Sec. 19a-167g-94. The uniform reporting of discharge abstract and billing data

For the purpose of sections 3, 4, 5, 8, 12, 18, and 29 of public act 89-371, and section 11 of public act 90-134, the following section shall be used to report discharge abstract and billing data in fiscal year 1991 and thereafter. The provisions of this section shall supersede the provisions of 19a-165q-2 of the integrated prospective payment system regulations.

(a) **Definitions.**For the purpose of this section and except as otherwise noted, the following words and phrases are defined below:

(1) "Agent" means a person or entity which has entered into an agreement or contract with the commission to perform administrative, processing, management, analytical, evaluative, or other related services with the data collected pursuant to this section.

(2) "Current hospitalization" or "hospitalization being recorded" refers to that episode of hospitalization defined by the patient's admission and discharge dates and the medical record number and patient control number associated with that episode. All the data being submitted by the hospital concerning the patient's hospitalization relate to this episode of hospitalization.

(3) "Discharge" is defined according to subdivision 19a-167g-55 (b) (22).

(4) "Patient identification" means the unique designation or number assigned to each patient within a hospital that distinguishes by itself the medical record of an individual patient from the medical record of all other patients in that institution.

(5) "Patient control number" means the unique designation or number assigned by the hospital to each patient's individual hospitalization that distinguishes by itself the medical and billing records of that hospitalization.

(6) "Date of birth" means the month, day, and year on which the patient whose hospitalization is being recorded was born.

(7) "Date of admission" means the month, day, and year on which the patient whose hospitalization is being recorded was admitted to the hospital.

(8) "Date of discharge" means the month, day, and year on which the patient whose hospitalization is being recorded was discharged from the hospital.

(9) "Sex" means a designation of the patient as:

designation	code
(A) Male	=M
(B) Female	=F
(C) Not determined	=U

The category "not determined" may only be used in rare instances where the sex of the patient either has not been or cannot be determined at the time of discharge.

(10) "Zip code" means the zip code of the post office where the patient customarily receives mail. If the patient resides outside the United States or its territories, the zip code shall be "99998."

(11) "Race" means a designation of the patient according to the categories listed below. For the purpose of reporting this information to the commission as part of this data set, each category is assigned the numeric codes listed below:

category	code

(A) White	=1
(B) Black	=2
(C) American Indian/Eskimo/Aleut	=3
(D) Hawaiian/Pacific Islander	=4
(E) Asian	=5
(F) Other Non-white	=6
(G) Unknown	=0

(12) "Ethnicity" refers to the patient's cultural origin. The patient must be classified into one of the categories of ethnicity listed below. For the purpose of reporting this information to the commission as part of this data set, each ethnic category is assigned the numeric codes listed below:

category	code
(A) Spanish origin/Hispanic	=1
(B) Non-Spanish origin/Non-Hispanic	=2

(13) "Previous admission" refers to the length of time between the date of admission for the hospitalization being recorded and the date of discharge for the patient's most recent previous inpatient hospitalization. For the purpose of reporting this information to the commission as part of this data set, the categories of previous admission are assigned the numeric codes listed below:

category	code
(A) Less than 31 days	=1
(B) More than 30 but less than 61 days	=2
(C) More than 60 but less than 91 days	=3
(D) More than 90 but less than 181 days	=4
(E) More than 180 days	=5
(F) No previous hospitalization	=6
(G) Unknown	=7

(14) "Hospital ID code" refers to the last four digits of the hospital's Medicare provider number for the unit from which the patient was discharged for the hospitalization being recorded.

(15) "Attending practitioner" means the physician, surgeon, homeopath, dentist, podiatrist, chiropractor, osteopath, or psychologist who was primarily responsible for the patient's care during the hospitalization being recorded. The attending practitioner will be designated by the hospital using the unique code established pursuant to subsection (e) of this section.

(16) "Operating practitioner" means the physician, surgeon, homeopath, dentist, podiatrist, chiropractor, osteopath, or psychologist who performed the principal procedure during the hospitalization being recorded. The operating practitioner will be designated by the hospital using the unique code established pursuant to subsection (e) of this section.

(17) "Principal diagnosis and secondary diagnoses" refer to diagnoses that affect the

hospitalization being recorded.

(A) "Principal diagnosis" refers to the condition which is established after study to be chiefly responsible for the admission of the patient to the hospital.

(B) "Secondary diagnoses" refers to those conditions, exclusive of the principal diagnosis, which exist at the time of the patient's admission or which develop subsequently to the admission and which affect the patient's treatment or length of stay for the hospitalization being recorded. Diagnoses which are associated with an earlier hospitalization and which have no bearing on the current hospitalization shall not be recorded as secondary diagnoses.

(18) Procedures and procedure days.

(A) "Procedure" means a significant procedure that is surgical in nature; carries a procedural or anesthetic risk; or requires specialized training or special facilities or equipment.

(B) "Procedure day" refers to the day on which the procedure was performed. The procedure day equals the number of days after the admission date on which the procedure was performed. If the procedure was performed on the date of admission, then the procedure day = 0.

(C) "Principal procedure" means that procedure most closely related to the principal diagnosis which is performed for the definitive treatment of the patient.

(i) The principal procedure cannot be a procedure which has been performed for a diagnostic or exploratory purpose only or to resolve a complication, unless these are the only types of procedures performed on the patient during the hospitalization being recorded.

(ii) "Complication" is defined in this section as any diagnosis other than the principal diagnosis.

(D) "Other procedures" means other significant procedures in addition to the principal procedure. These are to be reported with the procedure day on which the procedure was performed.

(19) "Admission status" describes the circumstances associated with the patient's admission and will be limited to the following:

circumstance	code
(A) Physician Referral	1
(B) Clinic Referral	2
(C) HMO Referral	3
(D) Transfer from a Hospital	4
(E) Transfer from a Skilled nursing facility	5
(F) Transfer from another health care facility	6
(G) Emergency room	7
(H) Court/law enforcement	8
(I) Newborn	9

(20) "Discharge status" means a designation associated with the circumstances of the patient's discharge and will be limited to the following:

designation	code
(A) Home	01
(B) Transferred to another short term hospital	02
(C) Transferred to a skilled nursing facility	03
(D) Transferred to an intermediate care facility	04
(E) Transferred to another type of institution	05
(F) Discharged to home health service	06
(G) Left against medical advice	07
(H) Expired	20

(21) "Expected principal source of payment" means that payment source that was expected at the time the data set was completed to provide the primary share of the payment for the hospitalization being recorded. These sources will be limited to the following:

payment source	code
(A) Self pay	A
(B) Worker's Compensation	B
(C) Medicare	C
(D) Medicaid	D
(E) Other Federal Program	E
(F) Commercial Insurance Company	F
(G) Blue Cross	G
(H) CHAMPUS	H
(I) Other	I
(J) Title V	Q
(K) No Charge	R
(L) HMO	S
(M) PPO	T

(22) "CHAMPUS" is defined in 19a-167g-55 (b) (13).

