Patient Abstract System
File Specifications

File Specifications for Hospitals, Ambulatory Surgical Centers (ASCs), and Abortion Facilities (AFs)

Key to Format and Justification Coding:
A= Alphabetic **N**= Numeric **R**= Right Justified **L**= Left Justified

A-Record (Master Record)						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Record Type	1	1	A	L		Always "A"
Provider identifier	2-11	10	A/N	L		When reporting directly to the State, enter the State assigned provider number beginning with 26 or 79. If reporting through an association, this field shall contain the National Provider Identifier (NPI).
Unique Encounter Identifier	12-36	25	A/N	L		Unique identifier within facility (Hospital, ASC, or AF) for each discharge record or patient encounter. (Different at each visit - Cannot be used twice in the same year).
Type of Encounter	37	1	N	L		1 = Inpatient 2 = Outpatient
Place of Service	38	1	N	L		**Codes for Hospital Inpatients:** 1 = Acute medical/surgical unit (non PPS exempt) 2 = Psychiatric unit or facility 3 = Medical rehabilitation unit or facility 4 = Alternate level of care (SNF/ICF/Other LTC/Hospice/ Sub Acute/Swing bed) 5 = Alcohol rehabilitation unit or facility 6 = Drug rehabilitation unit or facility 7 = Other **Codes for Hospital Outpatients:** 1 = Emergency room 2 = Outpatient surgery 3 = Observation only 4 = Other **Code for ASCs and AF Patients:** 2 = Outpatient Surgery
Patient Name	39-88	50	A	L	FL08B / 1035-1037	Format: Last name, First name (Example: Doe, John). • Use a comma to separate last and first names. • No space should be left between a prefix and a name, as in MacBeth. • Titles (for example, Sir, Msgr., and Dr.) should not be recorded. • Record hyphenated names with hyphen, as in Smith-Jones, Rebecca. • To record suffix, write the last name, leave a space and write the suffix then write the first name as in Snyder III, Harold, or Addams Jr., Glen. • **Not to be reported for patients receiving treatment for alcohol or drug abuse as defined in 42 CFR Part 2. Tobacco cessation is not included in 42 CFR Part 2 therefore Patient Name must be reported.**
Patient Social Security Number	89-97	9	N	L		SSN • Enter 9-digit SSN without hyphens • If patient prefers to provide only the last four digits of SSN, enter the last four digits, preceded by five 9s (e.g., 999991234). • If patient refuses to provide SSN, code with 99999999 (Allowed on no more than 10% of records) • **Not to be reported for patients receiving treatment for alcohol or drug abuse as defined in 42 CFR Part 2. Tobacco cessation is not included in 42 CFR Part 2 therefore Patient SSN must be reported.**

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Patient Birth Date	98-105	8	N	R	FL10/ 1251	MMDDCCYY • Use 8-digit date format (Example: 01022009)
Patient Sex	106	1	A	L	FL11/ 1068	Patient sex at time of admission or start of care: M = Male F = Female U = Unknown/indeterminate
Patient Ethnicity	107	1	N	L		1 = Hispanic or Latino 2 = Neither Hispanic nor Latino 8 = Patient Refused 9 = Unknown (Allowed on no more than 10% of records)
Patient Race	108	1	N	L		1 = White 2 = Black or African American 3 = American Indian/Alaska Native 4 = Asian 5 = Native Hawaiian/Pacific Islander 6 = Some Other Race 7 = Multi-racial (two or more races) 8 = Patient Refused 9 = Unknown (Allowed on no more than 10% of records)
State of Residence	109-110	2	N	R	FL09c/ 156	State FIPS Code • Use 2 digit numeric format (**97** = Homeless **98** = Non U.S. Resident)
Zip Code	111-115	5	N	R	FL09d/ 116	• First 5 digits only (Example: 65101) (**99997** = Homeless **99998** = Non-U.S. Resident)
County Code	116-118	3	N	R		• Required for Missouri residents. • Use 3 digit numeric format (Example: 001 = Adair County) (**997** = Homeless **998** = Non-U.S. Resident)
Census Tract	119-125	7	A/N	L		• 7 characters formatted as XXXX.XX (where "X" is a digit from 0-9) • If census tract is unavailable, leave this field blank and provide patient address information (street, city, zip) on the C-record.
Admission/Start of Care Date	126-133	8	N	R	FL12/ 1251	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Admission Hour	134-135	2	N	R	FL13/ 1251	• **Required for inpatient records only** 00 = 12:00 - 12:59 Midnight 01 = 1:00 - 1:59 02 = 2:00 - 2:59 03 = 3:00 - 3:59 04 = 4:00 - 4:59 05 = 5:00 - 5:59 06 = 6:00 - 6:59 07 = 7:00 - 7:59 08 = 8:00 - 8:59 09 = 9:00 - 9:59 10 = 10:00 - 10:59 11 = 11:00 - 11:59 12 = 12:00 - 12:59 Noon 13 = 1:00 - 1:59 14 = 2:00 - 2:59 15 = 3:00 - 3:59 16 = 4:00 - 4:59 17 = 5:00 - 5:59 18 = 6:00 - 6:59 19 = 7:00 - 7:59 20 = 8:00 - 8:59 21 = 9:00 - 9:59 22 = 10:00 - 10:59 23 = 11:00 - 11:59 99 = Unknown (Allowed on no more than 10% of records)

