INPATIENT

OUTPUT DATA DICTIONARY

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NOTE: **Bolded** and UPPER CASE are **IDENTIFYING DATA ELEMENTS** (see Data Protection Review Board (DPRB)
(See note below Regarding AIDS/HIV and Abortion Edits)

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I.
INTRODUCTION

I. Introduction

OVERVIEW

The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive data reporting system established in 1979 as a result of cooperation between the health care industry and government to collect patient level detail on patient characteristics, diagnoses, treatments and services. The purpose of SPARCS, as outlined in the regulations, was to create a statewide data set to contribute to the goal of providing high quality medical care at a reasonable cost to the inhabitants of the State by serving as an information source for organizations and agencies seeking to promote the efficient delivery of health care services. (Title 10 (Health) NYCRR 400.18 (e)(1)(i)).

Initially, data was collected for inpatient discharges only; SPARCS now collects data for every inpatient hospital discharge (IP)(1980), ambulatory surgery visit (AS)(1983),emergency department admission (ED) (2003), and most recently, outpatient visits (OP) (2011) from health care facilities certified under Article 28 of the New York State Public Health Law (NYSPHL).

The enabling legislation and regulations for SPARCS are located under Section 2816 of the Public Health Law and Section 400.18 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York (NYCRR).

BACKGROUND

The NYS Department of Health Office of Health Systems Management received grant funding from the Health Care Financing Administration (HCFA) in October, 1977. After establishing the necessary forms, procedures, and involvement of the health care community, data collection began in 1979 as a demonstration project.

In 1980, the first regulations were established in the Title 10 NYCCR to continue SPARCS under regulatory authority to collect inpatient data. The regulations required that inpatient data be submitted by all Article 28 facilities certified for inpatient services in New York State.

In April 1983 and June 1985, the State Hospital Review and Planning Council adopted additional regulations authorizing the reporting of ambulatory surgery data (AS) to the New York State Department of Health. These additional regulations required that outpatient data be submitted by all facilities providing ambulatory surgery services.

In April 1993, a national ad hoc task force released a new Universal Data Set (UDS) Specification that included reporting codes for use with the Uniform Bill (UB-92) paper form and a new electronic format. The UDS system streamlined multiple data submission formats into a single format, removing redundant reporting requirements for hospitals and other health care facilities. SPARCS adopted these national formats for billing and claims processing to simplify data reporting With this adoption, SPARCS reaped the benefits of using the national standards; In order to continue to progress with the current health care industry data standards, SPARCS continues to adopt changes approved by the National Uniform Billing Committee (NUBC).

Recognizing the need for emergency department data (ED), the New York State Legislature passed legislation in September 2001 mandating the collection of ED data through SPARCS. After identifying data elements that satisfied public health and health services administration

information needs, voluntary submissions started in 2003. Once the regulations were established for the collection of ED data in January 2005, mandatory collection began.

In April 2006 the New York State Legislature again amended Article 28 Section 2816 (2) (a) (iv) to mandate the reporting of all outpatient clinic visit data (OP). This new information was added to the collection of AS and ED visits on the outpatient file. This initiative became known as the Expanded Outpatient Data Collection (EODC) Project with data collection commencing with a phased in approach that started in the summer of 2011 from hospital outpatient departments. This new information was added to the Outpatient Output SPARCS file.

As a result of the new data collection, the need arose to restructure the output files. In 2012 the structure of the output files for both the inpatient and outpatient data were modified to organize the data elements into segments. This document reflects these changes.

SPARCS AND PATIENT PRIVACY

The responsibility for protecting the confidentiality and privacy of data related to patient care resides with the Commissioner of Health. The responsibility for tracking and monitoring the technical functioning of SPARCS data collection resides within the Bureau of Health Informatics. Staff is available to assist with every phase of the SPARCS data system.

As a public health entity, the NYS Department of Health and the SPARCS data set are not covered under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. However, the NYS Department of Health takes very seriously the protection of patient privacy. In fact, the NYS Department of Health created a Data Protection Review Board (DPRB) that has been in place since 1980. The DPRB approves the applications for identifiable data.

All users of the SPARCS Limited and Identifiable data must sign Data Use Agreements (DUAs). Regardless of the type of data or file being used, these DUAs are strictly enforced.

WHERE THE DATA COMES FROM:

SPARCS inpatient (IP) and outpatient (AS, ED, OP) data is provided by facilities certified under Article 28 of the Public Health Law. Any facility certified to provide inpatient services, ambulatory surgery services, emergency department services or outpatient services is required to submit data to SPARCS. This includes all New York State Hospitals and Diagnostic and Treatment Centers (D&TC's - commonly known as clinics). This includes both hospital owned and operated, as well as free-standing D&TC facilities. Regardless of their ownership, each facility must report data for each specific facility location. That is, if a hospital owns more than one location (i.e., Buffalo General Hospital, Millard Fillmore Hospital, Millard Fillmore Suburban, and DeGraff Memorial Hospital) each location must report separately to SPARCS.

FILE TYPES and FORMAT

SPARCS data users will find a vast array of information on our web site including specifics on data content, format, and obtaining data access. Users should note the distinction between the two Output Data Dictionaries (Inpatient and Outpatient). The Output Data Dictionary for Inpatient (hospital discharge data and emergency room visits that resulted in an inpatient stay data) and the Output Data Dictionary for Outpatient (emergency department only, ambulatory surgery, and outpatient services visit data) are two specific documents for data users.

With the collection of new outpatient services data in 2012, came the opportunity to redesign the output files. Beginning in August 2012, the file format for all data years (for all types of data) was modified. For SPARCS data users that obtained data prior to August 2012, this Data Dictionary will not apply since data was in the old format. For users obtaining data in August 2012 and after, (for any data year) this Data Dictionary will apply since the data is in the new format. Thus, if you requested Inpatient Data for years 2000-2005 after August 2012, this is the Data Dictionary to use for the new file format. Any file received after August 2012 will be in this new format, regardless of the year of data requested.

File Types:

To enable the use of SPARCS data as a national information resource for all researchers to contribute to the goal of providing high quality medical care at a reasonable cost, there are three distinct files available for usage. Additional information on these data sets is available on the NYS Health Department's website at http://www.health.ny.gov/statistics/sparcs/.

De-identified – This data file contains basic record level detail; it does not contain data that is protected health information (PHI) under HIPAA. The health information is not individually identifiable; all data elements that are considered identifiable have been redacted. For example, the direct identifiers regarding a date (admission date, procedure date, etc.) have the day and month portion of the date removed. This data file is public under the Freedom of Information Law (FOIL). There is a process under the NYS Department of Health for obtaining such information under FOIL. For more information on obtaining this data file please contact the following office:

Records Access Office
New York State Department of Health
Corning Tower, Room 2364
Albany, New York 12237-0044
Fax: (518) 486-9144
E-mail: foil@health.state.ny.us
Website: http://www.health.ny.gov/regulations/foil/howto.htm

Limited – This data file contains more information than the De-identified File that is described as "limited" under HIPAA. That is, the additional information does not contain any "direct identifiers" under HIPAA; but is "limited" by modifying the data elements. Specifically, the data is encrypted to render protected health information unusable, unreadable or indecipherable to unauthorized individuals. [1] . The encryption processes used by SPARCS has been tested by the National Institute of Standards and

[1] 45 CFR 164.304, definition of "encryption."

Technology (NIST) and judged to meet their standards. Other direct identifiers regarding a date (admission date, procedure date, etc.) have the day portion of the date removed (the month and year are available.)

This data file requires users to submit an application and sign a Data Use Agreement (DUA). The signed DUA allows the NYS Department of Health to disclose this information to users of the data without authorization from the data subjects. To obtain this data file, a completed "DOH-4395" limited data application and signed DUA should be submitted to:

Director, Data Release and Analytics Unit
New York State Department of Health
Corning Tower, Room 878
Albany, NY 12237
Phone: (518) 474-3189
E-mail: bio-info@health.state.ny.us

Identifiable – This file contains direct identifiers under HIPAA, such as patient's address, patient's date of birth, patient record numbers (medical record number, patient control number, etc.) and specific dates. Each data element page within this document will indicate if the data element is contained on the Identifiable Data Set. To obtain this data file a completed "DOH-4385" identifiable data application and signed DUA should be submitted to:

Executive Secretary
Data Protection Review Board
New York State Department of Health
Corning Tower, Room 878
Albany, NY 12237
Phone: (518) 473-8144
Fax: (518) 486-3518
E-mail: dprb@health.state.ny.us

In order to determine if a data element is included in one of the above datasets, please see the specific data element page in this document, or the "Table of Contents" document on the website. The Table of Contents document has a column for "De-identified", "Limited" and Identifiable" files; an "x" will be marked in the appropriate column indicating if the data element is available on a particular file.

File Format:

In 2012, the file format was changed to introduce the concept of data segments. These segments will help users of the data find specific data elements that relate to one another. The new segments for the Inpatient Output file are:

- Common Detail
- Patient
- Newborn
- Facility
- Physician
- Payer
- Data Collection
- Miscellaneous

- Treatment
- AMI
- HIPPA
- Charges
- Services
- Diagnosis
- Procedure
- DRGs

Due to the large number of data elements and the repetitive nature of some of the data elements, SPARCS cannot put all the information on one output record. The output files for SPARCS have historically employed the use of many records to display the event (hospital stay or visit). To do this within an output file structure, the records for the event are classified in the "Primary Record" and "Continuation Record(s). That is, if a patient has more information than can fit on the "Primary" record, the other information is contained on the "Continuation" record(s) for the same patient stay or visit. All patient hospital stays or visits will have a "Primary" record. Depending upon the events during the hospital stay or visit, there may be one or more continuation records.

RECORD TYPE:
PRIMARY:

- On all services less than or equal to ten (10).

Within the file structure, the Primary record contains majority of information on the patient hospital visit. The Primary record contains more segments than the continuation records. Table I outlines the segments contained on the Primary Record. Please note that the segment "Common Detail" is on both record types. The information or data elements contained in this segment are used to link to the primary and continuation records.

CONTINUATION:

- On all services greater than ten (10).

The Continuation Records are used to "continue" the information related to the patient's visit. Table I outlines the segments contained on the Continuation Record. In order to know how many continuation records there are for a patient stay/visit, you must use the data elements "Record Sequence Number" and "Record Sequence Count". Do not use Continuation Records without linking the information to the Primary Record.

TABLE I
SEGMENT LOCATIONS

		RECORD TYPE	
SEGMENT	**# of Data Elements**	**PRIMARY RECORD**	**CONTINUATION RECORD**
COMMON DETAIL -Discharge Number -Continuation Type -Record Sequence -Record Sequence Count	4	YES	YES
PATIENT	18	YES	NO
NEWBORN	3	YES	NO
FACILITY	7	YES	NO
PHYSICIAN	3	YES	NO
PAYER	17*	YES	NO
DATA COLLECTION	6	YES	NO
MICELLANEOUS	10	YES	NO
TREATMENT	26*	YES	NO
DIAGNOSIS	9*	YES	NO
PROCEDURE	11*	YES	NO
DRG	25	YES	NO
AMI	4	YES	NO
HIPAA	2	YES	NO
CHARGES	6	YES	NO
SERVICE	6*	YES	YES
*= data elements with multiple values collected are counted once, i.e, other diagnosis code 1 – 24			

As you see in the above table, besides the necessary "Common Detail", the "Service Segment" is the only segment continued onto the continuation records. The reason for this is because the amount of information contained on the claim for the services provided can vastly differ from individual to individual. The "Continuation Records" allow for additional information to be collected on services. The number of continuation records is contained in the data element "Record Sequence Count". The specific record of the sequence is contained in the data element "Record Sequence Number".

EXAMPLE OF A CONTINUATION RECORD

For example, Mr. Smith is a patient that had a long hospital stay; he is likely to have many services provided during his stay. On the Service Segment are the data elements contained in Table II. There can be up to 999 occurrences reported on the service level data elements on the claim. In our example, Mr. Smith had 83 different revenue codes associated with his claim. The first ten of these revenue codes on located on the "Primary Record", where the "Record Sequence Number" is always equal to one (1). The other revenue codes are located on the "Continuation Records".

TABLE II
Inpatient Service Segment – Data Elements and their Positions

Set of Data Elements	Short Name	Primary Contain:	Continuation Records Contain:
Revenue Code	Revcd	1 - 10	11 - 999
Revenue Type	RevType	1 - 10	11 - 999
Service Charges	ServChrg	1 - 10	11 - 999
Unit Type	Unit_type	1 - 10	11 - 999
Unit Quantity	Units	1 - 10	11 - 999
Service Non-covered Charges	ServNChrg	1 - 10	11 - 999

In order for a researcher to obtain the rest of Mr. Smith's information, they must obtain the appropriate continuation records by using the "Common Detail" segments / data elements to "link" the information. It is very important to link the appropriate primary record to the corresponding continuation record, particularly if Mr. Smith has been in the hospital more than once.

By using Table III below, you can see that Mr. Smith's first Continuation Record will contain the Revenue Codes 11-80; this Continuation Record will have the "Record Sequence Number" equal to two (2).

The remainder of Mr. Smith's revenue codes (81 -83) will be contained on the next Continuation Record; this Continuation Record will have the "Record Sequence Number" equal to three (3).

In this example, the "Record Sequence Count" for Mr. Smith's stay will be equal to "3" because there are a total of three records containing information; one primary record and two continuation records.

TABLE III
Example: How to use the Sequence Number on Continuation Records

Data Element / Sequence #	Revenue Code	Revenue Type	Service Charge	Unit Type	Unit Quantity	Service Non-Covered Charges
1 (Primary)	1-10	1-10	1-10	1-10	1-10	1-10
2 (Continuation)	11-80	11-80	11-80	11-80	11-80	11-80
3 (Continuation)	81-150	81-150	81-150	81-150	81-150	81-150
4 (Continuation)	151-220	151-220	151-220	151-220	151-220	151-220
5 (Continuation)	221-290	221-290	221-290	221-290	221-290	221-290
6 (Continuation)	291-360	291-360	291-360	291-360	291-360	291-360
7 (Continuation)	361-430	361-430	361-430	361-430	361-430	361-430
8 (Continuation)	431-500	431-500	431-500	431-500	431-500	431-500
9 (Continuation)	501-570	501-570	501-570	501-570	501-570	501-570
10 (Continuation)	571-640	571-640	571-640	571-640	571-640	571-640
11 (Continuation)	641-710	641-710	641-710	641-710	641-710	641-710
12 (Continuation)	711-780	711-780	711-780	711-780	711-780	711-780
13 (Continuation)	781-850	781-850	781-850	781-850	781-850	781-850
14 (Continuation)	851-920	851-920	851-920	851-920	851-920	851-920
15 (Continuation)	921-990	921-990	921-990	921-990	921-990	921-990
16 (Continuation)	991-999	991-999	991-999	991-999	991-999	991-999

II.

DATA ELEMENT GUIDE

II. DATA ELEMENT GUIDE
PRIMARY RECORDS

COMMON DETAIL - Primary Records

Record Positions	Data Element	Type	Size	Description
1-14	Discharge Sequential Number	NUM	14	Discharge year, plus an eight digit sequentially assigned number by SPARCS
15	Continuation Indicator	NUM	1	0 = no continuation records 1 = continuation record exists
16-18	Record Sequence Number	NUM	3	Primary Record =001 Continuation Records will be = 002 thru 016
19-21	Record Sequence Count	NUM	3	Total number of records reported for a patient stay. (Primary and all possible continuation records)

PATIENT SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
22-27	Filler	CHAR	6	No data
28-47	Patient Control Number	CHAR	20	Patient's unique number assigned by the provider
48-64	Medical Record Number	CHAR	17	The number used by the Medical Records Department to identify patient's permanent medical/health record file
65-74	Unique Personal Identifier	CHAR	10	Composed of portions of last name (first 2, last 2), first name (first 2), SSN (last 4)
75-93	Enhanced Unique Personal Identifier	CHAR	19	Unique Personal Identifier plus date of birth, and sex
94-101	Patient Birth Date	NUM	8	Patient Birth Date (CCYYMMDD)
102-104	Age	CHAR	3	Patient's age calculated on date of admission.
105-107	Age in Days (for Newborn)	NUM	3	Calculated age in days for all records with an age equal to 0 (under 1 year of age)
108	Patient Sex	CHAR	1	Sex of patient as recorded on date of admission or start of care. M = Male / F = Female / U = Unknown
109-110	Patient Race	CHAR	2	Code which best describes the race of patient. "01" = White "02" = Black or African American "03" = Native American or Alaskan Native "04" = Asian "05" = Native Hawaiian or Other Pacific Islander "88" = Other Race "99" = Unknown
111	Patient Ethnicity	CHAR	1	Code which best describes ethnic origin of patient. "1" = Spanish/Hispanic Origin "2" = Not of Spanish/Hispanic Origin "9" = Unknown
112-129	Patient Address Line 1	CHAR	18	Patient's street number, PO box number, or RFD
Record Positions	**Data Element**	**Type**	**Size**	**Description**
130-147	Patient Address Line 2	CHAR	18	Continuation of the mailing address (blank if n/a)
148-162	Patient City	CHAR	15	City, town or village
163-164	Patient State	CHAR	2	Capitalized two-letter abbreviation for the state
165-169	Patient Postal Service Zip Code	CHAR	5	Postal Service Zip Code (five digit)
170-173	Patient Postal Service Extension Code	CHAR	4	Zip Code Extension (four digit)
174-175	Patient County Code	NUM	2	A valid two-digit code in accordance with the Zip/County Code Edit Validation Table in Appendix F
176-177	SPARCS Region Code	CHAR	2	Assigned by SPARCS based on county of the facility

NEWBORN SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
178	Newborn Flag	CHAR	1	Flag indicating Newborn Discharge Status "0" = not newborn / "1" = newborn "2" = one of multiple newborns
179-195	Mother's Medical Record Number (MRN)	CHAR	17	Mother's Medical Record Number (MRN)
196-199	Newborn Birth Weight *(previously Neonate Birth Weight)*	NUM	4	Reported Weight of the Newborn

FACILITY SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
200-205	Facility Identifier *(previously SPARCS Identification Number)*	CHAR	6	Permanent Facility Identifier (PFI) assigned by the Department of Health upon certification
206	Facility Identifier Check Digit	CHAR	1	Follows the Facility Identifier Assigned by the SPARCS Administrative Unit.
207-276	Facility Name	CHAR	70	Facility Name as maintained by the NYSDOH Division of Health Facility Planning.
277	Health Service Area	NUM	1	Assigned by SPARCS based upon county of facility
278-279	Facility County	NUM	2	Assigned by SPARCS based upon county of facility
280-286	Operating Certificate Number	NUM	7	The number assigned by DOH Division of Health Facility Planning
287-296	National Provider ID *(previously Provider Identification Number)*	NUM	10	Facility's National Provider ID (NPI)

PHYSICIAN SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
297-304	Attending Provider State License Number	CHAR	8	The professional license number, issued by the NYS Dept of Education (Attending Physician ID)
305-312	Operating Physician State License Number	CHAR	8	The professional license number, issued by the NYS Dept of Education (Operating Physician ID)
313 - 320	Other Physician State License Number	CHAR	8	The professional license number, issued by the NYS Dept of Education (Other Physician ID)

PAYER SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
321 - 335	Source of Payment Typology 1-3	NUM	5	Identifies primary, secondary, and third payer expected to pay a portion of bill
336 395 454 513 572 631	Source of Payment 1-6	CHAR	1	Code indicating type of payment
337-338 396-397 455-456 514-515 573-574 632-633	X12 Source of Payment 1-6	CHAR	2	X-12 code indicating type of payment
339-357 398-416 457-475 516-534 575-593 634-652	Policy Number 1-6	CHAR	19	Insurance Policy Number

Record Positions	Data Element	Type	Size	Description
358-365 417-424 476-483 535-542 594-601 653-660	Payer ID 1-6	CHAR	8	NAIC ID Number or Plan Number for Insurance Company
366-369 425-428 484-487 543-546 602-605 661-664	Covered Days 1-6	NUM	4	Number of days covered by insurance
370-373 429-432 488-491 547-550 606-609 665-668	Non-Covered Days 1-6	NUM	4	Number of days not covered by insurance
374-386 433-445 492-504 551-563 610-622 669-681	Provider ID 1-6	CHAR	13	Insurance Company's ID for Facility (Facility NPI)
387-390 446-449 505-508 564-567 623-626 682-685	Alternate Care Days 1-6	NUM	4	Number of days at level of Non-Acute care
391-394 450-453 509-512 568-571 627-630 686-689	Leave of Absence (LOA) Days 1-6	NUM	4	Number of days in leave of absence status
690-691	Expected Principal Reimbursement	CHAR	2	Code identifying the payer expected to pay the major portion of the patient's bill.
692-693	Expected Reimbursement Other 1	CHAR	2	Code identifying the secondary payer expected to pay a portion of the patient's bill.
694-695	Expected Reimbursement Other 2	CHAR	2	Same as above
696-697	WC / NF Indicator 1	CHAR	2	Code identifying the third payer expected to pay a portion of the patient's bill.
698-706	WC / NF Amount	NUM	9	Code indicating if bill was covered by Workers' Compensation (WC) / No-Fault Insurance (NF)
707	Surplus, Catastrophic or Recurring Monthly Code	CHAR	1	Dollar amount covered by WC/NF
708-716	Surplus, Catastrophic or Recurring Monthly Amount	NUM	9	Code indicating a monthly payment was required of Medicaid patient towards cost of hospitalization. "1" = Surplus

DATA COLLECTION SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
717 - 722	Log Number	NUM	6	Assigned by SPARCS. Identifies submission to which the record belonged.
723	Transaction Code	CHAR	1	Identifies the type of transaction for the electronic institutional claims Code / Value / Type of Bill 1 / Delete / Third position code "8" 2 / Add / Third position code "1" 3 / Correction / Third position code "7"
724 - 731	Date Processed	CHAR	8	Date facility created the file to submit to SPARCS.
732 - 734	SPARCS Collector Code	NUM	3	SPARCS Collector Code
735	Claim Type	CHAR	1	Claim Type (I, A, E, O) "I" = Inpatient Services
736	File Type (Complete/Incomplete)	NUM	1	File Type (C - Complete / I - Incomplete)

MISCELLANEOUS SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
737	Residence Indicator	CHAR	1	Code indicating Homeless / Non-US Resident. "H" = HOMELESS Patient "F" = Non-United States Resident (Foreign Born) Blank if N/A
738	Special Program (DIS)	CHAR	1	Indicates entitlement to Medicaid benefits due to disability (Y = Disability, or blank if none)
739	Special Program (FP)	CHAR	1	Indicates entitlement to Medicaid benefits due to Family Planning Procedures (Y = Family Planning, or blank if none)
740	Special Program (PHP)	CHAR	1	Indicates entitlement to Medicaid benefits under Physically Handicapped Children's Program (PHC) (Y = PHC, or blank if none)
741	Special Program (SFP)	CHAR	1	Indicates entitlement to Medicaid benefits under the Special Funding Project (SFP). (Y = SPF, or blank if none)
742 - 761	Old SPARCS Accommodation Codes 1-5	CHAR	4	Old SPARCS Accommodation Codes 1, 2, 3, 4, and 5 indicating entitlement to Medicaid benefits under SFP.
762 – 764	Bed Placement Indicator	CHAR	3	Bed placement indicator used from 1994 to 1996. "UB" = Unit Bed / "SB" = Scatter Bed / blank = n/a
765	Do Not Resuscitate (DNR) Indicator	CHAR	1	Indicates if Do Not Resuscitate Order (DNR) "Y" = A DNR Order Does exist "N" = A DNR Order Does Not exist
766	Emergency Department (ED) Indicator	CHAR	1	Emergency Department Indicator based on submitted revenue codes. E = revenue code of 045X, or blank
767 – 769	Exempt Unit Indicator	CHAR	3	Identifies discharge from unit exempt from Diagnosis Related Group (DRG) reimbursement.

TREATMENT SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
770 – 777	Statement Covers Period From Date	NUM	8	Beginning date of the billing period (CCYYMMDD)
778 – 785	Statement Covers Period Through	NUM	8	Ending date of the billing period (Discharge

Record Positions	Data Element	Type	Size	Description
	Date			Date) (YYYMMDD)
786 – 793	Admission/Start of Care Date	NUM	8	Date of Admission (CCYYMMDD)
794 – 796	Admit Week Day	CHAR	3	Day of week patient was admitted (1st three letters)
797 – 798	Admission Hour	NUM	2	Hour admitted to inpatient care
799	Unscheduled/Scheduled Admission Indicator	CHAR	1	Describes urgency of admission to hospital. "1" = Unscheduled / "2" = Scheduled "9" = Information not available.
800 – 807	Discharge Date	NUM	8	Date of discharge or death. (CCYYMMDD)
808 – 810	Discharge Week Day	CHAR	3	Weekday of discharge or death (1st three letters)
811 – 812	Discharge Hour	NUM	2	Hour of discharge or death
813 – 816	Length of Stay	NUM	4	Total number of patient days (excluding leave of absence days)
817 – 820	Insured Days	NUM	4	Number of days covered by the primary payer as qualified by the payer (Insured Days)
821 – 824	Non-Insured Days	NUM	4	Non-Insured Days
825 – 828	Total Leave of Absence Days	NUM	4	Total leave of absence days for the inpatient stay
829 – 832	Alternate Care Days	NUM	4	Total number of patient days at a level of care other than acute.
833	Alternate Care Type	CHAR	1	Code specifying the type of alternate care: "1" = Residential Health Care Facility "2" = Medically Related Home Care Services "3" = Domiciliary Care "4" = Other Institution "5" = Home Health Service
834 – 841	Alternate Care Date	NUM	8	First date that acute care was no longer needed (CCYYMMDD)
842 – 845	Acute Certified Days	NUM	4	Total number of days at acute level of care

Record Positions	Data Element	Type	Size	Description
846 – 847 864 – 865 882 – 883 900 – 901 918 – 919 936 – 937 954 – 955 972 – 973 990 – 991 1026 - 1027 1044 - 1045 1062 - 1063 1080 - 1081 1098 - 1099 1116 - 1117 1134 – 1135 1152 - 1153 1170 - 1171 1188 - 1189 1206 - 1207 1224 - 1225 1242 - 1243 1260 – 1261 1278 - 1279 1296 - 1297 1314 – 1315 1332 - 1333 1350 – 1351 1368 - 1369	Non-Acute Care Type 1-30	CHAR	2	Code indicating type of non-acute care reported "74" = Leave of Absence "75" = SNF or Residential Care Facility (ALC) "81" = Home Health Level of Care (ALC) "82" = Other Level of Care (ALC)
848 – 855 866 – 873 884 – 891 902 – 909 920 – 927 938 – 945 956 – 963 974 – 981 992 – 999 1010 - 1017 1028 - 1035 1046 - 1053 1064 - 1071 1082 - 1089 1100 - 1107 1118 - 1125 1136 - 1143 1154 - 1161 1172 - 1179 1190 - 1197 1208 - 1215 1226 - 1233 1244 - 1251 1262 - 1269 1280 - 1287 1298 - 1305 1316 - 1323 1334 - 1341 1352 - 1359 1370 - 1377	Non-Acute From Date 1-30	NUM	8	Date non-acute care began (CCYYMMDD)

Record Positions	Data Element	Type	Size	Description
856 – 863 874 – 881 892 – 899 910 – 917 928 – 935 946 – 953 964 – 971 1000 - 1007 1018 - 1025 1036 - 1043 1054 - 1061 1072 - 1079 1090 - 1097 1108 - 1115 1126 - 1133 1144 - 1151 1162 - 1169 1180 - 1187 1198 - 1205 1216 - 1223 1234 - 1241 1252 - 1259 1270 - 1277 1288 - 1295 1306 - 1313 1324 - 1331 1342 - 1349 1360 - 1367 1378 – 1385	Non-Acute Through Date 1-30	NUM	8	Date non-acute care ended (CCYYMMDD)
1386	Same Day Discharge Indicator	CHAR	1	Flag indicating if patient admitted and discharged same day. 0 = not same day , 1 = same day
1387 - 1388	Discharge Status/ Disposition	CHAR	2	Code which best identifies the patient's destination or status upon discharge
1389 - 1391	Type of Bill	CHAR	3	Three-digit numeric code identifying the specific type of bill
1392	Service Category	CHAR	1	Service Category Group of the discharge record 1 = Medical 2 = Surgical 3 = Pediatric 4 = Obstetrical 5 = Nursery/Newborn 6 = Psychiatric
1393	Type of Admission	CHAR	1	Code indicating manner the patient was admitted "1" = Emergency "2" = Urgent "3" = Elective "4" = Newborn "5" = Trauma "9" = Information not available
1394	Source of Admission/Point of Origin	CHAR	1	Code indicating point of patient origin for admission

DIAGNOSIS SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
1395 - 1401	Admission Diagnosis Code	CHAR	7	Code describing condition upon admission
1402 – 1408	Principal Diagnosis Code	CHAR	7	Code indicating condition established after study to have been chiefly responsible for admission

Record Positions	Data Element	Type	Size	Description
1409	Filler *(previously Diagnosis POA*)	CHAR	1	Not currently reported.
1410 - 1416 1418 - 1424 1426 - 1432 1434 - 1440 1442 - 1448 1450 - 1456 1458 - 1464 1466 - 1472 1474 - 1480 1482 - 1488 1490 - 1496 1498 - 1504 1506 - 1512 1514 - 1520 1522 - 1528 1530 - 1536 1538 - 1544 1546 - 1552 1554 - 1560 1562 - 1568 1570 - 1576 1578 - 1584 1586 - 1592 1594 - 1600	Other Diagnosis Code 1-24	CHAR	7	Any other condition affecting treatment and/or length of stay
1417 1425 1433 1441 1449 1457 1465 1473 1481 1489 1497 1505 1513 1521 1529 1537 1545 1553 1561 1569 1577 1585 1593 1601	Present on Admission (POA) Indicator 1-24	CHAR	1	Indicates if onset of diagnosis preceded or followed admission to hospital 1 = Yes - Present at inpatient admission 2 = No - Not present at inpatient admission 3 = Clinically Undetermined 9 = Unknown X = Exempt from POA reporting
1602 - 1604	Clinical Classification Software (CCS) Diagnosis Category	CHAR	3	CCS Diagnosis Category using the reported ICD-9-CM code
1605 - 1618	After Anesthesia Indicator 1-14	CHAR	1	Indicates if corresponding Other Diagnosis Code occurred after administration of anesthesia. "1" = Yes / "2" = No / "9" = Unknown / blank = n/a
1619 - 1620	Accident Related Code	CHAR	2	Identifies specific event relating to the bill that may affect payer processing

