CMQCC
California Maternal
Quality Care Collaborative

California Maternal Data Center

Data Submission Process and Discharge Data Specifications

January 1, 2017

Thank you for participating in the CMQCC California Maternal Data Center (MDC). All data file submissions are to be submitted via the MDC secure online tool or via SFTP per the timetable and specifications attached below.

Questions or Comments

Please contact CMQCC staff at 650-736-4110 or datacenter@cmqcc.org.

Contents

Summary Guidelines and Timelines

- Participating hospitals will submit a Patient Discharge Data (PDD) file to the MDC on a monthly, bi-monthly or quarterly basis (per the hospital's preference). *Monthly is generally preferred to support hospital QI!*
- Submissions should be based on discharge date and are to be made on a calendar month basis, representing *inpatient* discharges from the first day of the month through the last day of the month for the given reporting period.
- You may submit multiple months in a single file, but please ensure the files represent the entire month for each month you are submitting (no partial-month data).
- The files should be submitted 50-60 days after the close of the reporting period.
- An Example of Data Submission Timing
  - If submitting on a monthly basis, discharge data for January 1 - 31 is due on March 20-30
  - If submitting on a quarterly basis, discharge data for January 1 - March 30 is due on May 20-30
- There are two file format options: Fixed Width or CSV. CMQCC strongly recommends using existing programming based on your OSHPD Patient Discharge Data Submissions (Fixed Width format) if possible. Please see *Creating the Discharge Data File* description below to determine which format your facility will use to submit data.

Registering with MDC Prior to Submitting Data

Your hospital's designated "Primary Administrator" must first register your hospital; that Administrator will then invite the "data submitter" to register within the MDC System. You will receive an e-mail invitation from datacenter@cmqcc.org with the subject line "CMQCC Maternal Data Center User Invitation". This e-mail should be addressed specifically to you. (Please do not try to register through e-mail invitations forwarded to you from other staff members at your hospital.)

To register:

- Click on the link included in the invitation e-mail addressed to you from datacenter@cmqcc.org.
- Create a login name and personal password.
- Enter phone numbers that you personally will answer.
  These phone numbers are part of the MDC security protocols: each time you access patient level information, the MDC will transmit a computer-generated pin number through a call or text to your registered phone numbers.

Uploading Data Files

After the initial registration, you will submit data through the MDC secure online tool at the following URL:

https://datacenter.cmqcc.org

Data submissions to the MDC site are controlled by two-factor authentication. In order to submit a data file, you will:

- Enter your login name and personal password.
- In the upper right corner, click "Data Entry Status"
- Select "Upload Data" in upper right
- Click "Discharge Data File"
- You will receive a prompt for the second factor authorization: the temporary pin required when handling patient level data. Click "Call" or "Text" to select the phone number at which you wish to receive the computer-generated pin number.
- Input the temporary pin provided via the call or text and click "Log In".
- Select "Choose File" to find the file to be uploaded from your system.
- Press Upload. The data may process for several minutes depending on the size of your file. Once the file is accepted, the word "Complete" will display within the *Discharge Data* bar for the most recent month of data included in the file. If you hover over the word "Complete" you will see a count of the maternal and newborn discharge records imported into the MDC.

If errors are found, you will receive an error message. Please contact CMQCC if you need assistance in interpreting the message. The Support link is the best way to contact CMQCC staff. Click Support in the top black bar and then click Contact MDC Support. Your message will automatically include documentation of the page you were visiting when the Support link is selected.

You also have the option to upload discharge data files via SFTP. See User Guide in the MDC Support Section **Automated File Submissions via SFTP.**

Creating the Discharge Data File

The Discharge Data File uses the same coding as the OSHPD Patient Discharge Data (PDD) submission. If you have any questions about the mapping of specific fields, the personnel in charge of your facility's OSHPD PDD submission is likely the best resource.

CMQCC recommends that hospitals assign the MDC file creation to the same department that generates the OSHPD PDD file. Other hospitals following this path required only 1-2 hours to create and upload the MDC file. Accordingly, File Format Option 1 (Attachment B1 below) is also recommended.

File Format

There are two file format options for the Discharge Data File:

Option 1: OSHPD PDD submission format (*Fixed Width File* format): i.e., column delineated in which each field has a set number of characters and there are no commas. Per ***Attachment B1*** below, you may use the data specifications at the OSHPD MIRCal link with the noted MDC modifications.

Option 2: CSV file format, with each case in a single row. If a column value is empty, leave no space between the commas: (,,). ICD-9 OR ICD-10 codes must include periods after the appropriate digits. The CSV format is specified for each data element in ***Attachment B2*** below.