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Priority (Type) of Admission/Visit	136	1	N	L	FL14/ 1315	• **Required for inpatient records only** 1 = Emergency (The patient requires immediate 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). 3 = Elective (The patient's condition permits adequate time to schedule the services). 4 = Newborn (Use of this code requires special Point of Origin Codes for newborns FL15). 5 = Trauma center/hospital as licensed or designated by the state or local govt. authority authorized to do so, per American College of Surgeons and involving a trauma activation. 6-8 Reserved for Assignment by NUBC 9 = Information not available (Allowed on no more than 10% of records)
Point of Origin for Admission/Visit	137	1	A/N	L	FL15/ 1314	**Code Structure for Adult/Pediatric Patients**: 1 = Non-Health Care Facility Point of Origin The patient was admitted or presented for outpatient services to this facility. 2 = Clinic or Physician's Office The patient was admitted or presented to this facility for outpatient services upon the recommendation of a physician, a healthcare clinic or outpatient department. 3 = Reserved for assignment by the NUBC 4 = Transfer from a hospital. The patient was transferred for services to this facility or referred from a different acute-care facility. (For transfers from hospital inpatient in the same facility, see code D below). 5 = Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Assisted Living Facility (ALF) 6 = Transfer from another Health Care Facility The patient was admitted or presented for outpatient services to this facility from another type of health care facility not defined elsewhere in this code list. 7 = Reserved for assignment by the NUBC 8 = Court/Law Enforcement. The patient was admitted or presented for outpatient services 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 (Allowed on no more than 10% of records) A = Reserved for assignment by the NUBC 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 ASC or AF The patient was admitted or presented for outpatient services or referenced diagnostic services by an ASC or AF. F = Transfer from Hospice Facility The patient was admitted or presented to this facility for outpatient or referenced diagnostic services as a transfer from a hospice facility. G-Z Reserved for assignment by the NUBC **Code Structure for Newborns**: 1-4 Reserved for assignment by the NUBC (Newborns) 5 = Born inside this hospital 6 = Born outside of this hospital 7-9 Reserved for assignment by the NUBC (Newborns)