Record Positions	Data Element	Type	Size	Description
				01 Accident /Medical Coverage 02 No Fault Insurance Involved/ Including Auto Accident/Other 03 Accident /Tort Liability 04 Accident /Employment Related 05 Accident /No Medical or Liability Coverage 06 Crime Victim
1621 - 1628	Accident Related Date	NUM	8	Date corresponding to the significant event relating to the bill that may affect payer processing (CCYYMMDD)
1629 - 1635	External Cause of Injury	CHAR	7	ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
1636 - 1642	Place of Injury Code	CHAR	7	Identifies place where the corresponding injury was reported in External Cause-of-Injury Code

PROCEDURE SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
1643 – 1649	Principal Procedure Code	CHAR	7	Identifies the inpatient principal procedure performed at claim level during period covered by this event
1667 - 1673 1691 - 1697 1715 - 1721 1739 - 1745 1763 - 1769 1787 - 1793 1811 - 1817 1835 - 1841 1859 - 1865 1883 - 1889 1907 - 1913 1931 - 1937 1955 - 1961 1979 - 1985	Procedure (ICD) Code 1-14	CHAR	7	ICD code identifying any significant procedure, other than Principal Procedure
1650 – 1657	Principal Procedure Date	NUM	8	Date Principal Procedure performed.
1674 - 1681 1698 - 1705 1722 - 1729 1746 - 1753 1770 - 1777 1794 - 1801 1818 - 1825 1842 - 1849 1866 - 1873 1890 - 1897 1914 - 1921 1938 - 1945 1962 - 1969 1986 - 1993	Other Procedure Date 1-14	NUM	8	Date Other Procedure performed.
1658 1682 1706 1730 1754 1778 1802 1826 1850 1874	Pre-Admit Indicator 1-15	CHAR	1	Indicates if procedure was before (-), on (+), or after (+) Admission Date. Blank if no procedure.
1898	Pre-Admit Indicator 1-15 ***contd.***	CHAR	1	Indicates if procedure was before (-), on (+), or

Record Positions	Data Element	Type	Size	Description
1922 1946 1970 1994				after (+) Admission Date. Blank if no procedure.
1659 – 1662 1683 - 1686 1707 - 1710 1731 - 1734 1755 - 1758 1779 - 1782 1803 - 1806 1827 - 1830 1851 - 1854 1875 - 1878 1899 - 1902 1923 - 1926 1947 - 1950 1971 - 1974 1995 - 1998	Pre-Op Days 1-15	CHAR	4	Number of days between procedure and admission date
1663 – 1666 1687 - 1690 1711 - 1714 1735 - 1738 1759 - 1762 1783 - 1786 1807 - 1810 1831 - 1834 1855 - 1858 1879 - 1889 1903 - 1906 1927 - 1930 1951 - 1954 1975 - 1978 1999 - 2002	Post-Op Days 1-15	CHAR	4	Number of days between procedure and discharge date.
2003 - 2005	Clinical Classification Software (CCS) Procedure Category	CHAR	3	CCS Procedure Category based on reported procedure code
2006 - 2007	Method of Anesthesia Used	NUM	2	Type of anesthesia administered during stay. "00" = No Anesthesia "10" = Local Anesthesia "20" = General Anesthesia "30" = Regional Anesthesia "40" = Other
2008 - 2016	Blood Furnished Amount	NUM	9	The total number of pints of whole blood or units of packed red cells furnished
2017	Age Warning Flag	CHAR	1	Flags conflict between reported diagnosis and ICD-CM reference file's Age-specific edits. 1 = conflict, blank = no conflict
2018	Procedure Date Warning Flag	CHAR	1	Flags conflict when procedure date conflicts with (is no more than three (3) days prior to) Admission Date/Start of Care. "1" = Conflict / blank = No conflict
2019	Coding Method Used	CHAR	1	Identifies coding structure used. All procedure and diagnosis codes for inpatient stays are ICD-9-CM

DRG SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
2020 - 2022	Federal Diagnostic Risk Grouper (DRG)	CHAR	3	Categorizes patient records for calendar year of date of discharge. Current Version of MS-DRG
2023 - 2024	Federal Major Diagnostic Category (MDC)	CHAR	2	Categorizes patient records for calendar year of date of discharge. Current Version of MS-MDC
2025 - 2027	Past Federal Diagnostic Related Group (DRG)	CHAR	3	This DRG is specific to the past/prior calendar year of the date of discharge.
2028 - 2029	Past Federal Major Diagnostic Category (MDC) – *previously MDC Prior Federal*	CHAR	2	This MDC is specific to the past/prior calendar year of the date of discharge
2030 - 2032	New Federal Diagnostic Related Group (DRG)	CHAR	3	This DRG is specific to the following (new) calendar year of the date of discharge.
2033 - 2034	New Federal Major Diagnostic Category (MDC)	CHAR	2	This MDC is specific to the following (new) calendar year of the date of discharge.
2035 - 2037	All Patient Diagnosis Related Group (AP DRG)	CHAR	3	All Patient Diagnosis Related Group (AP DRG). This DRG is specific to the calendar year of the date of discharge.
2038 - 2039	All Patient Major Diagnostic Category (AP MDC)	CHAR	2	The All Patient Major Diagnostic Category (AP MDC). This AP MDC is specific to the calendar year of the date of discharge.
2040 - 2042	Past All Patient Diagnostic Related Group (AP DRG)	CHAR	3	This DRG is specific to the prior calendar year of the date of discharge.
2043 - 2044	Past All Patient Major Diagnostic Category (AP MDC)	CHAR	2	This AP MDC is specific to the past/prior calendar year of the date of service.
2045 - 2047	New All Patient Diagnosis Related Group (AP DRG)	CHAR	3	This AP DRG is specific to the following calendar year of the date of discharge.
2048 - 2049	New All Patient Major Diagnostic Category (AP MDC)	CHAR	2	This AP MDC is specific to the following year of the date of discharge.
2050 - 2052	All Patient Refined Diagnosis Related Group (APR DRG)	CHAR	3	All Patient Refined Diagnosis Related Group (APR DRG). This APR DRG is specific to the calendar year of the date of discharge.
2053 - 2054	All Patient Refined Major Diagnostic Category (APR MDC)	CHAR	2	All Patient Refined Major Diagnostic Category (APR MDC). This APR MDC is specific to the calendar year of the date of discharge.
2055	All Patient Refined Risk of Mortality (APR ROM)	CHAR	1	All Patient Refined Risk of Mortality (APR ROM). This APR ROM is specific to the calendar year of the date of discharge.
2056	All Patient Refined Severity of Illness (APR SOI)	CHAR	1	All Patient Refined Severity of Illness (APR SOI). This SOI is specific to the calendar year of the date of discharge.
2057 - 2059	Past All Patient Refined Diagnosis Related Group (APR DRG)	CHAR	3	This APR DRG is specific to the past/prior calendar year of the date of discharge.
2060 - 2061	Past All Patient Refined Major Diagnostic Category (APR MDC)	CHAR	2	This APR MDC is specific to the past/prior calendar year of the date of discharge.
2062	Past All Patient Refined Risk of Mortality (APR ROM)	CHAR	1	This APR ROM is specific to the past/prior calendar year of the date of discharge.
2063	Past All Patient Refined Severity of Illness (APR SOI)	CHAR	1	This APR SOI is specific to the past/prior calendar year of the date of discharge.
2064 - 2066	New All Patient Refined Diagnosis Related Group (APR DRG)	CHAR	3	This APR DRG is specific to the following calendar year of the date of discharge.
2067 - 2068	New All Patient Refined Major Diagnostic Category (APR MDC)	CHAR	2	This APR MDC is specific to the following calendar year of the date of discharge.
2069	New All Patient Refined Risk of Mortality (APR ROM)	CHAR	1	This APR ROM is specific to the following calendar year of the date of discharge.
2070	New All Patient Refined Severity of Illness (APR SOI)	CHAR	1	This APR SOI is specific to the following calendar year of the date of discharge.
2071 - 2074	Diagnosis Related Group (DRG) Billed	CHAR	4	Diagnosis Related Group (DRG) Billed obtained from grouping diagnoses and procedures

AMI SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
2075	AMI Warning Flag	NUM	1	Acute Myocardial Infarction (AMI) Warning Indicator "1" = AMI code reported/"0" = No AMI code reported.
2076 - 2078	Heart Rate on Arrival	NUM	3	Patient heart rate in beats per minute (bpm) taken at first patient contact after arrival with Principal/Primary Diagnosis of AMI. ### = Equals Patient Heart Rate on Arrival. “888” = Undocumented in Medical Chart “999” = Unknown blank = Not applicable,
2079 - 2081	Systolic BP on Arrival	NUM	3	Systolic BP in mg/dl at first patient contact after arrival with Principal/Primary Diagnosis of AMI ### = Systolic Blood Pressure upon arrival. “888” = Undocumented in Medical Chart “999” = Unknown blank = Not applicable
2082 - 2084	Diastolic BP on Arrival	NUM	3	Diastolic BP in mg/dl at first patient contact after arrival with Principal/Primary Diagnosis of AMI ### = Diastolic Blood Pressure upon arrival. “888” = Undocumented in Medical Chart “999” = Unknown blank = Not applicable

HIPAA SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
2085	AIDS Flag	CHAR	1	Indicates if any indication of AIDS/HIV in discharge record (Y or N)
2086	Abortion Flag	CHAR	1	Indicates if any indication of abortion in discharge record (Y or N)

CHARGES SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
2087 - 2098	Total Charges	NUM	12	Sum of Total Accommodations Charges and Total Ancillary Charges for the patient's stay.
2099 - 2108	Accommodation Total Charges	CHAR	10	Accommodations Days multiplied by the Accommodations Rate.
2109 - 2118	Ancillary Total Charges	CHAR	10	Total of all Ancillary Charges incurred during stay
2119 - 2130	Total Non-Covered Charges	NUM	12	Sum of Total Accommodations Non-Covered Charges and Total Ancillary Non-Covered Charges for the stay
2131 - 2140	Accommodation Non-Covered Charges	CHAR	10	Charges not reimbursable by the primary payer
2141 - 2150	Ancillary Non-Covered Charges	CHAR	10	Total of all Ancillary Non-Covered Charges during stay

SERVICE SEGMENT - Primary Records

Record Positions	Data Element	Type	Size	Description
2151 – 2154 2186 - 2189 2221 - 2224 2256 - 2259 2291 - 2294 2326 - 2329 2361 - 2364	NUBC Revenue Code 1-10	CHAR	4	Identifies specific accommodations, ancillary service or unique billing calculations or arrangements. (Revenue Code)

Record Positions	Data Element	Type	Size	Description
2396 - 2399 2431 – 2434 2466 – 2469				
2155 2090 2225 2260 2295 2330 2365 2400 2435 2470	Revenue Type 1-10	CHAR	1	Identifies the type of revenue code utilized via accommodation codes and/or ancillary codes "A" = Accommodation "R" = Ancillary
2156 – 2165 2191 - 2200 2226 - 2235 2261 - 2270 2296 - 2305 2331 - 2340 2366 - 2375 2401 - 2410 2436 - 2445 2471 - 2480	Service Charge 1-10	NUM	10	The sum of Total Accommodations Charges and Total Ancillary Charges for the patient's stay.
2166 – 2167 2201 - 2202 2236 - 2237 2271 - 2272 2306 - 2307 2341 - 2342 2376 - 2377 2411 - 2412 2446 - 2447 2481 - 2482	Unit Type 1-10	CHAR	2	Code specifying the measurement units in which a value is being expressed, or manner in which a measurement has been taken.
2168 – 2175 2203 - 2210 2238 - 2245 2273 - 2280 2308 - 2315 2343 - 2350 2378 - 2385 2413 - 2420 2448 - 2455 2483 - 2490	Unit Quantity 1-10	NUM	8	The number of service units that occurred during the bill period for the patient
2176 – 2185 2211 - 2220 2246 - 2255 2281 - 2290 2316 - 2325 2351 - 2360 2386 - 2395 2421 - 2430 2456 - 2465 2491 - 2500	Non-Covered Charge 1-10	NUM	10	Non-covered charges for the primary payer as it pertains to the associated revenue code.

SECONDARY RECORDS

COMMON DETAIL - Secondary Records

Record Positions	Data Element	Type	Size	Description
1-14	Discharge Sequential Number	NUM	14	The discharge year, plus an eight digit sequentially assigned number
15	Continuation Record Type Flag	NUM	1	A code which indicates if continuation records exist for this discharge and what type of information caused this overflow
16-18	Record Sequence Number	NUM	3	The number assigned sequentially by SPARCS to indicate the record's position within a set of records for a particular patient stay/discharge
19-21	Record Sequence Count	NUM	3	The total number of records reported for a particular patient stay/discharge

CONTINUATION RECORDS - Secondary Records

Record Positions	Data Element	Type	Size	Description
22-50	Filler	N/A	29	No data
51-54 86-89 121-124 156-159 191-194 226-229 261-264 296-299 331-334 366-369 401-404 436-439 471-474 506-509 541-544 576-579 611-614 646-649 681-684 716-719 751-754 786-789 821-824 856-859 891-894 926-929 961-964 996-999 1031-1034 1066-1069 1101-1104 1136-1139 1171-1174 1206-1209 1241-1244 1275-1279 1311-1314 1346-1349 1381-1384 1416-1419 1451-1454 1486-1489 1521-1524 1556-1559	NUBC Revenue Code 11-80	CHAR	4	Identifies specific accommodations, ancillary service or unique billing calculations or arrangements. (Revenue Code)

Record Positions	Data Element	Type	Size	Description
1591-1594 1626-1629 1661-1664 1696-1699 1731-1734 1766-1769 1801-1804 1836-1839 1871-1874 1906-1909 1941-1944 1976-1979 2011-2014 2046-2049 2081-2084 2116-2119 2151-2154 2186-2189 2221-2224 2256-2259 2291-2294 2326-2329 2361-2364 2396-2399 2431-2434 2466-2469	NUBC Revenue Code 11-80 (Con't)	CHAR	4	Identifies specific accommodations, ancillary service or unique billing calculations or arrangements. (Revenue Code)
55 90 125 160 195 230 265 300 335 370 405 440 475 510 545 580 615 650 685 720 755 790 825 860 895 930 965 1000 1035 1070	Revenue Type 11-80	CHAR	1	Identifies the type of revenue code utilized via accommodation codes and/or ancillary codes

Record Positions	Data Element	Type	Size	Description
1105 1140 1175 1210 1245 1280 1315 1350 1385 1420 1455 1490 1525 1560 1595 1630 1665 1700 1735 1770 1805 1840 1875 1910 1945 1980 2015 2050 2085 2120 2155 2190 2225 2260 2295 2330 2365 2400 2435 2470	Revenue Type 11-80 ***cont'd.***	CHAR	1	Identifies the type of revenue code utilized via accommodation codes and/or ancillary codes "A" = Accommodation "R" = Ancillary
56-65 91-100 126-135 161-170 196-205 231-240 266-275 301-310 336-345 371-380 406-415 441-450 476-485 511-520 546-555 581-590 616-625 651-660 686-695 721-730 756-765	Service Charge 11-80	NUM	10	The sum of Total Accommodations Charges and Total Ancillary Charges.

Record Positions	Data Element	Type	Size	Description
791-800 826-835 861-870 896-905 931-940 966-975 1001-1010 1036-1045 1071-1080 1106-1115 1141-1150 1176-1185 1211-1220 1246-1255 1281-1290 1316-1325 1351-1360 1386-1395 1421-1430 1456-1465 1491-1500 1526-1535 1561-1570 1596-1605 1631-1640 1666-1675 1701-1710 1736-1745 1771-1780 1806-1815 1841-1850 1876-1885 1911-1920 1946-1955 1981-1990 2016-2025 2051-2060 2086-2095 2121-2130 2156-2165 2191-2200 2226-2235 2261-2270 2296-2305 2331-2340 2366-2375 2401-2410 2436-2445 2471-2480	Service Charge 11-80 ***cont'd.***	NUM	10	The sum of Total Accommodations Charges and Total Ancillary Charges.
66-67 101-102 136-137 171-172 206-207 241-242 276-277 311-312 346-347 381-382 416-417 451-452 486-487	Unit Type 11-80	CHAR	2	Code specifying the measurement units in which a value is being expressed, or manner in which a measurement has been taken

Record Positions	Data Element	Type	Size	Description
521-522 556-557 591-592 626-627 661-662 696-697 731-732 766-767 801-802 836-837 871-872 906-907 941-942 976-977 1011-1012 1046-1047 1081-1082 116-1117 1151-1152 1186-1187 1221-1222 1256-1257 1291-1292 1326-1327 1361-1362 1396-1397 1431-1432 1466-1467 1501-1502 1536-1537 1571-1572 1606-1607 1641-1642 1676-1677 1711-1712 1746-1747 1781-1782 1816-1817 1851-1852 1886-1887 1921-1922 1956-1957 1991-1992 2026-2027 2061-2062 2096-2097 2131-2132 2166-2167 2201-2202 2236-2237 2271-2272 2306-2307 2341-2342 2376-2377 2411-2412 2446-2447 2481-2482	Unit Type 11-80 ***cont'd.***	CHAR	2	Code specifying the measurement units in which a value is being expressed, or manner in which a measurement has been taken
68-75 103-110 138-145 173-180 208-215	Unit Quantity 11-80	NUM	8	The number of service units that occurred during the bill period for the patient

Record Positions	Data Element	Type	Size	Description
243-250				
278-285				
313-320				
348-355				
383-390				
418-425				
453-460				
488-495				
523-530				
558-565				
593-600				
628-635				
663-670				
698-705				
733-740				
768-775				
803-810				
838-845				
873-880				
908-915				
943-950				
978-985				
1013-1020				
1048-1055				
1083-1090				
1118-1125				
1153-1160				
1188-1195				
1223-1230				
1258-1265				
1293-1300				
1328-1335				
1363-1370				
1398-1405	Unit Quantity 11-80 ***cont'd.***	NUM	8	The number of service units that occurred during the bill period for the patient
1433-1440				
1468-1475				
1503-1510				
1538-1545				
1573-1580				
1608-1615				
1643-1650				
1678-1685				
1713-1720				
1748-1755				
1783-1790				
1818-1825				
1853-1860				
1888-1895				
1923-1930				
1958-1965				
1993-2000				
2028-2035				
2063-2070				
2098-2105				
2133-2140				
2168-2175				
2203-2210				
2238-2245				
2273-2280				
2308-2315				
2343-2350				
2378-2385				

Record Positions	Data Element	Type	Size	Description
2413-2420 2448-2455 2483-2490	Unit Quantity 11-80 ***cont'd.***	NUM	8	The number of service units that occurred during the bill period for the patient
76-85 111-120 146-155 181-190 216-225 251-260 286-295 321-330 356-365 391-400 426-435 461-470 496-505 531-540 566-575 601-610 636-645 671-680 706-715 741-750 776-785 811-820 846-855 881-890 916-925 951-960 986-995 1021-1030 1056-1065 1091-1100 1126-1135 1161-1170 1196-1205 1231-1240 1266-1275 1301-1310 1336-1345 1371-1380 1406-1415 1441-1450 1476-1485 1511-1520 1546-1555 1581-1590 1616-1625 1651-1660 1686-1695 1721-1730 1756-1765 1791-1800 1826-1835 1861-1870 1896-1905 1931-1940 1966-1975 2001-2010 2036-2045 2071-2080	Non-Covered Charge 11-80	NUM	10	Non-covered charges for the primary payer as it pertains to the associated revenue code.

Record Positions	Data Element	Type	Size	Description
2106-2115 2141-2150 2176-2185 2211-2220 2246-2255 2281-2290 2316-2325 2351-2360 2386-2395 2421-2430 2456-2465 2491-2500	Non-Covered Charge 11-80 ***cont'd.***	NUM	10	Non-covered charges for the primary payer as it pertains to the associated revenue code.

NOTES:

AIDS/HIV EDITS - all identifiable data elements are redacted (blank/zeroed out) leaving all other data elements intact. All exact dates are modified to give only month and year. Birth weights are truncated (rounded down to nearest 100 grams)

ABORTION EDITS - all identifiable data elements are redacted, including Physician license numbers, when there is any indication of abortion.

III.
PRIMARY RECORDS

Common Portion of All Records

SPARCS Inpatient Segment:	Common Detail on Primary Record
Data Element Name:	Discharge Sequential Number
Record Position:	1-14
Format – Length:	Numeric – 14
Effective Date:	Implemented May 1, 2005 and added to all years' discharge files.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The discharge year, plus an eight digit sequentially assigned number by SPARCS. This data element is used to identify each discharge. It is also used to link the primary and continuation records.

Codes and Values:
1. An assigned numeric value.

OUTPUT Edits on Element:
1. Must be a numeric value.

2. If Abortion Flag equals 'Y' then the Discharge Number is reconfigured.

INPUT Edits on Element:
Not applicable. This is a derived field.

SPARCS Inpatient Segment:	**Common Detail on Primary Record**
Data Element Name:	Continuation Indicator
Record Position:	15
Format – Length:	Numeric – 1
Effective Date:	Implemented May 1, 2005 and added to all years' files.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A code which indicates if continuation records exist for this discharge. This is a derived data element.

Codes and Values:

1. "0" = no continuation records

2. A value of "1" or greater means this is a continuation record.

OUTPUT Edits on Element:

1. Must be a numeric value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

SPARCS Inpatient Segment:	**Common Detail on Primary Record**
Data Element Name:	Record Sequence Number
Record Position:	16 - 18
Format – Length:	Numeric - 3
Effective Date:	January 1, 1994
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The number assigned by SPARCS to indicate the record's position within a set of records for a particular patient discharge.

This number is sequential (001, 002, etc.). For example, the "Record Sequence" number for the second record in a set of 3 records required to report all the data for a particular patient stay/discharge is set equal to "002". All primary records will have a record sequence number equal to '001'.

Codes and Values:

1. Right justified and zero filled.
2. Primary Record = '001'
3. Continuation Records = '002' to '092'

OUTPUT Edits on Element:

1. Must be numeric ('001' to '092').

INPUT Edits on Element:
Not applicable. This is a derived data element.

SPARCS Inpatient Segment:	**Common Detail on Primary Record**
Data Element Name:	Record Sequence Count
Record Position:	19 - 21
Format – Length:	Numeric - 3
Effective Date:	January 1, 1994
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total number of records reported for a particular patient stay/discharge.

This data element is assigned in conjunction with Record Sequence Number.

A patient discharge will result in one primary record and possible continuation records. All primary records will have a Record Sequence Number equal to one. For example, if a patient discharge has a "Record Sequence Count" equal to '005', this means that there is a total of five records containing information for that patient stay; the primary record and four continuation records.

Codes and Values:
1. Right justified and zero filled.

OUTPUT Edits on Element:
1. Must be numeric ('001' to '016').

INPUT Edits on Element:
Not applicable. This is a derived data element.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Patient Control Number
Record Position:	28-47
Record Position for Encrypted*	2701-2744
Format – Length:	Character - 20
Format - Length for Encrypted*	Character - 44
Effective Date:	January 1, 1994
Contained In:	De-Identified Data Set: NO Limited Data Set: YES; Encrypted only Identifiable Data Set: YES
Deniable Data Element:	Yes

**Patient Control Number is on the Limited Data Set as an Encrypted Data Element.*

Description:

A patient's unique number assigned by the hospital to facilitate retrieval of individual financial and clinical records and posting of the payment, and for that particular patient's discharge. This is typically a key element in provider information systems for retrieval of an individual's records. This number is usually the same as the Patient's Admitting Number.

Codes and Values:

1. Must have been left justified with no embedded blanks and space filled.

2. Equals patient control number.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Must not have equaled zero or blanks.

2. Must have been numeric (0-9) and/or alphabetic (A-Z). Special characters were invalid entries.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Medical Record Number
Record Position:	48-64
Record Position for Encrypted*	2745 - 2788
Format – Length:	Character - 17
Format Length for Encrypted*	Character - 44
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: NO Limited Data Set: YES; Encrypted only. Identifiable Data Set: YES
Deniable Data Element:	Yes

**Medical Record Number is available on the Limited Data Set as an Encrypted Data Element.*

Description:

The number used by the Medical Records Department to identify the patient's account number for the hospital. This number is **not** the same as the Patient Control Number.

Codes and Values:

1. Left justified with no embedded blanks and space filled.

2. Equals Medical Record Number

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Must not have equaled zero or blanks

2. Must have been numeric (0-9) and/or alphabetic (A-Z). Special characters were invalid entries.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Unique Personal Identifier
Record Position:	65-74
Record Position for Encrypted*	2789-2810
Format – Length:	Character - 10
Format Length for Encrypted*	Character - 22
Effective Date:	January 1, 1995
Contained In:	De-Identified Data Set: NO Limited Data Set: YES for Encrypted only; otherwise, NO. Identifiable Data Set: YES
Deniable Data Element:	Yes

**Unique Personal Identifier is available on the Limited Data Set as an Encrypted Data Element.*

Description:

A composite field composed of portions of the patient's last name, first name, and social security number. This field, in conjunction with the Patient Birth Date and Patient Sex, is designed to provide matching criteria for individual patient records for longitudinal analysis without compromising the confidentiality of the record.

The source of the characters in the 10 positions are:

Composite 1

Position 1-4: First two (2) and last two (2) characters of the **patient's last name**. The birth name of the patient is preferable if it is available on the facility's information system.

Composite 2

Position 5-6: First two (2) characters of the **patient's first name**.

Composite 3

Position 7-10: Last four (4) digits of the **patient's Social Security number**.

Examples:

Patient Information		Creating Unique Personal Identifier			
Full Name	Last 4 SS #	Composite 1	Composite 2	Composite 3	Derived as:
Joe Tan	1234	TAAN	JO	1234	TAANJO1234
Bill Su Jr.	4321	SUSU	BI	4321	SUSUBI4321
E John Smith	0987	SMTH	E_[blank]	0987	SMTHEE0987
Bob O'Brien	3456	OBEN	BO	3456	OBENBO3456
Sue Jones-Davis	unknown	JOIS	SU	0000	JOISSU0000

Codes and Values:

1. First and second components must have been UPPERCASE alphabetic characters. If the last name was less than four characters, the first two and the last two characters should have been used even if some characters were repeated.
2. Social Security number component must have been numeric.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Each sub-field must have contained a valid entry.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Enhanced Unique Personal Identifier
Record Position:	75-93
Record Position for Encrypted*	2811-2854
Format – Length:	Character - 19
Format Length for Encrypted*	Character - 44
Effective Date:	Implemented June 2012 and added to years 1995 and forward.
Contained In:	De-Identified Data Set: NO Limited Data Set: YES for Encrypted only; otherwise, NO. Identifiable Data Set: YES
Deniable Data Element:	Yes

**Enhanced Unique Personal Identifier is available on the Limited Data Set as an Encrypted Data Element.*

Description:

A composite field composed of portions of the patient's last name, first name, social security number, the patient's date of birth, and the sex of the patient as recorded on the date of the admission or start of care. This field is designed to enhance matching criteria for individual patient records for longitudinal analysis without compromising the confidentiality of the record.

The source of the characters are:

Composite 1

Position 1-4: First two (2) and last two (2) characters of the **patient's last name**. The birth name of the patient is preferable if it is available on the facility's information system.

Composite 2

Position 5-6: First two (2) characters of the **patient's first name.**

Composite 3

Position 7-10: Last four (4) digits of the **patient's Social Security number**.

Composite 4

Position 11-18: **patient's Date of Birth** as reported.

Composite 5

Position 19: **patient's Sex** as reported.

Examples:

Patient Information				Creating Enhanced Unique Personal Identifier			
Full Name	Last 4 SS #	Date of Birth	Sex	Composite 1	Composite 2	Composite 3 + 4 +5	Derived as:
Joe Tan	1234	3/15/1991	M	TAAN	JO	123403151991M	TAANJO123403151991M
Bill Su Jr.	4321	1/7/1961	M	SUSU	BI	432101071961M	SUSUBI432101071961M
E John Smith	0987	6/26/1993	M	SMTH	EE	098706261993M	SMTHEE098706261993M
Bob O'Brien	3456	1/15/1951	M	OBEN	BO	345601151951M	OBENBO345601151951M
Sue Jones-Davis	unknown	11/3/1959	F	JOIS	SU	000011031959F	JOISSU000011031959F

Codes and Values:

1. First and second components must have been UPPERCASE alphabetic characters. If the last name was less than four characters, the first two and the last two characters should have been used even if some characters were repeated.

2. Social Security number component must have been numeric. If no Social Security Number is available, this component must be zeros.

3. The patient's date of birth must be valid in accordance with the Date Edit Validation Table in Appendix A, in the format: CCYYMMDD = Century Year Month Day.

4. The patient's sex must equal:
   "M" = Male
   "F" = Female
   "U" = Unknown

Inpatient OUTPUT Edit:

1. If Abortion or HIV Flag equals 'Y', this data element is redacted unless otherwise noted..

INPUT Edits on Element:

1. Each sub-field must have contained a valid entry.

2. The patient's date of birth cannot have been after Admission Date/Start of Care.

3. For the patient's gender, there exists multiple relationship edits between Patient Sex and sex-specific diagnosis and procedure codes as defined by the ICD-9-CM reference file edit flags.

Data Element Name:	Patient Birth Date
Record Position:	94-101
Record Position for Encrypted*	2855-2876
Format – Length:	Character - 8
Format – Length for Encrypted*	Character - 22
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and month only Identifiable Data Set: YES
Deniable Data Element:	Yes

**The entire Patient Birth Date is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:
The date of the patient's birth.

Codes and Values:
1. Format must have been CCYYMMDD = Century Year Month Day *(Example: 19591103).*

2. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.