File Specifications
See Attachments B1 or B2 below. CMQCC requests the following modifications to OSHPD's PDD File Specifications:

- For Fixed Width files, replace Patient Social Security Number (SSN) with null value of "123456789"or zeros. For CSV files, omit the SSN field completely. If it proves difficult to replace/remove the SSN field on the hospital end, the MDC application can null it out for you. See the User Guide **Removing SSNs from PDD File Submissions**
- Hospitals may choose between submitting all patient discharge records *or* limiting the submission to delivery-related discharges (CMQCC recommends the latter if feasible). If you do limit your submission to delivery-related discharges, please use the list of codes in Attachment A below to filter your data. If you submit all discharge records, CMQCC will apply the filters for you.
- Some fields are optional for CMQCC; optional fields are highlighted in yellow. If you choose not to submit data for these fields, please take care to format the blank values as specified for each file format option.

Note on the Abstract Record Number:
CMQCC is requesting provision of the Abstract Record Number (ARN)—a unique patient identifier *(e.g., medical record number, hospital visit number, account number, case number)* assigned by the hospital. The ARN will be encrypted immediately upon receipt at the MDC server; the true-value ARN will remain viewable by hospital personnel for ease in identifying patient records for record review. ***Hospitals should submit an ARN (e.g., medical record number, hospital visit number, account number, case number) that enables record reviews by authorized clinical personnel.***

OPTIONAL *Supplemental* Data File

Your hospital has the option of submitting additional supplemental CSV data files derived from internal systems (e.g. EMR, core measure vendor system). The supplemental files might be used to:

- Replace data already in the MDC system from the Birth Certificate data or your administrative data submission (e.g. Gestational Age).
- Pre-populate the "chart-review" data elements (e.g. labor or Prior Uterine Surgery) in the MDC system.
- Include a flag that denotes a record as part of the hospital's Joint Commission sample (from the core measure vendor system).

The specifications for the optional supplemental data file can be found in the separate document **Supplemental Data File Specifications.** Feel free to contact CMQCC to learn more about the optional supplemental submission.

OPTIONAL *Discharge Data Addendum* Files

Ability to Add Cases to Previously-Submitted Discharge Data Files
If you discover that a case is missing from a monthly/quarterly Discharge Data file that you had *previously* submitted to the MDC, you can now add these individual discharge cases via a *Discharge Addendum* file. To submit these new "addendum" cases:

- Create your *Discharge Addendum* File using the same *Discharge Data* file specifications/format delineated below.
- From the MDC Home Page, click "Data Entry Status"
- In the upper right corner, click "Upload Data"
- Select "Discharge Addendum File"
- Click "Choose File" to select the file you created, and click "Upload"

Note: This feature does ***not*** enable overwriting/replacement of the originally-submitted discharge records; i.e. any cases in the *Addendum File* that are duplicates of previously-submitted cases in the *Discharge Data File* will ***not*** replace the original record.

Summary of Changes to MDC Data Specifications since January 2012

Changes since 10/10/16 Version

Instructions

Information on two new MDC features:

- Automatic identification and replacement of SSNs within the MDC File Submission (*see page 3: File Specifications*).
- Ability to upload PDD Addendum Files in the event that *individual* discharge records were omitted from the original *Discharge Data File* submission. (*see Page 3: OPTIONAL Discharge Data Addendum Files*)

Code Sets: Pages 9-15

Per new OSHPD reporting requirements, several fields will be submitted using the UB code sets starting with January 1, 2017 discharges. While OSHPD will require the new code sets, the MDC will be able to accept *either* the original or the updated code sets for the following fields:

- Dates (Date of Birth, Admission Date, Discharge Date, Procedure Dates) in CCYYMMDD format
- Sex (page 10)
- Source of Admission-Site (page 10)
- Source of Admission-Route (page 11)
- Type of Admission (page 11)

Per revised OSHPD reporting requirements, the field "Licensure of Site" will no longer be a required data element.

Changes since 7/14/16 Version

Throughout

- Clarification that the PDD file should only include *inpatient* discharge records, not ambulatory/outpatient records.

Changes since 7/23/15 Version

Section A1: Records to Include in MDC Data Submission

- Refinements were made to the newborn inclusion criteria; specifically V29 codes will no longer be used to identify newborns for inclusion.

Changes since 7/15/15 Version

Section A2: Records to Include in MDC Data Submission

- Refinements were made to the ICD-10 codes to be used to identify cases for inclusion in the Maternal Data Center submissions.