(23) "Title V" means the Maternal and Child Health Services Block Grant as provided under Title V of the Social Security Act.

(24) "HMO" and "PPO" refer to alternative delivery systems and are defined in 19a-167g-55 (b) (3).

(25) "Birthweight" means the weight in grams of a newborn infant recorded at birth. This value must be coded if the admission status is newborn.

(26) "Total revenue center charges" means the total charges appearing on the patient's bill. This amount should correspond to revenue code "001" on a standard UB-82 bill.

(27) A "group of revenue data elements" means an individual, distinct revenue code and its corresponding units of service and charges for the hospitalization being recorded. One group of revenue data elements consists of the revenue center code, its units of service, and its total charges.

(28) "UB-82 data" refers to those uniform billing data elements generated by hospitals for the purpose of billing hospital charges to patients for services rendered after September 30, 1984. These data elements are contained on a "UB-82 form" which is that version of the Uniform Hospital Billing Form promulgated by the National Uniform Billing Committee, established by the American Hospital Association, as from time to time amended. The UB-82 form has also been adopted as Health Care Financing Administration (HCFA) Form 1450 pursuant to Sections 1814 (a) (1) and 1871 of the federal Social Security Act.

(29) "Discharge abstract" refers to those items of medical and demographic information which are normally available in the patient's medical record and which may be abstracted from that medical record as data elements. The discharge abstract for the hospitalization being recorded summarizes the important clinical features of that patient's hospitalization. For the purpose of this section, the items of medical and demographic information referred to by the term "discharge abstract data" are data elements numbered 4, 6–12, 14–15, 17–18 on record type 2, items numbered 4, 6–14 on record type 3, and items numbered 4, 6–8, 10–11, 13–14, 16–17, 19–20, and 22–23 on record type 4 of subsection (h) (8), below. Some of these items may also be found on the patient's UB-82 billing form. These data elements may also be part of the UB-82 data.

(30) A "test tape" is defined as the submission of a sample of a hospital's discharge abstract and billing data set as part of the initial submission of data pursuant to subsection (b) (5) or for the purpose of testing technical changes made by the hospital which affect the submission of its discharge abstract and billing data set on computer tape. The test tape shall conform exactly to all the technical specifications provided for in this section. The sample of the data set contained on a hospital's test tape shall not exceed one-twelfth (1/12) of that hospital's total discharges for fiscal year 1989.

(31) Reports.

(A) A "report" is defined as data or information extracted or prepared from the data collected under this section or section 19a-165q-2 of the commission's regulations. This includes data derived from other sources when such data are combined with the data collected under this section. The report may be presented in any form, either on paper or contained in computer-accessible files on-or offline on magnetic media, such as magnetic tapes, disks, or drums.

(B) If a report, either by itself or in combination with another report, can identify an individual patient or practitioner either by personal identification code, by name, or by a combination of data elements, then it will be considered "confidential."

(C) If a report, either by itself or in combination with another report, cannot identify an individual patient or practitioner either by personal identification code, by name, or by a combination of data elements, then it will be considered "nonconfi-dential."

(32) "Data element" means an individual category of data taken from a discharge's medical record or hospital bill (UB-82 data). Data elements to be filed pursuant to this section are prescribed in subsection (h) (9), and, when appropriate, are defined in subsection (a).

(33) "Data record" refers to a 282-byte array of a computer file containing data elements specific to a hospital or to individual discharges from a hospital. Six types of data records

shall be filed by a hospital pursuant to this section. They are referred to as data record type 1 through data record type 6. These data record types are described in subsections (h) (4) and (h) (9).

(34) "Data set" refers to the complete set of data records filed by a hospital for a reporting period. The data set shall contain the discharge abstract and billing data for each individual discharged from that hospital during the reporting period. The data set shall be composed of one header record (data record type 1), one trailer record (data record type 6) for each hospital, and a group of data records (data record types 2 through 5, inclusive) for each individual discharged from that hospital. These data records shall include the data elements prescribed in subsection (h) (9).

(35) "Payer identification" means the code number or the payer name which identifies the payer organization from which the hospital expects at the time of discharge some payment for the bill. Up to three payer organizations shall be reported in order of their expected contributions to the payment of the hospital bill.

(36) "Estimated responsibility" means the amount estimated by the hospital at the time of discharge to be paid by the indicated payer.

(37) "Deductible" means that amount estimated by the hospital at the time of discharge to be applied to the patient's deductible amount for the indicated payer.

(38) "Coinsurance" means that amount estimated by the hospital at the time of discharge to be applied to the patient's coinsurance amount for the indicated payer.

(39) A "report cell" means the intersection of a row and column of data elements in a report.

(b) **Filing Requirements and Filing Periods.**

(1) Before the end of each calendar quarter after September 30, 1990, each hospital shall file with the commission or its agent a complete discharge abstract and billing data set, as specified in subsection (h).

(2) This data set shall contain the data records for each individual discharged from that hospital during the preceding calendar quarter. The data set for a calendar quarter shall be filed prior to the end of the calendar quarter following the calendar quarter in which the discharges whose data are contained therein occurred. For example, the data set to be filed before March 31, 1991, shall contain the data records for each individual discharged from that hospital from October 1, 1990, until December 31, 1990. Nothing in this section is intended to alter the data filing requirements of section 19a-167g-42. Data for the calendar quarter July 1, 1990 through September 30, 1990 continues to be due the commission under section 19a-167g-42.

(3) For its first submission pursuant to this section, the hospital shall file a test tape pursuant to subsection (b) (5).

(4) Ninety (90) days prior to the end of the filing periods specified in subsection (b) (1), the commission shall notify the hospital of any supplemental instructions for submission of the hospital discharge abstract and billing data set.

(5) Submission of test tapes.

(A) The initial submission of discharge abstract and billing data sets under this section is due before April 1, 1991. As part of that submission, a hospital shall submit a test tape for its data set. Thereafter, when a change in the instructions or specifications for the

submission of the hospital discharge abstract and billing data set occurs which requires a modification of the submission format of the data set, hospitals may submit up to three test tapes to verify that they have implemented the format changes correctly.

(B) The first test tape must be submitted within ninety (90) days following the first day of the fiscal quarter in which the specification changes are required to be initiated.

(C) The commission's agent will process the test tapes upon receipt, accept or reject the test tapes based upon their conformance to the specifications required, and notify each hospital or their designated data vendor with a written evaluation of each test tape.