OUTPUT Edits on Element:
1. If Abortion or HIV Flag equals 'Y', this data element is redacted unless otherwise noted.

2. The age, calculated as the difference between the Patient Birth Date and the Admission Date/Start of Care, must have been less than 125.

INPUT Edits on Element:
1. Cannot have been after Admission Date/Start of Care.

2. Must have equaled the patient's date of birth.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Age
Record Position:	102-104
Format – Length:	Character - 3
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES - ≥ 90, then equals O90 Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The patient's age in years calculated as of the date of admission calculated by the difference in the date of admission and the date of birth.

Codes and Values:

1. Right justified, zero filled.

2. For a patient under one year of age or a newborn, age = "000".

3. For a patient over the age of 90, the age is will be = “O90” on the de-identified file.

OUTPUT Edits on Element:

1. Derived by SPARCS based on Patient Birth Date and Admission Date/Start of Care.

2. When a patient is over the age of 90, the age is will be = “O90” on the de-identified file.

INPUT Edits on Element:

Not applicable. This is a derived data element.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Age in Days (for Newborn)
Record Position:	105-107
Format – Length:	Number - 3
Effective Date:	Implemented May 1, 2005 and added to all years' discharge records.
Contained In:	De-Identified Data Set: NO Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

Calculated age in days for all records with an age equal 0, based on the Patient Birth Date and Admission Date/Start of Care.

Codes and Values:

1. Numeric value for patient under one year of age.

OUTPUT Edits on Element:

1. This is a derived field that is only for children less than one year old.

INPUT Edits on Element:

1. Not applicable. This is a derived field that is only for children less than one year old.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Patient Sex
Record Position:	108
Format – Length:	Character - 1
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The sex of the patient as recorded on the date of the admission or start of care.

Codes and Values:

1. "M" = Male
   "F" = Female
   "U" = Unknown

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
Not applicable.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Patient Race
Record Position:	109-110
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which best describes the race of the patient.

Codes and Values:

1. "01" = White
   "02" = Black or African American
   "03" = Native American or Alaskan Native
   "04" = Asian
   "05" = Native Hawaiian or Other Pacific Islander
   "88" = Other Race
   "99" = Unknown

OUTPUT Edits on Element:

1. These are derived data elements.

INPUT Edits on Element:
Note: *In 2007 facilities were instructed to use the approved X12-837 values for Race and Ethnicity in the DMG segment for public reporting.*

1. Must have equaled “01” or “02” or “03” or “04” or “05” or “88” or “99” when reported in the NTE segment.

2. Must have equaled Center for Disease (CDC) values when reported in the DMG segment:
   "R1" = American Indian or Alaskan Native
   "R2" = Asian
   "R3" = Black or African-American
   "R4" = Native Hawaiian or Pacific Islander
   "R5" = White
   "R9" = Other Race

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Patient Ethnicity
Record Position:	111
Format – Length:	Character - 1
Effective Date:	January 1, 1986
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which best describes the ethnic origin of the patient.

Codes and Values:

1. "1" = Spanish/Hispanic Origin
   "2" = Not of Spanish/Hispanic Origin
   "9" = Unknown

OUTPUT Edits on Element:

1. Depending upon which segment is used to report this data element, it may be translated to the above values for consistency.

INPUT Edits on Element:
***Note**: In 2007 facilities were instructed to use the approved X12-837 values for Race and Ethnicity in the DMG segment for public reporting.*

1. Must have equaled “1” or “2” or “9” when reported in the NTE segment.

2. Must equal Center for Disease (CDC) values when reported in the DMG segment:
   “E1” = Hispanic or Latino Ethnicity
   “E2” = Non-Hispanic or Latino Ethnicity

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Patient Address Line 1
Record Position:	112-129
Record Position for Encrypted*	2877-2920
Format – Length:	Character - 18
Format – Length for Encrypted*	Character - 44
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: NO Limited Data Set: YES for Encrypted only; otherwise, NO. Identifiable Data Set: YES
Deniable Data Element:	Yes

**Patient Address Line 1 is only available on the Limited Data Set as solely an Encrypted Data Element.*

Description:

The mailing address of the patient's principal residence at the time of admission/visit, and can be reflected as a street number, post office box number or RFD.

Codes and Values:

1. Standard abbreviations as listed in Address Abbreviations in the Official United States Postal Service (USPS) Abbreviations Web site: www.usps.com/ncsc/lookups/usps_abbreviations.html.

   For reference there are also standard abbreviations listed in Appendix E - Address Abbreviations.

2. Homeless patients may be coded as "HOMELESS".

3. Left justified and space filled.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals ‘Y’, this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Must be entered.

2. Facilities were instructed to use standard abbreviations from the United States Postal Services (as listed above).

PATIENT SEGMENT

Data Element Name:	Patient Address Line 2
Record Position:	130-147
Record Position for Encrypted*	2921-2964
Format – Length:	Character - 18
Format – Length for Encrypted*	Character - 44
Effective Date:	January 1, 1994
Contained In:	De-Identified Data Set: NO Limited Data Set: YES for Encrypted only; otherwise, NO. Identifiable Data Set: YES
Deniable Data Element:	Yes

**Patient Address Line 2 is only available on the Limited Data Set as solely an Encrypted Data Element.*

Description:
The continuation of the mailing address of the patient's principal residence at the time of admission/visit.

Codes and Values:

1. Standard abbreviations as listed in Address Abbreviations in the Official United States Postal Service (USPS) Abbreviations Web site: www.usps.com/ncsc/lookups/usps_abbreviations.html.

   For reference there are also standard abbreviations listed in Appendix E - Address Abbreviations.

2. If this data element was not applicable, it contains blanks.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals ‘Y’, this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Must be a valid entry.

2. If this field was not applicable, it must be blank.

PATIENT SEGMENT

Data Element Name:	Patient City
Record Position:	148-162
Format – Length:	Character - 15
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: NO Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The name of the city, town or village in which the patient's principal residence is located on the day of admission/visit.

Codes and Values:

1. Facilities are instructed to use the standard city, town or village names approved by the U.S. Postal Service for mailing purposes.

2. Homeless patients are coded as "HOMELESS".

OUTPUT Edits on Element:

1. If Abortion Flag equals ‘Y’, this data element is redacted, unless otherwise noted.

INPUT Edits on Element:

1. Must be entered.

PATIENT SEGMENT

Data Element Name:	Patient State
Record Position:	163-164
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The capitalized two-letter abbreviation for the state in which the patient's principal residence is located on the day of admission/visit, including US Territories, Commonwealths and Canadian Provinces.

Codes and Values:

1. Must have been valid in accordance with the State Edit Validation Table in Appendix G. For a complete listing of "State Abbreviations" go to the Official United States Postal Service (USPS) Abbreviations Web site: www.usps.com/ncsc/lookups/usps_abbreviations.html

2. “99” = Homeless or Unknown

   "XX" = Other than United States or Canada.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must be entered.

SPARCS Inpatient Segment: **Primary**

PATIENT SEGMENT

Data Element Name:	Patient Postal Service Zip Code and Extension Code
Record Position:	165-173
Record Position for Encrypted*	2965-2986
Format – Length:	Character - 9
Format – Length for Encrypted*	Character - 22
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: Only the first three digits of the zip code if the population is greater than 20,000, otherwise blank; Extension - NO Limited Data Set: YES; Extension - NO Identifiable Data Set: YES; Extension - YES
Deniable Data Element:	No: 5-digit zip code Yes: Extension Zip Code

** Patient Postal Service Zip Code Extension Code (four digits) is only available on the Limited Data Set as solely an Encrypted Data Element.*

Description:

The Zip Code (five digits) and Extension Code (four digits) assigned by the U.S. Postal Service to the patient's principal residence at the time of admission or date of visit.

Codes and Values:

1. For United States residences, this Data Element is divided into a five-digit Zip Code and a four-digit Extension Code. For Canadian residences, this Data Element is defined as a six character Zip Code and 3 character filler.
2. Must have been left-justified and contained no embedded blanks. In cases where only a five-digit code was entered, the remaining four positions must have been space filled.
3. "XXXXX" = Unknown
   "YYYYY" = Foreign Country (Other Than Canada)
4. See Appendix F for Zip/County Code Edit Validation Table

OUTPUT Edits on Element:

1. When the Abortion Indicator or HIV Flag is equal to 'Y' only the first three digits of the zip code are released if the population is greater than 20,000, else redacted.
2. When the Abortion Indicator or HIV Flag is equal to 'Y', the Zip Code Extension is redacted, unless otherwise noted.

INPUT Edits on Element:

1. A minimum of a five-digit zip code is required for United States residences.
2. Must have been a valid code for the Patient County Code assigned to the patient's principal residence in accordance with the Zip/County Code Edit Validation Table in Appendix F.
3. If Patient Postal Service Zip Code was "10000"-"14999" or "06390", Patient State must have equaled "NY", and Patient County Code must have been "01"-"62" or "99".
4. Must be entered.

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	Patient County Code
Record Position:	174-175
Format – Length:	Number - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: NO Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code assigned to the county where the patient's principal residence is located on the day of admission.

Codes and Values:

1. A valid two-digit code in accordance with the Zip/County Code Edit Validation Table in Appendix F.

2. "99" = Homeless
   "88" = Patient lives outside of New York State

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted, unless otherwise noted.

INPUT Edits on Element:

1. Must have been a valid county code for the Patient Postal Service Zip Code assigned to the patient's principal residence. If not the record would have been rejected.

2. Must have been compatible with Patient State. If the Patient County Code is in New York State (01-62), then Patient State must equal "NY".

3. A valid two-digit code in accordance with the Zip/County Code Edit Validation Table in Appendix F.

4. If a Patient County Code was outside New York State (88), Patient State must NOT have equaled "NY".

SPARCS Inpatient Segment: **Primary Records**

PATIENT SEGMENT

Data Element Name:	SPARCS Region Code
Record Position:	176-177
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: NO Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

This is a geographical subdivision of the State of New York within which the health care facility is located, and is assigned by SPARCS based upon the county of the facility. Currently there are eleven regions. For the list of regions by county see NYS County/Region/HSA Table in Appendix U.

Codes and Values:

1. A two digit number between 01 and 11.

OUTPUT Edits on Element:

1. If Abortion Flag equals "Y", this data element is redacted.

INPUT Edits on Element:

Not applicable. This is a derived data element.

SPARCS Inpatient Segment: **Primary Records**

NEWBORN SEGMENT

Data Element Name:	Newborn Flag
Record Position:	178
Format – Length:	Character - 1
Effective Date:	Implemented May 2005 and added to all years' discharge.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

A flag to indicate the patient's newborn status as determined by the first 5 characters of the Principal/Primary Diagnosis Code content having any of the listed codes.

Codes and Values:

1. "0" = not a newborn
   "1" = newborn
   "2" = one of multiple newborns

OUTPUT Edits on Element:

These categories are intended for the coding of liveborn infants who are utilizing health care (e.g. crib or bassinet occupancy).

1. "V30" = Single liveborn
   Specifically: 'V300', 'V301', 'V3000', or 'V3001'

2. "V31" = Twin, mate liveborn
   "V32" = Twin, mate stillborn
   "V33" = Twin, unspecified
   "V34" = Other multiple, mates all liveborn
   "V35" = Other multiple, mates all stillborn
   "V36" = Other multiple, mates live and stillborn
   "V37" = Other multiple, unspecified
   "V39" = Unspecified

   Specifically: 'V310', 'V311', 'V320', 'V321', 'V330', 'V331', 'V340', 'V341', 'V350', 'V351', 'V360', 'V361', 'V370', 'V371', 'V3100', 'V3101', 'V3200', 'V3201', 'V3300', 'V3301', 'V3400', 'V3401', 'V3500,' 'V3501', 'V3600', 'V3601', 'V3700', V3701'

Note:

The following four-digit sub-divisions are for use with categories V30-V39:

"0" – Born in hospital
"1" – Born before admission to hospital
"2" – Born outside hospital and not hospitalized

Example: V30.x

The following two fifth-digits are for use with the forth-digit .0, Born in hospital:

"0" – delivered without mention of cesarean section

"1" – delivered by cesarean delivery

Example: V30.xx

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

Not applicable. This is a derived data element.

SPARCS Inpatient Segment: **Primary Records**

NEWBORN SEGMENT

Data Element Name:	Mother's Medical Record Number (for Newborn)
Record Position:	179-195
Record Position for Encrypted*	2987-3030
Format – Length:	Character - 17
Format – Length for Encrypted*	Character - 44
Effective Date:	January 1, 1990
Contained In:	De-Identified Data Set: NO Limited Data Set: YES; Encrypted Identifiable Data Set: YES
Deniable Data Element:	Yes

**Mother's Medical Record Number (MRN) is available on the Limited Data Set as an Encrypted Data Element.*

Description:
The medical record number of the newborn child's mother which links the newborn's hospital stay and the mother's stay.

Codes and Values:

1. Present when a valid newborn diagnosis code was entered in the Principal/Primary Diagnosis Code.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals 'Y', this data element is redacted, unless otherwise noted.

INPUT Edits on Element:

1. Must have been left justified with no embedded blanks and space filled.

2. Must not have equaled zero.

3. Must have been numeric (0-9) and/or alphabetic (A-Z). Special characters are invalid.

4. For Medicare discharges before 10/01/89 and non-Medicare discharges before 01/01/90, valid newborn codes are:

V300	V301	V310	V311	V320	V321	V330	V331
V340	V341	V350	V351	V360	V361	V370	V371

5. For Medicare discharges after 9/30/89 and non-Medicare discharges after 12/31/89, valid newborn codes are:

V3000	V3001	V301	V3100	V3101	V311	V3200	V3201	V321
V3300	V3301	V331	V3400	V3401	V341	V3500	V3501	V351
V3600	V3601	V361	V3700	V3701	V371			

6. When a valid newborn diagnosis code was reported in the Principal/Primary Diagnosis Code and the mother was not admitted to the hospital, then all 9's were reported in the Mother's Medical Record Number for Newborn Child.

7. If this field was not applicable it contains blanks.

SPARCS Inpatient Segment: **Primary Records**

NEWBORN SEGMENT

Data Element Name:	Newborn Birth Weight *(Previously Neonate Birth Weight)*
Record Position:	196-199
Format – Length:	Number - 4
Effective Date:	January 1, 1987
Contained In:	De-Identified Data Set: NO Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	Yes

Description:

Actual birth weight (in grams) or weight at time of admission for an extramural birth. Required on all claims with Type of Admission of 4 and on other claims as required by state law.

Codes and Values:

1. A valid number between "0100" and "9000".
2. The amount must have been entered as a positive whole number.
3. Right justified and zero filled.
4. Birth Weights less than "0099" grams were reported as "0100" grams.
5. If this field was not applicable it contains zeros or remains blank.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals 'Y', this data element is rounded to the nearest hundred grams *(e.g. 2583g = 2600g).*

INPUT Edits on Element:

1. If the Admission Date was within 28 days of the Patient Birth Date, the Newborn Birth Weight must have been reported.
2. If the Newborn Birth Weight was reported as less than 1500 grams, and the New York State Patient Discharge Status was reported as code "01" home, then the Length of Stay must have been greater than 10 days.
3. Must have been a valid number between "0100" and less than "9001".

SPARCS Inpatient Segment: **Primary Records**

FACILITY SEGMENT

Data Element Name:	Facility Identifier *Previously SPARCS Identification Number*
Record Position:	200-205
Format – Length:	Character - 6
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES – Redacted for abortion records Limited Data Set: YES – Redacted for abortion records Identifiable Data Set: YES – Redacted for abortion records
Deniable Data Element:	No

Description:

The number is assigned by the Department of Health upon certification. It is a six-digit Facility Identifier used for a specific physical building location. This was previously referred to as the Permanent Facility Identifier (PFI) or SPARCS Identification Number. Department regulations state that services must be reported under the physical location where they are provided. Common ownership of different facilities does not change this requirement.

Codes and Values:

1. A six-digit number.

2. A valid number as maintained by the NYSDOH Division of Health Facility Planning.

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted.

INPUT Edits on Element:

1. Must have been a valid entry.

SPARCS Inpatient Segment: **Primary Records**

FACILITY SEGMENT

Data Element Name:	Facility Identifier Check Digit
Record Position:	206
Format – Length:	Character - 1
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
Upon submission, the Facility Identifier Check digit follows the Facility Identifier number and is used to facilitate editing during the SPARCS input process. The facility identifier check digit is used for internal control purposes.

Codes and Values:
1. A numeric value from 0-9.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. The edit on the Facility Identifier Check Digit is in relationship to the submitted Facility Identifier. If the check digit is incorrect, the submission will fail.

Note: The Facility Identifier Check Digit is assigned by the SPARCS Administrative Unit.

SPARCS Inpatient Segment: **Primary Records**

FACILITY SEGMENT

Data Element Name:	Facility Name
Record Position:	207-276
Format – Length:	Character - 70
Effective Date:	Implemented May, 2005 and added to all years' discharge records.
Contained In:	De-Identified Data Set: YES – Redacted for abortion records Limited Data Set: YES – Redacted for abortion records Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The name of the facility where services were performed based on the Facility Identifier, previously referred to as the Permanent Facility Identifier (PFI). This name is maintained by the NYSDOH Division of Health Facility Planning.

***Note*:** This data element contains the Facility Name current to the update date of this record. It is not specific to its discharge year.

Codes and Values:

1. Valid Facility Name.

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted.

INPUT Edits on Element:

Not applicable. This is an assigned data element.

SPARCS Inpatient Segment: **Primary Records**

FACILITY SEGMENT

Data Element Name:	Health Service Area
Record Position:	277
Format – Length:	Number - 1
Effective Date:	Implemented May 2005 and added to all years' discharge records.
Contained In:	De-Identified Data Set: YES– Redacted for abortion records Limited Data Set: YES– Redacted for abortion records Identifiable Data Set: YES
Deniable Data Element:	No

Description:

This is a geographical subdivision of the State of New York within which the health care facility is located, and is assigned by SPARCS based upon the county of the facility. Currently there are eleven regions. For the list of regions by county see NYS County/Region/HSA Table in Appendix U.

Codes and Values:

1. A one digit number between 1 and 8.

OUTPUT Edits on Element:

1. This is a derived data element.

2. If Abortion Flag equals 'Y', this data element is redacted.

INPUT Edits on Element:

Not applicable.

SPARCS Inpatient Segment: **Primary Records**

FACILITY SEGMENT

Data Element Name:	Facility County
Record Position:	278-279
Format – Length:	Number - 2
Effective Date:	Implemented in May 2005 and added to all years' discharge records.
Contained In:	De-Identified Data Set: YES– Redacted for abortion records Limited Data Set: YES– Redacted for abortion records Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The county where the health care facility is located. For the list of county codes see NYS County/Region/HSA Table in Appendix U.

Codes and Values:

1. Values are located in Appendix U – NYS County/Region/HSA Table.

2. A valid two-digit numeric code.

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted.

INPUT Edits on Element:

Not applicable. This is an assigned data element.

SPARCS Inpatient Segment: **Primary Records**

FACILITY SEGMENT

Data Element Name:	Operating Certificate Number
Record Position:	280-286
Format – Length:	Number - 7
Effective Date:	Implemented May 2005 and added to all years' discharge records.
Contained In:	De-Identified Data Set: YES – Redacted for abortion records Limited Data Set: YES – Redacted for abortion records Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The number assigned by the Department of Health Division of Health Facility Planning.

Department regulations state that services must be reported under the physical location where they are provided. Common ownership of different facilities does not change this requirement.

***Note*:** This data element contains the Operating Certificate Number current to the update date of this record. It is not specific to its discharge year.

Codes and Values:

1. Maintained by the Health Facility Information Systems (HFIS), by the Division of Health Facility Planning. The Operating Certificate Numbers are available on the Health Commerce System, under the HFIS application.

2. A valid number as maintained by the NYSDOH Division of Health Facility Planning.

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted.

INPUT Edits on Element:

1. Not applicable. This is an assigned data element.

SPARCS Inpatient Segment: **Primary Records**

FACILITY SEGMENT

Data Element Name:	National Provider ID
Record Position:	287-296
Format – Length:	Number - 10
Effective Date:	January 1, 2011
Contained In:	De-Identified Data Set: YES – Redacted for abortion records Limited Data Set: YES – Redacted for abortion records Identifiable Data Set: YES
Deniable Data Element:	No

Description:

Released if reported.

The unique identification number assigned to the provider submitting the bill, and is released when reported. Required for billing providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI. Required when reporting for Centers for Medicare and Medicaid Services.

Codes and Values:

1. Equals facility's National Provider ID (NPI)

2. Prior to HIPAA implementation, the number was assigned by the payer associated with this provider submitting the bill.

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

Not collected at this time.

Note:

The NPI is ten numeric characters in length.

SPARCS Inpatient Segment: **Primary Records**

PHYSICIAN SEGMENT

Data Element Name:	Attending Provider State License Number
Record Position:	297-304
Format – Length:	Character - 8
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES – Redacted for abortion records Limited Data Set: YES – Redacted for abortion records Identifiable Data Set: YES – Redacted for abortion records
Deniable Data Element:	Yes Restricted for selected records *(See Appendix Z and TT)*

Description:

The professional license number, issued by the New York State Department of Education, used to identify the physician or other health care professional primarily responsible for the care of the patient.

In some instances the health facility's policy may dictate that an Attending Provider or chief of service may be assigned to any number of patients who may not have a primary care physician.

Codes and Values:

1. The first two positions of this field indicate the category of license held by the health care professional (see License Code Description in Appendix J.).

2. The third through eight positions are the six digit New York State Education Department license number.

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted.

INPUT Edits on Element:

1. Must have been valid numerically for category range of entry.
   Example: Physician must have first 2 digits "00", and the valid range is between 00000001-00300000 and 00900000-00999999.

2. For physicians, the actual license number is validated against the NYS Education Department license file.

SPARCS Inpatient Segment: **Primary Records**

PHYSICIAN SEGMENT

Data Element Name:	Operating Physician State License Number
Record Position:	305-312
Format – Length:	Character - 8
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES – Redacted for abortion records Limited Data Set: YES – Redacted for abortion records Identifiable Data Set: YES – Redacted for abortion records
Deniable Data Element:	Yes Restricted for selected records *(See Appendix Z and TT)*

Description:

The professional license number, issued by the New York State Department of Education, used to identify the physician or other health care professional who performed the principal procedure.

Note: Hospital policy may dictate which physician license number will be used for this data element. In some instances hospital policy may dictate that an Attending Provider or chief of surgery may be assigned to any number of patients who may not have a primary care physician.

Codes and Values:

1. The first two positions of this field indicate the category of license held by the health care professional (see License Code Description in Appendix J).

2. The third through eight positions are the six digit New York State Education Department license number.

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted

INPUT Edits on Element:

1. Must have been valid numerically for category range of entry.
   Example: Physician must have first 2 digits "00", and the valid range is between 00000001-00300000 or 00900000-00999999.

2. If the Operating Physician State License Number was entered, the Principal Procedure Code and the Principal Procedure Date must have also been reported.

SPARCS Inpatient Segment: **Primary Records**

PHYSICIAN SEGMENT

Data Element Name:	Other Operating Physician State License Number
Record Position:	313-320
Format – Length:	Character - 8
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES – Redacted for abortion records Limited Data Set: YES – Redacted for abortion records Identifiable Data Set: YES – Redacted for abortion records
Deniable Data Element:	Yes Restricted for selected records *(See Appendix Z and TT)*

Description:

The professional license number, issued by the New York State Department of Education, used to identify the physician or other health care professional (other than the Attending Provider or Operating Physician) who was involved in the patient's care or treatment (i.e., consulting physician, second operating physician, and nurse/midwife).

Codes and Values:

1. The first two positions of this field indicate the category of license held by the health care professional (see License Code Description in Appendix J)).

2. The third through eight positions are the six digit New York State Education Department license number

OUTPUT Edits on Element:

1. If Abortion Flag equals 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. If reported, must have been valid numerically for category range of entry.
   Example: Physician must have first 2 digits "00", and the valid range is between 00000001-00300000 and 00900000-00999999.

SPARCS Inpatient Segment: **Primary Records**

PAYER SEGMENT

Data Element Name:	Source of Payment Typology 1
Record Position:	321-325
Format – Length:	Number - 5
Effective Date:	July 1, 2009
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

Source of Payment Typology I (SoP I) is a hierarchical code list used to identify the payer expected to pay the MAJOR portion of the patient's bill. It provides a range of codes from broad categories to related sub-categories that are more specific. Facilities were directed to report the expected payer using the greatest level of detail without sacrificing accuracy of the information.

Facilities with Managed Care Plans (MCPs) were directed to concentrate on the variety of Managed Care Plans (HMO and PPO), as well as the funding for these MCPs (Medicare or Medicaid).

The code set is maintained by the Public Health Care Data Consortium (www.phdsc.org)

Codes and Values:

1. A valid code in accordance with the Source of Payment Typology Codes in Appendix P.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. Source of Payment Typology I must have been entered.

2. Must have been left justified and space-filled right.

3. Medicaid and Medicare payers must be reported with a minimum of two digits from the typology. That is when:

Claim Filing Indicator is Reported as:	SoP I must be:
16, MA, MB	1xxx
MC	2xxx

PAYER SEGMENT

Data Element Name:	Source of Payment Typology 2
Record Position:	326-330
Format – Length:	Number - 5
Effective Date:	July 1, 2009
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
Source of Payment Typology II (SoP II) is used to identify the secondary payer expected to pay a portion of the patient's bill if applicable.

Source of Payment Typology II is a hierarchical code list. It provides a range of codes from broad categories to related sub-categories that are more specific. Report the expected payer using the greatest level of detail without sacrificing accuracy of the information.
Facilities with Managed Care Plans (MCPs) were directed to concentrate on the variety of Managed Care Plans (HMO and PPO), as well as the funding for these MCPs (Medicare or Medicaid).

The code set is maintained by the Public Health Care Data Consortium (www.phdsc.org).

Codes and Values:

1. A valid code in accordance with the Source of Payment Typology Codes in Appendix P.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. If entered, Source of Payment Typology II must have been a valid code.

2. Must have been left justified and space-filled right.

SPARCS Inpatient Segment: **Primary Records**

PAYER SEGMENT

Data Element Name:	Source of Payment Typology 3
Record Position:	331-335
Format – Length:	Number - 5
Effective Date:	July 1, 2009
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
Source of Payment Typology III (SoP III) is used to identify the third payer expected to pay a portion of the patient's bill if applicable.

Source of Payment Typology III is a hierarchical code list. It provides a range of codes from broad categories to related sub-categories that are more specific. Report the expected payer using the greatest level of detail without sacrificing accuracy of the information. Facilities with Managed Care Plans (MCPs) were directed to concentrate on the variety of Managed Care Plans (HMO and PPO), as well as the funding for these MCPs (Medicare or Medicaid).
The code set is maintained by the Public Health Care Data Consortium (www.phdsc.org).

Codes and Values:

1. A valid code in accordance with the Source of Payment Typology Codes in Appendix P.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. If entered, Source of Payment Typology III must have been a valid code.

2. Must have been left justified and space-filled right.

PAYER SEGMENT

Data Element Name: Source of Payment 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
Source of Payment 1	336	Source of Payment 4	513
Source of Payment 2	395	Source of Payment 5	572
Source of Payment 3	454	Source of Payment 6	631

Format – Length: Character - 1
Effective Date: January 1, 1994
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The code which indicates the type of payment for this occurrence.

Codes and Values:

1. "A"=Self-Pay
   "B"=Workers' Compensation
   "C"=Medicare
   "D"=Medicaid
   "E"=Other Federal Program
   "F"=Insurance Company
   "G"=Blue Cross
   "H"=CHAMPUS
   "I"=Other Non-Federal Program
   "J"= Point of Service (POS)
   "K"= Dental Maintenance Organization
   "L"= Automobile Medical
   "M"= Disability
   "N"= Federal Employees Program
   "O"= Liability Medical
   "P"= Title V
   "Q"= Mutually Defined

OUTPUT Edits on Element:

1. The following table details reported values for the Claim Filing Indicator and how they are grouped in the Source of Payment on the Output File:

Output- Source of Payment	Claim Filing Indicator
A – Self Pay	09 – Self Pay
B – Workers' Compensation	WC – Workers' Compensation Health Claim
C - Medicare	MA – Medicare Part A MB – Medicare Part B
D - Medicaid	MC - Medicaid
E – Other Federal Program	OF – Other Federal Program VA – Veterans' Affairs Plan
F –Insurance Company	12 – Preferred Provider Organization (PPO) 14 – Exclusive Provider Organization (EPO) 15 – Indemnity Insurance 16 – Health Maintenance Organization (HMO) Medicare Risk CI – Commercial Insurance Co. HM – Health Maintenance Organization
G – Blue Cross	BL – Blue Cross
H- CHAMPUS	CH – CHAMPUS
I – Other Non-Federal Program	11 – Other Non-Federal Programs
J – Point of Service	13 – Point of Service
K – Dental Maintenance Organization	17 – Dental Maintenance Organization
L – Automobile Medical	AM – Automobile Medical
M – Disability	DS – Disability
N – Federal Employees Program	FI – Federal Employees Program
O – Liability Medical	LM – Liability Medical
P – Title V	TV – Title V
Q – Mutually Defined	ZZ – Mutually Defined

INPUT Edits on Element:

1. For all payers Source of Payment Code, Covered Days, and Non-Covered Days were required.

2. The table below indicate the additional data items that are required, depending on the value in the Claim Filing Indicator.
   The Payer ID, Insured's Policy Number and Billing NPI are required when the Claim Filing Indicator and Source of Payment Typology are reported with a Medicaid or Medicare payer type.