Changes since 2/7/15 Version

Attachment A

Attachment A specifies the ICD codes to be used for identifying maternal and newborn records are now included.

- Attachment A1 provides the ICD-9 codes to be used for files that represent discharge dates before October 1, 2015.
- Attachment A2 provides the ICD-10 codes to be used for files that represent discharge dates on and after October 1, 2015. In addition, for the infant records, the date range (Admission Date – Date of Birth) has been changed from 28 days to 2 days.

Changes since 6/20/14 Version

Attachment B1, Page 7.

For hospitals submitting using the OSHPD Fixed Width format, CMQCC recommends replacing SSNs with the numeric "123456789" rather than spaces or zeros. This is to support correct character spacing in the fixed width file.

Page 10: Discharge Disposition Field

Per new OSHPD reporting requirements, the "Discharge Disposition" field changed to the UB format starting with January 1, 2015 discharges. When uploading data files after 3/16/2015 in the MDC system, you will be asked which Discharge Disposition coding the file includes: OSHPD (i.e. the pre-2015 California codes) vs. UB. The system will default to the "UB" unless you formally select the "OSHPD" option.

Changes since 5/7/2013 Version

Attachment A: **Baby Discharge Records, Page 6**. The criterion for including Baby Discharge Records has been changed. For hospitals that wish CMQCC to calculate a Neonatal Mortality rate per the AHRQ specifications ((AHRQ NQI #2), please include all discharge records with "Admission Date – Date of Birth ≤ 28 days" (rather than < 5 days or less than < 2 days). Also, new ICD-9 codes have been added to the filtering criteria (those labeled "Neonatal observation and evaluation diagnosis codes" and "Out-of-hospital live birth diagnosis codes")

Attachment B1, Page 7.
Because the MDC Fixed Width format specifications (Standard OSHPD format) are virtually identical to the OSHPD data specifications, we replaced the field-by-field descriptions in the MDC data specifications with a link to OSHPD's MIRCAL specifications and noted the specific modifications to the MDC file.

Changes since 1/10/2013 Version

Attachment A: **Baby Discharge Records, Page 6**. The criterion for including Baby Discharge Records has been changed. In addition to the ICD-9 code filters, please also include all discharge records with "Admission Date – Date of Birth ≤ 2 days", rather than < 5 days.

Birth Data File. The "Birth Data File" is no longer accepted. CMQCC will use Birth Certificate data from state Vital Records instead. However, hospitals may overwrite Birth Certificate data by submitting an optional supplemental data file—described above and specified in the separate Attachment C: *Data Specs_CMQCC_Supplemental Data File.*

Attachment B1 and B2: Labor and SROM Fields
Pilot hospitals were previously able to submit the fields *Active Labor* and *SROM* as part of their administrative data submission. **Hospitals will now need to submit these fields in a separate file**, per **Supplemental Data File Specifications**

Attachment B1 and B2: The fields *Present on Admission for Principal Diagnosis* and *Present on Admission for Other Diagnoses* were previously optional fields. Newly joining hospitals will be required to submit these fields. Because these fields may reduce chart review burden for the Newborn BSI measure, hospitals submitting data prior to May 2013 may also wish to begin adding these fields to their data submission if they have not already done so.

Changes since 4/2/2012 Version

Attachment B2: CSV File Format, Page 8. Clarification regarding utilization of column headers for CSV files. Column headers, as denoted in the specifications below, must be used for all fields you are submitting. If the field is optional and you are choosing *not* to submit it, please omit the column header. Optional fields are highlighted in yellow.

Attachment B2: CSV File Format, Page 8. Clarification regarding use of periods within ICD-9 codes with CSV File Format submissions. CSV file submissions will require ICD-9 codes to include periods:

- After the third digit for ICD-9 Diagnosis Codes of more than three digits.
- After the second digit for ICD-9 Procedure Codes of more than two digits.

Changes since 1/20/2012 Version

Attachment A: Mother Discharge Records, Page 6. The DRG codes have been removed from the list of inclusionary criteria for Maternal Discharge Records.

Attachment A: Baby Discharge Records, Page 6. The DRG codes have been removed from the list of inclusionary criteria for Baby Discharge Records.

Attachment B2: CSV File Format, Page 8. *Source of Admission* fields (3) and *Type of Admission* (1) are now required fields.

Attachment B2: CSV File Format, Page 8: The *DRG* field has been removed completely.

