



CARDIAC SURGERY SUPPLEMENTAL CLINICAL DATA REPORTING MANUAL

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Table of Contents

OVERVIEW	3
Options for Data Submission.....	3
Data File Format	4
Where to Send the Data	5
Cardiac Surgery Supplemental Clinical Data Collection Requirements	5
Discharges for which Supplemental Clinical Data is to be Submitted	5
Summary of Supplemental Clinical Data Elements.....	6
Data Collection Instructions and Source Documents	6
DATA FILE LAYOUT	13
DATA ELEMENT DESCRIPTIONS	19
VALIDATIONS AND EDITS	30
APPENDIX: Cardiac Surgery Supplemental Clinical Data Worksheet	31

OVERVIEW

Hospitals are required to submit supplemental clinical data as described throughout this manual for inpatient discharges of patients 18 years of age and older in which a coronary artery bypass graft (CABG) and/or heart valve surgery was performed. This data, along with the Pennsylvania Uniform Claims and Billing Form data (UB-04) and laboratory data submitted by hospitals, will be used to risk adjust cases for hospital and surgeon specific cardiac surgery reports.

Options for Data Submission

Hospitals are required to submit the supplemental clinical data in one of the two options described below.

1. Submit a data file according to the Data File Format and Data File Layout specifications described throughout this manual. The data file includes the following types of data elements:
 - Required Linking – UB-04 elements needed to properly link the supplemental clinical data, UB-04 data, and laboratory data for a particular CABG and/or valve surgery discharge.
 - Supplemental Clinical – Supplemental clinical data elements related to the *first* CABG and/or valve procedure during the admission.
 - Record Review – Data elements that indicate the hospital or surgeon is requesting a review of medical record documentation for preoperative acute renal failure, preoperative cardiogenic shock, and/or special request for exclusion.
 - UB-04 Data – Select UB-04 data elements. Preparing this file provides hospitals with an opportunity to verify select UB-04 data elements for their CABG and/or valve surgery cases. Therefore, some differences between the data submitted in a hospital's supplemental clinical data file and the data submitted in that hospital's UB-04 data file might be expected. This file format also provides hospitals the opportunity to submit additional ICD-10-CM/PCS¹ diagnosis and procedure codes beyond those included in the UB-04 data submission, up to a total of 25 diagnosis and 25 procedure codes.

OR

¹ ICD-10-CM/PCS: International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System

2. Use the web-based tool provided by PHC4 to manually enter the supplemental clinical data and the record review indicators. This tool also provides hospitals the opportunity to submit additional ICD-10-CM/PCS diagnosis and procedure codes beyond those included in the hospitals' UB-04 data submission. The data elements in the web-based tool are exactly the same as those listed in the Data File Layout referred to above.

Once the UB-04 data has been submitted to PHC4, hospitals can extract the "Required Linking" and "UB-04 Data" data elements from the UB-04 data into the web-based tool using the Cardiac Surgery Data Administration tool. The option to "Extract all cardiac surgery data from billing data" is displayed at the bottom of the Main Page. This will extract all of the records in your hospital's UB-04 data with a CABG and/or valve procedure code for patients 18 years of age and older. Hospitals can then complete the manual data entry (as described in this manual) and begin review and attestation of the cardiac surgery data (as described in the *Guide for Review and Attestation of Cardiac Surgery Data* available at <http://www.phc4.org/dept/dc/dcmanuals.htm>).

For both data submission options, once the data submission is complete hospitals will: 1) confirm the accuracy of the data, 2) verify surgeon assignment, and 3) obtain hospital and surgeon attestation.

Data File Format

- The data file format is a fixed-width delimited flat text file.
- Each line of the text file must contain a single record.
- Each record must be 740 characters long, with a carriage return-line feed after each record.
- Standard text characters with ASCII values between 32 and 126 are accepted.
- Characters not accepted:
 - ASCII values 31 or less (pagination characters such as but not limited to tabs or page breaks)
 - ASCII values 127 and higher (characters such as non-Latin characters such as Greek or Cyrillic letters - α , β , \ae , Φ , etc., and letters with accent marks such as tildes, umlauts, graves, etc. - \a , \o , \e , \n , etc.)
- The text file may be compressed into a zip file prior to sending.

Where to Send the Data

- For both data submission options, the UB-04 data file must be submitted prior to submitting the cardiac surgery data. The cardiac surgery data must be submitted using PHC4's secure portal at <https://www.phc4submit.org> according to the quarterly inpatient billing (UB-04) and laboratory data collection submission timeframes.
- Schedules for data reporting and review and attestation of the cardiac surgery data are located on PHC4's website at <http://www.phc4.org>.

Cardiac Surgery Supplemental Clinical Data Collection Requirements

Discharges for which Supplemental Clinical Data is to be Submitted

Hospitals are required to submit supplemental clinical data elements for CABG and/or heart valve surgery discharges of patients 18 years of age and older as identified by the presence of one or more CABG or valve ICD-10-PCS procedure codes in the principal and/or secondary procedure positions. The CABG and valve procedure codes can be downloaded here:

<http://www.phc4.org/dept/dc/docs/CardiacSurgeryDataStudyPopulationDefinition.xlsx>

Summary of Supplemental Clinical Data Elements

Provide the following clinical data elements for the **first** CABG and/or valve procedure from anytime during the admission.

- Anesthesia Start Date and Anesthesia Start Time
- American Society of Anesthesiologists (ASA) Class
- ASA Emergency Indicator
- Coronary Artery Disease (CAD)
 - Circumflex
 - Circumflex Branch
 - Left Anterior Descending (LAD)
 - Left Anterior Descending (LAD) Branch
 - Left Main
 - Right Coronary Artery (RCA)
 - Right Coronary Artery (RCA) Branch
- Ejection Fraction

Data Collection Instructions and Source Documents

Anesthesia Start Date, Anesthesia Start Time, ASA Class, and ASA Emergency Indicator

Anesthesia Start Date and Anesthesia Start Time should be provided for the **first** CABG and/or valve procedure from anytime during the admission. Use the date and time anesthesia was started. These data elements should be available for every discharge with a CABG and/or valve procedure.

