. Bailey's SITE would be "Residential Care Facility" (2). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), as shown below.

SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	2	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	2

TOTAL CHARGES — Section 97230

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), report Total Charges for the last year (365 days) of stay only.

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 discharges occurring on or after January 1, 2006:

16. TOTAL CHARGES

(Report whole dollars only, right justified)

Reporting Requirements:

When there are no charges (**no bill generated**) for the hospital stay, $1 should be reported.

Charges should be rounded to the nearest dollar.

Charges for newborns must be reported on the newborn's discharge data record and excluded from the mother's discharge data record.

Total Charges are the amount billed for the stay at full established rates (before contractual adjustments).

Examples of charges to be **included**:

Daily hospital services
Ancillary services
Other services defined as patient care
Prepayments (e.g., deposits and prepaid admissions)
Bundled ambulatory surgery, outpatient, and/or observation charges
Late revenue adjustments

Examples of charges to be **excluded**:

- Hospital-based physician fees
- Medicare bed hold charges for skilled nursing care
- Television
- Telephone
- Guest trays
- Take-home drugs
- Video cassette recorder
- Follow-up home health visits

Patient Length of Stay: This is calculated by subtracting the Admission Date from the Discharge Date. A patient admitted and discharged on the same day is calculated as one day.

Patient Charges per Day: This is calculated by dividing the reported Total Charges by the Length of Stay.

Length of Stay Greater than 365 Days:

Only total charges for the final 365 days are to be reported.

OSHPD divides reported total charges by 365 to find the average charge per day. This average charge per day is then multiplied by the length of stay. The result is the adjusted total charges, which is the amount appearing in OSHPD publications.

Seven Digit Format:
OSHPD's standard format and specifications for reporting total charges requires seven digits (0000000 through 9999999); this allows a maximum charge for one patient of $9,999,999. If the field size is less than seven digits, a total charge of $99,999 or $999,999 indicates to OSHPD that the charges exceed the field size utilized by the hospital or designated agent.

Physician Professional Component:
When the hospital bills patients for physician services and remits a fee to the physician, whether the fee is in the form of a salary or a percentage of the total charges, the fee must be excluded from total charges. This is necessary in order to obtain comparability of charge data on all hospitals.

Total Charges: Each episode of inpatient care must be reported.

Patient's Charge per Day: This is calculated by dividing the reported Total Charges by the Length of Stay

Transfer Within the Hospital: Transfers between Types of Care within the Hospital must be reported to OSHPD as two or more separate discharge data records, including separate total charges.

Total Package:
A person admitted for a course of treatment (e.g., for psychological problems, substance abuse treatment, treatment of an eating disorder) is told that the payment covers the total package for all treatments and any later need for inpatient care for the same purpose (within a certain period of time). After the patient is discharged, a discharge record must be reported. If the patient is readmitted, another discharge record must be reported when the patient leaves the hospital, even if no additional charge will be made to the patient. The second and any subsequent record for this course of treatment would report total charges of $1 (no charge) to OSHPD.

Live Organ Donors:
When a (live) person is admitted for the purpose of donating an organ, a discharge data record must be reported whether or not a charge is made. If no charge is made, report total charges of $1 (no charge).

Interim Billing:
Some hospitals have a policy, for billing purposes, of discharging and readmitting their extended stay patients at the end of each month. Only one discharge data record must be reported to OSHPD. That one record must include charges for all days of inpatient care.

TYPE OF ADMISSION **Section 97223**

Effective with discharges on January 1, 1995, the patient's type of admission shall be reported using one of 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 discharges occurring on or after January 1, 2006:

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

(c) Scheduled. Admission was arranged with the hospital at least 24 hours prior to the admission.

DISCUSSION

See Examples 1 and 2 at the end of this section.

An admission is scheduled when arrangements are made 24 hours or more before the admission.

Pre-admission forms filled out by the patient or family and sent to the hospital do not constitute a scheduled admission; see Type of Admission (TOA) Example 3.

(d) Unscheduled. Admission was not arranged with the hospital at least 24 hours prior to the admission.

