

114.1 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
HOSPITALS AND CLINICS

114.1 CMR 17.00: REQUIREMENT FOR THE SUBMISSION OF HOSPITAL CASE MIX AND  
CHARGE DATA

Section

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17.01: General Provisions

(1) Scope and Purpose. 114.1 CMR 17.00 governs acute hospital Case Mix and Charge Data submission requirements. The Data contain information about each inpatient admission, outpatient observation stay and emergency department visit. 114.1 CMR 17.00 specifies the data elements that must be submitted in accordance with specifications set forth in the Division's Data Specification Manuals. Case Mix and Charge Data are used to, among other things, establish payment rates, and inform health care policy development and public health studies. Case Mix and Charge Data are confidential data under M.G.L. c. 66A and may be disclosed only in accordance with the provisions of 114.5 CMR 2.00.

(2) Effective Date. 114.1 CMR 17.00 is effective for the reporting period beginning October 1, 2006. Data submission for reporting periods ending September 30, 2006 are governed by the provisions of 114.1 CMR 17.00 and administrative bulletins in effect on the last day of the reporting period.

(3) Authority. 114.1 CMR 17.00 is adopted pursuant to M.G.L. c. 118G.

17.02: Definitions

As used in 114.1 CMR 17.00 and Electronic Records Submission Specification manuals, unless the context clearly requires otherwise, the following words shall have the following meanings:

Acute Hospital. A hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Case Mix Data. Case specific, diagnostic discharge data that describes socio-demographic characteristics of the patient, the medical reason for admission or visit, treatment and services provided the patient and duration and status of the patient's stay in or visit to the hospital. Case Mix Data are a slightly modified version of the UB-92 data set and includes the data elements specified in the Division Data Specification Manuals.

Charge Data. The full, undiscounted total and service specific charges billed by the hospital to the general public as defined in M.G.L. c. 118G. Charge data shall include, but not be limited to, the UB-92 data elements and codes specified in the Division's Data Specification Manuals.

CPT. The Current Procedural Terminology coding system used to describe medical procedures and services, developed and maintained by the American Medical Association. CPT codes and descriptions only are copyrighted by the American Medical Association.

Data Specification Manuals. The Inpatient Discharge Data Submission Specification Manual, the Outpatient Observation Data Submission Specification Manual, and the Outpatient Emergency Department Visit Data Submission Specification Manual.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

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Emergency Department (ED). The department of a hospital, or health care facility off the premises of a hospital that is listed on the license of the hospital and qualifies as a Satellite Emergency Facility under 105 CMR 130.820 through 130.836, that provides emergency services as defined in 105 CMR 130.020. Emergency services are further defined in the Hospital Uniform Reporting Manual (HURM), Chapter III, § 3242. For purposes of 114.1 CMR 17.00, outpatient emergency departments include both the on-campus department of the hospitals that provides emergency services and any satellite emergency facilities on the hospital's license as defined in 105 CMR 130.820.

Emergency Department Visit. Any visit by a patient to an emergency department that results in registration at the ED but does not result in an outpatient observation stay nor the inpatient admission of the patient at the reporting facility. An ED visit occurs even if the only service provided to a registered patient is triage or screening. An ED visit is further defined in the HURM Chapter III, § 3242.

External Cause of Injury Codes (E-codes). International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes E800-E999 (E-codes) are used to categorize events and conditions describing the external cause of injuries, poisonings, and adverse effects. The principal E-code describes the mechanism that caused the most severe injury, poisoning, or adverse effect. Additional E-codes are used to report place of occurrence or to completely describe the mechanism(s) that contributed to the injury or poisoning or the causal circumstances surrounding any injury or poisoning.

HCPCS. The Centers for Medicare and Medicaid Services' Common Procedure Coding System.

HURM. The Hospital Uniform Reporting Manual promulgated under 114.1 CMR 4.00.

ICD-9-CM Coding System. The United States version of the International Classification of Diseases - Clinical Modification coding system recommended for coding diagnoses and procedures by the U.S. Department of Health and Human Services.

Medical Record Number. The unique number assigned to each patient within the hospital that distinguishes the patient and the patient's hospital record(s) from all others in that institution.

Observation Services. Those services furnished on a hospital's premises that are reasonable and necessary to further evaluate the patient's condition and provide treatment to determine the need for possible admission to the hospital. These services include the use of a bed and periodic monitoring by a hospital's physician, nursing and other staff. Observation services are further defined in the HURM § 3241. If the patient is admitted, observation services are reported as inpatient observation services and included in the inpatient discharge record. If the patient is not admitted, observation services are reported as outpatient observation services and included in the outpatient observation stay record.