ASA Class is the classification of physical status developed by the American Society of Anesthesiologists based on the presence and severity of disease for the patient. This data element should be available for every discharge with a CABG and/or valve procedure.

Descriptions of the ASA class are as follows:

ASA Physical Status 1 - A normal healthy patient.

ASA Physical Status 2 - A patient with mild systemic disease.

ASA Physical Status 3 - A patient with severe systemic disease.

ASA Physical Status 4 - A patient with severe systemic disease that is a constant threat to life.

ASA Physical Status 5 - A moribund patient who is not expected to survive without the operation.

ASA Physical Status 6 - A declared brain-dead patient whose organs are being removed for donor purposes.

ASA Emergency Indicator is assigned by the anesthesiologist to indicate the surgery is an emergency. An "E" is documented following the anesthesia class on the anesthesia record or pre-anesthesia evaluation sheet. If the first CABG and/or valve surgery was performed as an

emergency then a “Y” indicating “Yes” should be entered in this field. If the surgery was not an emergency, then an “N” indicating “No” should be entered.

Source documents for these anesthesia-related supplemental clinical data elements include the anesthesia record and/or pre-anesthesia evaluation.

Coronary Artery Disease

Provide the results of coronary artery disease (CAD) documented prior to the Anesthesia Start Date and Anesthesia Start Time for the **first** surgical episode with a CABG and/or valve surgery. If there are multiple reports from different days, use the report that is dated closest to the date of surgery. The CAD data may be collected from source documents dated within 180 days prior to admission. When the heart catheterization was performed prior to admission or prior to transfer to your hospital, attempts should be made to obtain the report. If no report is available, refer to Source Documents for additional options. Collect the highest percent CAD stenosis documented for each major coronary artery and each branch.

The goal is to capture CAD from the time the patient is admitted up to the first CABG and/or valve surgery. That is, when a patient is admitted and undergoes a cardiac catheterization and/or percutaneous coronary intervention (angioplasty, atherectomy, stent insertion) the documented CAD should be collected. If a percutaneous coronary intervention is performed prior to admission the CAD in the treated coronary artery/branch should be considered removed and should not be collected.

Example:

A patient had a heart catheterization and stent insertion one month prior to admission and the 80% stenosis in the RCA was reduced to 0%. You should consider the area of stenosis removed/corrected.

Enter: CAD – Right Coronary Artery (RCA) – 0%.

Example:

A patient was admitted to the hospital and underwent an emergency heart catheterization. An area of 80% stenosis in the RCA was found and a stent was inserted reducing the stenosis to 0%. The patient required CABG surgery later in the admission. You should consider the stenosis a patient risk factor for this admission and collect the area of stenosis prior to the stent insertion.

Enter: CAD – Right Coronary Artery (RCA) – 80%.

Example:

A patient had a heart catheterization and stent insertion one month prior to admission and the 80% stenosis in the RCA was reduced to 0%. The patient was admitted to the hospital and underwent another heart catheterization that showed 85% restenosis in the RCA at the previous stent insertion site. The patient required CABG surgery later in the

admission. You should consider the area of restenosis a patient risk factor for this admission and collect the area of restenosis.

Enter: CAD – Right Coronary Artery (RCA) – 85%.

If the CAD does not have a percent of stenosis documented but rather a qualitative description consult with the cardiology department in your facility to determine the percent stenosis equivalent.

Example:

A cardiac catheterization report states “there is high-grade stenosis of the left anterior descending artery.”

Action: Contact your cardiology department.

If the qualitative description is equivalent to a total occlusion enter 100.

Example:

On a cardiac catheterization report there is documentation of a “complete block” of the RCA.

Enter: 100 in CAD – Right Coronary Artery (RCA) field.

If both a percent (%) value and a qualitative description are present, submit only the percent (%) value.

Example:

The heart catheterization report states “severe 95% CAD in the LAD.” You do not have to determine what percent “severe” indicates because a percent is stated.

Enter: 95 in CAD – Left Anterior Descending (LAD) field.

If there is no documented stenosis in any coronary artery and/or artery branch the corresponding CAD fields associated with these vessels should be left blank. Acceptable values are 0-100 or blank if the coronary artery and/or artery branch is not mentioned in any of the applicable source documents or no report is available. Collect numerical values (1-100 percent) for documented stenosis of a coronary artery and/or artery branch and when a vessel is noted to be stenosis-free (0 percent).

Example:

The heart catheterization report states “there is left main stenosis of 20%, LAD shows an area of 80%, and RCA is patent with no areas of stenosis.” There are no other vessels mentioned in the report.

Enter: 20 in CAD – Left Main, 80 in CAD – Left Anterior Descending (LAD) and 0 in CAD – Right Coronary Artery (RCA) fields. All other CAD fields should be left blank.

If a coronary artery or artery branch is bypassed, collect the highest percent stenosis stated for the native vessel. Do not enter the percent stenosis noted in the bypass graft.

Example:

The heart catheterization report states “there is 90% CAD in the native LAD and the bypass graft of the LAD shows 40% stenosis.”

Enter: 90 in CAD – Left Anterior Descending (LAD) field.

When a heart catheterization report describes stenosis at the origin of a branch, use the wording to determine whether to collect it as CAD in a coronary artery or CAD in an artery branch.

Examples:

The heart catheterization report states “60% stenosis of the right coronary artery at the origin of the posterior descending artery.” In this example, the stenosis is actually in the right coronary artery, not the branch. The phrase “origin of the posterior descending artery” describes where the stenosis is located in the right coronary artery.

Enter: 60 in CAD – Right Coronary Artery (RCA) field.

The heart catheterization report states “The first diagonal branch shows a 60% stenosis at its origin.” In this example, the stenosis is actually in the branch, not in the left anterior descending. “At its origin” describes the location of the stenosis in the branch.

Enter: 60 in CAD – Left Anterior Descending (LAD) Branch field.