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
P7 Condition Code	138-139	2	A/N	L	FL18-28	• **Required for inpatient records only** • Report condition code "P7" to indicate direct inpatient admission from emergency room
Date of Discharge/Ending Date of Service	140-147	8	N	R		MMDDCCYY • Use 8-digit date format (Example: 10012013)
Discharge Hour	148-149	2	N	R	FL16/ 1251	• **Required for inpatient records only** 00 = 12:00 - 12:59 Midnight 01 = 1:00 - 1:59 02 = 2:00 - 2:59 03 = 3:00 - 3:59 04 = 4:00 - 4:59 05 = 5:00 - 5:59 06 = 6:00 - 6:59 07 = 7:00 - 7:59 08 = 8:00 - 8:59 09 = 9:00 - 9:59 10 = 10:00 - 10:59 11 = 11:00 - 11:59 12 = 12:00 - 12:59 Noon 13 = 1:00 - 1:59 14 = 2:00 - 2:59 15 = 3:00 - 3:59 16 = 4:00 - 4:59 17 = 5:00 - 5:59 18 = 6:00 - 6:59 19 = 7:00 - 7:59 20 = 8:00 - 8:59 21 = 9:00 - 9:59 22 = 10:00 - 10:59 23 = 11:00 - 11:59 99 = Unknown (Allowed on no more than 10% of records)
Observation Units	150-152	3	N	R		The number of hours spent by a patient held for observation.
Patient Discharge Status	153-154	2	N	R	FL17/ 1352	**The designation of the circumstances associated with the patient's discharge** 01 = Discharged to home or self-care (Routine Discharge) 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 organized home health service organization in anticipation of covered skilled care 07 = Left against medical advice or discontinued care 08 = Reserved for National Assignment 09 = Admitted as an inpatient to this hospital 10-19 Reserved for National Assignment 20 = Expired 21 = Discharged/Transferred to Court/Law Enforcement 22-29 Reserved for National Assignment 30 = Still Patient 31-39 Reserved for National Assignment 43 = Discharged/Transferred to a Federal Healthcare Facility 44-49 Reserved for National Assignment 50 = Discharged/Transferred to Hospice-Home 51 = Discharged/Transferred to Hospice-Medical Facility **(Patient Discharge Status continued on next page)**

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Patient Discharge Status (codes continued)	153-154	2	N	R	FL17/ 1352	52-60 Reserved for National Assignment 61 = Discharged/Transferred within this institution to a hospital-based Medicare approved swing bed 62 = Discharged/Transferred to an Inpatient Rehab Facility or Rehab Unit 63 = Discharged/Transferred to a Medicare Certified Long Term Care Hospital 64 = Discharged/Transferred to a Nursing Facility certified under Medicaid but not Medicare 65 = Discharged/Transferred to a Psychiatric Hospital or Psychiatric Unit 66 = Discharged/Transferred to a Critical Access hospital 67-68 Reserved for National Assignment 69 = Discharged/Transferred to a Designated Disaster Alternative Care Site 70 = Discharged/Transferred to another type of Healthcare Institution not defined elsewhere in this list. 81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission 82 = Discharged/Transferred to a short term General Hospital for inpatient care with a planned acute care hospital inpatient readmission 83 = Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission 84 = Discharged/Transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission 85 = Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a planned acute care hospital inpatient readmission 86 = Discharged/Transferred to home under care of Organized Home Health Service Organization with a planned acute care hospital inpatient readmission 87 = Discharged/Transferred to Court/Law Enforcement with a planned acute care hospital inpatient readmission 88 = Discharged/Transferred to a Federal Health Care Facility with a planned acute care hospital inpatient readmission 89 = Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a planned acute care hospital inpatient readmission 90 = Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a hospital with a planned acute care hospital inpatient readmission 91 = Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission 92 = Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission 93 = Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a hospital with a planned acute care hospital inpatient readmission 94 = Discharged/Transferred to a Critical Access Hospital (CAH) with a planned acute care hospital inpatient readmission 95 = Discharged/Transferred to another type of health care Institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission 96-99 Reserved for National Assignment

