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NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

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New Hampshire Uniform Health Facility Discharge Data Set

NH UHFDDS

User Manual

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INTRODUCTION

Background

The New Hampshire Uniform Healthcare Facility Discharge Data Set (UHFDDS) is collected under the authority of RSA 126-25 and Administrative Rule He-C 1500. UHFDDS is one of the most useful and complete datasets available to public health officials and health care planners, who use the data for the purposes of assessing hospital utilization and the incidence and burden of disease and injury among New Hampshire residents. Discharge data is released back to the hospitals and to other entities upon request for independent study and analysis.

In 2009, the New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS), in partnership with the Department of Information Technology (DoIT), took the dataset internal after many years of using a vendor. DPHS and DoIT worked diligently to create a new system to receive, process, edit, validate, and store the data received by 32 reporting hospitals in the state of New Hampshire.

Reporting

All hospitals licensed by the New Hampshire Department under RSA 151:2 are required by law to report patient-level discharge information to the DHHS. Discharges are also collected from select rehabilitation hospitals, rehabilitation and psychiatric units within acute care hospitals, and from free-standing ambulatory surgical treatment centers that are part of a hospital.

Rule Change

In 2010 the NH UHFDDS governing rule He-C 1500 was changed to improve the quality of the data, and expand on the data elements collected. The current rule is based on the UB-04 form, and the new system has been created in accordance with UB-04 definitions, layouts and standards. File submissions are mandated to be in 837i format, which is the standard format used by institutional providers to transmit health care claims electronically. DHHS has worked closely with all reporting hospitals to accommodate the rule change and file formats being submitted.

More information on the reporting requirements can be found online at:

http://www.gencourt.state.nh.us/rules/state_agencies/he-c1500.html

The submission manual and other important documents can be found at:

http://www.dhhs.nh.gov/dphs/hsdm/hospital/publications.htm

DATA ELEMENT CODES

As noted above, discharge data is submitted in accordance with the UB-04 form data specifications. Please reference your UB-04 specifications manual for the data element name, a brief definition, reporting requirements, and notes that further explain or elaborate on the reporting of information and coding.

Hospital Code and Type: DHHS creates three datasets from the discharge data received: Inpatient, Outpatient and Specialty. Below are the hospitals that report to DHHS, their respective Hospital Code and Type:

Hospital Code	Hospital Name	Type
APD	Alice Peck Day Memorial Hospital	Acute Care
AVH	Androscoggin Valley Hospital	Acute Care
CHE	Cheshire Medical Center	Acute Care
CMC	Catholic Medical Center	Acute Care
CON	Concord Hospital	Acute Care
COT	Cottage Hospital	Acute Care
DHM	Dartmouth Hitchcock Medical Center	Acute Care
DHP	Dartmouth Hitchcock Medical Center - Psych	Specialty Care
ELL	Elliot Hospital	Acute Care
EXE	Exeter Hospital	Acute Care
FMH	Frisbie Memorial Hospital	Acute Care
FRH	Franklin Regional Hospital	Acute Care
HAM	Hampstead Hospital	Specialty Care
HSR	Healthsouth Rehabilitation Hospital	Specialty Care
HUG	Huggins Hospital	Acute Care
LIT	Littleton Regional Hospital	Acute Care
LRG	Lakes Region General Healthcare	Acute Care
MCH	Monadnock Community Hospital	Acute Care
MEM	Memorial Hospital	Acute Care
NHH*	New Hampshire Hospital	Specialty Care
NLH	New London Hospital	Acute Care
NRH	Northeast Rehabilitation Hospital	Specialty Care
PAV	Portsmouth Pavilion	Specialty Care
PMC	Parkland Medical Center	Acute Care
POR	Portsmouth Regional Hospital	Acute Care
SMH	Speare Memorial Hospital	Acute Care
SNH	Southern New Hampshire Medical Center	Acute Care
STJ	St. Joseph Hospital	Acute Care
UCV	Upper Connecticut Valley Hospital	Acute Care
VRH	Valley Regional Hospital	Acute Care
WDH	Wentworth Douglass Hospital	Acute Care
WMC	Weeks Medical Center	Acute Care

*** Important Note: Data for New Hampshire Hospital (NHH) does not contain discharges for 4/11/10 – 4/15/10 or 4/26/10 – 4/30/10, and contains no Principle or Admitting Diagnosis codes**

Age: Patients aged between 0 and 89 will be displayed as exact age; patients over 90 are aggregated.

Gender:

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

Residence: Patients' residences are calculated using Federal Information Processing Standards, or "FIPS" codes, a national standard created by the federal government. Below are the FIPS codes for NH counties, as well as the state code for Maine, Massachusetts and Vermont. Out of state patients are only coded to the State level, not County. Additional State FIPS codes not listed below can be looked up online.