UB-92. The current version of the uniform bill, composed of a data set negotiated by the National Uniform Billing Committee, to be used by major third party payers and most hospitals, hospital-based skilled nursing facilities and home health agencies.

Units of Service. Units of Service shall be reported according to the HURM, except where otherwise noted in the Electronic Records Submission Specification Manuals.

17.03: Required Data

(1) General Requirements. Hospitals shall submit data on patient demographics, diagnoses and procedures, physicians, and charges for each inpatient discharge, outpatient observation stay, and emergency department visit. The required data elements are listed in 114.1 CMR 17.03(5). Hospitals must submit required data in accordance with 114.1 CMR 17.04 and the Data Specification Manuals.

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(2) Inpatient Merged Case Mix and Charge Data. Hospitals shall submit Inpatient hospital merged case mix and charge data for all discharges. This data includes information about patient demographics, physicians, diagnoses, E-codes, procedures, admission type and source, patient status disposition, payment type and source, accommodation revenue center charges and days, and ancillary revenue center charges. If the patient is admitted after an Emergency Department Visit or Outpatient Observation Stay, the record should be reported as an inpatient discharge with the appropriate ED and observation identifiers. Upon admission, observation services should be reported as inpatient observation services and included with the inpatient discharge record.

(3) Outpatient Observation Data. Hospitals shall submit Outpatient Observation Data for all observation stays. An Outpatient Observation Stay is reported for each patient that receives Observation Services and is not admitted. An example of an outpatient observation stay might be a post surgical day care patient that, after a normal recovery period, continues to require hospital observation and is then released from the hospital. The Outpatient Observation Data includes, but is not limited to, information about patient demographics, physicians, diagnoses, procedures, observation type and source, patient's departure status, payment source and charges. If the patient received Observation Services but is not admitted following an Emergency Department visit, the visit should be reported as an outpatient observation stay with an appropriate ED identifier.

(4) Outpatient Emergency Department Visit Data. Hospitals shall submit outpatient emergency department visit data for all emergency department visits, including Satellite Emergency Facility visits, by patients whose visits result in neither an outpatient observation stay nor an inpatient admission at the reporting facility. This data includes, but is not limited to, information about patient demographics, physicians, diagnoses, services, visit source and disposition, payment source, charges, mode of transport, and E-codes.

(5) Required Data Elements. The following table shows the required data elements for each database. The Data Specification Manuals contain additional data submission requirements, including, but not limited to, required fields, file layouts, file components, edit specifications, and other technical specifications.

	<u>Inpatient</u>	<u>Outpatient Observation</u>	<u>ED Data</u>
Provider Name	X		X
Provider Address	X		X
Provider City	X		X
Provider State	X		X
Provider Zip	X		X
Period Starting and Ending Date (CCYYMMDD)	X		X
Organization ID for Provider	X	X	X
Medical Record Number	X	X	X
Patient Sex	X	X	X
Patient Birthday (CCYYMMDD)	X	X	X
Patient Employer Zip Code	X		
Type of Admission, Observation or Visit	X	X	X
Primary Source of Admission, Observation or Visit	X	X	X
Secondary Source of Admission, Observation or Visit	X	X	X

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Required Data Elements (continued)	<u>Inpatient</u>	<u>Outpatient Observation</u>	<u>ED Data</u>
Transfer Hospital Organization ID	X	X	X
Admission, Registration or Beginning Date	X	X	X
Discharge Date or Ending Service Date	X	X	X
Registration or Observation Initial Encounter Time		X	X
Service Hours		X	
Discharge Time			X
Veterans Status	X		
Primary Source of Payment	X	X	X
Patient Status or Departure Status	X	X	X
Billing or Account Number	X	X	X
Primary Payer Type	X		
Claim Certificate Number	X	X	X
Patient Social Security Number	X	X	X
Birth Weight-grams	X		
DNR Status	X		
Secondary Payer Type	X		
Secondary Source of Payment	X	X	X
Mother's Social Security Number	X	X	X
Mother's Medical Record Number	X		
ED Flag	X	X	
Outpatient Observation Stay Flag	X		
Race 1	X	X	X
Race 2	X	X	X
Other Race	X	X	X
Hispanic Indicator	X	X	X
Ethnicity 1	X	X	X
Ethnicity 2	X	X	X
Other Ethnicity	X	X	X
Hospital Service Site Reference	X	X	X
Homeless Indicator	X	X	X
Permanent Patient Street Address	X	X	X
Permanent Patient City/Town	X	X	X
Permanent Patient State	X	X	X
Permanent Patient Zip Code	X	X	X
Permanent Patient Country	X	X	X
Temporary US Patient Street Address	X	X	X
Temporary US Patient City/Town	X	X	X
Temporary US Patient State	X	X	X
Temporary US Patient Zip Code	X	X	X
Revenue Code (Accommodations)	X		
Unit of Service (Accom. Days)	X		
Total Charges (Accom.)	X		
Leave of Absence Days	X		
Revenue Code (Ancillary)	X		
Units of Service (Ancillary)	X		
Total Charges (Service)	X		
Principal External Cause of Injury Code (E-code)	X		X
Principal Diagnosis Code	X	X	X