Attachment A1

Inpatient Records to Include in MDC Data Submission: ICD-9 Codes

For Discharges Prior to October 1, 2015

Please include *inpatient* discharge records that meet any of the following criteria in you MDC Submission. If not feasible to filter your discharge records based on the codes below, you may choose to submit the hospital's complete set of *inpatient* discharges; if so, MDC will apply this algorithm to your submission and discard all unnecessary records.

Mother Records **All inpatient discharge records meeting ANY of the following criteria:**		
ICD-9 Codes	V27 (any)	Outcome of Delivery
	640.81, 640.91, 641.01, 641.11, 641.21, 641.31, 641.81, 641.91, 642.01, 642.02, 642.11, 642.12, 642.21, 642.22, 642.31, 642.32, 642.41, 642.42, 642.51,642.52, 642.61, 642.62, 642.71, 642.72, 642.91, 642.92, 643.01, 643.11, 643.21, 643.81, 643.91, 644.21, 645.11, 645.21, 646.01, 646.11, 646.12, 646.21, 646.22, 646.31, 646.41, 646.42, 646.51, 646.52, 646.61, 646.62, 646.71, 646.81, 646.82, 646.91, 647.01, 647.02, 647.11, 647.12, 647.21, 647.22, 647.31, 647.32, 647.41, 647.42, 647.51, 647.52, 647.61, 647.62, 647.81, 647.82, 647.91, 647.92, 648.01, 648.02, 648.11, 648.12, 648.21, 648.22, 648.31, 648.32, 648.41, 648.42, 648.51, 648.52, 648.61, 648.62, 648.71, 648.72, 648.81, 648.82, 648.91, 648.92, 649.01, 649.02, 649.11, 649.12, 649.21, 649.22, 649.31, 649.32, 649.41, 649.42, 649.51, 649.61, 649.62, 649.81, 649.82	Complication Mainly Related to Pregnancy (Joint Commission Table Number 11.01)
	650, 651.01, 651.11, 651.21, 651.31, 651.41, 651.51, 651.61, 651.71, 651.81, 651.91, 652.01, 652.11, 652.21, 652.31, 652.41, 652.51, 652.61, 652.71, 652.81, 652.91, 653.01, 653.11, 653.21, 653.31, 653.41, 653.51, 653.61, 653.71, 653.81, 653.91, 654.01, 654.02, 654.11, 654.12, 654.21, 654.31, 654.32, 654.41, 654.42, 654.51, 654.52, 654.61, 654.62, 654.71, 654.72, 654.81, 654.82, 654.91, 654.92, 655.01, 655.11, 655.21, 655.31, 655.41, 655.51, 655.61, 655.71, 655.81, 655.91, 656.01, 656.11, 656.21, 656.31, 656.41, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.01, 658.11, 658.21, 658.31, 658.41, 658.81, 658.91, 659.01, 659.11, 659.21, 659.31, 659.41, 659.51, 659.61, 659.71, 659.81, 659.91	Normal Delivery and Other Indications for Care (Joint Commission Table 11.02)
	660.01, 660.11, 660.21, 660.31, 660.41, 660.51, 660.61, 660.71, 660.81, 660.91, 661.01, 661.11, 661.21, 661.31, 661.41, 661.91, 662.01, 662.11, 662.21, 662.31, 663.01, 663.11, 663.21, 663.31, 663.41, 663.51, 663.61, 663.81, 663.91, 664.01, 664.11, 664.21, 664.31, 664.41, 664.51, 664.81, 664.91, 665.01, 665.11, 665.22, 665.31, 665.41, 665.51, 665.61, 665.71, 665.72, 665.81, 665.82, 665.91, 665.92, 666.02, 666.12, 666.22, 666.32, 667.02, 667.12, 668.01, 668.02, 668.11, 668.12, 668.21, 668.22, 668.81, 668.82, 668.91, 668.92, 669.01, 669.02, 669.11, 669.12, 669.21, 669.22, 669.32, 669.41, 669.42, 669.51, 669.61, 669.71, 669.81, 669.82, 669.91, 669.92	Complication Mainly in the Course of Labor and Delivery (Joint Commission Table 11.03)
	670.02, 670.12, 670.22, 670.32, 670.82, 671.01, 671.02, 671.11, 671.12, 671.21, 671.22, 671.31, 671.42, 671.51, 671.52, 671.81, 671.82, 671.91, 671.92, 672.02, 673.01, 673.02, 673.11, 673.12, 673.21, 673.22, 673.31, 673.32, 673.81, 673.82, 674.01, 674.02, 674.12, 674.22, 674.32, 674.42, 674.82, 674.92, 675.01, 675.02, 675.11, 675.12, 675.21, 675.22, 675.81, 675.82, 675.91, 675.92, 676.01, 676.02, 676.11, 676.12, 676.21, 676.22, 676.31, 676.32, 676.41, 676.42, 676.51, 676.52, 676.61, 676.62, 676.81, 676.82, 676.91, 676.92	Complication of the Puerperium (Joint Commission Table 11.04)
	72.0, 72.1, 72.21, 72.29, 72.31, 72.39, 72.4, 72.6, 72.51, 72.52, 72.53, 72.54, 72.71, 72.79, 72.8, 72.9, 73.22, 73.59, 73.6, 74.0, 74.1, 74.2, 74.4, 74.99	Delivery-related Procedure Codes