(D) If a hospital's test tape is accepted by the agent, no additional test tapes will be processed by the agent for that hospital. If the hospital's test tape is rejected by the agent, the hospital shall submit a revised test tape for reevaluation within fifteen (15) business days of the hospital's or data vendor's receipt of the agent's evaluation of its rejected test tape.

(E) The submission of test tapes does not, in itself, exempt a hospital from the filing requirements of subsections (b) (1) and (b) (2).

(F) A hospital will not be considered to have violated the provisions of subsection (b) (2) if it has adhered to the testing schedule described in subsections (b) (5) (B) through (b) (5) (D) and has not submitted more than three test tapes.

(G) If any hospital requests the submission of a test tape for any reason other than those specified in (b) (5) (A), or if a hospital is required to submit more than three test tapes for any filing period, then the cost of processing the additional test tapes shall be borne by the hospital.

(6) Exemptions to the filing requirements.

(A) A hospital may be granted a partial, temporary exemption from filing those data elements specified in (6) (F) if the data elements cannot be provided to the commission in a timely manner by the hospital.

(B) The commission shall grant an exemption provided the hospital applies for it and the commission finds that the application demonstrates sufficient grounds for the exemption.

(C) Specifically, if the hospital is not collecting the specified data elements on or about October 1, 1990, and cannot begin collecting them on that date due to computer software or data collection forms which do not provide for their collection, and the hospital's application sufficiently supports this claim, then the hospital shall be granted a partial exemption for those data elements until such time as the commission deems appropriate.

(D) The application for exemption shall contain at least the following materials:

(i) A statement of which data elements cannot be provided in a timely manner and why they cannot be provided.

(ii) Samples of the hospital's discharge abstract and UB-82 data element collection forms or other data element collection instruments with effective dates on or about October 1, 1990.

(iii) Sworn statements from the hospital's data processing vendor(s) and/or data processing manager stating that the hospital cannot provide the data elements to the commission in a timely manner and why it cannot.

(iv) The earliest date on which the hospital expects to provide the data elements to the commission.

(v) Any other supporting documentation considered relevant to the hospital's application by the hospital or the commission.

(E) The exemption shall be partial and until such time as the commission determines is reasonably required for the hospital to comply.

(F) The following data elements may be exempted from the filing requirements of this section until such date as the commission may deem appropriate, but no later than October 1, 1991: ethnicity, previous admission, secondary diagnosis 5, secondary diagnosis 6, secondary diagnosis 7, secondary diagnosis 8, secondary diagnosis 9, other procedure 5, other procedure 5 day, other procedure 6, other procedure 6 day, other procedure 7, other procedure 7 day, other procedure 8, other procedure 8 day, other procedure 9, other procedure 9 day, birthweight, payer identification 1, payer identification 2, payer identification 3. In addition, the data element race may be partially exempted, so that a hospital which receives such an exemption shall be required to collect that data element as required by the regulations in effect during fiscal year 1990.

(G) The following data elements shall be exempted from the filing requirements of this section until October 1, 1991: estimated responsibility 1, deductible 1, coinsurance 1, estimated responsibility 2, deductible 2, coinsurance 2, estimated responsibility 3, deductible 3, and coinsurance 3.

(H) Hospitals not granted an exemption by the commission shall begin gathering the specified data elements in their required formats, as prescribed in subsections (a) and (h), on October 1, 1990, for initial submission to the commission on April 1, 1991.

(7) Hospitals may request an extension of the filing periods in this section pursuant to section 19a-160-16 of the commission's regulations.

(c) **Billing data.** As provided in subsection (h), the hospital shall report the detailed charges for each discharge in a group of data records that are already merged with the discharge abstract data elements. The charges shall be reported in detail, itemized by individual three-digit UB-82 revenue code in a manner consistent with the reporting of the charge data elements on the UB-82 form.

(d) **Standards for data; notification; response.**

(1) Each discharge abstract and billing data set submitted by a hospital for patients discharged after September 30, 1990, shall be evaluated by the commission or its agent according to the following standards:

(A) For each data set submitted by a hospital, the values or codes for any data element within an individual discharge's data records shall be valid values or codes or contained within valid ranges of values for the data element. Invalid codes or values will be rejected as errors. Data elements and their valid values or codes are specified in subsections (a) and (h). Invalid codes are specified in subsection (h) (10).

(B) Those data elements which are related to other data elements within an individual discharge's data records must be internally consistent in substantive content or they will be rejected as errors. Edits to be applied for consistency are specified in subsection (h) (11).

(C) Coding values indicating "data not available," "data unknown," or any other such value or term indicating that the valid code, value, or range of values for particular data elements is not available will not be accepted for individual data items. Submission of such values for data elements will be rejected as errors.

(D) Any discharge which is assigned to DRG 469 or 470 after grouping by the version of the Medicare grouper valid for the period in which the patient is discharged shall be rejected as an error. The hospital shall review the medical record for such discharge and modify the discharge data set accordingly so that the discharge is correctly assigned to a DRG other than 469 or 470.

(2) Upon completion of this evaluation, the commission or its agent shall promptly notify each hospital whose data sets do not satisfy the standards for any filing period. This notification shall identify the discharge abstract or billing data elements for any discharge which are in error, suspected of being in error, or otherwise do not satisfy the standards.

(A) This notification will specify the problematic data elements.

(B) Error documentation and correction procedures will be provided to each hospital with each notification.

(3) Each hospital notified pursuant to subsection (d) (2) shall make the changes necessary to correct the errors and satisfy the standards and submit these changes to the commission or its agent within 30 days of the notification.

(e) **Central registry for practitioner codes.**

(1) All practitioners who provide services at a hospital within the state must be registered with the commission by means of a central registry.

(2) The registry will contain the practitioner's name, address, birthdate, state health department license number, any other information as may be required by the commission to uniquely distinguish the practitioner from any other practitioner providing services in the state, and an identification number which uniquely distinguishes the practitioner from any other practitioner providing services in the state.

(3) The commission designates the Connecticut Health Care Provider Billing Identification System (CHCPBIS) to be the central registry specified in subsection (1), above, and the CHCPBIS provider code number to be the identification number which the hospitals shall use for the attending and operating practitioner data elements described in (a) (15) and (a) (16), respectively. As designee, the CHCPBIS shall provide the information specified in subsection (e) (2) to the commission on a regular and timely basis.

(4) Should the designee cease to maintain this registry or fail to provide the specified information to the commission on a regular and timely basis, the commission shall declare the designation made in subsection (3) void. In this case, the identification number provided by the hospitals for the attending and operating practitioner data elements should be that practitioner code required by the Health Care Financing Administration (HCFA) in its administration of the Medicare Program.