DISCUSSION

See Examples 3, 4, 5, and 6 at the end of this section.

An admission is unscheduled when arrangements are made less than 24 hours before the admission.

Pre-admission forms filled out by the patient or family and sent to the hospital do not constitute a scheduled admission; see Type of Admission (TOA) Example 3.

(e) Infant. An infant less than 24 hours old.

DISCUSSION

See Examples 7 and 8 at the end of this section.

This category includes newborns and all other neonates less than 24 hours old. All records with the date of birth the same as the admission date must be reported as infant.

A patient with a date of birth two or more days before the admission date should not be reported as infant.

(f) Unknown. Nature of admission not known. Does not include stillbirths.

DISCUSSION

See Example 9 at the end of this section.

This category includes patients whose TOA cannot be determined as either scheduled or unscheduled.

EXAMPLES FOR TYPE OF ADMISSION

SCHEDULED

1. Helen is expected to deliver on April 1. Her physician schedules her admission for April 3 to induce labor. She is admitted on April 3. Report "Scheduled."

2. Henry is seen by his physician on March 15, and upon examination at 9:00 a.m. on March 15, it is determined that a cholecystectomy is necessary. He is scheduled for a cholecystectomy at 1:00 p.m. on March 16. He is admitted at 11:00 a.m. on March 16 for the scheduled cholecystectomy. Report "Scheduled."

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

1

EXAMPLES FOR TYPE OF ADMISSION

UNSCHEDULED

3. June is expected to deliver on April 1. She goes to the hospital in labor and is admitted on that date. Even though the pre-admission forms may have been filled out months previously, report "Unscheduled."

4. At 2:00 p.m. on March 14, Jack is examined, and it is determined that admission is necessary. He is scheduled for admission at 4:00 p.m. on March 15. Complications develop, and Jack is admitted at 11:00 a.m. on March 15. Report "Unscheduled."

5. Jason is scheduled two weeks in advance for surgery at your hospital's licensed ambulatory surgery facility. After surgery, complications develop in the recovery area, and he is admitted to inpatient care. Report "Unscheduled" on the inpatient care record.

6. On December 22, at 10:00 a.m., Mary's physician called the skilled nursing facility and made arrangements to transfer her from acute care at the hospital on December 23, at 2:00 p.m. On December 22, Mary is transferred to the skilled nursing facility at 4:00 p.m. because a bed became available early. Report "Unscheduled" on the skilled nursing facility care record.

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

2

EXAMPLES FOR TYPE OF ADMISSION

INFANT

7. Heather is born at Hospital A and immediately (within 24 hours) is transferred to Hospital B's NICU. Both Hospital A and Hospital B report Infant.

8. Elmeta is born at home on July 10, at 3:00 a.m. On July 10, she develops jaundice and is admitted to the hospital at 11:00 p.m. Report Infant.

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

3

EXAMPLES FOR TYPE OF ADMISSION

UNKNOWN

9. Donna presents to the admitting office and states that her physician had previously scheduled her admission. The patient's information is in the reservation log; however, neither the date nor the time the call was taken is recorded. Report Unknown.

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

4

ZIP CODE **Section 97219**

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 patient discharge. Foreign residents shall be reported as "YYYYY" and unknown ZIP Codes shall be reported as "XXXXX." If the city of residence is known, but not the street address, report the first three digits of the ZIP Code, and the last two digits as zeros. Hospitals shall distinguish the "homeless" (patients who lack a residence) from other patients lacking a numeric ZIP Code of residence by reporting the ZIP Code of homeless patients as "ZZZZZ." If the patient has a 9-digit ZIP Code, only the first five digits shall be reported.

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 discharges occurring on or after January 1, 2006:

5. ZIP CODE

Reporting Requirements:

- The ZIP Code of the usual residence of the patient must be reported.
- Report visitors from a foreign country as YYYYY.
- Report an unknown residence as XXXXX.
- Report homeless persons as ZZZZZ.
- If the city is known, but not the street, report the first three digits for the city and the last two digits as zero. Example: Sacramento, California, 95800.
- 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.