Residence (FIPS) Code	Patient Residence
33001	Belknap County, New Hampshire
33003	Carroll County, New Hampshire
33005	Cheshire County, New Hampshire
33007	Coos County, New Hampshire
33009	Grafton County, New Hampshire
33011	Hillsborough County, New Hampshire
33013	Merrimack County, New Hampshire
33015	Rockingham County, New Hampshire
33017	Strafford County, New Hampshire
33019	Sullivan County, New Hampshire
23	Maine
25	Massachusetts
50	Vermont

Additional Residence Codes

Residence (Non-FIPS) Code	Residence
77	No Fixed Residence
87	Canada
88	Outside USA, other than Canada
99	Unknown

Race: The highest level codes representing the race code set are as follows

R1 = American Indian / Alaskan Native
R2 = Asian
R3 = Black or African American
R4 = Native Hawaiian or Pacific Islander
R5 = White
R7 = Refused/declined to provide
R8 = Unknown
R9 = Other Race

Ethnicity: There are two minimum categories for data on ethnicity: Hispanic or Latino, and Not Hispanic or Latino. The highest level codes representing the ethnicity code set are as follows

E1 = Hispanic or Latino
E2 = Not Hispanic or Latino
E7 = Refused/declined to provide
E8 = Unknown

Multiple Race and Ethnicity codes are permitted. Please refer to page 10 – 11 of the NH UHFDDS Submission Manual for information on reporting guidelines and additional coding information. http://www.dhhs.nh.gov/dphs/hsdm/hospital/documents/submissionmanual2011.pdf

Length of Stay (LOS): Calculated using the difference (in days) between Discharge/End of Care Date and Admission/Start of Care Date; if Admission/Start of Care Date is missing, Statement Begin Period / Start of Service Date will be used to derive Length of Stay; If Length of Stay = 0 (because these two dates are the same - admitted and discharged on the same day), then Length of Stay will be set to 1.

Primary Payor: This field is submitted as a text field, and then coded by DHHS into one of the following categories

Payer Classification Name	Payer ID
Commercial	1
Medicare	2
Medicaid	3
Other Federal Government	4
Workers Compensation	5
Uninsured	6
Self-Pay	7
Other	8

Patient Discharge Status (also called "Disposition"):

Code	Discharge/Disposition
01	Discharged to Home or Self Care
02	Discharged/Transferred to Short-Term General Hospital for Inpatient Care
03	Discharged/Transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
04	Discharged/Transferred to a Facility that Provides Custodial or Supportive Care
05	Discharged/Transferred to a Designated Cancer Center or Children's Hospital
06	Discharged/Transferred to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice or Discontinued Care
09	Admitted as an Inpatient to this Hospital
20	Expired
21	Discharged/Transferred to Court/Law Enforcement
30	Still Patient
40	Expired at Home
41	Expired at Medical Facility (e.g. hospital, SNF, ICF or free standing hospice)

42	Expired - Place Unknown
43	Discharged/Transferred to a Federal Healthcare Facility
50	Hospice - Home
51	Hospice - Medical Facility (Certified) Providing Hospice Level of Care
61	Discharged/Transferred to a Hospital-Based Medicare Approved Swing Bed
62	Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital
63	Discharged/Transferred to a Medicare Certified Long Term Carr Hospital (LTCH)
64	Discharged/Transferred to a Nursing Facility under Medicaid but not Certified under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharged/Transferred to a Critical Access Hospital (CAH)
70	Discharged/Transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List
99	Unknown

Priority Type of Admission or Visit:

Code	Priority (Type) of Admission or Visit
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma
9	N/A

Point of Origin for Admission or Visit (also called "Admission Source"):

Code	Admission Source
1	Non-Health Care Facility Point of Origin
2	Clinic or Physician's Office
3	Physician Referral – **effective through October 2007**
4	Transfer from a Hospital (Different Facility)
5	Transfer from Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6	Transfer from Another Health Care Facility
7	Transfer from ED – **effective through July 2010**
8	Transfer by Law Enforcement or Court
9	Information Not Available
B	Transfer From Another Home Health Agency – **effective through July 2010**
C	Readmission to Home Health Agency – **effective through July 2010**
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
E	Transfer From Ambulatory Surgery Center
F	Transfer From Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program

Code	Admission Code for Newborns
1	Normal Delivery
2	Premature
3	Sick Baby
4	Born on Arrival
5	Born Inside This Hospital
6	Born Outside This Hospital
9	Information Not Available

DISCHARGE INFORMATION

Hospital discharge data that is submitted to DHHS is reported in billing/claims data based on the UB-04 form. Since some of the data is reported in claims detail, with multiple claims for the patients' stay, DHHS is charged with taking all of the claim information for a given hospital stay, and "rolling up" the data into one instance of a hospital discharge. Below is the logic used when DHHS receives multiple claims and has to "roll up" the data into a discharge:

Inpatient and Specialty ==> All claims with the same set of values for all of the following data elements are grouped together and loaded to the database as a single discharge row and assigned a unique Discharge ID:

Discharge Year
Hospital
Discharge Type
Patient Medical Record Number
Admission Date

Outpatient ==> All claims with the same set of values for all of the following data elements are grouped together and loaded to the database as a single discharge row and assigned a unique Discharge ID:

Discharge Year
Hospital
Discharge Type
Patient Medical Record Number
Statement From/To Date Range

Discharge ID: A code assigned by DHHS during processing to uniquely identify the discharge.