(5) Should HCFA cease to require a unique practitioner identifier for the Medicare program, then each hospital shall be responsible for providing the commission or its agent with the practitioner's name, current address, birthdate, and state health department license number or such other information as may be required by the commission to uniquely distinguish each practitioner from any other practitioner providing services in the state as new practitioners begin providing services to the hospital. Upon receipt of this information, the commission or its agent will assign each practitioner his or her own unique identification number.

(f) **Noncompliance.**

(1) Except as specified in subsection (f) (2), the failure to file, report or correct the discharge abstract or billing data sets according to the provisions of this section shall be considered a violation of public act 89-371 and these regulations. Any hospital determined by the commission to have violated the provisions of this section shall be subject to the provisions of Section 19a-160-120 of the commission's regulations and any other remedies or penalties available to the commission.

(2) A hospital which files discharge abstract and billing data sets which do not satisfy the standards under subsection (d) of this section shall not be considered in violation of these regulations if:

(A) the hospital corrects all such data sets as specified in subsection (d) (3) of this section; or

(B) the number of individual discharges whose data records fail to meet the standards for the filing period does not exceed one percent of the total number of individual discharges required to be filed in that period.

(g) **Maintenance of confidentiality.**

(1) Only such data as are relevant and necessary to implement public acts 89-371 and 90-134 will be collected by the commission.

(2) All data collected under this section of these regulations will be maintained accurately and diligently.

(3) Only such members of the commission, its attorney, agents, or their employees who have a specific need to review discharge and billing data collected pursuant to this section or confidential reports prepared from such data will be entitled to access to such data or reports.

(4) The commission, its attorney, agents, or their employees who are involved in the administration, management, processing, analysis, or other use of the discharge abstract and billing data shall not make public any confidential reports.

(5) The following data elements are confidential and shall not be released to the public: patient identification number, patient control number, date of birth, date of admission, date of discharge, attending practitioner, and operating practitioner.

(6) Notwithstanding the provision of subsection (g) (4), nonconfidential reports from which individual patient and practitioner data cannot be identified shall be made available to the public.

(7) Data elements and suppression thresholds for nonconfidential reports.

(A) To create a nonconfidential report, the following data elements collected under this section will be replaced by substitute data elements which have been modified for purposes of confidentiality as follows:

(i) Birthdate will be replaced by age group. Age groups shall contain age ranges of no less than five years and must be compatible with those released by the U.S. Census Bureau. All ages greater than 90 years will be included in the same group.

(ii) Date of discharge will be replaced by fiscal quarter and year of discharge.

(iii) Admission date and discharge date will be replaced by average length of stay in aggregate reports and length of stay in other nonconfidential reports.

(iv) Zip code will be replaced by an aggregation of zip codes composed of at least two contiguous zip codes and subject to the provisions of subsection (7) (B).

(v) Birthweight will be replaced by birthweight group. Each birthweight group shall contain birthweight ranges of no less than 500 grams. These ranges must end in even hundred grams (e.g. 2,001–2,500 grams).

(vi) Payer identification will be aggregated to only those payer categories specified in subsection (a) (21), Expected Principal Source of Payment.

(vii) All billing data elements related to patient charges will be replaced by the corresponding average charges in aggregate reports.

(B) Thresholds for data suppression for nonconfidential reports.

(i) Except for average length of stay and average charges, a nonconfidential, aggregated report shall not contain information or data based on fewer than six individual patients, as defined by the patient identification number, in a single report cell. In the case of average length of stay and average charges, if the average is based on fewer than six patients, the number of patients upon which it is based will not be released.

(ii) Except for average length of stay and average charges, a nonconfidential, aggregated report shall not contain information or data based on fewer than two individual practitioners, as defined by the attending or operating practitioner codes, in a single report cell.

(iii) An aggregated report shall not contain the payer data elements "estimated responsibility," "deductible," and "coinsurance" if the values of these data elements are based on fewer than two individual payers, as defined by the payer identification codes, in a single report cell.

(iv) Any nonaggregated report which contains data elements by discharge shall not contain the data element "hospital code," and shall contain a substitute for the data element "zip code." This substitute shall be composed of an aggregation of zip codes equivalent to the health service areas created pursuant to the National Health Planning and Resources Development Act, Public Law 93-641.

(C) Combinations of all other data elements not restricted by subsections (g) (4), (g) (5), and (g) (7) may be released in nonconfidential reports.

(8) Procedures for requesting, producing, and releasing nonconfidential reports.

(A) All reports under consideration by the commission for public release shall be considered confidential until determined to be nonconfidential by the process described in this subsection.

(B) Requests for any data collected under this section must be made in writing to the chairman of the commission. The request shall contain a list of the data elements being sought, a detailed description of the content and organization of any report and an example of the report's layout showing how the data will be organized and presented. It shall also contain a statement by the requestor confirming that the request conforms to the confidentiality provisions of this subsection.

(C) A designated commissioner shall review the request and respond within four business days as follows:

(i) A request which seeks data elements deemed confidential by subsection (g) (7) (A) or which does not meet the thresholds of subsection (g) (7) (B) shall be denied within four (4) business days.

(ii) A request for data from which it can be readily determined from the face of the request that an individual patient or physician cannot be identified and that the request

conforms to (g) (7) (A) and (g) (7) (B) will be approved for preparation. The requestor will be notified of such approval within four (4) business days. The requestor shall assume the cost of preparing a requested report not already in existence. Such cost may be required to be paid in whole or in part prior to the preparation of the report.

(iii) A request for data from which it cannot be readily determined whether an individual patient or physician can be identified or whether the request conforms to (g) (7) (A) and (g) (7) (B) will be subjected to the procedure set forth in (E) below prior to a determination by a commissioner that the request will be approved for preparation. The requestor shall be notified within four (4) business days that the request will undergo such a procedure.

(D) All requests for data will be publicly noticed as an addendum to the commission's calendar. This notice will contain the name of the requestor and the general nature of the request. If the request identifies the data as that of an individually identified hospital, the commission will notify the hospital at this time that a request for data collected pursuant to this section has been filed. Any person may obtain a copy of such request on application to the commission. Any person may raise concerns about whether the requested report conforms to the confidentiality requirements of this subsection but the raising of any concerns shall not toll any determination by a designated commissioner whether to approve or deny a request except as set forth in (E) below.

(E) for requests which fall under subsection (g) (8) (C) (iii), any person may raise concerns about whether the requested report conforms to the confidentiality requirements of this subsection provided he or she does so in writing within ten (10) business days of the public notice given under (D). Any concerns will be considered by the designated commissioner before the request is approved for preparation.

(i) A designated commissioner shall review such request. If the commissioner determines that such request conforms to the confidentiality requirements of this subsection, the request may be approved for preparation. The requestor shall assume the cost of preparing a requested report not already in existence. Such cost may be required to be paid in whole or in part prior to the preparation of the report.