Claim Filing Indicator Code	Payer ID	Insured's Policy Number	Billing NPI (Previously Provider ID)
09, 11, 13, 14, 15, 17, AM, CH, DS, FI, LM, OF, TV, VA, WC, ZZ	---------	----------	--------
12, CI, HM,	Required	Required-IP only	--------
16, BL, MA, MB, MC	Required	Required-IP only	Required

3. For the first Claim Filing Indicator Code reported this edit applies:

Medicaid and Medicare payers must be reported with a minimum of two digits from the typology. That is when:

Claim Filing Indicator is Reported as:	**SoP* I must be:**
16, MA, MB	1xxx
MC	2xxx

** = SoP for Medicare and Medicaid must be reported with a minimum of two digits from the typology.*

SPARCS Inpatient Segment: **Primary Records**

PAYER SEGMENT

Data Element Name: Claim Filing Indicator Code 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
Claim Filing Indicator 1	337-338	Claim Filing Indicator 4	514-515
Claim Filing Indicator 2	396-397	Claim Filing Indicator 5	573-574
Claim Filing Indicator 3	455-456	Claim Filing Indicator 6	632-633

Format – Length: Character - 2
Effective Date: January 1, 1994
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The code which indicates the type of payment for this occurrence.

Codes and Values:

1. **Codes and Values: (Bolded codes added 7/1/11).**

"09" = Self-pay
"11" = Other Non-Federal Programs
"12" = Preferred Provider Organization (PPO)
"13" = Point of Service (POS)
"14" = Exclusive Provider Organization (EPO)
"15" = Indemnity Insurance
"16" = Health Maintenance Organization (HMO) Medicare Risk
"17" = Dental Maintenance Organization
"AM" = Automobile Medical
"BL" = Blue Cross/Blue Shield
"CH" = CHAMPUS
"CI" = Commercial Insurance Co.
"DS" = Disability
"FI" = Federal Employees Program
"HM" = Health Maintenance Organization
"LM" = Liability Medical
"MA" = Medicare Part A
"MB" = Medicare Part B
"MC" = Medicaid
"OF" = Other Federal Program (**Use "OF" when submitting Medicare Part D Claims.)**
"TV" = Title V
"VA" = Veterans Affairs Plan
"WC" = Workers' Compensation Health Claim
"ZZ" = Type of Insurance is not known.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. For all payers Source of Payment Code, Covered Days, and Non-Covered Days were required.

2. The table below indicate the additional data items that are required, depending on the value in the Claim Filing Indicator Code:
   The Payer ID, Insured's Policy Number and Billing NPI are required when the Claim Filing Indicator (and Source of Payment Typology) are reported with a Medicaid or Medicare payer type.

Claim Filing Indicator Code for Other Subscriber	Payer ID	Insured's Policy Number	Billing NPI (Previously Provider ID)
09, 11, 13, 14, 15, 17, AM, CH, DS, FI, LM, OF, TV, VA, WC, ZZ	---------	----------	--------
12, CI, HM,	Required	Required IP only	--------
16, BL, MA, MB, MC	Required	Required IP only	Required

3. For the first Claim Filing Indicator reported this edit applies:

   Medicaid and Medicare payers must be reported with a minimum of two digits from the typology. That is when:

Claim Filing Indicator is Reported as:	SoP* I must be:
16, MA, MB	1xxx
MC	2xxx

** = SoP for Medicare and Medicaid must be reported with a minimum of two digits from the typology.*

SPARCS Inpatient Segment: **Primary Records**

PAYER SEGMENT

Data Element Name: Insured's Policy Number 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
Insured's Policy #1	339-357	Insured's Policy #4	516-534
Insured's Policy #2	398-416	Insured's Policy #5	575-593
Insured's Policy #3	457-475	Insured's Policy #6	634-652

Record Position for Encrypted*

Data Element	Record Position	Data Element	Record Position
Insured's Policy #1	3031-3074	Insured's Policy #4	3163-3206
Insured's Policy #2	3075-3118	Insured's Policy #5	3207-3250
Insured's Policy #3	3119-3162	Insured's Policy #6	3251-3294

Format – Length: Character - 19

Format – Length for Encrypted* Character - 44

Effective Date: 1/1/1992

Contained In: De-Identified Data Set: NO
Limited Data Set: NO
Identifiable Data Set: YES

Deniable Data Element: Yes - See Appendix Z for release restrictions.

** Policy Number 1-6 is only available on the Limited Data Set as solely an Encrypted Data Element.*

Description:

The unique identification number assigned by the payer to identify the patient.

Codes and Values:

1. Facilities were directed to enter the following values:

Payer	Type of Number
Blue Cross	Enter the information depending on specific Blue Cross Plan needs and contract requirement.
CHAMPUS	Enter information depending on CHAMPUS regulations.
Medicaid	Enter Medicaid Client Identification Number (CIN) of the insured or case head Medicaid number shown on the Medicaid Identification Card.
Medicare	Enter the patient's Medicare HIC number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form or as reported by the Social Security Office.

2. For all other payer types, Commercial Insurers, etc. enter the insured's unique number assigned by the payer.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Inpatient only. Required if the first reported Claim Filing Indicator Code was 12, BL, CI, HM, Medicare (MA, MB or 16) or Medicaid (MC).

2. Required if Source of Payment Typology I was Medicare (1xxxx) or Medicaid (2xxxx).

3. If SoP II and/or SoP III were reported with the Medicare or Medicaid values, then the Insured's Policy Number for the Secondary or other subscriber should have been reported.

PAYER SEGMENT

Data Element Name: Payer ID Number 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
Payer ID 1	358-365	Payer ID 4	535-542
Payer ID 2	417-424	Payer ID 5	594-601
Payer ID 3	476-483	Payer ID 6	653-660

Format – Length: Character - 8

Effective Date: 1/1/1982

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

The number identifying the payer organization associated with this sequence for which the provider might expect some payment of the bill.

Typically the Primary payer is in the first sequence, and subsequent payers are in contained in the Payer ID Number data elements 2-6.

Codes and Values:

1. Facilities were directed to enter values using the following:

Payer		Type of Number
Blue Cross	=	Plan Number Refer to Appendix L
Commercial Insurers	=	NAIC or DOI Number Refer to Appendix K Commercial Insurance and HMO companies are regulated by the Department of Insurance (DOI) and issued either a NAIC or internal DOI numbers. In lieu of DOI numbers, DOH numbers are issued. Some billing situations require NEIC numbers to be reported. For additional information on these numbers, and specific HMO codes, refer to Appendix K.
Medicaid	=	State Agency Assigned number to be determined. Refer to Appendix O for Medicaid Managed Care Plan IDs.
Medicare	=	Blue Cross Number or Commercial Insurer NAIC Number depending on intermediary
CHAMPUS	=	NAIC Number

2. If this field was not applicable it must have been blank.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. If Source of Payment Code was 12, 16, CI, BL, HM, MA, MB, MC, then Other Payer Identification should have been reported.

2. If Source of Payment Typology (SoP) was 21xxx (Medicaid Managed Care), then Payer Identification Number should have equaled a value from Appendix O.

PAYER SEGMENT

Data Element Name: Covered Days 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
Covered-Days 1	366-369	Covered-Days 4	543-546
Covered-Days 2	425-428	Covered-Days 5	602-605
Covered-Days 3	484-487	Covered-Days 6	661-664

Format – Length: Number - 4

Effective Date: 1/1/1982 – 8/1/2011
1/1/1982 – 12/31/2007
Collection Changes:
1/1/2008 – 8/2/2011

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:
The number of days covered by the payer for this occurrence as qualified by the payer organization.

Typically days covered by the primary payer are in the first sequence, and subsequent days are in contained in the Covered Days data elements 2-6.

Codes and Values:
1. Right justified and zero filled.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. The sum of Covered Days and Non-Covered must not exceed Total Length of Stay (Statement Through Date minus Admission Date/Start of Care) for any payer sequence.

Note:
Prior to December, 2007: Reporting of covered and non-covered days was reported in various input formats (UBF/DDA and UDS) that allowed the reporting of specific payers to be associated with the reporting of days.

January 1, 2008: With the collection of the X12-837 format there was no provision to associate the specific payer with days. Do not use covered/non-covered days in association with specific payers during this timeframe.

Due to this issue that the X12-837 does not associate the days to a specific payer, the data element (covered/non-covered) was stopped in 2011. Please refer to the Insured Days/Non-Insured Days data element.

PAYER SEGMENT

Data Element Name: Non-Covered-Days 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
Non-Covered-Days 1	370-373	Non-Covered-Days 4	547-550
Non-Covered-Days 2	429-432	Non-Covered-Days 5	606-609
Non-Covered-Days 3	488-491	Non-Covered-Days 6	665-668

Format – Length: Number - 4

Effective Date: 1/1/1994 – 12/31/2007

Collection Changes:

1/1/2008 – 8/2/2011

Contained In: De-Identified Data Set: YES

Limited Data Set: YES

Identifiable Data Set: YES

Deniable Data Element: No

Description:

Days of care not covered by the payer for this occurrence.

Typically the days not covered by the primary payer are in the first sequence, and the days not covered by subsequent payers are in sequence 2-6.

Codes and Values:

1. Right justified and zero filled.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. The sum of Non-Covered Days and Covered Days must not have exceeded Total Length of Stay ("Statement Covers Through Date minus Admission Date/Start of Care) for any payer sequence.

Note:

Prior to December, 2007: Reporting of covered and non-covered days was reported in various input formats (UBF/DDA and UDS) that allowed the reporting of specific payers to be associated with the reporting of days.

January 1, 2008: With the collection of the X12-837 format there was no provision to associate the specific payer with days. Do not use covered/non-covered days in association with specific payers during this timeframe.

Due to this issue that the X12-837 does not associate the days to a specific payer, the data element (covered/non-covered) was stopped in 2011. Please refer to the Insured Days/Non-Insured Days data element.

SPARCS Inpatient Segment: **Primary Records**

PAYER SEGMENT

Data Element Name: Billing National Provider Identification Number (NPI) 1-6 (*previously Provider ID*)

Record Position:

Data Element	Record Position	Data Element	Record Position
Billing NPI 1	374-386	Billing NPI 4	551-563
Billing NPI 2	433-435	Billing NPI 5	610-622
Billing NPI 3	492-504	Billing NPI 6	669-681

Format – Length: Character - 13
Effective Date: January 1, 1982
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The unique identification number assigned to the provider submitting the bill. Required for billing providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date (2004) when the provider is eligible to receive an NPI. Required when reporting for Centers for Medicare and Medicaid services.

Codes and Values:
1. Equals facility's National Provider ID (NPI) after the HIPAA implementation.

2. Prior to HIPAA implementation (prior to 2004) the number assigned was by the payer associated with this provider submitting the bill.

3. Must have been left justified with no embedded blanks and space filled.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must have been a valid entry if Source of Payment Code was Medicare, Medicaid, or Blue Cross.

PAYER SEGMENT

Data Element Name: Alternate Level of Care (ALC) Days 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
ALC Days 1	387-390	ALC Days 4	564-567
ALC Days 2	446-449	ALC Days 5	623-626
ALC Days 3	505-508	ALC Days 6	682-685

Format – Length: Number - 4
Effective Date: 1/1/1982 – 1/1/1999
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The total number of patient days associated with this sequence at a level of care other than acute.

Codes and Values:
1. Must have been right justified and zero filled.

2. If this field was not applicable it must have contained zeros.

OUTPUT Edits on Element:
1. This is a derived data element from 1982 – 1999.

2. Must have been less than the Length of Stay.

INPUT Edits on Element:
1. The number of days must have been less than or equal to the number of days from the Date Alternate Care Required to the Discharge Date.

2. Total Alternate Level of Care Days for multiple payer submissions must not exceed Length of Stay.

3. If Alternate Level of Care Days was entered, Type of Alternate Care Required and Date Alternate Care Required were also reported. If Type and Date of Alternate Care Required were reported, at least one Alternate Level of Care Day for one of the record sequences must have been reported.

PAYER SEGMENT

Data Element Name: Leave of Absence (LOA) Days 1-6

Record Position:

Data Element	Record Position	Data Element	Record Position
LOA-Days 1	391-394	LOA-Days 4	568-571
LOA-Days 2	450-453	LOA-Days 5	627-630
LOA-Days 3	509-512	LOA-Days 6	686-689

Format – Length: Number - 4

Effective Date: 1/1/1987

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

The number of days, associated with this sequence, which the patient was in leave of absence status.

Codes and Values:

1. Must have been right justified and zero filled.

2. If this field was not applicable it must have contained zeros.

OUTPUT Edits on Element:

1. Calculated using the date range for Leave of Absence Days.

2. Must have been less than the Length of Stay.

INPUT Edits on Element:

1. Not applicable. This is a calculated data edit using the Occurrence Span for Leave of Absence Dates.

PAYER SEGMENT

Data Element Name:	Expected Principal Reimbursement
Record Position:	690-691
Format – Length:	Character - 2
Effective Date:	1/1/ 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which identifies the payer expected to pay the **major** portion of the patient's bill. The Medicare and Medicaid HMO payer codes were used when the HMO responsible for payment received the reimbursement from one of the respective payers for the patient. If this information was not available from the patient's insurance card or from the admittance interview, the Other HMO payer code was used.

Codes and Values:

1. Must have been a valid code in accordance with the Expected Reimbursement Codes in Appendix D.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Inpatient Only: Prior to October 1, 1995 edits pertaining to ICD-9-CM codes were validated on the basis of the Discharge Date and the Expected Principal Reimbursement. The edit application reflects the yearly updating of the ICD-9-CM codes. ICD-9-CM updates become effective on October 1 for Medicare, CHAMPUS, and Medicare HMO discharges and on January 1 of the following year for all other payer discharges.

   NOTE: After October 1, 1995, based on the Department of Health Memorandum (Health Facilities Series: H4 95-7) issued on May 1, 1995, all edits pertaining to ICD-9-CM codes were validated on the basis of the Statement Covers Period – Through Date (Discharge Date). The edit application reflects the yearly updating of the ICD-9-CM codes. The ICD-9-CM updates became effective on October 1 for all payers.

PAYER SEGMENT

Data Element Name:	Expected Reimbursement Other 1
Record Position:	692-693
Format – Length:	Character - 2
Effective Date:	1/1/1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which identifies secondary source of payment which is expected to pay some part of the hospital bill.

The Medicare and Medicaid HMO payer codes were used when the HMO responsible for payment received the reimbursement from one of the respective payers for the patient. If this information was not available from the patient's insurance card or from the admittance interview, the Other HMO payer code was used.

Codes and Values:

1. Must have been a valid code in accordance with the Expected Reimbursement Codes in Appendix D.

2. If this field was not applicable it must have contained blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must have been a valid entry.

PAYER SEGMENT

Data Element Name:	Expected Reimbursement Other 2
Record Position:	694-695
Format – Length:	Character - 2
Effective Date:	1/1/1994
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which identified the tertiary source of payment which was expected to pay some part of the hospital bill.

The Medicare and Medicaid HMO payer codes were used when the HMO responsible for payment received the reimbursement from one of the respective payers for the patient. If this information was not available from the patient's insurance card or from the admittance interview, the Other HMO payer code was used.

Codes and Values:

1. Must have been a valid code in accordance with the Expected Reimbursement Codes in Appendix D.

2. If this field was not applicable it must have contained blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must have been a valid entry.

PAYER SEGMENT

Data Element Name:	Worker's Compensation/No Fault Indicator
Record Position:	696-697
Format – Length:	Character - 2
Effective Date:	1/1/1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which indicates whether the bill was covered by Workers' Compensation or No-Fault Insurance. Workers' Compensation is a form of liability insurance which provides health care coverage for employment-related causes and is the primary payer over all third-party payer sources. No-Fault is a form of vehicular insurance which provides health care coverage for vehicle-related accidents in New York State.

Codes and Values:

1. "NF" = No-Fault, Including Auto/Other
   "WC" = Workers' Compensation

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. Derived data element based on "Value Code" collected.

INPUT Edits on Element:

1. This is a derived data element from the "Value Code" data element collected. This element was created when the corresponding value codes were equal to:
   "14" = No Fault, including Auto/Other
   "15" = Worker's Compensation

2. If submitted, the record must have contained the appropriate value code.

PAYER SEGMENT

Data Element Name:	Worker's Compensation/No Fault Amount
Record Position:	698-706
Format – Length:	Number - 9
Effective Date:	1/1/1994
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The dollar amount of the bill that is covered by Workers' Compensation or No-Fault Insurance.

Codes and Values:

1. Right justified and zero filled.

2. The amount was entered in dollars and cents. This amount was defined with **TWO** implied decimal places and must have been entered as a positive amount.

3. If not applicable this field contains zeroes.

OUTPUT Edits on Element:

1. Derived data element based on "Value Amount" collected.

INPUT Edits on Element:

1. This is a derived data element from the "Value Amount" data element collected. The corresponding amount was collected for the derived field when the "Value Code" was equal to:
   "14" = No Fault, including Auto/Other
   "15" = Worker's Compensation

2. If submitted, the record must have contained the appropriate "Value Code" and corresponding value amount.

PAYER SEGMENT

Data Element Name:	Surplus, Catastrophic or Recurring Monthly Income Code
Record Position:	707
Format – Length:	Character - 1
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	

Description:
The code which indicates that a monthly payment was required of this Medicaid patient towards the cost of their hospitalization.

Codes and Values:

1. "1" = Surplus
   "2" = Catastrophic.
   "3" = Recurring Monthly Income

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. Derived data element based on “Value Code” collected.

INPUT Edits on Element:

1. This is a derived data element from the “Value Code” data element collected. This data element was collected when value codes were equal to:
   “21” = Catastrophic
   “22” = Surplus
   “23” = Recurring Monthly Income.

2. If submitted, the record must have contained the appropriate “Value Code”.

PAYER SEGMENT

Data Element Name:	Surplus, Catastrophic or Recurring Monthly Income Amount
Record Position:	708-716
Format – Length:	Number - 9
Effective Date:	1/1/1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The monthly payment required of Medicaid patients towards the cost of their hospitalization.

Codes and Values:
1. Right justified and zero filled.

2. The amount must have been entered in dollars and cents. This amount was defined with **TWO** implied decimal places and must have been entered as a positive amount.

OUTPUT Edits on Element:
1. Derived data element based on "Value Amount" collected.

INPUT Edits on Element:
1. This is a derived data element from the "Value Amount" data element collected. This data element was when "Value Code" was equal to:
   "21" = Catastrophic
   "22" = Surplus
   "23" = Recurring Monthly Income

2. If submitted, the record must have contained the appropriate Value Code and corresponding "Value Amount".

DATA COLLECTION SEGMENT

Data Element Name:	Log Number
Record Position:	717-722
Format – Length:	Number - 6
Effective Date:	1/1/ 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The sequential number assigned by SPARCS that identifies the submission to which the record belonged.

Codes and Values:
1. Must be an assigned number between 000001 and 999999.

OUTPUT Edits on Element:
Not Applicable.

INPUT Edits on Element:
1. No edit applied. Number assigned sequentially at the time of successful file submission.

Note:
Facilities may submit multiple files within a submission month for varying discharge months.

DATA COLLECTION SEGMENT

Data Element Name:	Transaction Code
Record Position:	723
Format – Length:	Character - 1
Effective Date:	1/1/ 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

This code is used for processing records into the SPARCS Master File. The Transaction Code comes from the third digit of the three digit numeric data element called 'Type of Bill' by the National Uniform Billing Committee (NUBC). This data element is referenced in the ASC X12N reporting guide as the "Claim Frequency Code". This code identifies the type of transaction for the electronic institutional claims: informational, new, replacement and void/cancel.

Codes and Values:

1. Code	Value	Type of Bill
"1"	Delete	Third position code "8"
"2"	Add	Third position code "1"
"3"	Correction	Third position code "7"

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. The following values are collected at intake:

Claim Transaction Type	Value	Description
1	Admit thru Discharge Claim (New Claim)	Use this code when billing for a confined treatment or inpatient period. This will include bills representing a total confinement or course of treatment and bills that represent an entire benefit period of the primary third party payer.
7	Replacement of Prior Claim	This code is used when a specific bill has been issued for a specific provider, patient, payer, insured and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identity information.
8	Void/Cancel of Prior Claim	This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, patient, payer, insured and "Statement Covers Period".

2. Must have been entered. If not, the record would have been rejected.

3. Must have been a valid value. If not, the record would have been rejected.

DATA COLLECTION SEGMENT

Data Element Name:	Date Processed
Record Position:	724-731
Format – Length:	Character - 8
Effective Date:	1/1/ 1982
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year, Month, Day Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The date the facility created the file to submit to SPARCS.

Codes and Values:

1. Equals the actual date of the Transaction Set Creation.

2. Should be in the format CCYYMMDD.

3. Should be date in accordance with the Date Edit Validation Table in Appendix A.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DATA COLLECTION SEGMENT

Data Element Name:	SPARCS Collector Code
Record Position:	732-734
Format – Length:	Number – 3
Effective Date:	1/1/1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The three-digit identification number used to identify the hospital or vendor (data collector) submitting the data. Not to be confused with the Facility Identification Number. This code is used to identify the data submitter. If the data submitter is a vendor, an approved vendor agreement form has been signed and registered by SPARCS. The agreement form is an annual agreement between the vendor and facility that allows the vendor to submit SPARCS data on behalf of the facility.

Codes and Values:

1. Equals SPARCS Collector Code.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. A valid SPARCS collector code in accordance with the SPARCS Facility Profile Reference file maintained by the SPARCS Administrative Unit.

2. Must have corresponded with the approved Facility Identifier.

DATA COLLECTION SEGMENT

Data Element Name:	Claim Type
Record Position:	735
Format – Length:	Character - 1
Effective Date:	Implemented August 2012 and added to all years' discharge records.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

Claim Type is used to help define the data sets collected. SPARCS collects two data files from facilities: Inpatient and Outpatient. When processing the two different files collected, several data elements (type of bill and Revenue Code) are used to distinguish data types, particularly on the Outpatient file collection. The Inpatient file submission only results in one Claim Type – Inpatient.

Codes and Values:

1. "I" = "Inpatient Services"

OUTPUT Edits on Element:

1. All successful Inpatient records are coded as "I".

INPUT Edits on Element:

Not applicable. This is a derived data element.

DATA COLLECTION SEGMENT

Data Element Name:	Source File Type (Complete/Incomplete)
Record Position:	736
Format – Length:	Number - 1
Effective Date:	Implemented May 1, 2005, and added to all year's files.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The type of source file from which this record originated. Pre-1994 SPARCS inpatient data was created by matching a patient's hospital information from two separate files: the Discharge Data Abstract File (DDA) and the Uniform Billing File (UBF). The Complete File contains patient DDAs matched to the patient's corresponding final bills (UBF). The Incomplete File comprises those records from the DDA file and UBF not contained in the Complete File. Starting in 1994, inpatient data was reported in single record (UDS format). As of January 1, 1994, all records are coded to a value of "C".

The Incomplete File contains:

i. DDAs without any billing information
ii. DDAs with an interim bill but not a final bill
iii. Final bills with no DDA
iv. Interim bills with no DDA

Codes and Values:

1. "C" = Complete file record
   "I" = Incomplete file record

OUTPUT Edits on Element:

This is a derived field.

INPUT Edits on Element:

Not applicable. This is a derived field.

MISCELLANEOUS SEGMENT

Data Element Name:	Residence Indicator
Record Position:	737
Format – Length:	Character - 1
Effective Date:	January 1, 1997
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A code which indicates the residence status of a patient as either: HOMELESS at the time of discharge or that the patient was a Non-United States Resident.

Note: Patients discharged to a shelter are also categorized as HOMELESS.

Codes and Values:

1. "H" = HOMELESS Patient
   "F" = Non-United States Resident (Foreign Born)

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:
Derived data element based on “Condition Code” collected.

INPUT Edits on Element:

1. This is a derived data element from the “Condition Code” data element collected. This element was created when the corresponding Condition Code were equal to:

   “17” = Patient is Homeless
   “25” = Patient is Non-United States (US) Resident

2. If submitted, the record must have contained the appropriate “Condition Code”.

MISCELLANEOUS SEGMENT

Data Element Name:	Special Program; Disability (DIS)
Record Position:	738
Format – Length:	Character - 1
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which indicates if the patient was entitled to Medicaid benefits due to a specified physical impairment or treatment for a condition of a disabling nature.

A disabling condition means the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted (or can be expected to last) for a continuous period of not less than 12 months.

Codes and Values:

1. "Y" = Disability

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. Derived data element based on “Condition Code” collected.

INPUT Edits on Element:

1. This is a derived data element from the “Condition Code” data element collected. This element was created when the corresponding Condition Code were equal to:

   “A5” = Disability

2. If submitted, the record must have contained the appropriate “Condition Code”.

MISCELLANEOUS SEGMENT

Data Element Name:	Special Program; Family Planning (FP)
Record Position:	739
Format – Length:	Character - 1
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which indicates if the patient was entitled to Medicaid benefits due to a specified physical impairment or treatment for family planning procedures by state law.

Codes and Values:

1. "Y" = Family Planning

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. Derived data element based on “Condition Code” collected.

INPUT Edits on Element:

1. This is a derived data element from the “Condition Code” data element collected. This element was created when the corresponding Condition Code were equal to:

   “A4” = Family Planning.

2. If submitted, the record must have contained the appropriate “Condition Code”.

MISCELLANEOUS SEGMENT

Data Element Name:	Special Program; Physical Handicapped Children's Program (PHC)
Record Position:	740
Format – Length:	Character - 1
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The code which indicated if the patient was entitled to Medicaid benefits due to a specified physical impairment or treatment under the Physically Handicapped Children's (PHP) Program. Services provided under this program receive special funding through Title VII of the Social Security Act or the TRICARE program for the Handicapped.

Codes and Values:

1. "Y" = Physically Handicapped Children's Program.

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. Derived data element based on "Condition Code" collected.

INPUT Edits on Element:

1. This is a derived data element from the "Condition Code" data element collected. This element was created when the corresponding Condition Code were equal to:

   "A2" = Physically Handicapped Children's Program (PHP).

2. If submitted, the record must have contained the appropriate "Condition Code".

MISCELLANEOUS SEGMENT

Data Element Name:	Special Program; Special Federal Funding (SFP)
Record Position:	741
Format – Length:	Character - 1
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which indicates if the patient was entitled to Medicaid benefits due to a specified physical impairment or treatment under the Special Funding Project (SFP).

Codes and Values:

1. "Y" = Special Federal Funding

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. Derived data element based on “Condition Code” collected.

INPUT Edits on Element:

1. This is a derived data element from the “Condition Code” data element collected. This element was created when the corresponding Condition Code were equal to:

   “A3” = Special Federal Funding (SFP)

2. If submitted, the record must have contained the appropriate “Condition Code”.

MISCELLANEOUS SEGMENT

Data Element Name: Old SPARCS Accommodation Codes 1-5 (*Previously SPARCS Accommodation Codes*)

Record Position:

Data Element	Record Position	Data Element	Record Position
Old SPARCS Accomm 1	742	Old SPARCS Accomm 4	745
Old SPARCS Accomm 2	743	Old SPARCS Accomm 5	746
Old SPARCS Accomm 3	744		

Format – Length: Character - 4
Effective Date: 1/1/1980 - 12/31/1999
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
From 1980 until 1999 the SPARCS system collected accommodation codes that were created by New York State. A crosswalk of these codes to the NUBC Revenue Codes was created. The old accommodation codes were replaced with the NUBC Revenue Codes for this data element.

Note: This data element was available for a limited time period.

Codes and Values:
1. See Appendix I – Revenue Codes.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must have been a valid entry.

MISCELLANEOUS SEGMENT

Data Element Name:	Placement of Bed Indicator
Record Position:	762-764
Format – Length:	Character - 3
Effective Date:	1/1/1994 - 5/1/1996
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The bed placement indicator was used shortly from 1994 to 1996. This indicator was used to detail the patient accommodation within a hospital that had exempt status for billing purposes.

Codes and Values:

1. "UB" = Unit Bed - Patient accommodation was bed within an organized hospital unit for which costs and statistics are separately maintained and an exempt payment (per diem or enhanced DRG rate) was expected for the patients in this unit.

   "SB" = Scatter Bed - Patient accommodation was bed within an organized hospital unit which was not limited to exempt status patients but to which patients qualifying for exempt payment were admitted.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. Must have been a valid entry.
2. Must have been left justified with no embedded blanks and space filled.
3. If this field was not applicable, it contains blanks.

MISCELLANEOUS SEGMENT

Data Element Name:	Do Not Resuscitate Indicator
Record Position:	765
Format – Length:	Character - 1
Effective Date:	1/1/1996 - 12/31/1997. Collection of this data element discontinued January 1998.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A code which indicates whether a DO NOT RESUSCITATE (DNR) Order written by a physician and placed in the patient's medical record to withhold cardiopulmonary resuscitation in the event of cardiopulmonary arrest existed for the patient's hospital stay at the time of discharge.

***Note*:** Collection of this data element discontinued in January of 1998.

Codes and Values:

1. "Y" = A DNR Order **Does** exist for the patient's hospital stay

   "N" = A DNR Order **Does Not** exist for the patient's hospital stay

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must be a valid entry.

MISCELLANEOUS SEGMENT

Data Element Name:	Emergency Department Indicator
Record Position:	766
Format – Length:	Character - 1
Effective Date:	1/1/2003
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The Emergency Department Indicator is set based on the submitted revenue codes. If the record contained an Emergency Department revenue code of 045X, the indicator is set to "E", otherwise it will be blank.

This data element reflects a visit that had services in the Emergency Department that resulted in Inpatient stay.

Codes and Values:
1. "E" = Emergency Department Services indicated on record.
   Blank (no value) = when not applicable.

OUTPUT Edits on Element:
1. Derived data element based on the value of the Revenue Code.

INPUT Edits on Element:
1. Must be a valid Revenue Code.

Note:
Please see the Claim Type data element in relation to the Emergency Department Indicator data element.

In 2003 SPARCS started the collection of all Emergency Department data on the Outpatient file. The information about the ED visit itself (in the Emergency Department) is *not* contained in the Inpatient Record.

MISCELLANEOUS SEGMENT

Data Element Name:	Exempt Unit Indicator
Record Position:	767-769
Format – Length:	Character - 3
Effective Date:	January 1, 1990
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which identifies a discharge from a unit within the facility that is exempt from Diagnosis Related Group (DRG) reimbursement.