Refer to Table 2 to identify the location of common coronary artery branches. If there is a branch identified, but not listed in Table 2, contact the cardiology department in your facility to determine the appropriate location of the coronary artery branch.

Table 2: Common Branches of the Coronary Arteries

Major Coronary Artery	Common Branches
Circumflex	Atrioventricular branch Lateral branch Obtuse marginal Posterolateral branch Ramus intermedius
Left anterior descending	Diagonal branch Perforating branch Septal branch
Right coronary artery	Atrioventricular nodal branch Conus arteriosus branch Marginal branch Posterior interventricular branch Posterior descending artery

Example of terms used to identify coronary artery disease would include attenuation, block, CAD, clot, disease-(specific vessel), lesion, narrowing, obstruction, occlusion, plaque, stenosis, stricture, taper, thrombosis, and thrombus.

Source Documents – any operative note/report, diagnostic imaging report, radiology report, transfer summary, physician consult, physician progress note or History & Physical. However, do not use the narrative from the transfer summary, physician consult, physician progress note or History & Physical in place of the actual report if it is available. Reports should be written or dictated by a physician or other healthcare provider such as fellow, resident, medical student, physician assistant, nurse practitioner or nurse anesthetist.

The entire document should be used to collect data elements, including the body of the report and the impression, except for the sections labeled indications, plans or recommendations. If both a preliminary and a final report are available for the same test, use the final report.

Ejection Fraction

Provide the results documented prior to the Anesthesia Start Date and Anesthesia Start Time for the **first** surgical episode with a CABG and/or valve surgery. If there are multiple reports from different days, use the report that is dated closest to the date of surgery. The ejection fraction (EF) data may be collected from source documents dated within 180 days prior to admission. When the ejection fraction was measured prior to admission or prior to transfer to your hospital, attempts should be made to obtain the report. If no report is available, refer to Source Documents for additional options.

If both an EF percent (%) and an EF qualitative description are present on the report closest to the Anesthesia Start Date and Time for the first surgical episode with a CABG and/or valve surgery, submit only the EF percent (%).

If only one of the EF percent (%) or EF qualitative description values are present on the report closest to the first surgical episode, submit only that value and do not review any older documentation for the other value.

Examples:

An echocardiogram is found to be the report closest to the Anesthesia Start Date and Time for the first CABG and/or valve surgery and the report states “there is severely reduced left ventricular systolic function with an EF-20%.”

Enter: 20 in Ejection Fraction – Percent field. Do not enter anything into Ejection Fraction – Qualitative field.

Echocardiogram report from July 13th states “EF-20%” and a heart catheterization report from July 12th states “there is severely reduced left ventricular systolic function.” The first CABG and/or valve surgery was performed July 15th.

Enter: 20 in Ejection Fraction – Percent field. Do not enter anything into Ejection Fraction – Qualitative field.

Heart catheterization report from July 19th states “there is a moderate reduction in the left ventricular systolic function” and an earlier echocardiogram dated on May 22nd states “Ejection fraction-50%.” The first CABG and/or valve surgery was performed July 21st.

Enter: MO in Ejection Fraction – Qualitative field. Do not enter anything into Ejection Fraction – Percent field.

Ejection Fraction – Percent: If more than one EF percent is stated on the same report and one value is called global or overall, submit the global or overall value. If none of the values are referred to as global or overall, submit the lowest value.

Examples:

Echocardiogram report: “EFs are measured in segments: 37%, 41%, 52%. Global EF 44%.”

Enter: 44 in Ejection Fraction – Percent field.

Echocardiogram report: “EF is visually estimated at 45%, M-mode EF is 39%.” Neither ejection fraction value is referred to as global or overall.

Enter: 39 in Ejection Fraction – Percent field.

Ejection Fraction – Qualitative: if more than one qualitative description is stated, submit the worst value. Table 3 lists the qualitative terms.

Table 3: Qualitative Terms Used to Describe Ejection Fraction

Qualitative Terms	Submit This Value
Normal	NL
Mild or Unqualified	MI
Mild-Moderate	MM
Moderate	MO
Moderate-Severe	MS
Severe	SE

Example:

The body of an echocardiogram report states “ventricular function is moderately reduced.” The impression section of the report, states “severely reduced systolic function.”

Enter: SE in Ejection Fraction – Qualitative field.

If there is indication of a decreased EF but no qualitative wording or percent value is present, enter MI for Mild or Unqualified.

Example:

An echocardiogram report states “decreased ejection fraction.”

Enter: MI in Ejection Fraction – Qualitative field.

Examples of terms used to identify ejection fraction would include EF, LVEF, systolic (ventricular) function, and systolic (ventricular) performance.

Source Documents – any operative note/report, diagnostic imaging report, radiology report, transfer summary, physician consult, physician progress note or History & Physical. However, do not use the narrative from the transfer summary, physician consult, physician progress note or History & Physical in place of the actual report if it is available. Reports should be written or dictated by a physician or other healthcare provider such as fellow, resident, medical student, physician assistant, nurse practitioner or nurse anesthetist.

The entire document should be used to collect data elements including the body of the report and the impression except for the sections labeled indications, plans or recommendations. If both a preliminary and a final report are available for the same test, use the final report.

Laboratory Data and Risk Adjustment

The intention for risk adjustment is to continue using the laboratory test results from specimens collected prior to anesthesia start time and within the laboratory test collection timeframe that is specified in the *Laboratory Data Reporting Manual* (p.4).

These results will be identified by comparing the “Anesthesia Start Date” and “Anesthesia Start Time” submitted in the supplemental clinical data with the “Date Specimen Collected” and “Time Specimen Collected” submitted in the laboratory data.

As such, when laboratory test results within the admission timeframe are available for both prior to and after the anesthesia start time for the first CABG and/or valve surgery, we strongly suggest that hospitals submit laboratory results collected prior to the anesthesia start time. Having these results will help to fully capture the patient’s clinical condition (or risk) at the time of admission and prior to surgery.

Examples:

A patient is admitted at 4:00 pm and has a CABG procedure performed at 7:00 pm (start time of anesthesia).