(F) When prepared, a copy of the report will be reviewed by the designated commissioner for conformity to the confidentiality requirements of this subsection. If the report conforms to these requirements, it shall be authorized for release.

(G) The commission retains ownership rights to all data used in the report and will retain a copy of the final report. Nonconfidential reports approved for release will thereafter be available for copying by members of the public other than the original requestor.

(H) The commission will maintain a record of all approved requests for reports. The record will be available to the public on request. This record will contain the name of the person or party making the request, the nature of the request, and the date the request was approved for release.

(I) The commission reserves the right to refuse any request for a report which could threaten the confidentiality of an individual patient or practitioner.

(9) The commission shall ensure that any contract into which it enters with an agent using confidential data collected under this section shall contain provisions requiring the agent to comply with the provisions of this subsection. The commission, not its agent, is the sole owner of the data collected under this section. No agent may release any data or

report whatsoever, whether confidential or not, to any person or party, unless authorized in writing by the commission in accordance with this section.

(10) Security of the discharge abstract and billing data.

(A) The commission shall ensure that steps are taken to control access to any confidential data collected under this section or reports developed from these data. These steps shall include the use of information systems software and other security procedures designed to protect against unauthorized access. These security procedures shall be available to the public.

(B) Any agent of the commission must provide a detailed description of its data security provisions and the policies and procedures it will employ to ensure the security and confidentiality of the data collected under this section.

(C) To the greatest extent practicable, confidential reports maintained at the commission will be kept in controlled access areas. Confidential reports will be kept in locked files when not in use. Confidential reports maintained on the commission's computer system will be stored in limited-access directories. Documents containing confidential reports will be clearly labeled as confidential.

(11) The commission, its attorney, agents, and any of their employees who are involved in the collection, maintenance, analysis, or other use of the discharge abstract and billing data, will be informed of the policies and procedures contained in subsections (g) (1) through (g) (10) regarding the maintenance and use of these data.

(h) **Specifications for the submission of the discharge abstract and billing data sets.**

(1) Each hospital shall file with the commission or its agent a complete discharge abstract and billing data set on magnetic computer tape containing data records for each patient discharged from the hospital after September 30, 1990. The data records for each discharge shall contain complete discharge abstract and billing data for all the data elements specified in subsection (h) (9). When reported, the discharge abstract and billing data elements for each discharge shall already be merged into a single set of data records for that discharge, as prescribed in subsections (h) (2) (A) through (h) (2) (C).

(2) The organization of data records within a data set.

(A) For each discharge, the data elements to be filed shall be contained on one type 2 data record, one type 3 data record, one type 4 data record, and one or more type 5 data records. This means that multiple data records shall be filed for each discharge.

(B) The type 2 data record shall contain the discharge's demographic information. The type 3 data record shall contain the discharge's diagnostic information. The type 4 data record shall contain the discharge's procedural information. The type 5 data record(s) shall contain the discharge's revenue or billing information.

(C) All record types for an individual discharge shall follow one another immediately in sequence beginning with the type 2 data record for that discharge. Each discharge must have one type 2 data record followed by one type 3 data record, one type 4 data record, and at least one type 5 data record, in that order. For data record type 5, the sequence number shall reflect the order of appearance of type 5 records for an individual discharge.

(D) A type 1 data record must never immediately follow another type 1 data record. A type 2 data record for a given discharge must never immediately follow a type 2 data record for a different discharge.

(E) Each hospital shall submit a single header data record, data record type 1, and a single trailer data record, data record type 6, which will enclose the data records for all discharges contained in any submission, if more than one hospital's data set is submitted on a single tape, each hospital's data set shall be delimited by its own type 1 and type 6 data records.

(3) Rules for coding revenue data elements.

(A) The billing (or revenue) data elements shall be reported in a manner consistent with the reporting of UB-82 revenue data elements. Each revenue code for which the discharge has accrued charges must be reported along with the total charges corresponding to that revenue code. For each revenue code between 020 through 219, inclusive, for which the discharge has accrued charges, units of service corresponding to that revenue code must be reported.

(B) Revenue codes shall be reported to the third digit. Each charge must correspond to a valid UB-82 revenue code. Revenue codes must be acceptable values in the range between 020–999, inclusive, that appear in the UB-82 billing manual, maintained by the Connecticut UB-82 billing committee. Total units of service and total charges corresponding to the individual revenue codes for the hospitalization being recorded are to be reported as they are reported on the UB-82 form.

(C) Each type 5 data record can hold up to 18 groups of revenue data elements (i.e. revenue code, units of service by revenue code, and charges by revenue code). No blanks shall occur prior to the end of the last group of data elements for the last revenue code. Unused space for revenue data elements in the last or only type 5 data record must be zero filled.

(D) There shall be only one occurrance of a unique revenue code on each discharge's set of type 5 data records. This means that charges and units must be aggregated to the revenue code level.

(4) Rules for diagnosis and procedure coding.

(A) Principal and secondary diagnoses shall be recorded according to the conventions governing the coding of diagnoses contained in the most current version of the International Classification of Diseases, 9th Revision, Clinical Modification ('ICD-9-CM').

(B) Diagnoses shall be coded in the most specific category available for that diagnosis at the time of discharge. A diagnosis may not be assigned a less specific code if a more specific code is available for that diagnosis.

(C) The diagnosis codes must be legitimate, lowest-level, ICD-9-CM codes with decimal points omitted. Diagnosis codes shall be entered as a 5-digit code even though there may only be 3 or 4 significant digits. Decimal points are to be implied, not explicit. This means that all digits in the code must be entered, including leading and trailing zeros. If the lowest-level code for a diagnosis has only three or four significant digits, including leading and trailing zeros, blanks must be entered in positions 4 and/or 5 if necessary.

(D) The first four secondary diagnoses recorded shall be consistent with those contained on the discharge's UB-82 bill for the hospitalization being recorded. The remaining five diagnoses shall be taken from either the discharge's UB-82 bill or the discharge abstract. If, for the hospitalization being recorded, a discharge has nine or more unique secondary diagnoses on either the UB-82 bill or the discharge abstract, then the hospital must report

nine secondary diagnoses on the data record. If a discharge has fewer than nine unique secondary diagnoses on both the UB-82 bill and the discharge abstract, then the unused space reserved for the additional diagnoses shall be blank filled.

(E) The reporting of procedure codes shall follow the same rules as those outlined for diagnosis codes in (A) through (C), above, except that the procedure codes shall be entered as a 4-digit instead of a 5-digit code. Procedure codes shall be entered as a 4-digit code even though there may only be 2 or 3 significant digits. The codes entered must be legitimate lowest level ICD-9-CM codes except that decimal points are to be implied, not explicit. This means that leading and trailing zeros must be entered and blanks must be entered in positions 3 and/or 4 if necessary. Other procedure fields are to be blank filled if not applicable.