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Required Data Elements (continued)	<u>Inpatient</u>	<u>Outpatient Observation</u>	<u>ED Data</u>
Assoc. Diagnosis Code I – XIV	X	X (I-V)	X (I-V)
Number of ANDs	X		
Other Caregiver	X	X	X
Condition Present on Admission – Principal E-Code	X		X
Condition Present on Admission, Observation or Visit – Principal Diagnosis Code	X	X	X
Condition Present on Admission, Observation or Visit – Assoc. Diagnosis Code I – XIV	X	X (I-V)	X (I-V)
Principal Procedure Code	X	X	X
Date of Principal Procedure	X	X	
Additional Significant Procedure I – XIV	X	X (I-III)	X (I-III)
Procedure Code Type (ICD-9-CM or CPT4)			X
Significant Proc. Date I – XIV	X	X (I-III)	
CPT Procedure 1 – 5		X	
Attending or ED Physician License Number	X	X	X
Other Physician Number			X
Operating Physician for Principal Procedure License Number	X	X	
Operating Physician for Significant Procedure I – XIV License Number	X	X (I-III)	
Emergency Severity Index			X
Transport			X
Ambulance Run Sheet Number			X
Stated Reason for Visit			X
Service Line Item (CPT or HCPCS code)			X
Number of ED Treatment Beds at Site			X
Number of ED-based Observation Beds at Site			X
Total Number of ED-based at Site			X
ED Visits – Admitted to Inpatient at Site			X
ED Visits – Admitted to Outpatient Observation at Site			X
ED Visits – All Other Outpatient ED Visits at Site			X
ED Visits – Total Registered at Site			X
Number of Outpatient ED Visits			X
Total Charges Spec. Services	X		
Total Charges Routine Services	X		
Total Charges Ancillaries	X		
Total Charges (All Chgs)	X	X	X
Number of Discharges	X		
Total Days	X		
Total Charges Accommodations	X		
Total Charges Ancillaries	X		

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17.04: Data Submission Requirements

(1) Data Specifications. Hospitals shall submit required data in accordance with the requirements of the Data Submission Specification Manuals, which set forth the required data file format, record specifications, data elements, definitions, code tables and edit specifications for each database. Hospitals shall submit the data directly to the Division or, in the alternative, to a suitable agent as designated by the Division for collecting, processing and/or holding the data.

(2) Data Quality Standards. The Division will review each hospital data submission in accordance with the edit specifications. The Data Submission Specification Manuals identify the required data elements that are checked for errors and edited for compliance with the edit specifications.

(a) Edit Reports. All errors will be recorded for each patient Record and for the Submission as a whole. An Edit Report will be provided to the Hospital, displaying detail for all errors found in the submission. The standards for rejecting data submissions are based on the presence of errors as listed in the Manuals.

(b) Rejection of Submissions. The Division will notify a hospital whether its submission has been accepted or rejected. A submission will be rejected in its entirety if

1. If there is a major error in any header/trailer/summary record such as an incorrect or missing value in a required field or major error in the file format; or
2. 1% or more of discharges are rejected as containing errors, or
3. 50 consecutive records are rejected as containing errors.

Hospitals must correct and resubmit rejected data until it is notified that the submission has been accepted.

(c) Amended Submissions. A hospital may amend its data submission by requesting Division approval to resubmit case mix data files. The hospital must notify the Division about the reasons for the changes and specify the changes to be made. Hospitals that resubmit data to add or amend records must submit such data in a single batch of the entire quarter's data with the appropriate amendments or additions identified as noted in the Specification Manuals.

(d) Case Mix Verification Process. The Division will provide each hospital with a summary reports of the data submitted for its review and verification. These reports provide aggregate information for certain data elements created from the data submitted by the hospital and are provided on a yearly basis. Additional profile reports may be made available on a quarterly basis to assist hospitals with correction of the data. The purpose of the verification process is to provide the hospital an opportunity to correct and resubmit data or to provide comments that can explain discrepancies identified by the hospital prior to the creation of the public data. Hospital comments are included in the yearly documentation manual that accompanies the data made available to applicants under 114.5 CMR 2.00.

(e) Other Provisions.

1. Acceptance of data under the edit check procedures specified in the Specifications Manuals shall not be deemed acceptance of the factual accuracy of the data contained therein.