Codes and Values:

1. "ALR" = Alcohol Rehabilitation
   "ALC" = Alternate Level of Care
   "CEP" = Comprehensive Psychiatric Emergency Program Observation
   "DGR" = Drug Rehabilitation
   "NDB" = Non-DRG Billable Claim
   "EPI" = Epilepsy
   "EXH" = All Services at Hospital are Exempt
   "MRH" = Medical Rehabilitation
   "PSY" = Psychiatric
   "XYZ" = HIV-AIDS
   "TBI" = Traumatic Brain Injury
   "VTD" = Ventilator Dependent

2. If this field was not applicable, it contains blanks.

OUTPUT Edits on Element:

1. This is a derived data element from the calculated Diagnostic Related Group (DRG).

2. Must have maintained a fixed width, and required spacing must have been maintained if element was not applicable.

INPUT Edits on Element:
Not applicable.

TREATMENT SEGMENT

Data Element Name:	Statement From Date (*previously Statement Covers Period From Date*)
Record Position:	770-777
Record Position for Encrypted*	3295-3316
Format – Length:	Number - 8
Format - Length	Number - 22
Effective Date:	1/1/1982
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and Month Identifiable Data Set: YES
Deniable Data Element:	This field is composed of both non-deniable and deniable components. **The 2-digit day is identifiable and is ONLY present on the identifiable file. See Appendix Z for release restrictions.

** Statement From Date is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:

The start date of the billing period. The "From" date should not be confused with the Admission Date. The Statement From Date is distinctly different than the Admission Date. The dates may coincide in some circumstances, but should not be confused. It is also not a requirement that the Admission Date fall in between the "From" Date and the Statement "Through" Date. The Statement Covers Period identifies the span of service dates included in a particular bill. The "From" Date is the earliest date of service on the bill.

Codes and Values:

1. CCYYMMDD = Century Year Month Day

2. Must have been valid date in accordance with the Date Edit Validation Table in Appendix A.

OUTPUT Edits on Element:

1. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Must have been on or before the Statement Thru Date.

2. Enter both dates as month, day, and year (CCYYMMDD). For example: November 3, 2010 must be entered as: 20101103.

Notes:

1. The Admission Date is purely the date the patient was admitted as an inpatient to the facility (or indicates the start of care date for home health and hospice). It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.

NUBC Examples of Correct Usage:

1. When Medicare patients receive outpatient services 72 hours prior to an inpatient admission, the outpatient charges are included on the inpatient bill. In this situation, the Statement Covers Period reflects the entire range of dates associated with the services on the billing statement. Therefore, the Admission Date and the "From" Date will differ. On an initial bill the "From" Date would be prior to the Admission Date.

2. A patient is treated in the Emergency Department and is subsequently admitted after midnight (the next day). The "From" Date and the ED (ICD-CM) Procedure Date would be the same, but the Admission Date would be the following day.

3. In a longer term stay situation, it is necessary for the provider to issue an initial bill, one or more interim bills, and a final bill. The Admission Date is reported on each bill and will be the same on all of these bills. The Statement Covers Period will vary and reflects only the dates of services performed during the respective billing period.

TREATMENT SEGMENT

Data Element Name:	Statement Through Date (*previously Statement Covers Period Through Date*)
Record Position:	778-785
Record Position for Encrypted*	3317-3338
Format – Length:	Number - 8
Format – Length for Encrypted*	Number - 22
Effective Date:	1/1/1982
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and Month Identifiable Data Set: YES
Deniable Data Element:	This field is composed of both non-deniable and identifiable components. **The 2-digit day is deniable and is ONLY present on the identifiable file. See Appendix Z for release restrictions.

** Statement Thru Date is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:
The end date of the billing period. The date when the patient was discharged from the hospital or death occurred.

Codes and Values:

1. CCYYMMDD = Century Year Month Day

2. Must have been valid date in accordance with the Date Edit Validation Table in Appendix A.

OUTPUT Edits on Element:

1. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Must have been on or before the 'Statement From Date'.

2. Multiple edits exist with this data element. When using the 'Statement Thru Date' to calculate 'Length of Stay', if the Neonate Birth Weight was reported as less than 1500 grams, and the 'Patient Discharge Status' was reported as code "01" home, then the 'Length of Stay' must have been greater than 10 days.

TREATMENT SEGMENT

Data Element Name:	Admission/Start of Care Date
Record Position:	786-793
Record Position for Encrypted*	3339-3360
Format – Length:	Number - 8
Format – Length for Encrypted*	Number - 22
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and Month Identifiable Data Set: YES
Deniable Data Element:	This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. See Appendix Z for release restrictions.

** Admission/Start of Care Date is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:
This is the date of the patient's admission to the hospital.

Codes and Values:

1. CCYYMMDD = Century Year Month Day

2. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.

OUTPUT Edits on Element:

1. Multiple edits exist with this data element in the Output file. The age, calculated as the difference between the 'Patient Birth Date' and the 'Admission /Start of Care Date' must have been less than 125.

2. When using the 'Admission/Start of Care Date' to calculate 'Length of Stay', if the 'Newborn Birth Weight' was reported as less than 1500 grams, and the 'Patient Discharge Status' was reported as code "01" home, then the 'Length of Stay' must have been greater than 10 days.

3. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted

INPUT Edits on Element:

1. Must have been on or before 'Statement Thru Date'.

2. Must have been on or before the 'Date Processed'.

3. Must have been on or after the opening date, and on or before the closing date, of an Article 28 facility as specified in the SPARCS Facility Reference File maintained by the SPARCS Administrative Unit.

TREATMENT SEGMENT

Data Element Name:	Admit Weekday
Record Position:	794-796
Format – Length:	Character - 3
Effective Date:	Implemented May 1, 2005 and added to all years' files.
Contained In:	De-Identified Data Set: NO Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The day of the week that the patient was admitted to the hospital.

Codes and Values:

1. "MON" = Monday
   "TUE" = Tuesday
   "WED" = Wednesday
   "THU" = Thursday
   "FRI" = Friday
   "SAT" = Saturday
   "SUN" = Sunday

OUTPUT Edits on Element:

1. This is a derived data element.

INPUT Edits on Element:
None.

TREATMENT SEGMENT

Data Element Name:	Admission Hour
Record Position:	797-798
Format – Length:	Number - 2
Effective Date:	January 1, 1980
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The hour during which the patient was admitted for inpatient care.

Codes and Values:

1. Must have been right justified and zero filled.

2. HHMM = Hour Minutes. The hour must have been recorded in whole numbers, disregarding minutes, in accordance with the Admission/Discharge Hour Code Table in Appendix B.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must have been a valid entry.

2. **SPARCS currently only edits and collects the first 2 numbers**. Please refer to the Admission/Discharge Code Table in Appendix B.

TREATMENT SEGMENT

Data Element Name:	Unscheduled/Scheduled Admission
Record Position:	799
Format – Length:	Character - 1
Effective Date:	1/1/1982 - 12/31/2000 *Populated:* 1/1/2001 – 9/30/2007
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The code which best describes the urgency of the patient's admission to the hospital.

***Note*:** This data element was available for a limited time period. Effective January 1, 2001 (for all discharges) this data element is no longer collected by SPARCS from provider information systems. For the period January 1, 2001 through September 30, 2007 it was derived and populated from the 'Type of Admission' and 'Source of Admission'. Effective October 1, 2007 (when 'Source of Admission' was replaced with the 'Point of Origin') this data element was no longer populated by SPARCS.

See Appendix X for details on the Unscheduled/Scheduled Admission Conversion Algorithm.

Codes and Values:

1. "1" = Unscheduled - An admission which was not arranged with the hospital at least 24 hours before the admission.

   "2" = Scheduled - An admission arranged through the hospital at least 24 hours before the admission.

   "9" = Information not available.

OUTPUT Edits on Element:

1. This was a derived data element from January 1, 2001 to September 30, 2007.

INPUT Edits on Element:

1. Must have been a valid entry for the period 1/1/1982 - 12/31/2000.

TREATMENT SEGMENT

Data Element Name:	Discharge Date
Record Position:	800-807
Record Position for Encrypted*	3361-3382
Format – Length:	Number - 8
Format – Length for Encrypted*	Number - 22
Effective Date:	January 1, 1980
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and Month Identifiable Data Set: YES
Deniable Data Element:	This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. See Appendix Z for release restrictions.

** Discharge Date is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:
The date when the patient was discharged or death occurred.

Note: Effective 1/1/1998 this field was populated from the 'Statement Covers Through Date'.

Codes and Values:

1. CCYYMMDD = Century Year Month Day

2. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.

OUTPUT Edits on Element:

1. When using the 'Discharge Date' *aka* 'Statement Covers Through Date', if the 'Neonate Birth Weight' was reported as less than 1500 grams, and the 'New York State Patient Discharge Status' was reported as code "01" home, then the 'Length of Stay' must have been greater than 10 days.

2. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Must have been on or after the 'Admission/Start of Care Date'.

2. Must have been on or before the 'Date Processed'.

3. Must have been on or after the opening date, or on or before the closing date, of an Article 28 facility as specified in the SPARCS Facility Reference File maintained by the SPARCS Administrative Unit.

TREATMENT SEGMENT

Data Element Name:	Discharge Weekday
Record Position:	808-810
Format – Length:	Character - 3
Effective Date:	Implemented May 1, 2005 and added to all years' files.
Contained In:	De-Identified Data Set: NO Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The weekday the patient was discharged from the hospital.

Codes and Values:

1. "MON" = Monday
   "TUE" = Tuesday
   "WED" = Wednesday
   "THU" = Thursday
   "FRI" = Friday
   "SAT" = Saturday
   "SUN" = Sunday

OUTPUT Edits on Element:
This is a derived data element.

INPUT Edits on Element:
Not applicable. This is a derived data element.

TREATMENT SEGMENT

Data Element Name:	Discharge Hour
Record Position:	811-812
Format – Length:	Number - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The hour when the patient was discharged or death occurred.

Codes and Values:

1. Must have been right justified and zero filled.

2. The hour must have been recorded in whole numbers, disregarding minutes, in accordance with the 'Admission/Discharge Hour' Code Table in Appendix B.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must have been a valid entry.

2. Please refer to the 'Admission/Discharge Hour' Code Table in Appendix B.

TREATMENT SEGMENT

Data Element Name:	Length of Stay
Record Position:	813-816
Format – Length:	Number - 4
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total number of patient days at an acute level and/or other than acute care level (excluding leave of absence days).

Codes and Values:
1. Numeric value greater than zero.

OUTPUT Edits on Element:
1. 'Length of Stay' (LOS) equals 'Discharge Date' minus 'Admission Date/Start of Care' minus 'Leave of Absence Days'.

2. If the 'Date of Discharge' equals the 'Date of Admission', then 'Length of Stay' (LOS) equals "1".

3. When the 'Neonate Birth Weight' is reported as less than 1500 grams, and the 'Patient Discharge Status Code' is reported as "01" (Home), then the 'Length of Stay' must be greater than 10 days.

INPUT Edits on Element:
Not applicable. This is a derived data element

TREATMENT SEGMENT

Data Element Name:	Insured Days
Record Position:	817-820
Format – Length:	Number - 4
Effective Date:	January 1, 2008
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The number of days covered by the primary payer as qualified by the payer. The days are reported by the facility based on the beneficiary's policy.

Codes and Values:
1. Numeric values greater than zero.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. The sum of 'Insured Days' and 'Non-Insured Days' must not exceed 'Total Length of Stay' ('Statement Through Date' minus 'Admission/Start of Care Date').

Note:
Facilities were required to switch to the X12-837 by 12/31/2007. Due to the collection change in 2008, the data elements 'Covered Days', 'Non-Covered Days' were not available by payer in the new format. These data elements were stopped, and the 'Insured Days' and 'Non-Insured Days' should be used in their place starting in 2008.

TREATMENT SEGMENT

Data Element Name:	Non-Insured Days
Record Position:	821-824
Format – Length:	Number - 4
Effective Date:	January 1, 2008
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The number of days not covered by the primary payer, and reported by the facility.

Codes and Values:
1. Numeric values greater than zero.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. The sum of 'Non-Insured Days' and 'Insured Days' must not exceed 'Total Length of Stay' ('Statement Thru Date' minus 'Admission Date/Start of Care').

Note:
Facilities were required to switch to the X12-837 by 12/31/2007. Due to the collection change in 2008, the data elements 'Covered Days', 'Non-Covered Days' were not available by payer in the new format. These data elements were stopped, and the 'Insured Days' and 'Non-Insured Days' should be used in their place starting in 2008.

TREATMENT SEGMENT

Data Element Name:	Total Leave of Absence Days
Record Position:	825-828
Format – Length:	Number - 4
Effective Date:	January 1, 1987
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The sum of 'Leave of Absence Days' reported in all the payer sequences for the corresponding inpatient stay.

Codes and Values:
1. Numeric values greater than zero.

2. If this field was not applicable, it will contain zeros.

OUTPUT Edits on Element:
1. This is a derived data element.

2. Field must be less than the 'Length of Stay'.

INPUT Edits on Element:
1. This is a derived data field from the 'Occurrence Span Code' information. The reported 'Occurrence Span Code' must have a value of "74" for 'Leave of Absence'.

2. The 'Occurrence Span Code From Date' must be on or before the 'Occurrence Span Through Date' for each 'Occurrence Span' that is reported.

3. The corresponding 'Occurrence Span From Date' and 'Thru Date' must be within the stay as defined by the 'Admission Date' and the 'Statement Thru Date'.

TREATMENT SEGMENT

Data Element Name:	Total Alternate Care Days
Record Position:	829-832
Format – Length:	Number - 4
Effective Date:	1/1/1994 – 1/1/1999
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total number of patient days associated with this sequence at a level of care other than acute.

Note: This data element was available for a limited time period.

Codes and Values:
1. Must have been right justified and zero filled.

2. If this field was not applicable it must have contained zeros.

OUTPUT Edits on Element:
1. 'Unit Quantity' and 'Unit Type' must have been less than the 'Length of Stay'.

2. The number of days must have been less than or equal to the number of days from the 'Date Alternate Care Required' to the 'Discharge Date'.

3. Total 'Alternate Level of Care Days' for multiple payer submissions must not exceed 'Length of Stay'.

4. If 'Alternate Level of Care Days' was entered, 'Type of Alternate Care Required' and 'Date Alternate Care Required' were also reported. If 'Type and Date of Alternate Care Required' were reported, at least one 'Alternate Level of Care Day' for one of the record sequences must have been reported.

INPUT Edits on Element:
1. This is a derived data element using the reported 'Occurrence SPAN Date' range.

TREATMENT SEGMENT

Data Element Name:	Type of Alternate Care Required
Record Position:	833
Format – Length:	Character - 1
Effective Date:	1/1/1994 - 1/1/1999
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The code which specifies the type of alternate care required for a patient determined to need a level of care other than acute during their hospitalization.

If a determination was made as to the type of care required but the patient's condition changed necessitating a different type of alternate care, the first determined type of alternate care required is entered.

Note: This data element was available for a limited period of time.

Codes and Values:

1. "1" = Residential Health Care Facility
   "2" = Medically Related Home Care Services
   "3" = Domiciliary Care
   "4" = Other Institution
   "5" = Home Health Service

2. If this field was not coded it contains blanks.

OUTPUT Edits on Element:

1. Calculated data element based a reported 'Occurrence Code':

Reported occurrence Code Description Narrative	Reported Value Occurrence Code	Reported Value/ ALC Code
Residential Health Care Facility	75	1
Medically Related Home Care Services	81	2
Domiciliary Care	82	3
Other Institution	82	4
Home Health Services	81	5

INPUT Edits on Element:

1. Not applicable. This data element is derived from the reported 'Occurrence Code'.

TREATMENT SEGMENT

Data Element Name:	Date Alternate Care Required
Record Position:	834-841
Record Position for Encrypted*	3383-3404
Format – Length:	Number - 8
Format – Length for Encrypted*	Number - 22
Effective Date:	1/1/1994 - 1/1/1999
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and Month Identifiable Data Set: YES
Deniable Data Element:	This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. The 4-digit year and the 2-digit month are non-deniable and are present on all files. Yes - See Appendix Z for release restrictions.

** Alternate Care Date is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:

The first date that acute care was no longer needed as determined by the UR/PRO Representative. A patient's status can change several times during a hospital stay. If it changed more than once and consequently required a change back from alternate level of care to acute care, the FIRST date that acute care was no longer needed was entered. This date is not necessarily the date the determination was made or the date the level of care was changed; it is the date that acute care was no longer needed.

Note: This data element was available for a limited time period.

Codes and Values:

1. CCYYMMDD = Century Year Month Day.

2. If this field was not applicable, it will contain zeros.

OUTPUT Edits on Element:

1. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. This data element is derived from the 'Occurrence Span Date'. The date must have been on or after the 'Admission Date' and prior to or the same as the 'Discharge Date'.

2. If 'Date Alternate Care Required' was entered, then 'Type of Alternate Care Required' and 'Total Alternate Level of Care Days' were also reported.

3. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.

TREATMENT SEGMENT

Data Element Name:	Total Acute Certified Days
Record Position:	842-845
Format – Length:	Number - 4
Effective Date:	1/1/1982 - 12/31/1997
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total number of patient days certified as medically necessary at an acute level of care.

Note: This data element was available for a limited time period.

Codes and Values:

1. Must have been less than or equal to "9999".

2. "0000" was a valid entry only if the entire stay was denied by the Utilization Review/PRO Representative.

3. Must have been right justified and zero filled.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. The number of days entered must have been less than or equal to the 'Length of Stay'.

TREATMENT SEGMENT

Data Element Name: Non-Acute Care Type (NACT) 1-30

Record Position

Data Element	Record Position	Data Element	Record Position	Data Element	Record Position
NACT 1	846-847	NACT 11	1026-1027	NACT 21	1206-1207
NACT 2	864-865	NACT 12	1044-1045	NACT 22	1224-1225
NACT 3	882-883	NACT 13	1062-1063	NACT 23	1242-1243
NACT 4	900-901	NACT 14	1080-1081	NACT 24	1260-1261
NACT 5	918-919	NACT 15	1098-1099	NACT 25	1278-1279
NACT 6	936-937	NACT 16	1116-1117	NACT 26	1296-1297
NACT 7	954-955	NACT 17	1134-1135	NACT 27	1314-1315
NACT 8	972-973	NACT 18	1152-1153	NACT 28	1332-1333
NACT 9	990-991	NACT 19	1170-1171	NACT 29	1350-1351
NACT 10	1008-1009	NACT 20	1188-1189	NACT 30	1368-1369

Format – Length: Character - 2
Effective Date: January 1, 1999
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element:

Description:
A code which indicates the type of non-acute care that was reported.

Codes and Values:
1. "74" = Leave of Absence.
   "75" = SNF Level of Care or Residential Care Facility.
   "81" = Home Health Level of Care – *Code removed in November of 2010.*
   "82" = Other Level of Care – *Code removed in November of 2010.*

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must be a valid entry for 'Occurrence SPAN Code'. Valid codes are "74", "75", "81" or "82".

2. Codes "81" and "82" are valid only for discharge dates prior to November 2010, and were eliminated after November 2010.

TREATMENT SEGMENT

Data Element Name: Non-Acute From (NACF) Date 1-30

Record Position:

Data Element	Record Position	Data Element	Record Position	Data Element	Record Position
NACF 1	848-855	NACF 11	1028-1035	NACF 21	1208-1215
NACF 2	866-873	NACF 12	1046-1053	NACF 22	1226-1233
NACF 3	884-891	NACF 13	1064-1071	NACF 23	1244-1251
NACF 4	902-909	NACF 14	1082-1089	NACF 24	1262-1269
NACF 5	920-927	NACF 15	1100-1107	NACF 25	1280-1287
NACF 6	938-945	NACF 16	1118-1125	NACF 26	1298-1305
NACF 7	956-963	NACF 17	1136-1143	NACF 27	1316-1323
NACF 8	974-981	NACF 18	1154-1161	NACF 28	1334-1341
NACF 9	992-999	NACF 19	1172-1179	NACF 29	1352-1359
NACF 10	1010-1017	NACF 20	1190-1197	NACF 30	1370-1377

Record Position for Encrypted*

Data Element	Record Position	Data Element	Record Position	Data Element	Record Position
NACF 1	3405-3426	NACF 11	3845-3866	NACF 21	4285-4306
NACF 2	3449-3470	NACF 12	3889-3910	NACF 22	4329-4350
NACF 3	3493-3514	NACF 13	3933-3954	NACF 23	4373-4394
NACF 4	3537-3558	NACF 14	3977-3998	NACF 24	4417-4438
NACF 5	3581-3602	NACF 15	4021-4042	NACF 25	4461-4482
NACF 6	3625-3646	NACF 16	4065-4086	NACF 26	4505-4526
NACF 7	3669-3690	NACF 17	4109-4130	NACF 27	4549-4570
NACF 8	3713-3734	NACF 18	4153-4174	NACF 28	4593-4614
NACF 9	3757-3778	NACF 19	4197-4218	NACF 29	4637-4658
NACF 10	3801-3822	NACF 20	4241-4262	NACF 30	4681-4702

Format – Length: Number - 8

Format – Length for Encrypted* Number - 22

Effective Date: January 1, 1999

Contained In: De-Identified Data Set: YES – Year only
Limited Data Set: YES – Year and Month
Identifiable Data Set: YES

Deniable Data Element: This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. The 4-digit year and the 2-digit month are non-deniable and are present on the De-identified file. See Appendix Z for release restrictions.

** Non-Acute From Date* 1-30 *is available on the Limited Data Set as an Encrypted Data Element. otherwise it is available only with the Year and Month.*

Description:

The date this occurrence of non-acute care began.

Codes and Values:

1. CC YY MM DD = Century Year Month Day
2. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.
3. If this field was not applicable it contains blanks.

OUTPUT Edits on Element:

1. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. The reported 'Occurrence SPAN Date' must have been on or after the 'Admission Date/Start of Care' and prior to or the same as 'Discharge Date'.

TREATMENT SEGMENT

Data Element Name: Non-Acute Thru Date (NATD) 1-30

Record Position:

Data Element	Record Position	Data Element	Record Position	Data Element	Record Position
NATD 1	856-863	NATD 11	1036-1043	NATD 21	1216-1223
NATD 2	874-881	NATD 12	1054-1061	NATD 22	1234-1241
NATD 3	892-899	NATD 13	1072-1079	NATD 23	1252-1259
NATD 4	910-917	NATD 14	1090-1097	NATD 24	1270-1277
NATD 5	928-935	NATD 15	1108-1115	NATD 25	1288-1295
NATD 6	946-953	NATD 16	1126-1133	NATD 26	1306-1313
NATD 7	964-971	NATD 17	1144-1151	NATD 27	1324-1331
NATD 8	982-989	NATD 18	1162-1169	NATD 28	1342-1349
NATD 9	1000-1007	NATD 19	1180-1187	NATD 29	1360-1367
NATD 10	1018-1025	NATD 20	1198-1205	NATD 30	1378-1385

Record Position for Encrypted*

Data Element	Record Position	Data Element	Record Position	Data Element	Record Position
NATD 1	3427-3448	NATD 11	3867-3888	NATD 21	4307-4328
NATD 2	3471-3492	NATD 12	3911-3932	NATD 22	4351-4372
NATD 3	3515-3536	NATD 13	3955-3976	NATD 23	4395-4416
NATD 4	3559-3580	NATD 14	3999-4020	NATD 24	4439-4460
NATD 5	3603-3624	NATD 15	4043-4064	NATD 25	4483-4504
NATD 6	3647-3668	NATD 16	4087-4108	NATD 26	4527-4548
NATD 7	3691-3712	NATD 17	4131-4152	NATD 27	4571-4592
NATD 8	3735-3756	NATD 18	4175-4196	NATD 28	4615-4636
NATD 9	3779-3800	NATD 19	4219-4240	NATD 29	4659-4680
NATD 10	3823-3844	NATD 20	4263-4284	NATD 30	4703-4724

Format – Length: Number - 8

Format – Length for Encrypted* Number - 22

Effective Date: January 1, 1999

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. The 4-digit year and the 2-digit month are non-deniable and are present on the De-identified file. See Appendix Z for release restrictions.

** Non-Acute Thru Date* 1-30 *is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:

The date this occurrence of non-acute care ended.

Codes and Values:

1. CCYYMMDD = Century Year Month Day.
2. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.
3. If this field was not applicable it contains blanks.

OUTPUT Edits on Element:

1. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. The reported 'Occurrence Span Date' must have been on or after the 'Admission Date/Start of Care' and prior to or the same as 'Discharge Date'.

SPARCS Inpatient Segment: **Primary Records**

TREATMENT SEGMENT

Data Element Name:	Same Day Discharge Indicator
Record Position:	1386
Format – Length:	Character - 1
Effective Date:	Implemented May 1, 2005, and added to all year's files.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

A flag indicating if the patient was admitted and discharged on the same day.

Codes and Values:

1. "0" = Not Same Day
   "1" = Same Day

OUTPUT Edits on Element:

1. A derived data element using the 'Statement From Date' and 'Statement Through Date'.

INPUT Edits on Element:

Not applicable. This is a derived data element.

TREATMENT SEGMENT

Data Element Name:	Patient Discharge Status (*previously NYS Patient Status or Discharge Disposition*)
Record Position:	1387-1388
Format – Length:	Character - 2
Effective Date:	1/1/1982 – 1/1/1993 reported as UDS codes that were translated to UB codes. Reported as Uniform Bill codes after 1993.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The code which best identifies the patient's destination or status upon discharge.

Codes and Values:

1. Must have been a valid code in accordance with codes listed in Appendix C (*Patient Discharge Status Codes*).

2. Must have been right justified and zero filled.

OUTPUT Edits on Element:

1. If Patient Discharge Status code "10" was reported, computed ‘Age’ must have equaled "000" [calculated from the ‘Patient Birth Date’ at the time of admission].

2. If the ‘Neonate Birth Weight’ was reported as less than 1500 grams, and the ‘Patient Status’ was reported as code "01" home, then the ‘Length of Stay’ must have been greater than 10 days.

INPUT Edits on Element:

1. Must have been a valid entry in accordance with values in Appendix C.

TREATMENT SEGMENT

Data Element Name:	Type of Bill
Record Position:	1389-1391
Format – Length:	Character - 3
Effective Date:	January 1, 1994
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A three-digit numeric code which identified the specific type of bill (inpatient, adjustments, voids, etc.). The first digit represents Type of Facility, the second digit the Bill Classification, and the third digit the Frequency.

Codes and Values:

1. First Digit: "1" = Hospital
   "8" = Special Facility (Rural Primary Care Facility Only)

   Second Digit: "1" = Inpatient (including Medicare Part A)
   "2" = Inpatient (Medicare Part B)
   "5" = Rural Primary Care Hospital

   Third Digit: "1" = Admit thru discharge claim (new)
   "7" = Replacement of prior claim (change)
   "8" = Void/cancel of prior claim (delete)

2. All positions must have been fully coded.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must have been a valid entry as assigned by the National Uniform Bill Committee (NUBC).

Note:
This data element is derived from two data field from the X12-837 forward. They are: 'Facility Type Code' and 'Claim Transaction Type'.

TREATMENT SEGMENT

Data Element Name:	Service Category Group
Record Position:	1392
Format – Length:	Character - 1
Effective Date:	Implemented May 1, 2005 and added to all years' files.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

Categorization of the discharge record by NYS Department of Health defined Service Category Group as described in the SPARCS Annual Report Series Tables. See Appendix S - Service Category Group Definitions.

Codes and Values:

1. "1" = Medical
   "2" = Surgical
   "3" = Pediatric
   "4" = Obstetrical
   "5" = Nursery/Newborn
   "6 "= Psychiatric

OUTPUT Edits on Element:

1. See Appendix S for grouping definitions using the ICD-9-CM Principal Diagnosis.

INPUT Edits on Element:

Not applicable. This is a derived data element.

TREATMENT SEGMENT

Data Element Name:	Type of Admission
Record Position:	1393
Format – Length:	Character - 1
Effective Date:	January 1, 1994
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which indicates the manner in which the patient was admitted to the health care facility.

Codes and Values:

1. "1" = Emergency - The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.

   "2" = Urgent - The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.

   "3" = Elective - The patient's condition permits adequate time to schedule the admission based on the availability of a suitable accommodation.

   "4" = Newborn - Use of this code necessitates the use of special codes in the Source of Admission.

   "5" = Trauma - Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

   "9" = Information not available. The provider cannot classify the type of admission.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must have been a valid entry.

TREATMENT SEGMENT

Data Element Name:	Point of Origin (*previously Source of Admission*)
Record Position:	1394
Format – Length:	Character - 1
Effective Date:	January 1, 1986
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The code indicating the point of patient origin for admission to the hospital. See Conversion Appendix for historical information.

Codes and Values:

1. "1" = Non-Health Facility Point of Origin
   Inpatient: The patient was admitted to this facility upon an order of a physician.

   "2" = Clinic
   Inpatient: The patient was referred to this facility as a transfer from a freestanding or non-freestanding clinic.

   "3" = Reserved for assignment by the NUBC.

   "4" = Transfer From a Hospital (Different Facility)
   Inpatient: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.

   "5" = Transfer From a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
   Inpatient: The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

   "6" = Transfer From Another Health Care Facility
   Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.

   "7" = Emergency Room (**Discontinued Effective 7/1/2010**)
   Inpatient: The patient was admitted to this facility after receiving services in this facility's emergency department.

   Excludes: Patients who came to the emergency room from another health care facility.

"8" = Court/Law Enforcement
Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.

"9" = Information Not Available
The means by which the patient was admitted to this hospital was not known.

"A" = Transfer from a Rural Primary Care Hospital (Only valid for discharges prior to 10/1/2007)
The patient was admitted to this facility as a transfer from a Rural Primary Care Hospital (RPCH) where he or she was an inpatient.

"D" = Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer (only valid for discharges prior to 10/1/2007).
Inpatient: The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

"E" = Transfer from Ambulatory Surgery Center (Effective 10/1/2007)
Inpatient: The patient was admitted to this facility as a transfer from an ambulatory surgery center.

"F" = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program (Effective 10/1/2007)

Inpatient: The patient was admitted to this facility as a transfer from a hospice.