Infant Records	**All inpatient discharge records meeting ANY of the following criteria:**	
Dates of Admission and Birth	Admission Date – Date of Birth ≤ 2 days	
ICD-9-CM V-Codes: **Live births (In-hospital and Out-of-Hospital)**	V30.xx	Single liveborn
	V31.xx	Twin liveborn, mate liveborn
	V32.xx	Twin liveborn, mate stillborn
	V33.xx	Twin liveborn, mate unspecified
	V34.xx	Other multiple, mates all liveborn
	V35.xx	Other multiple, mates all stillborn
	V36.xx	Other multiple, mates live and stillborn
	V37.xx	Other multiple, mates unspecified
	V39.xx	Unspecified liveborn

Attachment A2

Inpatient Records to Include in MDC Data Submission: ICD-10 Codes

For Discharges From October 1, 2015

Please include *inpatient* discharge records that meet *any* of the following criteria in you MDC Submission. If not feasible to filter your discharge records based on the codes below, you may choose to submit the hospital's complete set of *inpatient* discharges; if so, MDC will apply this algorithm to your submission and discard all unnecessary records.

Mother Records: All inpatient discharge records meeting ANY of the following criteria

Outcome of Delivery

Z37.0	Single live birth
Z37.1	Single stillbirth
Z37.2	Twins, both liveborn
Z37.3	Twins, one liveborn and one stillborn
Z37.4	Twins, both stillborn
Z37.50-Z37.59	Other multiple birth, all liveborn
Z37.60-Z37.69	Other multiple birth, some liveborn
Z37.7	Other multiple birth, all stillborn
Z37.9	Outcome of delivery, unspecified

Delivery (Letter "O" codes)

O80	Encounter for full-term uncomplicated delivery
O82	Encounter for cesarean delivery without indication

Delivery Procedure Codes (Joint Commission Table Number 11.01.1)

10D00Z0	Extraction of Products of Conception, Classical, Open Approach
10D00Z1	Extraction of Products of Conception, Low Cervical, Open Approach
10D00Z2	Extraction of Products of Conception, Extraperitoneal, Open Approach
10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
10D07Z4	Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening
10D07Z5	Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening
10D07Z6	Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening
10D07Z7	Extraction of Products of Conception, Internal Version, Via Natural or Artificial Opening
10D07Z8	Extraction of Products of Conception, Other, Via Natural or Artificial Opening
10E0XZZ	Delivery of Products of Conception, External Approach

Infant Records: All inpatient discharge records meeting ANY of the following criteria

Admission Date – Date of Birth ≤ 2 days

Liveborn infants

Z38.00-Z38.01	Single liveborn infant, born in hospital
Z38.1	Single liveborn infant, born outside hospital
Z38.2	Single liveborn infant, unspecified as to place of birth
Z38.30-Z38.31	Twin liveborn infant, born in hospital
Z38.4	Twin liveborn infant, born outside hospital
Z38.5	Twin liveborn infant, unspecified as to place of birth
Z38.60-Z38.69	Other multiple, born in hospital
Z38.7	Other multiple, born outside hospital
Z38.8	Other multiple, unspecified as to place of birth

Attachment B1
Inpatient Discharge Data File Specifications: OSHPD PDD Format

OPTION 1: Standard OSHPD PDD File Format (Attachment B2 below presents specifications for the alternative CSV file format)

The format, definitions and coding for the MDC fields are almost identical to those used for OSHPD PDD data submissions, found at the OSHPD Website: MIRCal Guides

Because your hospital is already required to submit patient discharge data to OSHPD, we strongly recommend you utilize your existing programming for the OSHPD submission to create the MDC data submission if at all possible.