Action: Review laboratory test results from Day 1 up to 7:00 pm.

A patient is admitted at 9:00 pm on Day 1 and has a CABG procedure performed on Day 2 at 8:00 am (start time of anesthesia).

Action: Review laboratory test results from Day 1 and Day 2 up to 8:00 am.

A patient is admitted at 4:00 pm and has a CABG procedure performed on Day 5.

Action: Review laboratory test results from Day 1.

Note that laboratory values can be reviewed and updated, if applicable, using PHC4’s Laboratory Data Administration tool.

DATA FILE LAYOUT

	Data Element Name	From	To	Data Type / Length	Formatting Notes
Required Linking	Patient Control Number	1	24	X(24)	Left-justify; unable to edit after submission
	Medical/Health Record Number	25	48	X(24)	Left-justify; unable to edit after submission
	Admission/Start of Care Date	49	54	9(6)	MMDDYY
	Statement Covers Period – Through	55	60	9(6)	MMDDYY
Supplemental Clinical	Anesthesia Start Date	61	66	9(6)	MMDDYY
	Anesthesia Start Time	67	70	9(4)	HHMM (24 hour format)
	ASA Class	71	71	9(1)	See this manual for codes
	ASA Emergency Indicator	72	72	X(1)	Y=Yes; N=No
	CAD – Circumflex	73	75	9(3)	Left-justify
	CAD – Circumflex Branch	76	78	9(3)	Left-justify
	CAD – Left Anterior Descending (LAD)	79	81	9(3)	Left-justify
	CAD – Left Anterior Descending (LAD) Branch	82	84	9(3)	Left-justify
	CAD – Left Main	85	87	9(3)	Left-justify
	CAD – Right Coronary Artery (RCA)	88	90	9(3)	Left-justify
	CAD – Right Coronary Artery (RCA) Branch	91	93	9(3)	Left-justify
	Ejection Fraction – Percent	94	95	9(2)	Left-justify
	Ejection Fraction – Qualitative	96	97	X(2)	See this manual for codes
	Record Review	Record Review Request – Preoperative Acute Renal Failure	98	98	X(1)
Record Review Request – Preoperative Cardiogenic Shock		99	99	X(1)	Y=Yes; N=No
Record Review Request – Special Request for Exclusion		100	100	X(1)	Y=Yes; N=No
UB-04 Data	Statement Covers Period – From	101	106	9(6)	MMDDYY
	Patient Sex	107	107	X(1)	M=Male; F=Female; U=Unknown
	Patient Hispanic/Latino Origin or Descent	108	108	X(1)	See UB-04 manual for codes
	Patient Race	109	109	X(1)	See UB-04 manual for codes
	Patient Birth Date	110	117	9(8)	MMDDYYYY
	Patient Zip Code	118	126	X(9)	Left-justify; XXXXXYYYY; if the +4 extension is unknown, leave the last four digits blank.
Patient Discharge Status	127	128	9(2)	See UB-04 manual for codes	

	Data Element Name	From	To	Data Type / Length	Formatting Notes
UB-04 Data (continued)	Total Charges	129	138	9(10)	Right-justify
	Prospective Payment System (PPS) Code – Hospital DRG	139	142	9(4)	Right-justify
	Health Plan Identification Number (NAIC)	143	157	X(15)	Left-justify
	Payer Type and Name	158	182	X(25)	Left-justify; See UB-04 manual for codes
	Principal Diagnosis Code	183	189	X(7)	Left-justify
	Principal Diagnosis Code Present on Admission (POA) Indicator	190	190	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 1 (Secondary Diagnosis Code 1)	191	197	X(7)	Left-justify
	Other Diagnosis Code 1 (Secondary Diagnosis Code 1) Present on Admission (POA) Indicator	198	198	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 2 (Secondary Diagnosis Code 2)	199	205	X(7)	Left-justify
	Other Diagnosis Code 2 (Secondary Diagnosis Code 2) Present on Admission (POA) Indicator	206	206	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 3 (Secondary Diagnosis Code 3)	207	213	X(7)	Left-justify
	Other Diagnosis Code 3 (Secondary Diagnosis Code 3) Present on Admission (POA) Indicator	214	214	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 4 (Secondary Diagnosis Code 4)	215	221	X(7)	Left-justify
	Other Diagnosis Code 4 (Secondary Diagnosis Code 4) Present on Admission (POA) Indicator	222	222	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 5 (Secondary Diagnosis Code 5)	223	229	X(7)	Left-justify
	Other Diagnosis Code 5 (Secondary Diagnosis Code 5) Present on Admission (POA) Indicator	230	230	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 6 (Secondary Diagnosis Code 6)	231	237	X(7)	Left-justify
	Other Diagnosis Code 6 (Secondary Diagnosis Code 6) Present on Admission (POA) Indicator	238	238	X(1)	See UB-04 manual for codes

	Data Element Name	From	To	Data Type / Length	Formatting Notes
UB-04 Data (continued)	Other Diagnosis Code 7 (Secondary Diagnosis Code 7)	239	245	X(7)	Left-justify
	Other Diagnosis Code 7 (Secondary Diagnosis Code 7) Present on Admission (POA) Indicator	246	246	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 8 (Secondary Diagnosis Code 8)	247	253	X(7)	Left-justify
	Other Diagnosis Code 8 (Secondary Diagnosis Code 8) Present on Admission (POA) Indicator	254	254	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 9 (Secondary Diagnosis Code 9)	255	261	X(7)	Left-justify
	Other Diagnosis Code 9 (Secondary Diagnosis Code 9) Present on Admission (POA) Indicator	262	262	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 10 (Secondary Diagnosis Code 10)	263	269	X(7)	Left-justify
	Other Diagnosis Code 10 (Secondary Diagnosis Code 10) Present on Admission (POA) Indicator	270	270	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 11 (Secondary Diagnosis Code 11)	271	277	X(7)	Left-justify
	Other Diagnosis Code 11 (Secondary Diagnosis Code 11) Present on Admission (POA) Indicator	278	278	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 12 (Secondary Diagnosis Code 12)	279	285	X(7)	Left-justify
	Other Diagnosis Code 12 (Secondary Diagnosis Code 12) Present on Admission (POA) Indicator	286	286	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 13 (Secondary Diagnosis Code 13)	287	293	X(7)	Left-justify
	Other Diagnosis Code 13 (Secondary Diagnosis Code 13) Present on Admission (POA) Indicator	294	294	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 14 (Secondary Diagnosis Code 14)	295	301	X(7)	Left-justify
	Other Diagnosis Code 14 (Secondary Diagnosis Code 14) Present on Admission (POA) Indicator	302	302	X(1)	See UB-04 manual for codes