2. If the Type of Admission is a Newborn, "4", the following coding scheme must be used for Source of Admission:
   - "1" = Normal Delivery (Only valid for discharges prior to 10/1/2007)
   - "2" = Premature Delivery (Only valid for discharges prior to 10/1/2007)
   - "3" = Sick Baby (Only valid for discharges prior to 10/1/2007)
   - "4" = Extra Mural Birth (Only valid for discharges prior to 10/1/2007)
   - "5" = Born Inside Hospital (Effective 10/1/2007)
     A baby born inside this Hospital.
   - "6" = Born Outside Hospital (Effective 10/1/2007)
     A baby born outside of this Hospital.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must have been a valid entry for 'Point of Origin'.

2. Prior to 1994 the data element collected was 'Source of Admission/Admission Source".

Note:
The National Uniform Bill Committee (NUBC) name of this data element changed from 'Source of Admission' to 'Point of Origin'.

DIAGNOSIS SEGMENT

Data Element Name:	Admitting Diagnosis Code
Record Position:	1395-1401
Format – Length:	Character - 7
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The diagnosis provided by the practitioner at the time of admission which describes the patient's condition upon admission to the hospital. Since the Admitting Diagnosis is formulated before all tests and examinations are complete, it may have been stated in the form of a problem or symptom and it may differ from any of the final diagnoses recorded in the medical record.

Codes and Values:

1. Must have been a valid ICD-CM code excluding the decimal point. To be valid, ICD-CM codes must have been entered at the most specific level to which they are classified in the ICD-CM Tabular List. Failure to enter all required digits in the diagnosis codes would have caused the record to be rejected.

2. Must have been left justified and entered exactly as shown in the ICD-CM coding reference, excluding the decimal point, and space filled.

3. E-codes were not valid as Admitting Diagnosis Codes. E-codes were reported in External Cause-of-Injury Code and Place-of-Injury Code.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Edits pertaining to ICD-CM codes were validated on the basis of the 'Discharge Date' and 'Expected Principal Reimbursement' depending on conditions described in Appendix N, which included age-specific and sex-specific diagnosis code conditions.

SPARCS Inpatient Segment: **Primary Records**

DIAGNOSIS SEGMENT

Data Element Name:	Principal Diagnosis Code
Record Position:	1402-1408
Format – Length:	Character - 7
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The 'Principal/Primary Diagnosis' is the condition established after study to have been chiefly responsible for occasioning the admission of the patient to the hospital for care. Since the 'Principal/Primary Diagnosis' represents the reason for the patient's stay, it may not necessarily have been the diagnosis which represented the greatest length of stay, the greatest consumption of hospital resources, or the most life-threatening condition. Since the 'Principal/Primary Diagnosis' reflects clinical findings discovered during the patient's stay, it may differ from 'Admitting Diagnosis'.

Codes and Values:

1. Must have been a valid ICD-CM code excluding decimal points. To have been valid, ICD-CM codes must have been entered at the most specific level to which they are classified in the ICD-CM Tabular List. Three-digit codes further divided at the four-digit level must have been entered using all four digits. Four-digit codes further subclassified at the five-digit level must have been entered using all five digits. Failure to enter all required digits in the diagnosis codes would have caused the record to be rejected.

2. Must have been left justified and entered exactly as shown in the ICD-CM coding reference, excluding the decimal point, and space filled.

OUTPUT Edits on Element:

1. If the 'Neonate Birth Weight' was reported as less than 1500 grams, and the 'New York State Patient Discharge Status' was reported as code "01" home, then the calculated 'Length of Stay' must be greater than 10 days.

INPUT Edits on Element:

1. Edits pertaining to ICD-CM codes are validated on the basis of the 'Discharge Date' and 'Expected Principal Reimbursement' depending on conditions described in Appendix N, which includes age-specific and sex-specific diagnosis code conditions.

2. When the edit flag on the ICD-CM reference file indicates an "unacceptable principal/primary diagnosis without a secondary diagnosis" an 'Other Diagnosis Code 1' must have been reported.

3. Diagnosis codes reported in the ICD-9-CM range of 800.00-999.99 required the reporting of a valid 'External Cause-of-Injury Code' unless as an exception in Appendix N.

4. E-codes were not valid as 'Principal/Primary Diagnosis Codes'. E-codes are reported in 'External Cause-of-Injury Code' and 'Place-of-Injury Code'.

DIAGNOSIS SEGMENT

Data Element Name: Other Diagnosis Code 1-24

Record Position:

Data Element	Record Position	Data Element	Record Position	Data Element	Record Position
ODC 1	1410-1416	ODC 9	1474-1480	ODC 17	1538-1544
ODC 2	1418-1424	ODC 10	1482-1488	ODC 18	1546-1552
ODC 3	1426-1432	ODC 11	1490-1496	ODC 19	1554-1560
ODC 4	1434-1440	ODC 12	1498-1504	ODC 20	1562-1568
ODC 5	1442-1448	ODC 13	1506-1512	ODC 21	1570-1576
ODC 6	1450-1456	ODC 14	1514-1520	ODC 22	1578-1584
ODC 7	1458-1464	ODC 15	1522-1528	ODC 23	1586-1592
ODC 8	1466-1472	ODC 16	1530-1536	ODC 24	1594-1600

Format – Length: Character - 7

Effective Date:

Effective Date	Reporting
January 1982	Other Diagnosis Code 1-4
January 1992	Other Diagnosis Code 5-8
January 1994	Other Diagnosis Code 9-14
August 2011	Other Diagnosis Code 15-24

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

Other Diagnoses include all conditions that coexisted at the time of admission, or developed subsequently, which affected the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which had no bearing on the current hospital stay were excluded.

Conditions should have been coded that affected patient care in terms of requiring: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring.

Codes and Values:

1. Must have been a valid ICD-CM code excluding the decimal point. To have been valid, ICD-CM codes must have been entered at the most specific level to which they are classified in the ICD-CM Tabular List. Three-digit codes further divided at the four-digit level must have been entered using all four digits. Four-digit codes further sub-classified at the five-digit level must have been entered using all five digits. Failure to enter all required digits in the diagnosis codes would have caused the record to be rejected.
2. Must have been left justified and entered exactly as shown in the ICD-CM coding reference, excluding the decimal point, and space filled.
3. Only E-codes in the ICD-9-CM range of E930.0 thru E949.9 are valid as 'Other Diagnosis Codes' (other E-codes are to be reported in 'External Cause-of-Injury Code' and 'Place-of-Injury Code'. Prior to 1990 and after December 1, 1998, additional E-codes could have been reported as valid 'Other Diagnosis Codes').
4. If this field was not applicable, it must have contained blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Edits pertaining to ICD-CM codes are validated on the basis of the 'Discharge Date' and 'Expected Principal Reimbursement' depending on conditions described in Appendix N, which includes age-specific and sex-specific diagnosis code conditions.

2. When the edit flag on the ICD-CM reference file for an "unacceptable principal/primary diagnosis without and secondary diagnosis" was applicable for the 'Principal/Primary Diagnosis Code', an 'Other Diagnosis Code 1' must have also been reported.

3. Diagnosis codes reported in the ICD-9-CM range of 800.00-999.99 required the reporting of a valid 'External Cause-of-Injury Code' unless listed as an exception in Appendix N.

4. If an 'Other Diagnosis Code' was reported, the corresponding 'Present on Admission Indicator' must have also been reported.

DIAGNOSIS SEGMENT

Data Element Name: Present on Admission (POA) Indicator 1-24

Record Position:

Data Element	Record Position	Data Element	Record Position	Data Element	Record Position
POA 1	1417	POA 9	1481	POA 17	1545
POA 2	1425	POA 10	1489	POA 18	1553
POA 3	1433	POA 11	1497	POA 19	1561
POA 4	1441	POA 12	1505	POA 20	1569
POA 5	1449	POA 13	1513	POA 21	1577
POA 6	1457	POA 14	1521	POA 22	1585
POA 7	1465	POA 15	1529	POA 23	1593
POA 8	1473	POA 16	1537	POA 24	1601

Format – Length: Character - 1

Effective Date:

Effective Date	Reporting
January 1990	POA 1-4
January 1992	POA 5-8
January 1994	POA 9-14
August 2011	POA 15-24

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

.

Description:

The 'Present on Admission Indicator Code' is used to identify the diagnosis onset as it relates to the diagnosis reported in the 'Other Diagnosis Code'. The 'Present on Admission Indicator' on 'Other Diagnoses' indicates whether the onset of the diagnosis preceded or followed admission to the hospital.

Effective January 1, 2011 all claims involving inpatient admissions to general acute care hospital or other facilities that are subject to a law or regulation (e.g. Deficit Reduction Act of 2005) are mandated to collect present on admission information, or as mutually agreed to under contract with an insurance company.

Codes and Values:

1. "1" = Yes - Present at the time of inpatient admission.

   "2" = No - Not present at the time of inpatient admission.

   "3" = Clinically Undetermined - Provider is unable to clinically determine whether condition was present on admission or not

   "9" = Unknown - Documentation is insufficient to determine if condition is present on admission

   "X" = Exempt from POA reporting for selected ICD-9-CM codes

2. If this field was not applicable it contains blanks.

OUTPUT Edits on Element:

1. In 2007 this became a data element based upon current values as approved by NUBC; the values collected were converted into the above values for consistency.

INPUT Edits on Element:

1. Must have equaled appropriate values at the time of submission (i.e., 2007 and forward values are:
   "Y" = Yes;
   "N" = No;
   "U" = Unknown;
   "W" = Clinically Undetermined
   "1" or blank = Exempt from Reporting

2. If an 'Other Diagnosis Code' was reported, then there must have been a corresponding Present on Admission Indicator, coded appropriately.

3. If 'Present on Admission Indicator', was reported, 'Other Diagnosis Code' must have also been reported.

DIAGNOSIS SEGMENT

Data Element Name:	Clinical Classification Software (CCS) Diagnosis Category
Record Position:	1602-1604
Format – Length:	Character - 3
Effective Date:	Implemented August 2012 and added to all years' discharge records
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	

Description:

The Clinical Classification Software (CCS) was developed by the Agency for Healthcare Research and Quality (AHRQ) as a tool to cluster patient diagnoses and procedures without having to sort through thousands of codes.

The CCS Diagnosis Category data element uses the reported ICD-9-CM code (when appropriate, future years will use the corresponding ICD-10-CM code). The "clinical grouper" makes it easier for researchers to explore the types of conditions. The "CCS Diagnosis Category" is the single level classification system that aggregates illness and conditions in to (currently) 285 mutually exclusive categories.

As part of the Healthcare Cost and Utilization Project (HCUP), a federal-state industry partnership, the CCS software and documentation is maintained on the HCUP website at: www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. (CCS was formerly called the Clinical Classification for Healthcare Policy research – CCHPR).

Example:

ICD Diagnosis Reference for Diagnosis Group - Acute bronchitis (Single Level)

ICD Code	Description	CCS Category
4660	ACUTE BRONCHITIS	125 – Acute Bronchitis
4661, 46611	AC BRONCHIOLITIS D/T RSV	125 – Acute Bronchitis
46619	AC BRONCHIOLITIS-ORG NEC	125 – Acute Bronchitis

Codes and Values:

1. See the above website for CCS Diagnosis Category Values

OUTPUT Edits on Element:

1. Calculated using the CCS software.

INPUT Edits on Element:

Not applicable. This is a derived data element

DIAGNOSIS SEGMENT

Data Element Name: After Anesthesia Indicator 1-14

Record Position:

Data Element	Record Position	Data Element	Record Position
After Anesth Ind 1	1605	After Anesth Ind 8	1612
After Anesth Ind 2	1606	After Anesth Ind 9	1613
After Anesth Ind 3	1607	After Anesth Ind 10	1614
After Anesth Ind 4	1608	After Anesth Ind 11	1615
After Anesth Ind 5	1609	After Anesth Ind 12	1616
After Anesth Ind 6	1610	After Anesth Ind 13	1617
After Anesth Ind 7	1611	After Anesth Ind 14	1618

Format – Length: Character - 1
Effective Date: 1/1/1994 – 4/9/1997
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The code which indicates whether the corresponding Other Diagnosis Code was judged to have occurred after the administration of anesthesia to the patient.

Note: This data element is available for a limited timeframe.

Codes and Values:

1. "1" = Yes, the diagnosis occurred after the administration of anesthesia.

   "2" = No, the diagnosis did not occur after the administration of anesthesia or NO anesthesia was administered.

   "9" = Unknown, if diagnosis occurred before or after the administration of anesthesia.

2. If this field was not applicable it contains blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. If an 'Other Diagnosis Code' was reported, then there must have been a corresponding After Anesthesia Indicator coded appropriately.

2. If 'After Anesthesia Indicator' was reported then, 'Other Diagnosis Code' and 'Other Diagnosis Present on Admission' must have also been reported.

DIAGNOSIS SEGMENT

Data Element Name:	Accident Related Code
Record Position:	1619-1620
Format – Length:	Character - 2
Effective Date:	January 1, 1982 – December 31, 1993 Converted in 1994 to the Uniform Bill Codes, and modified on all records.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The code which identifies the specific event relating to the bill that may affect payer processing.

Codes and Values:

1.

Value	Name	Description
01	Accident /Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.
02	No Fault Insurance Involved/ Including Auto Accident/Other	Code indicating the date of an accident including auto or other where state has applicable no fault liability laws (i.e., legal basis for settlement without admission of proof of guilt).
03	Accident /Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability.
04	Accident /Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Accident /No Medical or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of accident/injury.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

2. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. If Abortion or HIV Flags equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. If 'Occurrence Information Code' was reported, then a valid 'Occurrence Information Date' must also have been reported.

DIAGNOSIS SEGMENT

Data Element Name:	Accident Related Date
Record Position:	1621-1628
Record Position for Encrypted*	4725-4746
Format – Length:	Number - 8
Format – Length for Encrypted*	Number - 22
Effective Date:	January 1, 1994
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and Month Identifiable Data Set: YES
Deniable Data Element:	This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. The 4-digit year and the 2-digit month are non-deniable and are also present on the De-Identified file. Yes - See Appendix Z for release restrictions.

** Accident Related Date is available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:
The date corresponding to the significant event relating to the bill that may affect payer processing.

Codes and Values:

1. CCYYMMDD =Century Year Month Day

2. The Date must have been valid in accordance with the Date Edit Validation Table in Appendix A.

3. If not applicable this field contains blanks.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals ‘Y’, this data element is redacted.

INPUT Edits on Element:
None.

SPARCS Inpatient Segment: **Primary Records**

DIAGNOSIS SEGMENT

Data Element Name:	External Cause of Injury
Record Position:	1629-1635
Format – Length:	Character - 7
Effective Date:	January 1, 1990
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect. Hospitals complete this item whenever there is a diagnosis of an injury, poisoning, or adverse effect. The priorities for recording an External Code (E-Code) are: (1) principal diagnosis of an injury or poisoning, (2) other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis, and (3) other diagnosis with an external cause.

Only the first E-Code is recorded in this item. Additional E-Codes were not entered.

Codes and Values:

1. Must have been a valid ICD-9-CM "E" code excluding the decimal point. To have been valid, the code must have been entered at the most specific level classified in the ICD-CM Tabular List. Three-digit codes further divided to the four-digit level must have been entered using all four digits plus the prefix letter "E". Failure to enter the prefix "E" and all required digits would have caused the record to reject.

2. Must have been left justified including the prefix letter "E" and all digits exactly as shown in the ICD-CM coding reference excluding the decimal point, and space filled.

3. If this field was not applicable, it contains blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. A valid entry was required in this field when either the 'Principal/Primary Diagnosis Code' or an 'Other Diagnosis Code 1-14'***** reported were in the range 800.00-999.99.

2. When an 'External Cause-of-Injury Code' in the range of E850.0 to E869.9 or E880.0 to E928.9 was reported, then a 'Place-of-Injury Code' must also have been reported.

3. Prior to 1990, E-codes were reported in the 'Other Diagnosis Code 1-14' field.

4. After December 1, 1998, additional E-codes may have been reported in the 'Other Diagnosis Code 1-14' field.

**Starting in 2011, there are also 'Other Diagnosis Codes 15-24' collected, that should be examined for additional information.*

DIAGNOSIS SEGMENT

Data Element Name:	Place of Injury Code
Record Position:	1636-1642
Format – Length:	Character - 7
Effective Date:	January 1, 1990
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The code which identifies the place where the corresponding injury was reported in 'External Cause-of-Injury Code'.

Codes and Values:

1.

Value	Description
E849.0	Home accidents
E849.1	Farm accidents
E849.2	Mine and quarry accidents
E849.3	Accidents occurring in industrial places and premises
E849.4	Accidents occurring in place for recreation and sport
E849.5	Street and highway accidents
E849.6	Accidents occurring in public building
E849.7	Accidents occurring in residential institution
E849.8	Accidents occurring in other specified places
E849.9	Accidents occurring in unspecified place

2. Must have been a valid ICD-9-CM "E" code excluding the decimal point. To have been valid, the code must have been entered at the most specific level classified in the ICD-9-CM Tabular List. Three-digit codes further divided to the four-digit level must have been entered using all four digits plus the prefix letter "E". Failure to enter the prefix "E" and all required digits would have caused the record to reject.
3. Must have been left justified including the prefix letter "E" and all digits exactly as shown in the ICD-9-CM coding reference excluding the decimal point, and space filled.
4. If this field was not applicable, it contains blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must have been reported when 'External Cause-of-Injury Code' was in the range of E850.0 - E869.9 or E880.0 - E928.9.
2. Prior to 1990, E-codes were reported in the 'Other Diagnosis Code 1-14' field*****.
3. After December 1, 1998, additional E-codes may have been reported in the 'Other Diagnosis Code 1-14' field*.

Starting in 2011, there are also 'Other Diagnosis Codes 15-24' collected, that should be examined for additional information.

SPARCS Inpatient Segment: **Primary Records**

PROCEDURE SEGMENT

Data Element Name:	Principal Procedure Code
Record Position:	1643-1649
Format – Length:	Character - 7
Effective Date:	January 1,1982
Contained In:	De-Identified Data Set: YES
	Limited Data Set: YES
	Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The ICD code that identifies the inpatient principal procedure performed at the claim level during the period covered by this event.

The principal procedure was 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. A significant procedure was surgical in nature, carried a procedural risk, carried an anesthetic risk, or required specialized training. Surgery included incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation.

If there appeared to be two procedures that were principal, then the one most related to the principal diagnosis should have been selected as the principal procedure.

Codes and Values:

1. Must have been left justified and entered exactly as shown in the ICD coding reference, excluding the decimal point, and space filled.

2. If this field was not applicable, it contains blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Edits pertaining to ICD codes are validated on the basis of the ‘Discharge Date’ and ‘Expected Principal Reimbursement’ depending on conditions described in Appendix N, which includes sex-specific diagnosis code conditions.

2. If the ‘Principal Procedure Code’ was entered, the ‘Operating Physician State License Number’ and ‘Principal Procedure Date’ must have also been reported.

PROCEDURE SEGMENT

Data Element Name:	Principal Procedure Date
Record Position:	1650-1657
Record Position for Encrypted*	4747-4768
Format – Length:	Number - 8
Format – Length for Encrypted*	Number - 22
Effective Date:	1/1/1983
Contained In:	De-Identified Data Set: YES – Year only Limited Data Set: YES – Year and Month Identifiable Data Set: YES
Deniable Data Element:	This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. The 4-digit year and the 2-digit month are non-deniable and are also present on the De-Identified file. See Appendix Z for release restrictions.

** The entire Principal Procedure Date is only available on the Limited Data Set as an Encrypted Data Element; otherwise it is available only with the Year and Month.*

Description:
The date the Principal Procedure was performed.

Codes and Values:

1. CCYYMMDD = Century Year Month Day

2. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.

3. If this field was not applicable it contains blanks.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equal 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Date must have been no more than 3 days prior to 'Admission Date/Start of Care' and before or the same as 'Discharge Date'.

2. If 'Principal Procedure Date' was entered, the 'Operating Physician ID' and 'Principal Procedure Code' must also have been reported.

PROCEDURE SEGMENT

Data Element Name: Pre-Admit Procedure Indicator 1-15 (*previously Pre-Admit Indicator)*

Record Position:

Data Element	Record Position	Data Element	Record Position
Pre-Admit Ind 1	1658	Pre-Admit Ind 9	1850
Pre-Admit Ind 2	1682	Pre-Admit Ind 10	1874
Pre-Admit Ind 3	1706	Pre-Admit Ind 11	1898
Pre-Admit Ind 4	1730	Pre-Admit Ind 12	1922
Pre-Admit Ind 5	1754	Pre-Admit Ind 13	1946
Pre-Admit Ind 6	1778	Pre-Admit Ind 14	1970
Pre-Admit Ind 7	1802	Pre-Admit Ind 15	1994
Pre-Admit Ind 8	1826		

Format – Length: Character - 1
Effective Date: Implemented May 1, 2005 and added to all years' files.
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element:

Description:
A flag to indicate if the procedure was done before, on, or after the 'Admission Date'.

Codes and Values:

1. "-" If the procedure was done before the admit date
   "+" If the procedure was done on or after the admit date
   " " If no procedure was done (field is blank)

OUTPUT Edits on Element:
This is a derived data element.

INPUT Edits on Element:
Not applicable. This is a derived element.

PROCEDURE SEGMENT

Data Element Name: Pre-Op Days 1-15

Record Position:

Data Element	Record Position	Data Element	Record Position
Pre-Op Days 1	1659-1662	Pre-Op Days 9	1851-1854
Pre-Op Days 2	1683-1686	Pre-Op Days 10	1875-1878
Pre-Op Days 3	1707-1710	Pre-Op Days 11	1899-1902
Pre-Op Days 4	1731-1734	Pre-Op Days 12	1923-1926
Pre-Op Days 5	1755-1758	Pre-Op Days 13	1947-1950
Pre-Op Days 6	1779-1782	Pre-Op Days 14	1971-1974
Pre-Op Days 7	1803-1806	Pre-Op Days 15	1995-1998
Pre-Op Days 8	1827-1830		

Format – Length: Character - 4

Effective Date: Implemented May 1, 2005 and added to all years' files.

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

The number of days between a procedure and the 'Admission Date'. See the corresponding 'Pre-Admit Indicator' to determine if the procedure was before, after, or on the 'Admission Date'.

Codes and Values:

1. Equals Number of Days.

OUTPUT Edits on Element:

This is a derived data element.

INPUT Edits on Element:

Not applicable. This is a derived data element.

PROCEDURE SEGMENT

Data Element Name: Post-Op Days 1-15

Record Position:

Data Element	Record Position	Data Element	Record Position
Post-Op Days 1	1663-1666	Post-Op Days 9	1855-1858
Post-Op Days 2	1687-1690	Post-Op Days 10	1879-1889
Post-Op Days 3	1711-1714	Post-Op Days 11	1903-1906
Post-Op Days 4	1735-1738	Post-Op Days 12	1927-1930
Post-Op Days 5	1759-1762	Post-Op Days 13	1951-1954
Post-Op Days 6	1783-1786	Post-Op Days 14	1975-1978
Post-Op Days 7	1807-1810	Post-Op Days 15	1999-2002
Post-Op Days 8	1831-1834		

Format – Length: Character - 4
Effective Date: Implemented May 1, 2005 and added to all years' files.
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The number of days between a procedure and the discharge date. See the corresponding 'Pre-Admit Indicator' to determine if the procedure was before, after or on the admit date, which could result in values being greater than the total length of stay for this discharge.

Codes and Values:
1. Equals Number of Days.

OUTPUT Edits on Element:
This is a derived data element.

INPUT Edits on Element:
Not applicable. This is a derived data element.

PROCEDURE SEGMENT

Data Element Name: Other Procedure Code 1-14

Record Position:

Data Element	Record Position	Data Element	Record Position
Other Procedure 1	1667-1673	Other Procedure 8	1835-1841
Other Procedure 2	1691-1697	Other Procedure 9	1859-1865
Other Procedure 3	1715-1721	Other Procedure 10	1883-1889
Other Procedure 4	1739-1745	Other Procedure 11	1907-1913
Other Procedure 5	1763-1769	Other Procedure 12	1931-1937
Other Procedure 6	1787-1793	Other Procedure 13	1955-1961
Other Procedure 7	1811-1817	Other Procedure 14	1979-1985

Format – Length: Character – 7

Effective Date:

Effective Date	Reporting
January 1, 1982	Other Procedure Code 1-4
January 1, 1992	Other Procedure Code 5
January 1, 1994	Other Procedure Code 6-14

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

The ICD codes identifying all significant procedures, other than the 'Principal Procedure', that were performed. The facilities are asked to report those procedures that are most important for the episode of care, and specifically any therapeutic procedures closely related to the principal diagnosis.

A significant procedure was one that was surgical in nature, carried a procedural risk, carried an anesthetic risk, or required specialized training. Surgery included incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation.

Codes and Values:

1. Must have been left justified and entered exactly as shown in the ICD coding reference, excluding the decimal point, and space filled.

2. If this field was not applicable, it contains blanks.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. Edits pertaining to ICD codes are validated on the basis of the 'Discharge Date' and 'Expected Principal Reimbursement' depending on conditions described in Appendix N, which includes sex-specific diagnosis code conditions.
2. If 'Other Procedure Code 1-14' was entered, the corresponding 'Other Procedure Date 1-14' must have also been reported.

PROCEDURE SEGMENT

Data Element Name: Other Procedure Date 1-14

Record Position:

Data Element	Record Position	Data Element	Record Position
Oth Proc Date 1	1674-1681	Oth Proc Date 8	1842-1849
Oth Proc Date 2	1698-1705	Oth Proc Date 9	1866-1873
Oth Proc Date 3	1722-1729	Oth Proc Date 10	1890-1897
Oth Proc Date 4	1746-1753	Oth Proc Date 11	1914-1921
Oth Proc Date 5	1770-1777	Oth Proc Date 12	1938-1945
Oth Proc Date 6	1794-1801	Oth Proc Date 13	1962-1969
Oth Proc Date 7	1818-1825	Oth Proc Date 14	1986-1993

Record Position for Encrypted*

Data Element	Record Position	Data Element	Record Position
Oth Proc Date 1	4769-4790	Oth Proc Date 8	4923-4944
Oth Proc Date 2	4791-4812	Oth Proc Date 9	4945-4966
Oth Proc Date 3	4813-4834	Oth Proc Date 10	4967-4988
Oth Proc Date 4	4835-4856	Oth Proc Date 11	4989-5010
Oth Proc Date 5	4857-4878	Oth Proc Date 12	5011-5032
Oth Proc Date 6	4879-4900	Oth Proc Date 13	5033-5054
Oth Proc Date 7	4901-4922	Oth Proc Date 14	5055-5076

Format – Length: Number - 8
Format – Length for Encrypted* Number - 22
Effective Date: 1/1/1983
Contained In: De-Identified Data Set: YES – Year only
Limited Data Set: YES – Year and Month
Identifiable Data Set: YES
Deniable Data Element: This field is composed of both non-deniable and deniable components. **The 2-digit day is deniable and is ONLY present on the Master file. The 4-digit year and the 2-digit month are non-deniable and are also present on the De-Identified file. See Appendix Z for release restrictions.

**The entire Other Procedure Date 1-14 is only available on the Limited Data Set as an Encrypted Data Element; otherwise year and month; otherwise it is available only with the Year and Month.*

Description:
The date the 'Principal Procedure' was performed.

Codes and Values:

1. CCYYMMDD = Century Year Month Day

2. Must have been a valid date in accordance with the Date Edit Validation Table in Appendix A.

3. If this field was not applicable it contains blanks.

OUTPUT Edits on Element:

1. If Abortion or HIV Flag equals 'Y', this data element is redacted unless otherwise noted.

INPUT Edits on Element:

1. Date must have been no more than 3 days prior to 'Admission Date/Start of Care' and before or the same as 'Discharge Date'.

2. If 'Principal Procedure Date' was entered, the 'Operating Physician ID' and 'Principal Procedure Code' must also have been reported.

PROCEDURE SEGMENT

Data Element Name:	Clinical Classification Software (CCS) Procedure Category
Record Position:	2003-2005
Format – Length:	Character - 3
Effective Date:	Implemented July 2012 and added to all years' files.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	

Description:

The Clinical Classification Software (CCS) was developed by the Agency for Healthcare Research and Quality (AHRQ) as a tool to cluster patient diagnoses and procedures without having to sort through thousands of codes.

The "CCS Procedure Category" data element uses the reported procedure codes to group into procedure categories that will make it easier for researchers to explore the types of procedures being formed. The CCS single level classification system is used for this data element; there are currently 231 procedure categories.

As part of the Healthcare Cost and Utilization Project (HCUP), a federal-state industry partnership, the CCS software and documentation is maintained on the HCUP website at: www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. (CCS was formerly called the Clinical Classification for Healthcare Policy research – CCHPR).

Example:

ICD Procedure Reference for Procedure Group - Cardiac stress tests (Single Level)

ICD Code	Description	CCS Procedure Category
8941	TREADMILL STRESS TEST	201 – CARDIA STRESS TEST
8942	MASTERS' 2-STEP TEST	201 – CARDIA STRESS TEST
8943	BICYCLE ERGOMETER TEST	201 – CARDIA STRESS TEST
8944	CV STRESS TEST NEC	201 – CARDIA STRESS TEST

Codes and Values:

1. See the above website for CCS Procedure Category values.

OUTPUT Edits on Element:

1. Data values calculated using the CCS software.

INPUT Edits on Element:

Not applicable. This is a derived data element.

PROCEDURE SEGMENT

Data Element Name:	Method of Anesthesia Used
Record Position:	2006-2007
Format – Length:	Number - 2
Effective Date:	January 1, 1983
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

Type of anesthesia administered on the patient during the stay. If during the stay, anesthesia is administered more than once, the level of anesthesia is reported in the following hierarchical order: General, Regional, Other, and Local.

Codes and Values:

1. "00" = No Anesthesia

   "10" = Local Anesthesia

   Administered by the infiltration of a local anesthetic agent at the body site where pain might originate during the procedure. Local anesthesia is typically administered by the surgeon or other health care provider performing the procedure. Anesthesia care providers sometimes monitor the patient during the administration of local anesthesia by the surgeon or other provider, in which case the anesthetic procedure is sometimes referred to as "local/MAC". In this term, MAC stands for "Monitored Anesthesia Care".