The modifications for MDC are:

1. The field Social Security Number (record position 599-607) MUST be replaced with null values. CMQCC strongly recommends replacing SSNs with the numeric string "123456789" which will help to ensure the correct character spacing in a fixed-with file format. For options on how to null out SSNs, see the User Guide **Removing SSNs from PDD File Submissions.**

2. The field Abstract Record Number (record position 617-628) must contain a medical record number or patient account number that will enable authorized hospital staff to conduct record look-ups. The number will be encrypted upon receipt by MDC server, but will be re-constituted to its true value by authorized hospital staff (who will have an MDC password associated with your hospital's private key).

Additional Notes

- Use the patient's discharge date to filter the records for each reporting period.
- Each submission will include one or more months' worth of discharge data and should represent the *entire* set of records for each month included in the submission.

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Attachment B2
Discharge Data File Specifications: CSV Format

OPTION 2: Use these specifications if submitting using the a CSV File Format (Attachment B1 above presents specifications for the standard OSHPD file format; CMQCC strongly recommends using existing code per the OSHPD format if at all possible.)

- CSV File Format with each case in a single row
- Column headers, as denoted below, must be used for all fields you are submitting. If the field is optional and you are choosing not to submit it, please omit the column header. Optional fields are highlighted in blue.
- If a column value is missing, leave no space between the commas (,,)
- Inpatient Discharges only.
- Use the patient's discharge date to filter the records for each reporting period (each submission will include one or more months' worth of data and should represent the entire set of records for each month included in the submission).
- The definitions and coding for these fields are exactly the same as those used for OSHPD PDD data submissions EXCEPT CSV file submissions will require ICD-9/ICD-10 codes to include decimal points: after the third digit for ICD-9 OR ICD-10 Diagnosis Codes of more than three digits; and after the second digit for ICD-9 Procedure Codes of more than two digits. If you have any questions about the mapping of specific fields, the personnel in charge of your facility's OSHPD PDD submission is likely the best resource.

Data Element	Definition	Column Header	Codes	Type
Type of Care *(Optional for MDC)*	Licensure of bed occupied by inpatient	type_care	1 = Acute Care 3 = Skilled Nursing/Intermediate Care 4 = Psychiatric Care 5 = Chemical Dependency Recovery Care 6 = Physical Rehabilitation Care	N
Facility ID Number	Unique 6-digit identifier assigned to each facility by OSHPD. First two digits indicate county in which facility located.	facility_id	**Allowable values**: 000000-999999 **Special Instructions**: This field is required for each record.	N
Date of Birth	Patient date of birth	date_of_birth	MMDDYYYY or CCYYMMDD Special Instructions: Single-digit months and days must include a preceding zero.	N
Sex	Gender of patient Note: OSHPD has changed the acceptable codes to UB format starting with 1/1/2017 discharges. The MDC will be able to accept either the original or the updated set of codes.	sex	Pre-2017 Code Set 1 = Male 2 = Female 3 = Other 4 = Unknown or 2017 & Onward Code Set M = Male F = Female U = Unknown	A/N

Data Element	Definition	Column Header	Codes	Type
Race-Ethnicity	Patient's self-reported ethnicity (Hispanic/Non-Hispanic)	ethnicity	1 = Hispanic 2 = Non-Hispanic 3 = Unknown	N
Race-Race	Patient's self-reported race	race	1 = White 2 = Black 3 = Native American/Eskimo/Aleut 4 = Asian/Pacific Islander 5 = Other 6 = Unknown	N
Zip Code	Patient zip code of residence	zip_code	5-digit ZIP Code XXXXX = Unknown YYYYY = Foreign ZZZZZ = Homeless	A/N
Admission Date	Date patient admitted for inpatient care	admitted_on	MMDDYYYY or CCYYMMDD Special Instructions: Single-digit months and days must include a preceding zero.	N
Source of Admission-Site	Site from which patient originated Note: OSHPD has changed the acceptable codes to UB format starting with 1/1/2017 discharges. The MDC will be able to accept either the original or the updated set of codes.	admit_site	Pre-2017 Code Set 1 = Home 2 = Residential Care Facility 3 = Ambulatory Surgery 4 = Skilled Nursing/Intermediate Care 5 = Acute (Inpatient) Hospital Care 6 = Other (Inpatient) Hospital Care 7 = Newborn 8 = Prison/Jail 9 = Other or 2017 & Onward Code Set ***Point of Origin for patients with Type of Admission other than "Newborn"*** 1 = Non-Health Care Facility Point of Origin 2 = Clinic or Physician's Office 4 = Transfer from a Hospital (Different Facility) 5 = Transfer from a SNF, ICF, or ALF 6 = Transfer from another Health Care Facility 8 = Court/Law Enforcement 9 = Information not Available 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 a Hospice Facility ***Point of Origin for patients with Type of Admission "Newborn"*** 5 = Born Inside this Hospital 6 = Born Outside of this Hospital	A/N
Source of Admission-Licensure of Site *Optional for MDC*	License of site from which patient admitted Per OSHPD reporting requirements, this field will not be used after 1/1/2017	admit_licensure	Pre-2017 Code Set 1 = This Hospital 2 = Another Hospital 3 = Not a Hospital or 2017 & Onward Code Set DO NOT USE	N