Discharge Type: An indicator that denotes a discharge or episode of care as either Inpatient (IP); Outpatient (OP); or Specialty (SP).

Value Codes and Amounts: A code structure to relate amounts or values to identify data elements necessary to process a claim in the discharge as qualified by the payer organization. Refer to UB-04

Manual for code values; Amounts field will reflect the dollar amount that coincides with the Value Code.

Condition Code: A code used to identify conditions or events relating to a claim in the discharge that may affect processing. Refer to UB-04 Manual for code values.

Occurrence Code and Dates: The code and associated date that defines a significant event relating to a claim in the discharge that may affect payer processing. Please note that Occurrence Code Dates are not included in the Public Use dataset. Refer to UB-04 Manual for code values.

Principal Diagnosis Code: The ICD-9 code describing the principal diagnosis; that is, the condition established after study to be chiefly responsible for admitting the patient for care.
Note: "99999" = Unknown

Present on Admission for Principal Diagnosis: An indicator that denotes whether the condition was present at the time the order for admission occurred. The five reporting options are as follows:

Yes = "Y"
No = "N"
No information in the record = "U"
Clinically undetermined = "W"
Exempt from POA reporting = Blank field

Other Diagnosis Code: The ICD-9 code corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Excludes diagnoses that relate to earlier episode(s) which have no bearing on the current hospital stay.

Admitting Diagnosis Code: The ICD-9 code describing the patient's diagnosis at the time of admission. This data element is displayed in the dataset with an implied decimal point.

Patient Reason for Visit: The ICD-9 code describing the patient's reason for visit at the time of outpatient registration. Required for unscheduled/outpatient/ ambulatory visits. This data element is displayed in the dataset with an implied decimal point.

External Cause of Injury Code (E-Code): The ICD-9 code pertaining to external cause of injuries, poisoning, or adverse effect. This data element is displayed in the dataset with an implied decimal point.

Principal Procedure Code: The ICD-9 code that identifies the principal procedure performed at the claim level during the period covered by this claim. This data element is displayed in the dataset with an implied decimal point.

Other Procedure Code: The ICD-9 code that identifies another significant procedure (other than the principal procedure) performed during the period covered by this claim. This data element is displayed in the dataset with an implied decimal point.

Revenue Code: A code that identifies specific accommodation, ancillary service or unique billing calculations or arrangements. Refer to UB-04 Manual for code and subcategory values.

HCPCS or CPT/Accommodation Rates/HIPPS rate codes: The Healthcare Common Procedure Coding System (HCPCS) is applicable to ancillary service and outpatient bills; the Accommodation Rates is for Inpatient billing; and the Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics on which payment determinations are made under several prospective payment systems. The fields are situational depending on the services rendered. HCPCS may be accompanied by up to four Modifiers, as defined by the AMA under Current Procedural Terminology, or "CPT." Accommodation Rates are required when a room and board revenue code is reported. HIPPS Rate Codes are developed and published by The Centers for Medicare and Medicaid to establish a coding system for claim submission and payment. Please note that HIPPS Rate Codes may not be included in this dataset.

Service Units: A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.

Type of Bill: A code indicating the specific type of bill (e.g. hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. The fourth digit defines the frequency of the bill for the institutional and electronic professional claim. Refer to UB-04 Manual for code and frequency values.

Total Charge: Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non-covered charges. Total charges will equal the sum of all total charge amounts on the claims that "roll up" to the discharge (See Discharge Information for details on claim data "roll up" logic). This data element is displayed in the dataset with an implied decimal point.

Encounter Type: A code determined by the Revenue Code to display activity that took place in an Outpatient setting. One Encounter Type is displayed per discharge. The following table lists the code, the type, and how the code is assigned. The codes are listed below in the order in which they are assigned to the discharge. Note that all codes, except N/A, are assigned only to outpatient discharges.

Code	Encounter Type	Code Assignment Hierarchy
OBS	Observation	Revenue code 0762 on discharge
ED	Emergency Department	One or more of the following revenue codes on discharge: 0450, 0451, 0452, 0459
UC	Urgent Care	Revenue code 0456 on discharge
OTR	Other	Revenue codes present on discharge, but none of the codes are equal to any of the following: 0450, 0451, 0452, 0456, 0459, 0762
N/A	Non Applicable	Discharge type inpatient or specialty
UNK	Unknown	No revenue codes on discharge

Patient Relationship to Insured: Code indicating the relationship of the patient to the identified insured.

Code	Relationship to Insured
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Diagnosis Related Group Code (DRG Code): Diagnosis-related group (DRG) is a system to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use. DRG Codes are classified and maintained by the Centers for Medicare & Medicaid Services (CMS). DHHS runs the submitted discharge data through a DRG "grouper" software to derive the DRG code, if applicable, to the discharge. DRG Codes can be looked up online for definitions.