(F) The first two other procedures shall be consistent with those contained on the discharge's UB-82 bill for the hospitalization being recorded. The remaining seven procedures shall be taken from either the discharge's UB-82 bill or the discharge abstract.

(G) If a discharge has nine or more unique other procedures on either the UB-82 bill or the discharge abstract for the hospitalization being recorded, then the hospital must report nine other procedures on the data record. If a discharge has fewer than nine other procedures on both the UB-82 bill and the discharge abstract for the hospitalization being recorded, then the unused space reserved for the additional procedures shall be blank filled.

(H) For each procedure reported, the day on which the procedure was performed relative to the day of admission must also be reported. Procedures performed on day of admission shall reflect a procedure day of "000." Procedure day fields are to be blank filled if no corresponding procedure is recorded.

(I) If a procedure has been reported to diagnose or treat a complication, as defined in subsection (a) (12) (B) (ii), then the complication must be reported as a secondary diagnosis.

(5) Regarding the coding of admission status, if the discharge was admitted through the emergency room after having been transferred from any other health care facility, then this admission may not be coded as an emergency room admission.

(6) Regarding the coding of payer identification, follow UB-82 instructions for completing the data field specified in (h) (9), including the use of the three-digit carrier code if the primary payer is a commercial carrier. Preceed the three digit code by two zeros to completely fill the five-character, alpha-numeric field. Enter the expected primary payer as payer identification 1, and other payers as payer identification 2 and payer identification 3.

(7) Regarding the coding of estimated responsibility, deductible, and coinsurance, follow UB-82 instructions for completing these data fields for each payer identification. Enter the values of these data elements for the expected primary payer as estimated responsibility 1, deductable 1, and coinsurance 1, respectively, and the values of these data elements for other payers as estimated responsibility 2, deductable 2, and coinsurance 2, and estimated responsibility 3, deductible 3, and coinsurance 3, respectively.

(8) Magnetic Tape Specifications.

(A) Characteristics	Specifications
1. Number of tracks	9 track

2. Parity	Odd
3. Label type	OS Standard Labels or Nonlabeled
4. Density	1,600 BPI or 6,250 BPI
5. Character Code	EBCDIC
6. Record Format	Fixed-Length, Fixed-Blocked
7. Record Length	282 bytes
8. Records per Block	113
9. Block Size	31,866 Bytes

(B) The logical data record length shall be 282 and the blocking factor shall be equal to 113. Therefore, the blocksize equals 31,866.

(C) The submission of a magnetic tape requires a Standard Tape Submittal Form, in all cases.

(D) The standard tape submittal form, which must always be used, must be supplemented by an attached document, as applicable, which clearly identifies the tape contents as to the reporting period submitted for each hospital.

(E) Each tape can contain data sets from one or more hospitals as long as each hospital's data records are preceded by a Header Data Record (data record type 1) and followed by a Trailer Data Record (data record type 6), as specified in subsections (h) (2) and (H) (9). The hospital data set can include data from one or more quarters within one fiscal year; data from multiple fiscal years cannot be mixed on one tape.

(9) Record layout and format.

#Data Element Description	Format	Bytes	Start	Stop	Reference	#Instruction
Data Record Type 1: Data Set Header Record						
1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Hospital Name	X(40)	40	9	48	—	1,3
5 Processing Date	9(8)	8	49	56	—	7
6 Period Start Date	9(8)	8	57	64	—	7
7 Period End Date	9(8)	8	65	72	—	7
8 Filler	X(210)	210	73	282	—	—
Data Record Type 2: Demographic Data Record						
1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3

6 Date of Birth	9(8)	8	49	56	Definitions	7
7 Date of Admission	9(8)	8	57	64	Definitions	7
8 Date of Discharge	9(8)	8	65	72	Definitions	7
9 Sex	X(1)	1	73	73	Definitions	—
10 Race	9(1)	1	74	74	Definitions	—
11 Ethnicity	9(1)	1	75	75	Definitions	—
12 Zip Code	X(5)	5	76	80	Definitions	1,3
13 Filler	X(4)	4	81	84	—	—
14 Admission Status	9(1)	1	85	85	Definitions	2,4
15 Discharge Status	9(2)	2	86	87	Definitions	2,4
16 Birthweight	9(4)	4	88	91	Definitions	2,4
17 Previous Admission	9(1)	1	92	92	Definitions	—
18 Principal Payment Source	X(1)	1	93	93	Definitions	1,3
19 Payer Identification 1	X(5)	5	94	98	Definitions	2,4
20 Estimated Responsibility 1	9(6)	6	99	104	Definitions	2,4,9
21 Deductible 1	9(6)	6	105	110	Definitions	2,4,9
22 Coinsurance 1	9(6)	6	111	116	Definitions	2,4,9
23 Payer Identification 2	X(5)	5	117	121	Definitions	2,4
24 Estimated Responsibility 2	9(6)	6	122	127	Definitions	2,4,9
25 Deductible 2	9(6)	6	128	133	Definitions	2,4,9
26 Coinsurance 2	9(6)	6	134	139	Definitions	2,4,9
27 Payer Identification 3	X(5)	5	140	144	Definitions	2,4
28 Estimated Responsibility 3	9(6)	6	145	150	Definitions	2,4,9
29 Deductible 3	9(6)	6	151	156	Definitions	2,4,9
30 Coinsurance 3	9(6)	6	157	162	Definitions	2,4,9
31 Revenue Center Code 001	9(3)	3	163	165		2,4
32 Total Routine Units of Service	9(4)	4	166	169		2,4
33 Total Detailed Charges	9(8)	8	170	177		2,4,9
34 Filler	X(105)	105	178	282	—	—
Data Record Type 3: Diagnosis Data Record						
1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—