Data Element	Definition	Column Header	Codes	Type
Source of Admission-Route	Route by which patient admitted Note: OSHPD has changed the acceptable codes to UB format starting with 1/1/2017 discharges. The MDC will be able to accept either the original or the updated set of codes.	admit_route	Pre-2017 Code Set 1 = Your Emergency Room 2 = Not Your Emergency Room or 2017 & Onward Code Set 1 = Your Emergency Department 2 = Another Emergency Department 3 = Not admitted from an Emergency Department	N
Type of Admission	When patient's admission arranged Note: OSHPD has changed the acceptable codes to UB format starting with 1/1/2017 discharges. The MDC will be able to accept either the original or the updated set of codes.	admit_type	Pre-2017 Code Set 1 = Scheduled 2 = Unscheduled 3 = Infant, under 24 hrs old 4 = Unknown or 2017 & Onward Code Set 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information not available	N
Discharge Date	The date patient discharged from the hospital.	discharged_on	MMDDYYYY or CCYYMMDD Special Instructions: Single-digit months and days must include a preceding zero.	N
Principal Diagnosis	Condition established to be chief cause of admission	principal_diagnosis	ICD-9 or ICD-10 Code. Include periods after the third digit for all ICD-9 or ICD-10 diagnosis codes greater than three digits.	A/N
Present on Admission for Principal Diagnosis	The condition was present at time of admission	poa	Y = Yes N = No U = Unknown W = Clinically undetermined ,, (blank) = Code is exempt from POA reporting	A/N
Other Diagnoses and Present on Admission	1) Other conditions that coexist at time of admission, that develop during hospital stay or that affect treatment received or length of stay and 2) condition was present on admission	other_diagnosis_1, poa_1, other_diagnosis_2, poa_2, ….. to other_diagnosis_24, poa_24	ICD-9 or ICD-10 Code: Maximum of 24 other diagnosis fields and respective POA classification (Y, N, U, W, ‘’) for each diagnosis field. Include periods after the third digit for all ICD-9 or ICD-10 diagnosis codes greater than three digits.	
Principal Procedure Code	Procedure performed for definitive treatment	principal_procedure	ICD-9 or ICD-10 Code. Include periods after the second digit for all ICD-9 procedure codes greater than two digits.	A/N
Principal Procedure Date	Date on which principal procedure performed.	principal_procedure_date	MMDDYYYY or CCYYMMDD	N
Other Procedure Codes and Dates	All other procedures related to patient's stay (up to 20) and dates on which performed	other_procedure_1, other_procedure_1_date, ….. other_procedure_20, other_procedure_20_date	ICD-9 or ICD-10 Code and MMDDYYYY Date Format. Maximum of 20 additional procedures and their dates. Include periods after the second digit for ICD-9 procedure codes > 2 digits. Please use 40 columns regardless, using ,, format if no values in some columns	N