   "20" = General Anesthesia

   Administered by the intravenous injection of anesthetic agents, the inhalation of anesthetic agents, or (more often) a combination of the two. Anesthetic agents are sometimes (but infrequently) administered by other routes, such as via the nasal or rectal mucosa. General anesthesia involves loss of consciousness and loss of protective reflexes.

   "30" = Regional Anesthesia

   Administered by injecting a local anesthetic agent to interrupt nerve impulses on large nerves or nerve roots serving relatively large segments of the body. Included under the term regional anesthesia are the following: spinal anesthesia, epidural anesthesia, caudal anesthesia, brachial plexus anesthesia (including axillary block, interscalene block, supraclavicular block), sacral nerve block, femoral nerve block, and ankle block. (This list is not exhaustive.)

   "40" = Other

   Any anesthetic that does not fit one of the above categories should be classified "other". Analgesia or sedation that is administered to make a patient more comfortable during a procedure but does not involve loss of consciousness or loss of protective reflexes would come under this category.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. Must have been a valid entry.

PROCEDURE SEGMENT

Data Element Name:	Blood Furnished Amount
Record Position:	2008-2016
Format – Length:	Number - 9
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total number of pints of whole blood or units of packed red cells furnished to the patient, whether or not replaced.

Codes and Values:

1. Right justified and zero filled.

2. The amount was entered in decimal format. This amount is defined with **TWO** implied decimal places and must have been entered as a positive amount. For example, 8 pints of blood furnished would have been entered as: "**000000800".**

3. If not applicable this field contains blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. The 'Value Code' must have been entered as "37" for 'Units of Blood Furnished'. The corresponding 'Value Amount' (actual pints of blood) must have been entered.

2. If entered, the amount must be greater than zero.

PROCEDURE SEGMENT

Data Element Name:	Age Warning Flag
Record Position:	2017
Format – Length:	Character - 1
Effective Date:	January 1, 1996
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A flag set when a diagnosis from a list of exceptions agreed to by the Department of Health and the New York Health Information Management Association is in conflict with normal age-specific edits as defined in the ICD-CM coding reference file.

These claims have been accepted by the SPARCS system, but a warning message was returned to the health care facility to flag potential reporting problems at time of submission. A list of current exception diagnosis codes is available from SPARCS.

Codes and Values:
1. "1" = Age-specific conflict between reported data and ICD-CM reference file.

   " " = **NO** conflict between reported data and ICD-CM reference file (blank).

OUTPUT Edits on Element:
1. Derived data element based on the list of exceptions.

INPUT Edits on Element:
Not applicable. This is a derived data element.

PROCEDURE SEGMENT

Data Element Name:	Procedure Date Warning Flag
Record Position:	2018
Format – Length:	Character - 1
Effective Date:	January 1, 2000
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

A flag set when a procedure date for this discharge is reported no more than three (3) days prior to the 'Admission Date/Start of Care'. These claims have been accepted by the SPARCS system, but a warning message was returned to the health care facility to flag potential reporting problems at time of submission.

Codes and Values:

1. "1" = 'Procedure Date' reported no more than three (3) days prior to the 'Admission Date/Start of Care'

" " = **NO** conflict between reported data and reported procedure dates (blank).

OUTPUT Edits on Element:

1. This is a derived data element using the submitted fields as described above.

INPUT Edits on Element:

Not applicable. This is a derived data element.

PROCEDURE SEGMENT

Data Element Name:	Procedure Coding Method
Record Position:	2019
Format – Length:	Character - 1
Effective Date:	1/1/1994 - 1/1/2003
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A code which identifies the coding structure used for reporting procedures performed during the patient stay.

All procedure and diagnosis codes reported for inpatient stays are ICD-9-CM.

Note: This data element is available for a limited time frame.

Codes and Values:
1. "9" = ICD-9-CM

OUTPUT Edits on Element:
This is a derived data element.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Federal Diagnostic Risk Grouper (DRG)
Record Position:	2020-2022
Format – Length:	Character - 3
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The Federal Diagnosis Related Group (DRG) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), to categorize patient records for reimbursement and research purposes for the calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate DRG value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Federal Major Diagnostic Category (MDC)
Record Position:	2023-2024
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The Federal Major Diagnostic Category (MDC) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), to categorize patient records for reimbursement and research purposes for the calendar year of the date of discharge.

Codes and Values:
1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:
1. This is a derived data element using software to generate the appropriate MDC value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Past Federal Diagnosis Related Group (DRG) *(previously called DRG Prior Federal)*
Record Position:	2025-2027
Format – Length:	Character - 3
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The Past Federal Diagnosis Related Group (DRG) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), to categorize patient records for reimbursement and research purposes. This DRG is specific to the past/prior calendar year of the date of discharge.

Codes and Values:
1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:
1. This is a derived data element using software to generate the appropriate DRG value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Past Federal Major Diagnostic Category (MDC) *(previously called MDC Prior Federal)*
Record Position:	2028-2029
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The Past Federal Major Diagnostic Category (MDC) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), to categorize patient records for reimbursement and research purposes. This MDC is specific to the past/prior calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate MDC value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	New Federal Diagnostic Related Group (DRG)
Record Position:	2030-2032
Format – Length:	Character - 3
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The New Federal Diagnosis Related Group (DRG) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), to categorize patient records for reimbursement and research purposes. This DRG is specific to the following (new) calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate DRG value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	New Federal Major Diagnostic Category (MDC)
Record Position:	2033-2034
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The New Federal Major Diagnostic Category (MDC) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), to categorize patient records for reimbursement and research purposes. This MDC is specific to the following (new) calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate MDC value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	All Patient Diagnosis Related Group (AP DRG)
Record Position:	2035-2037
Format – Length:	Character - 3
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The All Patient Diagnosis Related Group (AP DRG) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), and in conjunction with 3M Corporation, to categorize patient records for reimbursement and research purposes for all patients (this evaluation and development of the AP DRG was in part due to the original DRGs being developed for only Medicare reimbursement). This DRG is specific to the calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate AP DRG value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	All Patient Major Diagnostic Category (AP MDC)
Record Position:	2038-2039
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The All Patient Major Diagnostic Category (AP MDC) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), and in conjunction with 3M Health Information Systems, to categorize patient records for reimbursement and research purposes for all patients (this evaluation and development of the AP DRG was in part due to the original DRGs being developed for only Medicare reimbursement). This MDC is specific to the calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate AP MDC value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

SPARCS Inpatient Segment: **Primary Records**

DRG SEGMENT

Data Element Name:	Past All Patient Diagnostic Related Group (AP DRG)
Record Position:	2040-2042
Format – Length:	Character - 3
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The Past All Patient Diagnosis Related Group (AP DRG) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), and in conjunction with 3M Health Information Systems, to categorize patient records for reimbursement and research purposes for all patients (this evaluation and development of the AP DRG was in part due to the original DRGs being developed for only Medicare reimbursement). This DRG is specific to the prior calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate AP DRG value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Past All Patient Major Diagnostic Category (AP MDC)
Record Position:	2043-2044
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The Past All Patient Major Diagnostic Category (AP MDC) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), and in conjunction with 3M Health Information Systems, to categorize patient records for reimbursement and research purposes for all patients (this evaluation and development of the AP DRG was in part due to the original DRGs being developed for only Medicare reimbursement). This MDC is specific to the past/prior calendar year of the date of service.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate AP MDC value.

INPUT Edits on Element:

Not applicable. This is a derive data element.

DRG SEGMENT

Data Element Name:	New All Patient Diagnosis Related Group (AP DRG)
Record Position:	2045-2047
Format – Length:	Character - 3
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The Diagnosis Related Group (DRG) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), and in conjunction with 3M Health Information Systems, to categorize patient records for reimbursement and research purposes for all patients (this evaluation and development of the AP DRG was in part due to the original DRGs being developed for only Medicare reimbursement). This DRG is specific to the following calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate AP DRG value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	New All Patient Major Diagnostic Category (AP MDC)
Record Position:	2048-2049
Format – Length:	Character - 2
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The All Patient Major Diagnostic Category (AP MDC) is developed by the former Healthcare Financing Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), and in conjunction with 3M Health Information Systems, to categorize patient records for reimbursement and research purposes for all patients (this evaluation and development of the AP DRG was in part due to the original DRGs being developed for only Medicare reimbursement). This MDC is specific to the following year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate new AP MDC value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	All Patient Refined Diagnosis Related Group (APR DRG)
Record Position:	2050-2052
Format – Length:	Character - 3
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The All Patient Refined Diagnosis Related Group (APR DRG) assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This APR DRG is specific to the calendar year of the date of discharge.

The All Patient Refined (APR) incorporate Severity of Illness subclasses into the AP DRGs (the APR DRGs were an expansion of the basic DRG to be more representative of the non-Medicare populations such as pediatric patients).

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate new APR DRG value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	All Patient Refined Major Diagnostic Category (APR MDC)
Record Position:	2053-2054
Format – Length:	Character - 2
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	N/A

Description:

The All Patient Refined Major Diagnostic Category (MDC) assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This APR MDC is specific to the calendar year of the date of discharge.

The All Patient Refined (APR) incorporate Severity of Illness subclasses into the AP DRGs (the APR DRGs were an expansion of the basic DRG to be more representative of the non-Medicare populations such as pediatric patients).

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate new AP MDC value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	All Patient Refined Risk of Mortality (APR ROM)
Record Position:	2055
Format – Length:	Character - 1
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	N/A

Description:

The All Patient Refined Risk of Mortality (APR ROM) flag is assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This APR ROM is specific to the calendar year of the date of discharge.

The All Patient Refined (APR) process incorporates Severity of Illness into the calculations. Each secondary diagnosis is assigned to one of the four Severity of Illness and one of the four Risk of Mortality levels. These flags are then just one factor in assigning the patient's subclass level.

Codes and Values:

1. "1" = Minor Mortality Level
   "2" = Moderate Mortality Level
   "3" = Major Mortality Level
   "4" = Extreme Mortality Level

2. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate new APR ROM value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	All Patient Refined Severity of Illness (APR SOI)
Record Position:	2056
Format – Length:	Character - 1
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	N/A

Description:
The All Patient Refined Severity of Illness (SOI) flag assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This SOI is specific to the calendar year of the date of discharge.

Codes and Values:

1. "1" = Minor Severity of Illness
   "2" = Moderate Severity of Illness
   "3" = Major Severity of Illness
   "4" = Extreme Severity of Illness

2. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate new APR SOI value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Past All Patient Refined Diagnosis Related Group (APR DRG)
Record Position:	2057-2059
Format – Length:	Character - 3
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	N/A

Description:
The Past All Patient Refined Diagnosis Related Group (APR DRG) assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This DRG is specific to the past/prior calendar year of the date of discharge.

Codes and Values:
1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:
1. This is a derived data element using software to generate the appropriate APR DRG value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Past All Patient Refined Major Diagnostic Category (APR MDC)
Record Position:	2060-2061
Format – Length:	Character - 2
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The Past All Patient Refined Major Diagnostic Category (APR MDC) assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This MDC is specific to the past/prior calendar year of the date of discharge.

Codes and Values:

1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate APR MDC value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Past All Patient Refined Risk of Mortality (APR ROM)
Record Position:	2062
Format – Length:	Character - 1
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The Past All Patient Risk of Mortality (APR ROM) flag assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This ROM is specific to the past/prior calendar year of the date of discharge.

Codes and Values:

1. "1" = Minor Mortality Level
   "2" = Moderate Mortality Level
   "3" = Major Mortality Level
   "4" = Extreme Mortality Level

2. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate APR ROM value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Past All Patient Refined Severity of Illness (APR SOI)
Record Position:	2063
Format – Length:	Character - 1
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The Past All Patient Refined Severity of Illness (APR SOI) flag assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This SOI is specific to the past/prior calendar year of the date of discharge.

Codes and Values:

1. "1" = Minor Severity of Illness
   "2" = Moderate Severity of Illness
   "3" = Major Severity of Illness
   "4" = Extreme Severity of Illness

2. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate APR SOI value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	New All Patient Refined Diagnosis Related Group (APR DRG)
Record Position:	2064-2066
Format – Length:	Character - 3
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	N/A

Description:
The New All Patient Refined Diagnosis Related Group (APR DRG) assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This DRG is specific to the following calendar year of the date of discharge.

Codes and Values:
1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:
1. This is a derived data element using software to generate the appropriate APR SOI value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	New All Patient Refined Major Diagnostic Category (APR MDC)
Record Position:	2067-2068
Format – Length:	Character - 2
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The New All Patient Refined Major Diagnostic Category (APR MDC) assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This MDC is specific to the following calendar year of the date of discharge.

Codes and Values:
1. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:
1. This is a derived data element using software to generate the appropriate APR SOI value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	New All Patient Refined Risk of Mortality (APR ROM)
Record Position:	2069
Format – Length:	Character - 1
Effective Date:	2/2010
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The New All patient Refined Risk of Mortality (ROM) flag assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This ROM is specific to the following calendar year of the date of discharge.

Codes and Values:

1. "1" = Minor Mortality Level
   "2" = Moderate Mortality Level
   "3" = Major Mortality Level
   "4" = Extreme Mortality Level

2. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate APR ROM value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	New All Patient Refined Severity of Illness (APR SOI)
Record Position:	2070
Format – Length:	Character - 1
Effective Date:	
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The New All Patient Refined Severity of Illness (SOI) flag assigned to the claim using the All Patient Refined Diagnostic Related Grouper software, which was developed by 3M Health Information Systems. This information is used to categorize patient records for reimbursement and research purposes. This SOI is specific to the following calendar year of the date of discharge.

Codes and Values:

1. "1" = Minor Severity of Illness
   "2" = Moderate Severity of Illness
   "3" = Major Severity of Illness
   "4" = Extreme Severity of Illness

2. See Appendix Y - Grouper Versions Used by Year Reference File Table.

OUTPUT Edits on Element:

1. This is a derived data element using software to generate the appropriate APR SOI value.

INPUT Edits on Element:

Not applicable. This is a derived data element.

DRG SEGMENT

Data Element Name:	Diagnosis Related Group (DRG) Billed
Record Position:	2071-2074
Format – Length:	Character - 4
Effective Date:	1/1/1994 – 12/31/1997
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The number of the Diagnosis Related Group (DRG) obtained from grouping the diagnoses and procedures and billed to the principal payer, or as used in the calculation of the charge payer cap for billings to charge payers.

Note: This data element was collected for a limited timeframe.

Codes and Values:

1. Must have been right justified and zero filled.

2. If this field was not applicable, it contains blanks.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must have been a valid entry when Exempt Unit Indicator was blank.

AMI SEGMENT

Data Element Name:	AMI Warning Flag
Record Position:	2075
Format – Length:	Number - 1
Effective Date:	July 1, 2007 – December 31, 2007
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	

Description:
A flag set when a diagnosis the principal/primary diagnosis code equals 410.0x - 410.9x.

Codes and Values:
1. "1" = AMI code reported.
   "0" = No AMI code reported.

OUTPUT Edits on Element:
1. A derived data element based on ICD codes.

INPUT Edits on Element:
Not applicable. This is a derived data element.

AMI SEGMENT

Data Element Name:	Heart Rate on Arrival
Record Position:	2076-2078
Format – Length:	Number - 3
Effective Date:	October, 2007
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

The patient heart rate in beats per minute (bpm) taken at first patient contact after arrival at this hospital for patients with a 'Principal/Primary Diagnosis' of Acute Myocardial Infarction (AMI) 410.0x-410.9x.

Codes and Values:

1. Equals 'Patient Heart Rate on Arrival'.

2. "888" = Undocumented in Medical Chart

3. "999" = Unknown (To be used only in circumstances where patient cannot have reading taken at time of arrival.)

4. " " [Blank] = Not applicable, (i.e. 'Principal/Primary Diagnosis' is not in the range of 410.0x – 410.9x).

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. Must be greater than or equal to zero.

2. Must be reported when 'Principal/Primary Diagnosis Code' equals 410.0x - 410.9x.

3. NTE segment is fixed width. Required spacing must be maintained if element is not applicable.

AMI SEGMENT

Data Element Name:	Systolic BP on Arrival
Record Position:	2079-2081
Format – Length:	Number - 3
Effective Date:	
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	

Description:
The patient systolic blood pressure in mg/dl taken at first patient contact after arrival at this hospital for patients with a 'Principal/Primary Diagnosis' of Acute Myocardial Infarction (AMI) 410.0x – 410.9x.

Codes and Values:

1. Equals 'Systolic Blood Pressure Upon Arrival'.
2. "888" = Undocumented in Medical Chart
3. "999" = Unknown (To be used only in circumstances where patient cannot have reading taken at time of arrival.)
4. " " = Not applicable, (i.e. the 'Principal/Primary Diagnosis' is not in the range of 410.0x – 410.9x).

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must be greater than or equal to zero.
2. Must be reported when 'Principal/Primary Diagnosis Code' equals 410.0x - 410.9x.
3. NTE segment is fixed width. Required spacing must be maintained if element is applicable.

AMI SEGMENT

Data Element Name:	Diastolic BP on Arrival
Record Position:	2082-2084
Format – Length:	Number - 3
Effective Date:	
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	

Description:
The patient diastolic blood pressure in mg/dl taken at first patient contact after arrival at this hospital for patients with a 'Principal/Primary Diagnosis' of Acute Myocardial Infarction (AMI) 410.0x – 410.9x.

Codes and Values:

1. Equals 'Diastolic Blood Pressure Upon Arrival'.
2. "888" = Undocumented in Medical Chart
3. "999" = Unknown (To be used only in circumstances where patient cannot have reading taken at time of arrival.)
4. " " = Not applicable, (i.e. the 'Principal/Primary Diagnosis' is not in the range of 410.0x – 410.9x).

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must be greater than or equal to zero.
2. Must be reported when 'Principal/Primary Diagnosis Code' equals 410.0x - 410.9x.
3. NTE segment is fixed width. Required spacing must be maintained if element is applicable.

SPARCS Inpatient Segment: **Primary Records**

HIPAA SEGMENT

Data Element Name:	AIDS / HIV Flag
Record Position:	2085
Format – Length:	Character - 1
Effective Date:	Implemented May 1, 2005 and added to all years' records.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:

A flag to indicate if the discharge record contains any indication of AIDS/HIV. See Appendix T - AIDS/HIV Record Editing.

Codes and Values:

1. "Y" = AIDS/HIV is indicated
   "N" = AIDS/HIV is not indicated

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

Note applicable. This is a derived field.

HIPAA SEGMENT

Data Element Name:	Abortion Flag
Record Position:	2086
Format – Length:	Character - 1
Effective Date:	Implemented May 1, 2005 and added to all years' records.
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A flag to indicate if the discharge record contains any indication of abortion. See Appendix TT - Abortion Record Editing .

Codes and Values:

1. "Y" = Abortion is indicated
   "N" = Abortion is not indicated

OUTPUT Edits on Element:
This is a derived data element.

INPUT Edits on Element:
Not applicable. This is a derived field.

CHARGES SEGMENT

Data Element Name:	Total Charges
Record Position:	2087-2098
Format – Length:	Number - 12
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The sum of 'Total Accommodations Charges' and 'Total Ancillary Charges' for the patient's stay.

Codes and Values:

1. Must have been right justified and zero filled.

2. This total amount entered in dollars and cents as a positive amount. There are **TWO** implied decimal places for the currency.

OUTPUT Edits on Element:

1. Calculated by SPARCS as the sum of 'Total Accommodations Charges' and 'Total Ancillary Charges'.

INPUT Edits on Element:
Not applicable. This is derived data element.

CHARGES SEGMENT

Data Element Name:	Total Accommodation Charges
Record Position:	2099-2108
Format – Length:	Character - 10
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The sum of all Accommodation charges incurred during the patient's stay.

Codes and Values:

1. Must have been right justified and zero filled.

2. The total amount entered in dollars and cents. There are **TWO** implied decimal places for the currency.

3. If this field was not applicable it contains zeros.

OUTPUT Edits on Element:

1. Calculated by SPARCS as the sum of all service line Accommodations Charges.

INPUT Edits on Element:

1. Sum of individual occurrences of 'Accommodations Total Charges' must have equaled 'Total Accommodations Charges'.

2. 'Accommodations Total Charges' must have equaled 'Accommodations Rate' times 'Accommodations Days'.

3. If 'Accommodations Total Charges' was entered, the other related Data Elements listed in the Accommodations Information Group Definition must also have been reported.

CHARGES SEGMENT

Data Element Name:	Ancillary Total Charges
Record Position:	2109-2118
Format – Length:	Character - 10
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total of all Ancillary Charges incurred during the patient's stay.

Codes and Values:

1. Must have been right justified and zero filled.

2. The total amount entered in dollars and cents. There are **TWO** implied decimal places for the currency.

3. If this field was not applicable, it contains zeroes.

OUTPUT Edits on Element:

1. Calculated by SPARCS as the sum of all service line Ancillary Charges.

INPUT Edits on Element:

1. Must have equaled the sum of the individual occurrences of the 'Inpatient Ancillary Total Charges'.

2. If 'Inpatient Ancillary Revenue Codes' of "001" thru "099" were reported, any associated charges were NOT included in 'Total Ancillary Charges'.

CHARGES SEGMENT

Data Element Name:	Total Non-Covered Charges
Record Position:	2119-2130
Format – Length:	Number - 12
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The sum of 'Total Accommodations Non-Covered Charges' and 'Total Ancillary Non-Covered Charges' for the patient's stay.

Codes and Values:
1. Must have been right justified and zero filled.

2. The total amount entered in dollars and cents. There are **TWO** implied decimal places for the currency.

OUTPUT Edits on Element:
1. Calculated by SPARCS as the sum of 'Total Accommodations Non-Covered Charges' and 'Total Ancillary Non-Covered Charges'.

INPUT Edits on Element:
Not applicable.

CHARGES SEGMENT

Data Element Name:	Total Non-Covered Accommodation Charges
Record Position:	2131-2140
Format – Length:	Character - 10
Effective Date:	January 1, 1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The accommodation (room) charges which were not reimbursable by the payer.

Codes and Values:

1. Must have been right justified and zero filled.

2. The total amount entered in dollars and cents. There are **TWO** implied decimal places for the currency.

3. If this field was not applicable it contains zeros.

OUTPUT Edits on Element:

1. Calculated by SPARCS as the sum of all service line non-covered Accommodations Charges.

INPUT Edits on Element:.

1. If 'Accommodations Non-Covered Charges' was entered, the other related Data Elements listed in the Accommodations Charges must also have been reported.

CHARGES SEGMENT

Data Element Name:	Total Non-Covered Ancillary Charges
Record Position:	2141-2150
Format – Length:	Character - 10
Effective Date:	1/1/1982
Contained In:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total of all 'Ancillary Non-Covered Charges' during the patient's stay.

Codes and Values:

1. Must have been right justified and zero filled.

2. The total amount entered in dollars and cents. There are **TWO** implied decimal places for the currency.

3. If this field was not applicable, it contains zeroes.

OUTPUT Edits on Element:

1. Sum of the individual occurrences of the 'Inpatient Ancillary Total Non-Covered Charges'.

INPUT Edits on Element:.

1. If 'Inpatient Ancillary Revenue Codes' of "001" thru "099" were reported, any associated charges were NOT included in 'Total Ancillary Non-Covered Charges'.

SERVICE SEGMENT

Data Element Name: Revenue Code 1-10 (*previously UB-92 Accommodation Code and Inpatient Ancillary Revenue Code*)

Record Position:

Data Element	Record Position	Data Element	Record Position
Rev Code 1	2151-2154	Rev Code 6	2326-2329
Rev Code 2	2186-2189	Rev Code 7	2361-2364
Rev Code 3	2221-2224	Rev Code 8	2396-2399
Rev Code 4	2256-2259	Rev Code 9	2431-2434
Rev Code 5	2291-2294	Rev Code 10	2466-2469

Format – Length: Character - 4
Effective Date: Jan. 1, 1994
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:

Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. The code set is maintained by the National Uniform Bill Committee (NUBC).

This data element is called the 'Service Line Revenue Code' in the X12 guidelines. It is commonly referred to as the 'Revenue Code'. Each service should be assigned a revenue code:

1. For inpatient services involving multiple services for the same item providers should aggregate the services under the assigned revenue code and then report the total number of units that represent those services.

2. If multiple services are provided on the same day for like services, that is, those with the same HCPCS, the provider should aggregate the like services for each day and report the date along with the number of units provided, as well as the revenue code. The exception is for the Evaluation and Management (E/M) HCPCS code. For E/M HCPCS, report each of these separately but also use Condition Code "G0" to indicate a Distinct Medical visit.

3. Services provided on different days should be listed separately along with the date of service, units and revenue code.

Codes and Values:

1. Must be a valid code in accordance with the Revenue Codes in Appendix I.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. If the 'Revenue Code' is entered, then the appropriate 'Service Line Rate', 'Service Units', 'Service Line Charge Amount', and 'Service Line Non-Covered Charge Amount' must also be reported.

2. If a Revenue Code is entered, the associated Total Charges and Total Non-Covered Charges must also be reported.

3. If Revenue Codes 0001 through 0099 are reported, the associated charges must NOT be included in the totals calculated for the Total Charges or Total Non-Covered Charges.

4. On Inpatient submissions, it is necessary to report at least one Revenue Code between the values of 010x and 100x with each inpatient claim.

5. For Outpatient submissions, there must be at least one total and non-covered charge for all revenue codes reported except for the 036x, 045x, 048x, 049x, 051x, 052x, 075x, 076x or 079x categories. For these exceptions the total and non-covered charges may be rolled up to the first occurrence of the revenue code category with zero reported for subsequent occurrences on each claim.

Note:
SPARCS allows for a maximum of 999 service lines to be reported**.**

Effective with discharges after 12/31/99, UB-92 Accommodation Codes are reported in place of SPARCS Accommodation Codes.

The UB-92 Accommodation Codes for all years prior to 2000 have been derived from the reported SPARCS Accommodation Codes based on the table in Appendix H.

SPARCS Inpatient Segment: **Primary Records**

SERVICE SEGMENT

Data Element Name: Revenue Type 1-10

Record Position:

Data Element	Record Position	Data Element	Record Position
Revenue Type 1	2155	Revenue Type 6	2330
Revenue Type 2	2190	Revenue Type 7	2365
Revenue Type 3	2225	Revenue Type 8	2400
Revenue Type 4	2260	Revenue Type 9	2435
Revenue Type 5	2295	Revenue Type 10	2470

Format – Length: Character - 1
Effective Date: January 1, 2011
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The Revenue type identifies the type of revenue code utilized, and is grouped into two categories: accommodation codes and ancillary codes.

Codes and Values:
1. "A" = Accommodation
   "R" = Ancillary

OUTPUT Edits on Element:
This is a derived data element based on revenue codes.

INPUT Edits on Element:
None.

SERVICE SEGMENT

Data Element Name: Service Charge 1-10

Record Position:

Data Element	Record Position	Data Element	Record Position
Service Charge 1	2156-2165	Service Charge 6	2331-2340
Service Charge 2	2191-2200	Service Charge 7	2366-2375
Service Charge 3	2226-2235	Service Charge 8	2401-2410
Service Charge 4	2261-2270	Service Charge 9	2436-2445
Service Charge 5	2296-2305	Service Charge 10	2471-2480

Format – Length: Number - 10
Effective Date: January 1, 1982
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The Service amount of all submitted charges on each service line segment for this claim. This will be the sum of revenue charges (accommodations charges and ancillary charges) for the patient's stay.

Codes and Values:

1. Must have been right justified and zero filled.

2. The Service amount entered in dollars and cents. There are **TWO** implied decimal places for the currency.

OUTPUT Edits on Element:

1. Calculated by SPARCS as the sum of all 'Line Item Charge Amounts' (all revenue codes, both accommodation and ancillary charges).

INPUT Edits on Element:
Not applicable.

SERVICE SEGMENT

Data Element Name: Unit Type 1-10

Record Position:-

Data Element	Record Position	Data Element	Record Position
Unit Type 1	2166-2167	Unit Type 6	2341-2342
Unit Type 2	2201-2201	Unit Type 7	2376-2377
Unit Type 3	2236-2237	Unit Type 8	2411-2412
Unit Type 4	2271-2272	Unit Type 9	2446-2447
Unit Type 5	2306-2307	Unit Type 10	2481-2482

Format – Length: Character - 2
Effective Date: January 1, 2011
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
Code specifying the measurement units in which a value is being expressed, or manner in which a measurement has been taken.

Codes and Values:
1. "DA" = Days
   "UN" = Unit

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must equal "DA" or "UN" when service line charges are reported.

2. SPARCS allows for a maximum of 999 service lines to be reported.

SERVICE SEGMENT

Data Element Name: Unit Quantity 1-10

Record Position:

Data Element	Record Position	Data Element	Record Position
Unit Quantity 1	2168-2175	Unit Quantity 6	2343-2350
Unit Quantity 2	2203-2210	Unit Quantity 7	2378-2385
Unit Quantity 3	2238-2245	Unit Quantity 8	2413-2420
Unit Quantity 4	2273-2280	Unit Quantity 9	2448-2455
Unit Quantity 5	2308-2315	Unit Quantity 10	2483-2490

Format – Length: Number - 8
Effective Date: January 1, 2011
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
A quantitative measure of services rendered that occurred by revenue category to or for the patient. The number of service units that occurred during the bill period for the patient. This will include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.

Codes and Values:

1. Equals Days or Units.

2. Must be greater than zero.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. When reporting days, the number must be less than or equal to the number of days in the billing period as documented in Admission Date/Start of Care and Statement Through Date. The total number of days reported must not exceed the calculated length of stay.

2. When reporting days, the appropriate revenue code, Service Rate (4050R only), Total Charges, and Total Non-Covered Charges must also be reported to reflect room and board accommodations.

3. When reporting units, the value of unit can be reported as "1" or more based on the provider's practice, health plan requirements or regulation.

4. When HCPCS codes are reported, the unit is defined by the HCPCS definition. Where the unit is not defined by the HCPCS codes, units can be reported as "1" or more based on the provider's practice, health plan requirements or regulation.