2. At the time of each quarterly Emergency Department data submission, hospitals shall report the number of beds in the on-campus emergency department and satellite emergency facility on the last day of the reporting period, and, for the entire reporting period, the number of outpatient ED visits, the number of ED visits resulting in an admission to an outpatient observation stay, and the number of ED visits resulting in admission to inpatient care.

3. Merged Hospitals. Hospitals must submit data for newly merged facilities using each individual facility's Organization ID prior to the merge. Merged hospitals may elect to continue to file separate files for each facility using the individual hospital's Organization ID or to file one submission per merged entity using each hospital's Organization ID in the designated service site organization ID field in accordance with the Specifications Manual. The provider must notify the Division in writing as to which method is used.

(3) Dates of Submission.

(a) Quarterly Submissions. Hospitals shall submit inpatient, outpatient observation, and outpatient emergency department data quarterly. Data must be submitted no later than 75 days following the end of the reporting period. Quarterly submissions are due at the Division on March 16<sup>th</sup>, June 14<sup>th</sup>, September 13<sup>th</sup>, and December 14<sup>th</sup> for all hospitals.

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(b) Required Resubmissions. If the Division notifies a hospital that is required to resubmit a data submission because the submission was rejected or as part of the Verification process, the hospital must resubmit its data no later than 30 days following the date of the notice to resubmit.

(c) Extension Requests. The Division may, for good cause, grant an extension in time to a hospital for submitting inpatient, outpatient observation, or outpatient emergency department discharge data.

17.05: Compliance

(1) Compliance Requirements. A Hospital that fails to comply with the requirements of 114.1 CMR 17.00 shall be subject to the penalties specified in 114.1 CMR 17.05(2) and (3). The Division may impose penalties if the hospital fails to fail required data; or if more than 1% of the hospital's records, on a quarterly basis, are excluded from the data base by the Division because the records do not pass critical edit checks.

(2) Penalties for Non-compliance.

(a) In accordance with the provisions of M.G.L. c. 118G, § 10, a hospital that fails to file case mix and charge data including inpatient discharge data, outpatient observation data, and outpatient emergency visit data required by 114.1 CMR 17.00 shall be subject to a civil penalty of not more than \$1000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction.

(b) Adjustment of Mass Health Payment. If a hospital fails to comply with the data submission requirements of 114.1 CMR 17.00, the hospital's MassHealth payment rate may be reduced. The Division will notify the Office of Medicaid to reduce the payment rate accordance with the terms of the hospital's contract with the Office of Medicaid to provide services to Medicaid patients. The hospital's rate may be reduced by 5% effective on the day following the date the submission is due. The rate will be reduced by the same dollar amount for each month of non-compliance. This adjustment shall not, in any case, exceed 50% of the hospital's Medicaid payment rate. If a hospital has not submitted the complete documentation at the time the hospital's rate is subject to change (*i.e.*, at the start of a new rate year, or upon commencement of an amendment that affects the MassHealth rate), the hospital's new rate cannot exceed the adjusted current rate.

17.06: Other Provisions

(1) Protection of Confidentiality of Data. The Division shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected there under are "personal data" within the meaning of that statute. In addition, the Division shall ensure that any contract entered into with other parties for the purposes of processing and analysis of data collected under 114.1 CMR 17.00 shall contain assurances such other parties shall also comply with the provisions of M.G.L. c. 66A. The Medical Record, Medicaid Recipient, Billing and Unique Health Information numbers shall be used only for the purpose of establishing an audit trail in the event that it is necessary to retrieve the primary source document for validation of the abstract data and for linking case mix data and for linking case mix and charge data. The Division shall also ensure that data collected under 114.1 CMR 17.00 and redisclosed to other parties shall be purged of the patients' medical record and billing numbers, Medicaid Recipient Identification Number (Claims Certificate Number), Unique Health Information Number and date of birth prior to redisclosure except as required by 114.5 CMR 2.00. The Medicaid Recipient Identification Number will be disclosed only to the Office of Medicaid. The Social Security Number will not be disclosed.

(2) Administrative and Technical Information Bulletins. The Division may revise the specifications or other administrative requirements from time to time by notice or administrative bulletin.

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(3) Severability. The provisions of 114.1 CMR 17.00 are declared to be severable and if any such provisions or the application of such provisions to any hospital or circumstances are held invalid or unconstitutional, such invalidity or unconstitutionality shall not be construed to affect the validity or unconstitutionality of any of the remaining provisions of 114.1 CMR 17.00 or of such provisions to hospitals or circumstances other than those as to which it is held invalid.

REGULATORY AUTHORITY

114.1 CMR 17.00: M.G.L. c. 118G.

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