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Medical/Health Record Number	155-178	24	A/N	L	FL03b/ 127	A number your facility assigns to each patient's medical/health record.
External Cause of Morbidity Code (ECM)	179-185	7	A/N	L	FL72a/ 1271	• **Should be reported when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment and Dx code is in range A00.0-T88.9 or Z00-Z99.89.** • **Required when Principal Dx code is in range S00-T35 or within range T66-T88.9. Codes in range T36-T65 are excluded from Cause reporting as these dx codes include the cause** • Enter an ICD-10-CM value using capital letters and remove the decimal point. • Report the code for the cause/intent, including medical misadventures most related to the principal diagnosis. • Use valid codes in ICD-10-CM range V00-Y90.9 or Y95 and *U01-*U03.
POA_ECM	186	1	A/N	L	FL72a (eighth digit)/ 1073	ECM Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
ECM_Place of Occurrence Code	187-193	7	A/N	L		Indicate the place of occurrence for the injury related health condition. • **Required with initial Injury diagnosis** • **Required when ECM code is in range V00-Y84.9** • Use valid codes in ICD-10-CM range Y92
ECM_Activity Code	194-200	7	A/N	L		Indicate the activity of the person seeking healthcare for an injury related health condition • **Required with initial Injury diagnosis** • **Required when ECM code is in range V00-Y39.9** • Use valid codes in ICD-10-CM range Y93
ECM_Status Code	201-207	7	A/N	L		Indicate the status of the person seeking healthcare for an injury related health condition • **Required with initial Injury diagnosis** • **Required when the injury occurred while patient was working (i.e: Civilian, Military, Volunteer, Other, or Unspecified**). • Use valid codes in ICD-10-CM range Y99
Principal or First Listed Diagnosis Code1	208-214	7	A/N	L	FL67/ 1271	An ECM code (ICD-10-CM range V00-Y999) is **invalid** as a principal diagnosis or first listed diagnosis.
POA_DX1	215	1	A/N	L	FL67 (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code2	216-222	7	A/N	L	FL67a/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
POA_DX2	223	1	A/N	L	FL67a (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code3	224-230	7	Á/ N	L	FL67b/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX3	231	1	A/N	L	FL67b (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code4	232-238	7	A/N	L	FL67c/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX4	239	1	A/N	L	FL67c (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code5	240-246	7	A/N	L	FL67d/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX5	247	1	A/N	L	FL67d (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code6	248-254	7	A/N	L	FL67e/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX6	255	1	A/N	L	FL67e (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code7	256-262	7	A/N	L	FL67f/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
POA_DX7	263	1	A/N	L	FL67f (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code8	264-270	7	A/N	L	FL67g/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX8	271	1	A/N	L	FL67g (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code9	272-278	7	A/N	L	FL67h/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX9	279	1	A/N	L	FL67h (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Principal Procedure Code1	280-289	10	A/N	L	FL74/ 1271 or FL44a	• Enter the principal procedure code (Use ICD-10-PCS codes for inpatients and use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Principal Procedure Date1	290-297	8	N	L	FL74/ 1251 or FL45a	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code2	298-307	10	A/N	L	FL74a/ 1271 or FL44b	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date2	308-315	8	N	L	FL74a/ 1251 or FL45b	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code3	316-325	10	A/N	L	FL74b/ 1271 or FL44c	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date3	326-333	8	N	L	FL74b/ 1251 or FL45c	MMDDCCYY • Use 8-digit date format (Example: 10012013)

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Other Procedure Code4	334-343	10	A/N	L	FL74c/ 1271 or FL44d	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date4	344-351	8	N	L	FL74c/ 1251 or FL45d	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code5	352-361	10	A/N	L	FL74d/ 1271 or FL44e	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date5	362-369	8	N	L	FL74d/ 1251 or FL45e	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code6	370-379	10	A/N	L	FL74e/ 1271 or FL44f	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date6	380-387	8	N	L	FL74e/ 1251 or FL45f	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Total Charges	388-394	7	N	R	FL47/ 782	Total charges • Include both covered and non-covered charges (those associated with revenue code 0001, self-pay, etc). • Round to nearest dollar (Examples: $700.00 = 700 or $12,000 = 12000)
Expected Source of Payment1	395-397	3	N	L		**Primary Payer Type** 001 = Medicare, not managed care (FFS, MSA) 002 = Medicaid , not managed care 003 = Other Government, not managed care 005 = Workers' Compensation, not managed care 006 = Self Pay 007 = All Commercial Payer, not managed care 008 = No Charge (Charity, Prof Courtesy, Research/Trial) 010 = Other, not managed care 101= Medicare, managed care (HMO,PPO,POS) 102 = Medicaid, managed care (HMO, PPO, PCCM) 103 = Other Government, managed care 105 = Workers' Compensation, managed care 107 = All Commercial Payers, managed care 110 = Other, managed care 999 = Unknown (Allowed on no more than 10% of records)