	Data Element Name	From	To	Data Type / Length	Formatting Notes
UB-04 Data (continued)	Other Diagnosis Code 15 (Secondary Diagnosis Code 15)	303	309	X(7)	Left-justify
	Other Diagnosis Code 15 (Secondary Diagnosis Code 15) Present on Admission (POA) Indicator	310	310	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 16 (Secondary Diagnosis Code 16)	311	317	X(7)	Left-justify
	Other Diagnosis Code 16 (Secondary Diagnosis Code 16) Present on Admission (POA) Indicator	318	318	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 17 (Secondary Diagnosis Code 17)	319	325	X(7)	Left-justify
	Other Diagnosis Code 17 (Secondary Diagnosis Code 17) Present on Admission (POA) Indicator	326	326	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 18 (Secondary Diagnosis Code 18)	327	333	X(7)	Left-justify
	Other Diagnosis Code 18 (Secondary Diagnosis Code 18) Present on Admission (POA) Indicator	334	334	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 19 (Secondary Diagnosis Code 19)	335	341	X(7)	Left-justify
	Other Diagnosis Code 19 (Secondary Diagnosis Code 19) Present on Admission (POA) Indicator	342	342	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 20 (Secondary Diagnosis Code 20)	343	349	X(7)	Left-justify
	Other Diagnosis Code 20 (Secondary Diagnosis Code 20) Present on Admission (POA) Indicator	350	350	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 21 (Secondary Diagnosis Code 21)	351	357	X(7)	Left-justify
	Other Diagnosis Code 21 (Secondary Diagnosis Code 21) Present on Admission (POA) Indicator	358	358	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 22 (Secondary Diagnosis Code 22)	359	365	X(7)	Left-justify
	Other Diagnosis Code 22 (Secondary Diagnosis Code 22) Present on Admission (POA) Indicator	366	366	X(1)	See UB-04 manual for codes

	Data Element Name	From	To	Data Type / Length	Formatting Notes
UB-04 Data (continued)	Other Diagnosis Code 23 (Secondary Diagnosis Code 23)	367	373	X(7)	Left-justify
	Other Diagnosis Code 23 (Secondary Diagnosis Code 23) Present on Admission (POA) Indicator	374	374	X(1)	See UB-04 manual for codes
	Other Diagnosis Code 24 (Secondary Diagnosis Code 24)	375	381	X(7)	Left-justify
	Other Diagnosis Code 24 (Secondary Diagnosis Code 24) Present on Admission (POA) Indicator	382	382	X(1)	See UB-04 manual for codes
	External Cause of Injury (ECI) Code 1	383	389	X(7)	Left-justify
	External Cause of Injury (ECI) Code 1 Present on Admission (POA) Indicator	390	390	X(1)	See UB-04 manual for codes
	External Cause of Injury (ECI) Code 2	391	397	X(7)	Left-justify
	External Cause of Injury (ECI) Code 2 Present on Admission (POA) Indicator	398	398	X(1)	See UB-04 manual for codes
	External Cause of Injury (ECI) Code 3	399	405	X(7)	Left-justify
	External Cause of Injury (ECI) Code 3 Present on Admission (POA) Indicator	406	406	X(1)	See UB-04 manual for codes
	Principal Procedure Code	407	413	X(7)	Left-justify
	Principal Procedure Date	414	419	9(6)	MMDDYY
	Other Procedure Code 1	420	426	X(7)	Left-justify
	Other Procedure Date 1	427	432	9(6)	MMDDYY
	Other Procedure Code 2	433	439	X(7)	Left-justify
	Other Procedure Date 2	440	445	9(6)	MMDDYY
	Other Procedure Code 3	446	452	X(7)	Left-justify
	Other Procedure Date 3	453	458	9(6)	MMDDYY
	Other Procedure Code 4	459	465	X(7)	Left-justify
	Other Procedure Date 4	466	471	9(6)	MMDDYY
	Other Procedure Code 5	472	478	X(7)	Left-justify
	Other Procedure Date 5	479	484	9(6)	MMDDYY
	Other Procedure Code 6	485	491	X(7)	Left-justify
	Other Procedure Date 6	492	497	9(6)	MMDDYY
	Other Procedure Code 7	498	504	X(7)	Left-justify
	Other Procedure Date 7	505	510	9(6)	MMDDYY
	Other Procedure Code 8	511	517	X(7)	Left-justify
	Other Procedure Date 8	518	523	9(6)	MMDDYY
	Other Procedure Code 9	524	530	X(7)	Left-justify
	Other Procedure Date 9	531	536	9(6)	MMDDYY
	Other Procedure Code 10	537	543	X(7)	Left-justify
	Other Procedure Date 10	544	549	9(6)	MMDDYY