5. A zero or negative value is not allowed.

6. SPARCS allows for a maximum of 999 service lines to be reported**.**

SERVICE SEGMENT

Data Element Name: Non-Covered Charge 1-10

Record Position:

Data Element	Record Position	Data Element	Record Position
Non-Cov Charge 1	2176-2185	Non-Cov Charge 6	2351-2360
Non-Cov Charge 2	2211-2220	Non-Cov Charge 7	2386-2395
Non-Cov Charge 3	2246-2255	Non-Cov Charge 8	2421-2430
Non-Cov Charge 4	2281-2290	Non-Cov Charge 9	2456-2465
Non-Cov Charge 5	2316-2325	Non-Cov Charge 10	2491-2500

Format – Length: Number - 10
Effective Date: January 1, 1982
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
Non-covered charge amount reflects the non-covered charges for the payer as it pertains to the associated revenue code.

Codes and Values:
1. Equals Non-Covered Charge Amount entered in dollars and cents.
   Example: *$125.24 would be entered as: 125.24*

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
1. Must equal Non-Covered Charge Amount.
2. If Non-Covered Charges are entered, the associated Revenue Code and Line Item Charge Amount must also be reported.
3. Non-Covered Charge Amount must be less than or equal to the corresponding Line Item Charge Amount.
4. If Non-Covered Charge Amount is entered, then Revenue Code, Service Unit Count, Line Item Charge Amount and HCPCS Accommodations Rate must also be reported.
5. It is necessary to report at least **one** Revenue Code with each outpatient claim (AS, ED, OP). There must be at least one Line Item Charge Amount and Non-Covered Charge Amount for all Revenue outpatient codes reported except for the 036x, 045x, 048x, 049x, 051x, 052x, 075x, 076x or 079x categories. For these exceptions the Line Item Charge Amount and non-covered charge amount may be rolled up to the first occurrence of the revenue code category with zero reported for subsequent occurrences on each outpatient claim.
6. SPARCS allows for a maximum of 999 service lines to be reported.

IV. CONTINUATION RECORDS

V. Continuation Records

Common Portion of All Records

SPARCS Inpatient Segment:	**Common Detail**
Data Element Name:	Discharge Sequential Number
Record Position:	1-14
Format – Length:	Numeric – 14
Effective Date:	May 1, 2005
Contained in:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The discharge year, plus an eight digit sequentially assigned number by SPARCS. This data element is used to identify each discharge. It is also used to link the primary and continuation records.

Codes and Values:

2. An assigned numeric value.

OUTPUT Edits on Element:

3. Must be a numeric value.

4. If Abortion Flag equals 'Y' then the Discharge Number is reconfigured.

INPUT Edits on Element:
Not applicable. This is a derived field.

SPARCS Inpatient Segment:	**Common Detail**
Data Element Name:	Continuation Indicator
Record Position:	15
Format – Length:	Numeric – 1
Effective Date:	May 1, 2005
Contained in:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
A code which indicates if continuation records exist for this discharge. This is a derived data element.

Codes and Values:

3. "0" = no continuation records

4. A value of "1" or greater means this is a continuation record.

OUTPUT Edits on Element:

2. Must be a numeric value.

INPUT Edits on Element:
Not applicable. This is a derived data element.

SPARCS Inpatient Segment:	**Common Detail**
Data Element Name:	Record Sequence Number
Record Position:	16 - 18
Format – Length:	Character - 3
Effective Date:	January 1, 1994
Contained in:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The number assigned by SPARCS to indicate the record's position within a set of records for a particular patient discharge.

This number is sequential (001, 002, etc.). For example, the "Record Sequence" number for the second record in a set of 3 records required to report all the data for a particular patient stay/discharge is set equal to "002". All primary records will have a record sequence number equal to '001'.

Codes and Values:

1. Right justified and zero filled.
2. "001" = Primary Record
3. "002" to "092" = Continuation Records

OUTPUT Edits on Element:

1. Must be numeric ('001' to '092').

INPUT Edits on Element:
Not applicable. This is a derived data element.

SPARCS Inpatient Segment:	**Common Detail**
Data Element Name:	Record Sequence Count
Record Position:	19 - 21
Format – Length:	Character - 3
Effective Date:	January 1, 1994
Contained in:	De-Identified Data Set: YES Limited Data Set: YES Identifiable Data Set: YES
Deniable Data Element:	No

Description:
The total number of records reported for a particular patient stay/discharge.

This data element is assigned in conjunction with Record Sequence Number.

A patient discharge will result in one primary record and possible continuation records. All primary records will have a Record Sequence Number equal to one. For example, if a patient discharge has a "Record Sequence Count" equal to '005', this means that there is a total of five records containing information for that patient stay; the primary record and four continuation records.

Codes and Values:

2. Right justified and zero filled.

OUTPUT Edits on Element:

2. Must be numeric ('001' to '092').

INPUT Edits on Element:
Not applicable. This is a derived data element.

Data Element Name: Revenue Code 11-80

Record Position:

Data Element	Record Position	Data Element	Record Position
Rev Code 11	51-54	Rev Code 46	1275-1279
Rev Code 12	86-89	Rev Code 47	1311-1314
Rev Code 13	121-124	Rev Code 48	1346-1349
Rev Code 14	156-159	Rev Code 49	1381-1384
Rev Code 15	191-194	Rev Code 50	1416-1419
Rev Code 16	226-229	Rev Code 51	1451-1454
Rev Code 17	261-264	Rev Code 52	1486-1489
Rev Code 18	296-299	Rev Code 53	1521-1524
Rev Code 19	331-334	Rev Code 54	1556-1559
Rev Code 20	366-369	Rev Code 55	1591-1594
Rev Code 21	401-404	Rev Code 56	1626-1629
Rev Code 22	436-439	Rev Code 57	1661-1664
Rev Code 23	471-474	Rev Code 58	1696-1699
Rev Code 24	506-509	Rev Code 59	1731-1734
Rev Code 25	541-544	Rev Code 60	1766-1769
Rev Code 26	576-579	Rev Code 61	1801-1804
Rev Code 27	611-614	Rev Code 62	1836-1839
Rev Code 28	646-649	Rev Code 63	1871-1874
Rev Code 29	681-684	Rev Code 64	1906-1909
Rev Code 30	716-719	Rev Code 65	1941-1944
Rev Code 31	751-754	Rev Code 66	1976-1979
Rev Code 32	786-789	Rev Code 67	2011-2014
Rev Code 33	821-824	Rev Code 68	2046-2049
Rev Code 34	856-859	Rev Code 69	2081-2084
Rev Code 35	891-894	Rev Code 70	2116-2119
Rev Code 36	926-929	Rev Code 71	2151-2154
Rev Code 37	961-964	Rev Code 72	2186-2189
Rev Code 38	996-999	Rev Code 73	2221-2224
Rev Code 39	1031-1034	Rev Code 74	2256-2259
Rev Code 40	1066-1069	Rev Code 75	2291-2294
Rev Code 41	1101-1104	Rev Code 76	2326-2329
Rev Code 42	1136-1139	Rev Code 77	2361-2364
Rev Code 43	1171-1174	Rev Code 78	2396-2399
Rev Code 44	1206-1209	Rev Code 79	2431-2434
Rev Code 45	1241-1244	Rev Code 80	2466-2469

Format – Length: Character - 4
Effective Date: Jan. 1, 1982
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description

Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements.

This data element is called the "Service Line Revenue Code" in the X12-837 guidelines. It is commonly referred to as the "Revenue Code". Each service should be assigned a revenue code:

1. For inpatient services involving multiple services for the same item providers should aggregate the services under the assigned revenue code and then report the total number of units that represent those services.

2. If multiple services are provided on the same day for like services, that is, those with the same HCPCS, the provider should aggregate the like services for each day and report the date along with the number of units provided, as well as the revenue code. The exception is for the Evaluation and Management (E/M) HCPCS code. For E/M HCPCS, report each of these separately but also use Condition Code "G0" to indicate a Distinct Medical visit.

3. Services provided on different days should be listed separately along with the date of service, units and revenue code.

Codes and Values:

1. Must be a valid code in accordance with the Revenue Codes in Appendix I.

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. If the Revenue Code is entered, then the appropriate Service Line Rate, Service Units, Service Line Charge Amount, and Service Line Non-Covered Charge Amount must also be reported.

2. If a Revenue Code is entered, the associated Total Charges and Total Non-Covered Charges must also be reported.

3. If Revenue Codes 0001 through 0099 are reported, the associated charges must NOT be included in the totals calculated for the Total Charges or Total Non-Covered Charges.

4. On Inpatient submissions, It is necessary to report at least one Revenue Code between the values of 010x and 100x with each inpatient claim.

5. For outpatient claims, there must be at least one total and non-covered charge for all revenue codes reported except for the 036x, 045x, 048x, 049x, 051x, 052x, 075x, 076x or 079x categories. For these exceptions the total and non-covered charges may be rolled up to the first occurrence of the revenue code category with zero reported for subsequent occurrences on each claim.

Note:

SPARCS allows for a maximum of 999 service lines to be reported.

Data Element Name: Revenue Type 11-80

Record Position:

Data Element	Record Position	Data Element	Record Position
Revenue Type 11	55	Revenue Type 46	1280
Revenue Type 12	90	Revenue Type 47	1315
Revenue Type 13	125	Revenue Type 48	1350
Revenue Type 14	160	Revenue Type 49	1385
Revenue Type 15	195	Revenue Type 50	1420
Revenue Type 16	230	Revenue Type 51	1455
Revenue Type 17	265	Revenue Type 52	1490
Revenue Type 18	300	Revenue Type 53	1525
Revenue Type 19	335	Revenue Type 54	1560
Revenue Type 20	370	Revenue Type 55	1595
Revenue Type 21	405	Revenue Type 56	1630
Revenue Type 22	440	Revenue Type 57	1665
Revenue Type 23	475	Revenue Type 58	1700
Revenue Type 24	510	Revenue Type 59	1735
Revenue Type 25	545	Revenue Type 60	1770
Revenue Type 26	580	Revenue Type 61	1805
Revenue Type 27	615	Revenue Type 62	1840
Revenue Type 28	650	Revenue Type 63	1875
Revenue Type 29	685	Revenue Type 64	1910
Revenue Type 30	720	Revenue Type 65	1945
Revenue Type 31	755	Revenue Type 66	1980
Revenue Type 32	790	Revenue Type 67	2015
Revenue Type 33	825	Revenue Type 68	2050
Revenue Type 34	860	Revenue Type 69	2085
Revenue Type 35	895	Revenue Type 70	2120
Revenue Type 36	930	Revenue Type 71	2155
Revenue Type 37	965	Revenue Type 72	2190
Revenue Type 38	1000	Revenue Type 73	2225
Revenue Type 39	1035	Revenue Type 74	2260
Revenue Type 40	1070	Revenue Type 75	2295
Revenue Type 41	1105	Revenue Type 76	2330
Revenue Type 42	1140	Revenue Type 77	2365
Revenue Type 43	1175	Revenue Type 78	2400
Revenue Type 44	1210	Revenue Type 79	2435
Revenue Type 45	1245	Revenue Type 80	2470

Format – Length: Character - 1

Effective Date: Implemented August 2011

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

The Revenue type identifies the type of revenue code utilized, and is grouped into two categories: accommodation codes and ancillary codes.

Codes and Values:

1. "A" = Accommodation
   "R" = Ancillary

INPUT Edits on Element:

Not applicable. This is a derived data element.

SPARCS Inpatient Segment: **Continuation Records**

Data Element Name: Service Charge 11-80 (*previously Accommodation Total Charges and Inpatient Ancillary Total Charges*)

Record Position:

Data Element	Record Position	Data Element	Record Position
Total Charge 11	56-65	Total Charge 46	1281-1290
Total Charge 12	91-100	Total Charge 47	1316-1325
Total Charge 13	126-135	Total Charge 48	1351-1360
Total Charge 14	161-170	Total Charge 49	1386-1395
Total Charge 15	196-205	Total Charge 50	1421-1430
Total Charge 16	231-240	Total Charge 51	1456-1465
Total Charge 17	266-275	Total Charge 52	1491-1500
Total Charge 18	301-310	Total Charge 53	1526-1535
Total Charge 19	336-345	Total Charge 54	1561-1570
Total Charge 20	371-380	Total Charge 55	1596-1605
Total Charge 21	406-415	Total Charge 56	1631-1640
Total Charge 22	441-450	Total Charge 57	1666-1675
Total Charge 23	476-485	Total Charge 58	1701-1710
Total Charge 24	511-520	Total Charge 59	1736-1745
Total Charge 25	546-555	Total Charge 60	1771-1780
Total Charge 26	581-590	Total Charge 61	1806-1815
Total Charge 27	616-625	Total Charge 62	1841-1850
Total Charge 28	651-660	Total Charge 63	1876-1885
Total Charge 29	686-695	Total Charge 64	1911-1920
Total Charge 30	721-730	Total Charge 65	1946-1955
Total Charge 31	756-765	Total Charge 66	1981-1990
Total Charge 32	791-800	Total Charge 67	2016-2025
Total Charge 33	826-835	Total Charge 68	2051-2060
Total Charge 34	861-870	Total Charge 69	2086-2095
Total Charge 35	896-905	Total Charge 70	2121-2130
Total Charge 36	931-940	Total Charge 71	2156-2165
Total Charge 37	966-975	Total Charge 72	2191-2200
Total Charge 38	1001-1010	Total Charge 73	2226-2235
Total Charge 39	1036-1045	Total Charge 74	2261-2270
Total Charge 40	1071-1080	Total Charge 75	2296-2305
Total Charge 41	1106-1115	Total Charge 76	2331-2340
Total Charge 42	1141-1150	Total Charge 77	2366-2375
Total Charge 43	1176-1185	Total Charge 78	2401-2410
Total Charge 44	1211-1220	Total Charge 79	2436-2445
Total Charge 45	1246-1255	Total Charge 80	2471-2480

Format – Length: Character - 10
Effective Date: January 1, 1982
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
The sum of Total Accommodations Charges and Total Ancillary Charges for the patient's stay.

Codes and Values:

1. Must have been right justified and zero filled.
2. This amount was defined with **TWO** implied decimal places and must have been entered as a positive amount.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:
Calculated by SPARCS as the sum of Total Accommodations Charges and Total Ancillary Charges.

SPARCS Inpatient Segment: **Continuation Records**

Data Element Name: Unit Type 11-80

Record Position:

Data Element	Record Position	Data Element	Record Position
Unit Type 11	66-67	Unit Type 46	1291-1292
Unit Type 12	101-102	Unit Type 47	1326-1327
Unit Type 13	136-137	Unit Type 48	1361-1362
Unit Type 14	171-172	Unit Type 49	1396-1397
Unit Type 15	206-207	Unit Type 50	1431-1432
Unit Type 16	241-242	Unit Type 51	1466-1467
Unit Type 17	276-277	Unit Type 52	1501-1502
Unit Type 18	311-312	Unit Type 53	1536-1537
Unit Type 19	346-347	Unit Type 54	1571-1572
Unit Type 20	381-382	Unit Type 55	1606-1607
Unit Type 21	416-417	Unit Type 56	1641-1642
Unit Type 22	451-452	Unit Type 57	1676-1677
Unit Type 23	486-487	Unit Type 58	1711-1712
Unit Type 24	521-522	Unit Type 59	1746-1747
Unit Type 25	556-557	Unit Type 60	1781-1782
Unit Type 26	591-592	Unit Type 61	1816-1817
Unit Type 27	626-627	Unit Type 62	1851-1852
Unit Type 28	661-662	Unit Type 63	1886-1887
Unit Type 29	696-697	Unit Type 64	1921-1922
Unit Type 30	731-732	Unit Type 65	1956-1957
Unit Type 31	766-767	Unit Type 66	1991-1992
Unit Type 32	801-802	Unit Type 67	2026-2027
Unit Type 33	836-837	Unit Type 68	2061-2062
Unit Type 34	871-872	Unit Type 69	2096-2097
Unit Type 35	906-907	Unit Type 70	2131-2132
Unit Type 36	941-942	Unit Type 71	2166-2167
Unit Type 37	976-977	Unit Type 72	2201-2202
Unit Type 38	1011-1012	Unit Type 73	2236-2237
Unit Type 39	1046-1047	Unit Type 74	2271-2272
Unit Type 40	1081-1082	Unit Type 75	2306-2307
Unit Type 41	116-1117	Unit Type 76	2341-2342
Unit Type 42	1151-1152	Unit Type 77	2376-2377
Unit Type 43	1186-1187	Unit Type 78	2411-2412
Unit Type 44	1221-1222	Unit Type 79	2446-2447
Unit Type 45	1256-1257	Unit Type 80	2481-2482

Format – Length: Character - 2

Effective Date: Implemented August 2011

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

Code specifying the measurement units in which a value is being expressed, or manner in which a measurement has been taken.

Codes and Values:

1. "DA" = Days
   "UN" = Unit

OUTPUT Edits on Element:

None.

INPUT Edits on Element:

1. Must equal "DA" or "UN" when service line charges are reported.

Note: SPARCS allows for a maximum of 999 service lines to be reported**.**

SPARCS Inpatient Segment: **Continuation Records**

Data Element Name: Unit Quantity 11-80

Record Position:

Data Element	Record Position	Data Element	Record Position
Unit Quantity 11	68-75	Unit Quantity 46	1293-1300
Unit Quantity 12	103-110	Unit Quantity 47	1328-1335
Unit Quantity 13	138-145	Unit Quantity 48	1363-1370
Unit Quantity 14	173-180	Unit Quantity 49	1398-1405
Unit Quantity 15	208-215	Unit Quantity 50	1433-1440
Unit Quantity 16	243-250	Unit Quantity 51	1468-1475
Unit Quantity 17	278-285	Unit Quantity 52	1503-1510
Unit Quantity 18	313-320	Unit Quantity 53	1538-1545
Unit Quantity 19	348-355	Unit Quantity 54	1573-1580
Unit Quantity 20	383-390	Unit Quantity 55	1608-1615
Unit Quantity 21	418-425	Unit Quantity 56	1643-1650
Unit Quantity 22	453-460	Unit Quantity 57	1678-1685
Unit Quantity 23	488-495	Unit Quantity 58	1713-1720
Unit Quantity 24	523-530	Unit Quantity 59	1748-1755
Unit Quantity 25	558-565	Unit Quantity 60	1783-1790
Unit Quantity 26	593-600	Unit Quantity 61	1818-1825
Unit Quantity 27	628-635	Unit Quantity 62	1853-1860
Unit Quantity 28	663-670	Unit Quantity 63	1888-1895
Unit Quantity 29	698-705	Unit Quantity 64	1923-1930
Unit Quantity 30	733-740	Unit Quantity 65	1958-1965
Unit Quantity 31	768-775	Unit Quantity 66	1993-2000
Unit Quantity 32	803-810	Unit Quantity 67	2028-2035
Unit Quantity 33	838-845	Unit Quantity 68	2063-2070
Unit Quantity 34	873-880	Unit Quantity 69	2098-2105
Unit Quantity 35	908-915	Unit Quantity 70	2133-2140
Unit Quantity 36	943-950	Unit Quantity 71	2168-2175
Unit Quantity 37	978-985	Unit Quantity 72	2203-2210
Unit Quantity 38	1013-1020	Unit Quantity 73	2238-2245
Unit Quantity 39	1048-1055	Unit Quantity 74	2273-2280
Unit Quantity 40	1083-1090	Unit Quantity 75	2308-2315
Unit Quantity 41	1118-1125	Unit Quantity 76	2343-2350
Unit Quantity 42	1153-1160	Unit Quantity 77	2378-2385
Unit Quantity 43	1188-1195	Unit Quantity 78	2413-2420
Unit Quantity 44	1223-1230	Unit Quantity 79	2448-2455
Unit Quantity 45	1258-1265	Unit Quantity 80	2483-2490

Format – Length: Number - 8

Effective Date: Implemented August 2011

Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES

Deniable Data Element: No

Description:

A quantitative measure of services rendered that occurred by revenue category to or for the patient. The number of service units that occurred during the bill period for the patient This will include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.

Codes and Values:

1. Equals Days or Units

2. Must be greater than zero.

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. When reporting days, the number must be less than or equal to the number of days in the billing period as documented in Admission Date/Start of Care and Statement Through Date. The total number of days reported must not exceed the calculated length of stay.

2. When reporting days, the appropriate revenue code, Service Rate (4050R only), Total Charges, and Total Non-Covered Charges must also be reported to reflect room and board accommodations.

3. When reporting units, the value of unit can be reported as "1" or more based on the provider's practice, health plan requirements or regulation.

4. When HCPCS codes are reported, the unit is defined by the HCPCS definition. Where the unit is not defined by the HCPCS codes, units can be reported as "1" or more based on the provider's practice, health plan requirements or regulation.

5. A zero or negative value is not allowed.

   Note: SPARCS allows for a maximum of 999 service lines to be reported**.**

Data Element Name: Non-Covered Charge 11-80 (*previously Accommodation Total Charges and Inpatient Ancillary Total Non-covered Charges)*

Record Position:

Data Element	Record Position	Data Element	Record Position
Non-Cov Chrg 11	76-85	Non-Cov Chrg 46	1301-1310
Non-Cov Chrg 12	111-120	Non-Cov Chrg 47	1336-1345
Non-Cov Chrg 13	146-155	Non-Cov Chrg 48	1371-1380
Non-Cov Chrg 14	181-190	Non-Cov Chrg 49	1406-1415
Non-Cov Chrg 15	216-225	Non-Cov Chrg 50	1441-1450
Non-Cov Chrg 16	251-260	Non-Cov Chrg 51	1476-1485
Non-Cov Chrg 17	286-295	Non-Cov Chrg 52	1511-1520
Non-Cov Chrg 18	321-330	Non-Cov Chrg 53	1546-1555
Non-Cov Chrg 19	356-365	Non-Cov Chrg 54	1581-1590
Non-Cov Chrg 20	391-400	Non-Cov Chrg 55	1616-1625
Non-Cov Chrg 21	426-435	Non-Cov Chrg 56	1651-1660
Non-Cov Chrg 22	461-470	Non-Cov Chrg 57	1686-1695
Non-Cov Chrg 23	496-505	Non-Cov Chrg 58	1721-1730
Non-Cov Chrg 24	531-540	Non-Cov Chrg 59	1756-1765
Non-Cov Chrg 25	566-575	Non-Cov Chrg 60	1791-1800
Non-Cov Chrg 26	601-610	Non-Cov Chrg 61	1826-1835
Non-Cov Chrg 27	636-645	Non-Cov Chrg 62	1861-1870
Non-Cov Chrg 28	671-680	Non-Cov Chrg 63	1896-1905
Non-Cov Chrg 29	706-715	Non-Cov Chrg 64	1931-1940
Non-Cov Chrg 30	741-750	Non-Cov Chrg 65	1966-1975
Non-Cov Chrg 31	776-785	Non-Cov Chrg 66	2001-2010
Non-Cov Chrg 32	811-820	Non-Cov Chrg 67	2036-2045
Non-Cov Chrg 33	846-855	Non-Cov Chrg 68	2071-2080
Non-Cov Chrg 34	881-890	Non-Cov Chrg 69	2106-2115
Non-Cov Chrg 35	916-925	Non-Cov Chrg 70	2141-2150
Non-Cov Chrg 36	951-960	Non-Cov Chrg 71	2176-2185
Non-Cov Chrg 37	986-995	Non-Cov Chrg 72	2211-2220
Non-Cov Chrg 38	1021-1030	Non-Cov Chrg 73	2246-2255
Non-Cov Chrg 39	1056-1065	Non-Cov Chrg 74	2281-2290
Non-Cov Chrg 40	1091-1100	Non-Cov Chrg 75	2316-2325
Non-Cov Chrg 41	1126-1135	Non-Cov Chrg 76	2351-2360
Non-Cov Chrg 42	1161-1170	Non-Cov Chrg 77	2386-2395
Non-Cov Chrg 43	1196-1205	Non-Cov Chrg 78	2421-2430
Non-Cov Chrg 44	1231-1240	Non-Cov Chrg 79	2456-2465
Non-Cov Chrg 45	1266-1275	Non-Cov Chrg 80	2491-2500

Format – Length: Number - 10
Effective Date: January 1, 1982
Contained In: De-Identified Data Set: YES
Limited Data Set: YES
Identifiable Data Set: YES
Deniable Data Element: No

Description:
Non-covered charge amount reflects the non-covered charges for the primary payer as it pertains to the associated revenue code.

Codes and Values:
1. Equals Non-Covered Charge Amount entered in dollars and cents.
   Example: *$125.24 would be entered as: 125.24*

OUTPUT Edits on Element:
None.

INPUT Edits on Element:

1. Must equal Non-Covered Charge Amount.

2. If Non-Covered Charges are entered, the associated Revenue Code and Line Item Charge Amount must also be reported.

3. Non-Covered Charge Amount must be less than or equal to the corresponding Line Item Charge Amount.

4. If Non-Covered Charge Amount is entered, then Revenue Code, Service Unit Count, Line Item Charge Amount and HCPCS Accommodations Rate must also be reported.

5. It is necessary to report at least **one** Revenue Code with each outpatient claim (AS, ED, OP). There must be at least one Line Item Charge Amount and Non-Covered Charge Amount for all Revenue outpatient codes reported except for the 036x, 045x, 048x, 049x, 051x, 052x, 075x, 076x or 079x categories. For these exceptions the Line Item Charge Amount and non-covered charge amount may be rolled up to the first occurrence of the revenue code category with zero reported for subsequent occurrences on each outpatient claim.

Note:

SPARCS allows for a maximum of 999 service lines to be reported.

V.
APPENDICES LISTING

V. Appendices

Below is a listing of the appendices to the Data Dictionary.
These appendices are maintained on the SPARCS website under the topics Data Collection (select Input Data Specifications, then Appendices) and Data Distribution (select either the Inpatient or Outpatient Data Dictionary, then Appendices). You can also go directly to the following URL http://www.health.ny.gov/statistics/sparcs/sysdoc/appendix.htm
Note that some appendices are specific to **data submitters** (input data) or **data users** (output data), while some apply to **both.** These uses are specified in the "Used by" column of the table below.

APPENDIX	NAME	DESCRIPTION	USED BY
A	Date Edit Validation Table	Valid codes for Month, Day, Year	Both
B	Hour Reference Table	4 digit and 2 digit codes corresponding to each hour of the day	Both
C	New York State Patient Status or Disposition	Discharge Status of Patient from health care facility. Codes established by NUBC.	Both
D	Expected Reimbursement Codes	Code Definitions for pay source	Both
E	Address Abbreviations	Abbreviations for all address fields	Both
F	Zip/County Code Edit Validation Table	County Codes and first 3 digits of Zip Codes by county	Both
G	State Edit Validation Table	Abbreviations for States, Territories, and Canadian Provinces	Both
H	UB Accommodation Codes	Moved to Appendix I	
I	Revenue Codes	Code Definitions for revenue codes	Both
J	License Code Descriptions	Valid codes for Health Care Professionals	Both
K	Payer IDs for Commercial Insurance and Other Payers	Provides resources to identify a variety of payers (commercial insurance companies, Medicaid FFS, Medicare FFS) for submitting "Payer ID" information. Lists codes for Medicaid Managed Care and Miscellaneous codes. Historical Codes for HMOs.	
L	Blue Cross and Blue Shield Plan Numbers	Plan Numbers By State and Canadian Province	Both
M	Input and Output Alphabetical Listing of Data Elements	List of all Data Elements with collection year, data element name, and number. Links to Data Dictionary for definitions, codes and values, and edit applications.	Both
N	Coding Conditions and Exceptions	Points out several important coding conditions as well as exceptions to common coding conditions	Submitters
NN	Programmers Guide for SPARCS requirements	Lists data elements and acceptable values. Indicates elements required by SPARCS.	Submitters
O	Medicaid Managed Care Payer ID Numbers	Lists payer ID, contract county, and plan type for Medicaid Managed Care Plans	Both

APPENDIX	NAME	DESCRIPTION	USED BY
OO	Medicaid Rate Codes	Links to resources on Medicaid Rate Codes	Both
P	Source of Payment Typology	Codes and descriptions for Source of Payment	Both
Q	Inpatient Edit Program Error Codes	Lists and describes error codes for inpatient data. Links to data dictionary for additional information.	Submitters
R	Outpatient Edit Program Error Codes	Lists and describes error codes for outpatient data. Links to data dictionary for additional information.	Submitters
S	Service Category Group Definitions	Defines the six service category groups as listed on the SPARCS inpatient record and used in the Annual Report Series Tables	Users
T	T-AIDS/HIV Record Editing	Explains edits to those records subject to HIV/AIDS review	Users
TT	Abortion Record Editing	Explains guidelines that result in the setting of the abortion flag, restricting release of physician license number	Users
U	NYS County/Region/HSA Table	List of codes for NYS county, Region, and HSA	Both
V	Edited Inpatient Output File Description	Lists data element names and positions in the Edited Inpatient Output File. Links to data dictionary for additional information.	Users
VV	Edited UDS Outpatient Output File Description	Lists data element names and positions in the Edited Outpatient Output File. Links to data dictionary for additional information.	Users
VVV	Inpatient Master File Description	Lists data element names and positions in the Edited Inpatient Master File. Links to data dictionary for additional information.	Users
VVVV	Inpatient Non-Identified Abbreviated File Description	Lists data element names and positions in the Inpatient De-Identified Abbreviated File. Links to data dictionary for additional information.	Users
W	Edited UDS Outpatient Output Conversion Source	Edited UDS Outpatient Output Conversion Source	Users
WW	Conversion Notes	Conversion Notes	Both
X	Unscheduled/Scheduled Admission Conversion Algorithm	Table to be used for determining scheduled vs. unscheduled admission	Users
Y	Grouper Versions Used by Year Reference Table	The values in the CURRENT, PRIOR and NEW Federal, AP State and APR State DRG, MDC, ROM and SOI fields are dependent upon the discharge year of the patient. Listed are the version numbers of the groupers used.	Users
Z	Identifying and Restricted Data	Lists identifying fields requiring approval of the Data Protection Review Board prior to release.	Users
ZZ	Using Continuation Records	Explains how “continuation records" are created when multiple discharge records are created for a single patient stay. Explains continuation record handling for data users.	Users

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