A-Record (Continued) Master Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Expected Source of Payment2	398-400	3	N	L		**Secondary Payer Type** 001 = Medicare, not managed care (FFS, MSA) 002 = Medicaid , not managed care 003 = Other Government, not managed care 005 = Workers' Compensation, not managed care 006 = Self Pay 007 = All Commercial Payer, not managed care 008 = No Charge (Charity, Prof Courtesy, Research/Trial) 010 = Other, not managed care 101= Medicare, managed care (HMO,PPO,POS) 102 = Medicaid, managed care (HMO, PPO, PCCM) 103 = Other Government, managed care 105 = Workers' Compensation, managed care 107 = All Commercial Payers, managed care 110 = Other, managed care 999 = Unknown (Allowed on no more than 10% of records)
Expected Source of Payment3	401-403	3	N	L		**Tertiary Payer Type** 001 = Medicare, not managed care (FFS, MSA) 002 = Medicaid , not managed care 003 = Other Government, not managed care 005 = Workers' Compensation, not managed care 006 = Self Pay 007 = All Commercial Payer, not managed care 008 = No Charge (Charity, Prof Courtesy, Research/Trial) 010 = Other, not managed care 101= Medicare, managed care (HMO,PPO,POS) 102 = Medicaid, managed care (HMO, PPO, PCCM) 103 = Other Government, managed care 105 = Workers' Compensation, managed care 107 = All Commercial Payers, managed care 110 = Other, managed care 999 = Unknown (Allowed on no more than 10% of records)
Attending Physician ID	404-414	11	A/N	L	FL76/ 67	National Provider Identifier (NPI) of the physician **who has primary responsibility for the patient's medical care and treatment**
Principal Procedure Physician ID	415-425	11	A/N	L	FL77/ 67	National Provider Identifier (NPI) of the physician **who performed the principal procedure**.

B-Record To be used when there are more diagnoses and/or procedures than will fit on the A-Record (Only report one B-record per A-record)						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Record Type	1	1	A	L		Always "B"
Provider identifier	2-11	10	A/N	L		When reporting directly to the State, enter the State assigned provider number beginning with 26 or 79. If reporting through an association, this field shall contain the National Provider Identifier (NPI).
B-Record (Continued) **To be used when there are more diagnoses and/or procedures than will fit on the A-Record**						

Field Name	Column Position	Field Length	Format	Justify	UB04 /X12	Description/Codes
Unique encounter identifier	12-36	25	A/N	L		Unique identifier within facility (Hospital, ASC, or AF) for each discharge record or patient encounter. A unique number that represents each patient's visit (Different at each visit - Cannot be used twice in the same year). • Must match corresponding A-Record's Unique Encounter Identifier
Other Diagnosis Code10	37-43	7	A/N	L	FL67i/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX10	44	1	A/N	L	FL67i (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code11	45-51	7	Á/ N	L	FL67j/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX11	52	1	A/N	L	FL67j (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code12	53-59	7	A/N	L	FL67k/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX12	60	1	A/N	L	FL67k (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code13	61-67	7	A/N	L	FL67l/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX13	68	1	A/N	L	FL67l (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code14	69-75	7	A/N	L	FL67m/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX14	76	1	A/N	L	FL67m (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting

B-Record (Continued) To be used when there are more diagnoses and/or procedures than will fit on the A-Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Other Diagnosis Code15	77-83	7	A/N	L	FL67n/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX15	84	1	A/N	L	FL67n (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code16	85-91	7	A/N	L	FL67o/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX16	92	1	A/N	L	FL67o (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code17	93-99	7	A/N	L	FL67p/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX17	100	1	A/N	L	FL67p (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code18	101-107	7	A/N	L	FL67q/ 1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX18	108	1	A/N	L	FL67q (eighth digit)/ 1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code19	109-115	7	A/N	L	1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX19	116	1	A/N	L	1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting

B-Record (Continued) To be used when there are more diagnoses and/or procedures than will fit on the A-Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Other Diagnosis Code20	117-123	7	A/N	L	1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX20	124	1	A/N	L	1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code21	125-131	7	A/N	L	1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX21	132	1	A/N	L	1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code22	133-139	7	A/N	L	1271	ICD-10-CM code • Include ECM code not yet reported in ECM field
POA_DX22	140	1	A/N	L	1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Diagnosis Code23	141-147	7	A/N	L	1271	ICD-10-CM code • Include ECM codes not yet reported in ECM field
POA_DX23	148	1	A/N	L	1073	Present on Admission Indicator • **Required for Acute Care Inpatient records only** Y = Yes (POA at the time of inpatient admission) N = No (Not present at the time of inpatient admission) U = Unknown (Documentation is insufficient to make this determination) W = Clinically undetermined (Provider is unable to clinically determine) 1 or Blank = Exempt from POA reporting
Other Procedure Code7	149-158	10	A/N	L	FL44g	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date7	159-166	8	N	R	FL45g	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code8	167-176	10	A/N	L	FL44h	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date8	177-184	8	N	R	FL45h	MMDDCCYY • Use 8-digit date format (Example: 10012013)

B-Record (Continued) To be used when there are more diagnoses and/or procedures than will fit on the A-Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Other Procedure Code9	185-194	10	A/N	L	FL44i	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date9	195-202	8	N	R	FL45i	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code10	203-212	10	A/N	L	FL44j	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date10	213-220	8	N	R	FL45j	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code11	221-230	10	A/N	L	FL44k	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date11	231-238	8	N	R	FL45k	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code12	239-248	10	A/N	L	FL44l	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date12	249-256	8	N	R	FL45l	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code13	257-266	10	A/N	L	FL44m	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date13	267-274	8	N	R	F45m	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code14	275-284	10	A/N	L	FL44n	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date14	285-292	8	N	R	FL45n	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code15	293-302	10	A/N	L	FL44o	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date15	303-310	8	N	R	FL45o	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code16	311-320	10	A/N	L	FL44p	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).

B-Record (Continued) To be used when there are more diagnoses and/or procedures than will fit on the A-Record						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04 /X12**	**Description/Codes**
Other Procedure Date16	321-328	8	N	R	FL45p	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code17	329-338	10	A/N	L	FL44q	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date17	339-346	8	N	R	FL45q	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code18	347-356	10	A/N	L	FL44r	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date18	357-364	8	N	R	FL45r	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code19	365-374	10	A/N	L	FL44s	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date19	375-382	8	N	R	FL45s	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Other Procedure Code20	383-392	10	A/N	L	FL44t	• Enter any additional procedure code not yet reported for this patient visit. (Use ICD-10-PCS codes for inpatients and Use CPT or HCPCS Level II codes for outpatients. Separate modifiers from procedure code using a hyphen. Two modifier limit).
Other Procedure Date20	393-400	8	N	R	FL45t	MMDDCCYY • Use 8-digit date format (Example: 10012013)
Filler	401-425	25				Spaces

C-Record To be used when census tract information is not available						
Field Name	**Column Position**	**Field Length**	**Format**	**Justify**	**UB04/ X12**	**Description/Codes**
Record Type	1	1	A	L		Always “C”
Provider identifier	2-11	10	A/N	L		When reporting directly to the State, enter the State assigned provider number beginning with 26 or 79. If reporting through an association, this field shall contain the National Provider Identifier (NPI).
Unique encounter identifier	12-36	25	A/N	L		Unique identifier within facility (Hospital, ASC, or AF) for each discharge record or patient encounter. A unique number that represents each patient’s visit (Different at each visit - Cannot be used twice in the same year). • Must match corresponding A-Record’s Unique Encounter Identifier
Residence Address Line 1	37-76	40	A/N	L	FL09a/ 166	Free form address line
Residence Address Line 2	77-116	40	A/N	L		Free form address line

C-Record (Continued) To be used when census tract information is not available						
City	117-146	30	A/N	L	FL09b/ 19	Name of city or town of residence for patient
Zip Code	147-151	5	N	R	FL09d/ 116	Zip Code • First 5 digits only (Example: 65101) 99997 = Homeless 99998 = Non-U.S. Resident (must match "A" record)
Filler	152-425	274				Spaces

FOOTNOTES:

- **File must be ASCII text, containing fixed-length records of 425 characters.**
- **Report all diagnoses and procedure codes using capital letters**
- **Do Not zero fill; "leading" zeros are acceptable only as part of a valid code--All data elements with no reportable value must be left blank.**
- **Do Not include any punctuation (except when related to a patient name, or when using a hyphen to separate procedure code modifier(s) from procedure code.**
- **Do Not include any special characters.**