	Data Element Name	From	To	Data Type / Length	Formatting Notes
UB-04 Data (continued)	Other Procedure Code 11	550	556	X(7)	Left-justify
	Other Procedure Date 11	557	562	9(6)	MMDDYY
	Other Procedure Code 12	563	569	X(7)	Left-justify
	Other Procedure Date 12	570	575	9(6)	MMDDYY
	Other Procedure Code 13	576	582	X(7)	Left-justify
	Other Procedure Date 13	583	588	9(6)	MMDDYY
	Other Procedure Code 14	589	595	X(7)	Left-justify
	Other Procedure Date 14	596	601	9(6)	MMDDYY
	Other Procedure Code 15	602	608	X(7)	Left-justify
	Other Procedure Date 15	609	614	9(6)	MMDDYY
	Other Procedure Code 16	615	621	X(7)	Left-justify
	Other Procedure Date 16	622	627	9(6)	MMDDYY
	Other Procedure Code 17	628	634	X(7)	Left-justify
	Other Procedure Date 17	635	640	9(6)	MMDDYY
	Other Procedure Code 18	641	647	X(7)	Left-justify
	Other Procedure Date 18	648	653	9(6)	MMDDYY
	Other Procedure Code 19	654	660	X(7)	Left-justify
	Other Procedure Date 19	661	666	9(6)	MMDDYY
	Other Procedure Code 20	667	673	X(7)	Left-justify
	Other Procedure Date 20	674	679	9(6)	MMDDYY
	Other Procedure Code 21	680	686	X(7)	Left-justify
	Other Procedure Date 21	687	692	9(6)	MMDDYY
	Other Procedure Code 22	693	699	X(7)	Left-justify
	Other Procedure Date 22	700	705	9(6)	MMDDYY
	Other Procedure Code 23	706	712	X(7)	Left-justify
	Other Procedure Date 23	713	718	9(6)	MMDDYY
	Other Procedure Code 24	719	725	X(7)	Left-justify
	Other Procedure Date 24	726	731	9(6)	MMDDYY
Operating Physician – Secondary Identifier (State License Number)	732	740	X(9)	Left-justify	

DATA ELEMENT DESCRIPTIONS

Patient Control Number	
Definition	Patient's unique number assigned by the provider to facilitate retrieval of the individual's account of services (accounts receivable) containing the financial billing records and any postings of payment.
Length and Type	24 character field; Alphanumeric; Left-justified
Record Location	1-24
Note	Links to the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Medical/Health Record Number	
Definition	The number assigned to the patient's medical/health record by the provider.
Length and Type	24 character field; Alphanumeric; Left-justified
Record Location	25-48
Note	Links to the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Admission/Start of Care Date	
Definition	For inpatient services, this is the date of admission.
Length and Type	6 character field; Numeric
Format	MMDDYY
Record Location	49-54
Note	Links to the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Statement Covers Period - Through	
Definition	The ending service date of the period included on the bill.
Length and Type	6 character field; Numeric
Format	MMDDYY
Record Location	55-60
Note	Links to the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Anesthesia Start Date	
Definition	The date anesthesia was started for the <i>first</i> CABG and/or valve surgery.
Length and Type	6 character field; Numeric
Format	MMDDYY
Record Location	61-66
Note	See web link on page 5 to identify cases to submit this data element. This information should be available for all CABG and/or valve surgery cases.

Anesthesia Start Time	
Definition	The time anesthesia was started for the first CABG and/or valve surgery.
Length and Type	4 character field; Numeric
Format	HHMM
Record Location	67-70
Note	See web link on page 5 to identify cases to submit this data element. This information should be available for all CABG and/or valve surgery cases. Enter as military time (HHMM). For example, 1:23 p.m. should be submitted as 1323. Use leading zeros when the time is less than 1000. For example, enter 0730 for 7:30 a.m.

ASA Class	
Definition	The ASA Class for the first CABG and/or valve surgery.
Length and Type	1 character field; Numeric
Record Location	71
Note	See web link on page 5 to identify cases to submit this data element. This information should be available for all CABG and/or valve surgery cases. This indicator can be obtained from the anesthesia record or the pre-anesthesia evaluation sheet. Enter the ASA Physical Status class as assigned by the anesthesiologist. Acceptable values are as follows: <ul style="list-style-type: none"> • 1 = A normal healthy patient. • 2 = A patient with mild systemic disease. • 3 = A patient with severe systemic disease. • 4 = A patient with severe systemic disease that is a constant threat to life. • 5 = A moribund patient who is not expected to survive without the operation. • 6 = A declared brain-dead patient whose organs are being removed for donor purposes.

ASA Emergency Indicator	
Definition	The “E” emergency indicator associated with ASA Class for the first CABG and/or valve surgery.
Length and Type	1 character field; Alphanumeric
Record Location	72
Note	See web link on page 5 to identify cases to submit this data element. The indicator to identify an emergent (E) case can be obtained from the anesthesia record or the pre-anesthesia evaluation sheet. It is documented with the anesthesia class. Acceptable values are as follows: <ul style="list-style-type: none"> • Y = Yes • N = No

CAD - Circumflex	
Definition	The percentage of stenosis specifically in the native circumflex artery.
Length and Type	3 character field; Numeric; Left-justified
Record Location	73-75
Note	<p>See web link on page 5 to identify cases to submit this data element. Acceptable values are 0-100 or blank if the circumflex artery is not mentioned in any of the applicable source documents or no report is available.</p> <p>Do not include percent (%) sign in reporting field.</p> <p>Do not include stenosis in a circumflex branch in this field.</p> <p>If more than one value available from the same report, submit the highest value.</p>

CAD – Circumflex Branch	
Definition	The percentage of stenosis specifically in a branch of the circumflex artery.
Length and Type	3 character field; Numeric; Left-justified
Record Location	76-78
Note	<p>See web link on page 5 to identify cases to submit this data element. Acceptable values are 0-100 or blank if the circumflex branch is not mentioned in any of the applicable source documents or no report is available.</p> <p>Do not include percent (%) sign in reporting field.</p> <p>Do not include stenosis in the native circumflex artery in this field.</p> <p>If more than one value available from the same report, submit the highest value.</p>

CAD – Left Anterior Descending (LAD)	
Definition	The percentage of stenosis specifically in the native LAD artery.
Length and Type	3 character field; Numeric; Left-justified
Record Location	79-81
Note	<p>See web link on page 5 to identify cases to submit this data element. Acceptable values are 0-100 or blank if the LAD is not mentioned in any of the applicable source documents or no report is available.</p> <p>Do not include stenosis in a LAD branch in this field.</p> <p>Do not include percent (%) sign in reporting field.</p> <p>If more than one value available from the same report, submit the highest value.</p>

CAD - Left Anterior Descending (LAD) Branch	
Definition	The percentage of stenosis specifically in a branch of the LAD artery.
Length and Type	3 character field; Numeric; Left-justified
Record Location	82-84
Note	See web link on page 5 to identify cases to submit this data element. Acceptable values are 0-100 or blank if the LAD branch is not mentioned in any of the applicable source documents or no report is available. Do not include percent (%) sign in reporting field. Do not include stenosis in the native LAD in this field. If more than one value available from the same report, submit the highest value.