3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3
6 Attending physician	X(9)	9	49	57	Definitions	1,3
7 Principal diagnosis	X(5)	5	58	62	ICD-9-CM	1,3,5,6
8 Secondary diagnosis 1	X(5)	5	63	67	ICD-9-CM	1,3,5,6
9 Secondary diagnosis 2	X(5)	5	68	72	ICD-9-CM	1,3,5,6
10 Secondary diagnosis 3	X(5)	5	73	77	ICD-9-CM	1,3,5,6
11 Secondary diagnosis 4	X(5)	5	78	82	ICD-9-CM	1,3,5,6
12 Secondary diagnosis 5	X(5)	5	83	87	ICD-9-CM	1,3,5,6
13 Secondary diagnosis 6	X(5)	5	88	92	ICD-9-CM	1,3,5,6
14 Secondary diagnosis 7	X(5)	5	93	97	ICD-9-CM	1,3,5,6
15 Secondary diagnosis 8	X(5)	5	98	102	ICD-9-CM	1,3,5,6
16 Secondary diagnosis 9	X(5)	5	103	107	ICD-9-CM	1,3,5,6
17 Filler	X(175)	175	108	282	—	—
Data Record Type 4: Procedure Data Record						
1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3
6 Operating physician	X(9)	9	49	57	Definitions	1,3
7 Principal procedure	X(4)	4	58	61	ICD-9-CM	1,3,5
8 Principal proc. day	9(3)	3	62	64	Definitions	2,3
9 Filler	X(9)	9	65	73	—	—
10 Other procedure 1	X(4)	4	74	77	ICD-9-CM	1,3,5
11 Other proc. 1 day	9(3)	3	78	80	Definitions	2,3
12 Filler	X(9)	9	81	89	—	—
13 Other procedure 2	X(4)	4	90	93	ICD-9-CM	1,3,5
14 Other proc. 2 day	9(3)	3	94	96	Definitions	2,3
15 Filler	X(9)	9	97	105	—	—
16 Other procedure 3	X(4)	4	106	109	ICD-9-CM	1,3,5
17 Other proc. 3 day	9(3)	3	110	112	Definitions	2,3
18 Filler	X(9)	9	113	121	—	—

19 Other procedure 4	X(4)	4	122	125	ICD-9-CM	1,3,5
20 Other proc. 4 day	9(3)	3	126	128	Definitions	2,3
21 Filler	X(9)	9	129	137	—	—
22 Other procedure 5	X(4)	4	138	141	ICD-9-CM	1,3,5
23 Other proc. 5 day	9(3)	3	142	144	Definitions	2,3
24 Filler	X(9)	9	145	153	—	—
25 Other procedure 6	X(4)	4	154	157	ICD-9-CM	1,3,5
26 Other proc. 6 day	9(3)	3	158	160	Definitions	2,3
27 Filler	X(9)	9	161	169	—	—
28 Other procedure 7	X(4)	4	170	173	ICD-9-CM	1,3,5
29 Other proc. 7 day	9(3)	3	174	176	Definitions	2,3
30 Filler	X(9)	9	177	185	—	—
31 Other procedure 8	X(4)	4	186	189	ICD-9-CM	1,3,5
32 Other proc. 8 day	9(3)	3	190	192	Definitions	2,3
33 Filler	X(9)	9	193	201	—	—
34 Other procedure 9	X(4)	4	202	205	ICD-9-CM	1,3,5
35 Other proc. 9 day	9(3)	3	206	208	Definitions	2,3
36 Filler	X(74)	74	209	282	—	—
Data Record Type 5: Billing Data Record(s)						
1 Record Type Indicator	9(2)	2	1	2	—	8
2 Record Sequence Number	9(2)	2	3	4	(h) (2) (C)	2,4,10
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3
6 Revenue Code #1	9(3)	3	49	51	UB-82 Manual	2,4
7 Units of Service by Revenue Code #1	9(4)	4	52	55	UB-82 Manual	2,4
8 Charges by Revenue Code #1	9(6)	6	56	61	UB-82 Manual	2,4,9
9 Revenue Code #2	9(3)	3	62	64	UB-82 Manual	2,4
10 Units of Service by Revenue Code #2	9(4)	4	65	68	UB-82 Manual	2,4
11 Charges by Revenue Code #2	9(6)	6	69	74	UB-82 Manual	2,4,9

12 Revenue Code #3	9(3)	3	75	77	UB-82 Manual	2,4
13 Units of Service by Revenue Code #3	9(4)	4	78	81	UB-82 Manual	2,4
14 Charges by Revenue Code #3	9(6)	6	82	87	UB-82 Manual	2,4,9
15 Revenue Code #4	9(3)	3	88	90	UB-82 Manual	2,4
16 Units of Service by Revenue Code #4	9(4)	4	91	94	UB-82 Manual	2,4
17 Charges by Revenue Code #4	9(6)	6	95	100	UB-82 Manual	2,4,9
18 Revenue Code #5	9(3)	3	101	103	UB-82 Manual	2,4
19 Units of Service by Revenue Code #5	9(4)	4	104	107	UB-82 Manual	2,4
20 Charges by Revenue Code #5	9(6)	6	108	113	UB-82 Manual	2,4,9
21 Revenue Code #6	9(3)	3	114	116	UB-82 Manual	2,4
22 Units of Service by Revenue Code #6	9(4)	4	117	120	UB-82 Manual	2,4
23 Charges by Revenue Code #6	9(6)	6	121	126	UB-82 Manual	2,4,9
24 Revenue Code #7	9(3)	3	127	129	UB-82 Manual	2,4
25 Units of Service by Revenue Code #7	9(4)	4	130	133	UB-82 Manual	2,4
26 Charges by Revenue Code #7	9(6)	6	134	139	UB-82 Manual	2,4,9
27 Revenue Code #8	9(3)	3	140	142	UB-82 Manual	2,4
28 Units of Service by Revenue Code #8	9(4)	4	143	146	UB-82 Manual	2,4
29 Charges by Revenue Code #8	9(6)	6	147	152	UB-82 Manual	2,4,9
30 Revenue Code #9	9(3)	3	153	155	UB-82 Manual	2,4
31 Units of Service by Rev	9(4)	4	156	159	UB-82	2,4

enue Code #9					Manual	
32 Charges by Revenue Code #9	9(6)	6	160	165	UB-82 Manual	2,4,9
33 Revenue Code #10	9(3)	3	166	168	UB-82 Manual	2,4
34 Units of Service by Revenue Code #10	9(4)	4	169	172	UB-82 Manual	2,4
35 Charges by Revenue Code #10	9(6)	6	173	178	UB-82 Manual	2,4,9
36 Revenue Code #11	9(3)	3	179	181	UB-82 Manual	2,4
37 Units of Service by Revenue Code #11	9(4)	4	182	185	UB-82 Manual	2,4
38 Charges by Revenue Code #11	9(6)	6	186	191	UB-82 Manual	2,4,9
39 Revenue Code #12	9(3)	3	192	194	UB-82 Manual	2,4
40 Units of Service by Revenue Code #12	9(4)	4	195	198	UB-82 Manual	2,4
41 Charges by Revenue Code #12	9(6)	6	199	204	UB-82 Manual	2,4,9
42 Revenue Code #13	9(3)	3	205	207	UB-82 Manual	2,4
43 Units of Service by Revenue Code #13	9(4)	4	208	211	UB-82 Manual	2,4
44 Charges by Revenue Code #13	9(6)	6	212	217	UB-82 Manual	2,4,9
45 Revenue Code #14	9(3)	3	218	220	UB-82 Manual	2,4
46 Units of Service by Revenue Code #14	9(4)	4	221	224	UB-82 Manual	2,4
47 Charges by Revenue Code #14	9(6)	6	225	230	UB-82 Manual	2,4,9
48 Revenue Code #15	9(3)	3	231	233	UB-82 Manual	2,4
49 Units of Service by Revenue Code #15	9(4)	4	234	237	UB-82 Manual	2,4
50 Charges by Revenue Code #15	9(6)	6	238	243	UB-82 Manual	2,4,9