Data Element	Definition	Column Header	Codes	Type
Principal External Cause of Injury E-Code *(Optional for MDC)*	The external cause of injury that resulted in the most severe injury, poisoning or adverse effect related to the admission	principal_external_cause	ICD-9 or ICD-10 Code	
Present on Admission for Principal External Cause of Injury E-Code *(Optional for MDC)*	The condition was present at time of admission	principal_external_cause_poa	Y = Yes N = No U = Unknown W = Clinically undetermined ' ' (blank) = Exempt from POA reporting Special Instructions: When there is an exempt E-code, the value is a space.	
Other External Cause of Injury E-Code and Present on Admission *(Optional for MDC)*	Additional external cause of injury, poisoning or adverse effect	other_external_casue_1, ex_poa_1, other_external_cause_2, ex_poa_2, ……	Maximum of 4 other E-code fields and POA classification for each If submitting this field, please use 8 columns regardless, using ,, format if no values in some columns	
Patient Social Security Number	Patient SSN	ssn	OMIT THIS FIELD, EITHER BY OMMITTING THE COLUMN HEADER OR BY OMMITTING THE VALUE FOR EACH RECORD USING ,, FORMAT	
Disposition of Patient	Consequent arrangement/event ending patient stay. Note: OSHPD has changed the acceptable codes to UB format starting with 1/1/2015 discharges. The MDC will be able to accept either set of codes. When uploading data files after in the MDC system, you will be asked which Discharge Disposition coding your file includes: OSHPD (i.e. the pre-2015 California codes) vs. UB codes. The system will default to the "UB" codes until you formally select the OSHPD option.	disposition	OSHPD/Pre-2015 California Codes: 01 - Routine Discharge 02 - Acute Care within This Hospital 03 - Other Type of Hospital Care within this Hospital (Psych, Chem Dep, Physical Rehab) 04 - Skilled Nursing/Intermediate Care within This Hospital 05 - Acute Care at Another Hospital 06 - Other Type of Hospital Care at Another Hospital (Not Skilled Nursing/Intermediate Care) 07 - Skilled Nursing/Intermediate Care Elsewhere 08 - Residential Care Facility 09 - Prison/Jail 10 - Against Medical Advice 11 - Died 12 - Home Health Service 13 - Other UB Codes/2015 Onward Codes 01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to a short term general hospital for inpatient care 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care	N

Data Element	Definition	Column Header	Codes	Type
			04 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility) 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 20 Expired 21 Discharged/transferred to court/law enforcement 43 Discharged/transferred to a federal health care 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 care hospital (LTCH) 64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), 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) 69 Discharged/transferred to a designated Disaster Alternative Care Site 70 Discharged/transferred to another type of health care institution not defined elsewhere in this code 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 (includes Intermediate Care Facility) 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	

Data Element	Definition	Column Header	Codes	Type
			92 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal) but not certified under Medicare with a planned acute care hospital inpatient readmission 93 Discharged/transferred to a psychiatric hospital or a 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 00 Other Special Instructions: Single digit values must include a preceding zero.	
Total Charges *(Optional for MDC)*	Total charges for services rendered during length of stay	charges	Whole dollars only—no cents. Code 9999999 for Total Charges exceeding 7 positions. Special Instructions:. The default value is all zeros.	
Abstract Record Number REQUIRED for MDC	Unique code identifying a particular patient record within reporting facility	medical_record_number	Medical record number or any patient identification number assigned by the facility. Use a number that will enable authorized hospital staff to conduct record look-ups. The number will be encrypted upon receipt by MDC server, but will be re-constituted to its true value by authorized hospital staff (with MDC passwords tied to the hospital's private key).	A/N
DNR Order *(Optional for MDC)*	DNR order written within 24 hours of patient admission (Y/N)	dnr	Y = Yes N = No	
Expected Source of Payment-Payer Category	Type of entity/organization expected to pay greatest share of patient bill (e.g. Medi-Cal, Private)	expected_payer_category	01 - Medicare 02 - Medi-Cal 03 - Private Coverage 04 - Workers' Compensation 05 - County Indigent Programs 06 - Other Government 07 - Other Indigent 08 - Self Pay 09 - Other Payer Special Instructions: Single-digit codes must include a preceding zero.	N
Expected Source of Payment-Type of Coverage	Type of coverage (e.g.,HMO, non-HMO managed care, Traditional)	expected_payer_type	1 - Managed Care – Knox-Keene or Medi-Cal County Organized Health System 2 - Managed Care – Other 3 - Traditional Coverage Special Instructions: Type of Coverage MUST be reported if Payer Category equals 01, 02, 03, 04, 05, or 06. If Payer Category equals 07, 08, or 09, then the default value is zero.	N

Data Element	Definition	Column Header	Codes	Type
Expected Source of Payment-Plan Code Number	4-digit code number for plans licensed in CA	plan_code_number	4-digit code number for plans licensed in CA	N
National Provider ID *Optional for MDC*	CMS assigned code--optional	prov_id	Assigned by the CMS National Plan and Provider Enumeration System (NPPES) Special Instructions: This is a placeholder for the National Provider Identifier. Facilities may report their NPI, but it is not required. The default value is all zeroes.	
Principal Language Spoken	Free-text field: either 3-digit code value or up to 24 characters	principal_language_spoken	Free-text field: either 3-digit code value or up to 24 characters. Refer to Section 97234, of the California Inpatient Data Reporting Manual for a list of valid codes.	A/N
Hospital Campus Identifier *Optional for MDC*	Additional ID that distinguishes one hospital campus from another when two or more sites are licensed under the same OSHPD Facility ID number.	campus_identifier	Up to 3 digit internal code of hospital choice	A/N