CAD - Left Main	
Definition	The percentage of stenosis specifically in the left main artery.
Length and Type	3 character field; Numeric; Left-justified
Record Location	85-87
Note	See web link on page 5 to identify cases to submit this data element. Acceptable values are 0-100 or blank if the left main artery is not mentioned in any of the applicable source documents or no report is available. Do not include percent (%) sign in reporting field. If more than one value available from the same report, submit the highest value.

CAD – Right Coronary Artery (RCA)	
Definition	The percentage of stenosis specifically in the native right coronary artery.
Length and Type	3 character field; Numeric; Left-justified
Record Location	88-90
Note	See web link on page 5 to identify cases to submit this data element. Acceptable values are 0-100 or blank if the RCA is not mentioned in any of the applicable source documents or no report is available. Do not include percent (%) sign in reporting field. Do not include stenosis in a right coronary artery branch in this field. If more than one value available from the same report, submit the highest value.

CAD - Right Coronary Artery (RCA) Branch	
Definition	The percentage of stenosis specifically in a branch of the right coronary artery.
Length and Type	3 character field; Numeric; Left-justified
Record Location	91-93
Note	See web link on page 5 to identify cases to submit this data element. Acceptable values are 0-100 or blank if the RCA branch is not mentioned in any of the applicable source documents or no report is available. Do not include percent (%) sign in reporting field. Do not include stenosis in the native right coronary artery in this field. If more than one value available from the same report, submit the highest value.

Ejection Fraction – Percent	
Definition	A measurement of how much blood is pumped out of the heart with each contraction (heartbeat).
Length and Type	2 character field; Numeric; Left-justified
Record Location	94-95
Note	See web link on page 5 to identify cases to submit this data element. Do not include percent (%) sign in reporting field. Do not include qualitative values in this field. If more than one value available from the same report, submit the lowest value. If “global” or “overall” value is documented, submit that value.

Ejection Fraction – Qualitative	
Definition	A measurement of how much blood is pumped out of the heart with each contraction (heartbeat).
Length and Type	2 character field; Alphanumeric
Record Location	96-97
Note	See web link on page 5 to identify cases to submit this data element. Acceptable values are as follows: <ul style="list-style-type: none"> • NL = Normal • MI = Mild or Unqualified • MM = Mild-Moderate • MO = Moderate • MS = Moderate-Severe • SE = Severe Do not include percentage values in this field. If more than one value available in the same report, submit the worst value.

Record Review Request – Preoperative Acute Renal Failure	
Definition	Indicator to show that the hospital and/or surgeon is requesting a review of medical record documentation for the clinical condition of acute renal failure in the immediate preoperative period.
Length and Type	1 character field; Alphanumeric
Record Location	98
Note	Acceptable values are as follows: <ul style="list-style-type: none"> • Y = Yes, requesting review for preoperative acute renal failure. • N = No, the record does not require review.

Record Review Request – Preoperative Cardiogenic Shock	
Definition	Indicator to show that the hospital and/or surgeon is requesting a review of medical record documentation for the clinical condition of cardiogenic shock in the immediate preoperative period.
Length and Type	1 character field; Alphanumeric
Record Location	99
Note	Acceptable values are as follows: <ul style="list-style-type: none"> • Y = Yes, requesting review for preoperative cardiogenic shock. • N = No, the record does not require review.

Record Review Request – Special Request for Exclusion	
Definition	Indicator to show that the hospital and/or surgeon is requesting a review of medical record documentation for special exclusion for a case in which the patient’s outcome was most directly related to a condition unrelated to the CABG and/or valve surgery.
Length and Type	1 character field; Alphanumeric
Record Location	100
Note	Acceptable values are as follows: <ul style="list-style-type: none"> • Y = Yes, requesting review for special request for exclusion. • N = No, the record does not require review.

Statement Covers Period – From	
Definition	The beginning service date of the period included on the bill.
Length and Type	6 character field; Numeric
Format	MMDDYY
Record Location	101-106
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4’s Inpatient UB-04 Data Reporting Manual for more information.

Patient Sex	
Definition	The sex of the patient as recorded at admission or start of care.
Length and Type	1 character field; Alphanumeric
Record Location	107
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4’s Inpatient UB-04 Data Reporting Manual for more information.

Patient Hispanic/Latino Origin or Descent	
Definition	Hispanic/Latino origin refers to people whose origins are from Spain, Mexico, or the Spanish speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality lineage, or country in which the person or his/her ancestors were born before their arrival in the United States.
Length and Type	1 character field; Alphanumeric
Record Location	108
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4’s Inpatient UB-04 Data Reporting Manual for more information.

Patient Race	
Definition	The patient’s racial background.
Length and Type	1 character field; Alphanumeric
Record Location	109
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4’s Inpatient UB-04 Data Reporting Manual for more information.

