HDD Validation Rules - Release 2 (2012-2013 Data)

Rule #	Data Element Name	Error Description	Data Source / Derivation / Notes	Validation Rule
34	Discharge Hour	Invalid/Missing Discharge Hour	837 file from hospital. Value is a code (from 00 to 23) that equates to a one-hour time span. See FL16 in UB-04 manual for a list of codes and definitions.	Discharge Hour must be present on Inpatient and Specialty Discharge Types and must be a valid code from 00 to 23.
35	Patient Discharge Status	Invalid/Missing Patient Discharge Status	837 file from hospital. We will make sure a valid code is present. We won't validate that the right code is being used in the right circumstance. See FL17 in UB-04 manual for valid codes.	Patient Discharge Status must be present and must be a valid code.
36	Patient Reason For Visit	Missing Patient Reason For Visit	837 file from hospital. The ICD-CM diagnosis code(s) describing the patient's reason for visit at time of outpatient registration. A claim may have a maximum of 3 codes. See FL70 in UB-04 manual for more information about this data element.	At least one Patient Reason For Visit must be present for **unscheduled outpatient visits.** For an unscheduled visit, Type of Bill is 13 or 85; Priority (Type) of Visit is 1, 2, or 5; and at least one Revenue Code is 045X, 0516, 0526, or 0762.
37	Patient Reason For Visit	Invalid Patient Reason For Visit		If a Patient Reason For Visit is present, then it must be a valid ICD diagnoses code. **Validation will not be implemented.**
38	Admission Hour	Invalid/Missing Admission Hour	837 file from hospital. Value is a code (from 00 to 23) that equates to a one-hour time span. See FL13 in UB-04 manual for a list of codes and definitions.	Admission Hour must be present on Inpatient and Specialty Discharge Types and must be a valid code from 00 to 23.
39	Priority (Type) of Admission or Visit	Invalid/Missing Admission Type	837 file from hospital. See FL14 in UB-04 manual for a list of codes and definitions for Priority (Type) of Admission or Visit (also called Admission Type).	Priority (Type) of Admission or Visit must be present on Inpatient and Specialty Discharge Types and must be one of the following codes: 1, 2, 3, 4, 5, 9.
40	Point of Origin for Admission or Visit	Invalid/Missing Admission Source	837 file from hospital. See FL15 in UB-04 manual for a list of codes and definitions for Point of Origin for Admission or Visit (also called Admission Source).	Point of Origin for Admission or Visit must be present on Inpatient and Specialty Discharge Types and must be one of the following codes: 1, 2, 4, 5, 6, 8, 9, D, E, F. For data with a Discharge/End of Service Date prior to 7/1/2010, valid codes also include: 7, B, C.

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41	Admitting Diagnosis Code	Invalid/Missing Admitting Diagnosis	837 file from hospital. See FL69 in UB-04 manual for more information.	Admitting Diagnosis Code must be present on Inpatient and Specialty Discharge Types and must be a valid ICD diagnosis code. **Validation will not be implemented.**
42	Other Diagnosis Code	Invalid Other (Secondary) Diagnosis Code	837 file from hospital. See FL67a-q in UB-04 manual for more information. A claim can have a maximum of 17 Other Diagnosis Codes.	If Other (Secondary) Diagnosis is present, then it must be a valid ICD diagnosis code. **Validation will not be implemented.**
43	External Cause of Injury (ECI) Code 1/2/3	Invalid ECI Code	837 file from hospital. ECI Codes begin with E. See FL72a-c in UB-04 manual for more information.	If ECI code is present, then the code must be valid. **Validation will not be implemented.**
44	Other Procedure Code	Invalid Other Procedure Code	837 file from hospital. See FL74 and FL74a-e in UB-04 manual for more information. A claim can have a maximum of 11 Other Procedure Codes.	If Other Procedure is present, then it must be a valid ICD procedure code. **Validation will not be implemented.**
45	Principal/Other Procedure Date	Invalid/Missing Procedure Date	837 file from hospital. See FL74 and FL74a-e in UB-04 manual for more information. A claim can have a maximum of 11 Other Procedure Codes and Dates.	Each Procedure Code must include a corresponding valid Procedure Date (month, day, and year).
46	Patient City	Missing Patient City	837 file from hospital.	Patient City must be present.
47	Patient State	Missing Patient State	837 file from hospital. Patient State is only required if Patient Country is USA. A missing Patient Country is assumed to be USA. If the country is USA and is entered, the ISO code "US" is used.	If Patient Country is blank or US, then Patient State must be present.
48	Patient State	Invalid Patient State Abbreviation	Need to build table of valid 2 alpha character state codes	If Patient State is present, then it must be a valid state code.
49	Medical Record Number	Medical Record Number Must Be Present	837 file from hospital.	Medical Record Number must be present.
50	Patient Race Code	Missing Race	837 file from hospital. One or more race codes can be specified for a patient.	At least one race code must be present for the patient.
51	Patient Race Code	Invalid Race Code	See Section 8.3 in NH Health Care Facility Discharge Data Submission Manual for list of valid race codes.	If a race code is present, then it must be a valid code.

Rule #	Data Element Name	Error Description	Data Source / Derivation / Notes	Validation Rule
52	Patient Ethnicity Code	Missing Ethnicity	837 file from hospital. One or more ethnicity codes can be specified for a patient.	At least one ethnicity code must be present for the patient.
53	Patient Ethnicity Code	Invalid Ethnicity	See Section 8.3 in NH Health Care Facility Discharge Data Submission Manual for list of valid ethnicity codes.	If an ethnicity code is present, then it must be a valid code.
54	Billing Provider NPI	Missing or Invalid Billing Provider NPI - Must Be 10 Digits Long	837 file from hospital.	Billing Provider NPI must be present and must be 10 digits.
55	Health Plan Identifier	Missing Health Plan Identifier	837 file from hospital. See FL51 in UB-04 manual for more information. A claim can have a maximum of 3 Health Plan Identifiers.	The Health Plan Identifier must be present for all payers present on the claim: Primary, Secondary, Tertiary.
	Notes			
	Validations are for all discharge types - Inpatient, Outpatient, Specialty - unless specifically stated otherwise in the validation rule.			