51 Revenue Code #16	9(3)	3	244	246	UB-82 Manual	2,4
52 Units of Service by Revenue Code #16	9(4)	4	247	250	UB-82 Manual	2,4
53 Charges by Revenue Code #16	9(6)	6	251	256	UB-82 Manual	2,4,9
54 Revenue Code #17	9(3)	3	257	259	UB-82 Manual	2,4
55 Units of Service by Revenue Code #17	9(4)	4	260	263	UB-82 Manual	2,4
56 Charges by Revenue Code #17	9(6)	6	264	269	UB-82 Manual	2,4,9
57 Revenue Code #18	9(3)	3	270	272	UB-82 Manual	2,4
58 Units of Service by Revenue Code #18	9(4)	4	273	276	UB-82 Manual	2,4
59 Charges by Revenue Code #18	9(6)	6	277	282	UB-82 Manual	2,4,9
Data Record Type 6: Data Set Trailer Record						
1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Total Hospital Discharges	9(6)	6	9	14	—	2,4,11
5 Total Hospital Patient-Days	9(9)	9	15	23	—	2,4,11
6 Total Hospital Charges	9(9)	9	24	32	—	2,4,9,11
7 Filler	X(250)	250	33	282	—	—

Instruction Codes:

1. Left justified.
2. Right justified.
3. Fill all open bytes with blank.
4. Fill all open bytes with zero.
5. Must be valid, lowest level ICD-9-CM code excluding decimal points; decimal implied according to the ICD-9-CM system. (XXX.XX for diagnoses; XX.XX for procedures)
6. For ICD-9-CM codes using “E” or “V,” “E” or “V” should be located in left-most position within field.
7. The format to be used for dates is YYYYMMDD.
8. The values for the Data Record Type Indicators shall be coded as follows:

Data Record Type 1 =01, Data Record Type 2 =02,
Data Record Type 3 =03, Data Record Type 4 =04,
Data Record Type 5 =05, Data Record Type 6 =06.

9. Enter values for this data element as a whole dollar amount. Round the actual value contained on the discharge's bill to the nearest whole dollar amount.

10. For Data Record Type 5, the sequence number shall reflect the order of appearance of Type 5 data records for each discharge. The sequence number for a discharge's first Type 5 data record equals 01; the sequence number for a discharge's second Type 5 data record equals 02; the sequence number for a discharge's third Type 5 data record equals 03; and so on.

11. Total hospital discharges shall equal the total number of patients discharged from the hospital during the reporting period and shall equal the total number of Type 2 data records filed in the hospital's data set. Total hospital patient days shall equal the sum of the lengths of stay for all hospital patients discharged from the hospital during the reporting period. Total hospital charges shall equal the total charges billed to all hospital patients discharged from the hospital during the reporting period.

(10) Required characteristics for the discharge and billing data elements.

(A) Invalid values for data fields.

Number	Fieldname	Invalid Field Coding
1.	Patient Identification	All zeros; all spaces; all nines
2.	Patient Control Number	All zeros; all spaces; all nines
3.	Date of Birth	Non-numeric data
4.	Date of Admission	Non-numeric data; invalid year
5.	Date of Discharge	Non-numeric data; invalid year
6.	Previous Admission	Non-numeric data; all zeros
7.	Patient Sex	Any designation code not found definitions
8.	Race	Non-numeric data; any designation code not found in definitions
9.	Ethnicity	Non-numeric data; any designation code not found in definitions
10.	Patient Zip Code	Non-numeric data; all zeros
11.	Hospital ID Code	Any designation code not found in definitions
12.	Attending Practitioner No.	All zeros; all spaces; all nines; any code not found on the Connecticut Health Care Provider Identification List
13.	Operating Practitioner No.	All zeros; all nines; any code not found on the Connecticut Health Care Provider

		Identification List
14.	Principal Diagnosis Code	All spaces; first digit is E; invalid ICD-9-CM diagnosis code
15.	Secondary Diagnosis Codes	Missing Principal Diagnosis Code; invalid ICD-9-CM diagnosis code
16.	Principal Procedure	Invalid ICD-9-CM procedure code
17.	Principal Procedure Day	Non-numeric data; number exceeding length-of-stay
18.	Other Procedures	Invalid ICD-9-CM procedure code; missing Principal Procedure
19.	Other Procedure Days	Non-numeric data; number exceeding length-of-stay
20.	Admission Status	Non-numeric data; any designation code not found in definitions
21.	Discharge Status	Non-numeric data; any designation code not found in definitions
22.	Expected Principal Source of Payment	Any designation code not found in definitions
23.	Birthweight	Non-numeric data
24.	Payer Identification	Any designation code not found in UB-82 Manual; non-numeric data
25.	Estimated Responsibility	Non-numeric data
26.	Deductible	Non-numeric data
27.	Coinsurance	Non-numeric data
28.	Total Actual Charges	Non-numeric data; all detail charges missing; total not in aggreement with sum of individual detail charges
29.	Revenue Codes	Valid UB-82 revenue center codes between 001 and 999
30.	Revenue Code Units of Service	Non-numeric data
31.	Detailed Revenue Code Charges	Non-numeric data

(B) The following edits from the Medicare Code Editor will be applied to the data. Data elements failing these edits will be rejected as errors.

(i) Invalid diagnosis or procedure code

(ii) Invalid fourth or fifth digit

(iii) E-code as principal diagnosis

(iv) Duplicate of principal diagnosis

(v) Manifestation code as principal diagnosis

(vi) Invalid age

(11) Consistency edits. The following edits will be applied to each patient data record to ensure the internal consistency of the patient data.

(A) The following edits from the Medicare Code Editor will be applied to the data. Data elements failing these edits will be rejected as errors.

(i) Age conflict

(ii) Sex conflict

(B) The following additional edits will be applied to the data. Data elements failing these edits will be rejected as errors.

(i) The sum of all charges for individual revenue codes must equal the total charges reported.

(ii) The total charges reported cannot be negative.

(iii) If a revenue code is reported, then charges must be reported for that revenue code.

(iv) If a revenue code between the values of 020 and 219 is reported, units of service must be reported for that revenue code.

(v) If a valid procedure code is reported, then a procedure day value which is less than or equal to the length of stay must be reported.

(vi) An operating practitioner must be reported for every principal procedure reported.

(vii) Birthweight must be coded if the Admission Status is newborn.

(Effective July 1, 1991)