Patient Birth Date	
Definition	The date of birth of the patient.
Length and Type	8 character field; Numeric
Format	MMDDYYYY
Record Location	110-117
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Patient Zip Code	
Definition	The Federal Zip Code for the mailing address of the patient with optional +4 extension.
Length and Type	9 character field; Alphanumeric; Left-justified
Format	XXXXXXXXYY, if the +4 extension is unknown, leave the last four digits blank.
Record Location	118-126
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Patient Discharge Status	
Definition	A code indicating the disposition or discharge status of the patient at the end service for the period covered on the bill, as reported in Statement Covers Period.
Length and Type	2 character field; Numeric
Record Location	127-128
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Total Charges	
Definition	Total charges for the entire length of stay.
Length and Type	10 character field; Numeric; Right-justified
Record Location	129-138
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Prospective Payment System (PPS) Code – Hospital DRG	
Definition	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. This is the value that was submitted with the inpatient billing data.
Length and Type	4 character field; Numeric; Right-justified
Record Location	139-142
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Health Plan Identification Number	
Definition	The number used by the health plan to identify itself.
Length and Type	15 character field; Alphanumeric; Left-justified
Record Location	143-157
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Payer Type and Name	
Definition	Code identifying Payer and Product Type as well as the actual name of the Payer from which the facility expects payment for the bill.
Length and Type	25 character field (two-digit Payer Type and 23 character Payer Name); Alphanumeric; Left-justified
Record Location	158-182
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Principal Diagnosis Code	
Definition	The ICD-10-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.)
Length and Type	7 character field; Alphanumeric; Left-justified
Record Location	183-189
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Principal Diagnosis Code Present on Admission (POA) Indicator	
Definition	A code indicating if the diagnosis was present at the time the order for inpatient admission occurs.
Length and Type	1 character field; Alphanumeric
Record Location	190
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Other Diagnosis Codes 1-24	
Definition	The ICD-10-CM diagnoses codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.
Length and Type	24 fields, 7 characters each; Alphanumeric; Left-justified
Record Location	Refer to Data File Layout
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information. Additional fields have been added to accept up to 24 Other Diagnosis Codes to be used in risk adjustment.

Other Diagnosis Code Present on Admission (POA) Indicators 1-24	
Definition	A code indicating if the diagnosis was present at the time the order for inpatient admission occurs.
Length and Type	24 fields, 1 character each; Alphanumeric
Record Location	Refer to Data File Layout
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information. Additional fields have been added to accept up to 24 Other Diagnosis Code Present on Admission Indicators to be used in risk adjustment.

External Cause of Injury (ECI) Codes 1-3	
Definition	The ICD-10-CM diagnosis codes pertaining to external causes of morbidity.
Length and Type	3 fields, 7 characters each; Alphanumeric; Left-justified
Record Location	Refer to Data File Layout
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

External Cause of Injury (ECI) Code Present on Admission (POA) Indicators 1-3	
Definition	A code indicating if the diagnosis was present at the time the order for inpatient admission occurs.
Length and Type	3 fields, 1 character each; Alphanumeric
Record Location	Refer to Data File Layout
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Principal Procedure Code	
Definition	The ICD-10-PCS procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by the bill and the corresponding date.
Length and Type	7 character field; Alphanumeric; Left-justified
Record Location	407-413
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Principal Procedure Date	
Definition	The corresponding date on which the Principal Procedure was performed.
Length and Type	6 character field; Numeric
Format	MMDDYY
Record Location	414-419
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

Other Procedure Codes 1-24	
Definition	The ICD-10-PCS procedure codes corresponding to all significant procedures other than the principal procedure. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.
Length and Type	24 fields, 7 characters each; Alphanumeric; Left-justified
Record Location	Refer to Data File Layout
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information. Additional fields have been added to accept up to 24 Other Procedure Codes and Dates to be used in risk adjustment.

Other Procedure Dates 1-24	
Definition	The date on which the corresponding Other Procedure was performed.
Length and Type	24 fields, 6 characters each; Numeric
Format	MMDDYY
Record Location	Refer to Data File Layout
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information. Additional fields have been added to accept up to 24 Other Procedure Codes and Dates to be used in risk adjustment.

Operating Physician – Secondary Identifier	
Definition	The identification number of the individual with the primary responsibility for performing the surgical procedure(s).
Length and Type	9 character field; Alphanumeric; Left-justified
Record Location	732-740
Note	Copied from the same data element submitted in the inpatient billing data. Please refer to PHC4's Inpatient UB-04 Data Reporting Manual for more information.

VALIDATIONS AND EDITS

The data file will be validated upon receipt to ensure that the data meets the definitions provided in the data file format, the data file layout and the data element descriptions. This includes, but is not limited to, items such as the file type, line lengths and data types, such as date and numeric formats.

APPENDIX

Cardiac Surgery Supplemental Clinical Data Worksheet

This worksheet is provided to assist with the abstraction of the supplemental clinical data and identification of additional ICD-10-CM/PCS diagnosis and procedure codes.

Demographic Information		
Patient Name		Medical/Health Record Number
Patient Control Number	Admission/Start of Care Date	Statement Covers Period – Through
Patient Birth Date	Operating Physician License Number and Name	
Notes:		

Anesthesia Information		
Anesthesia Start Date	ASA Class	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Anesthesia Start Time	ASA Emergency Indicator	<input type="checkbox"/> Yes <input type="checkbox"/> No

Procedure/Imaging Information			
Circumflex	%	Circumflex Branch	%
Left Anterior Descending (LAD)	%	Left Anterior Descending (LAD) Branch	%
Right Coronary Artery (RCA)	%	Right Coronary Artery (RCA) Branch	%
Left Main	%		
Ejection Fraction (lowest value)	%		
Ejection Fraction – Qualitative (worst value)			
<input type="checkbox"/> Normal (NL)		<input type="checkbox"/> Moderate (MO)	
<input type="checkbox"/> Mild or Unqualified (MI)		<input type="checkbox"/> Moderate-Severe (MS)	
<input type="checkbox"/> Mild-Moderate (MM)		<input type="checkbox"/> Severe (SE)	

Cardiac Surgery Supplemental Clinical Data Worksheet *continued*

Record Review Information		
Preoperative Acute Renal Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Preoperative Cardiogenic Shock	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Request for Exclusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PHC4 currently accepts one principal and 17 secondary diagnosis codes and one principal and five secondary procedure codes with the submission of the UB-04 data. During the web-based data entry process hospitals have the opportunity to provide additional ICD-10-CM/PCS diagnosis and procedure codes.

Additional ICD-10-CM Diagnosis Codes			
Code	Description ¹	Code	Description ¹

Additional ICD-10-PCS Procedure Codes			
Code	Description ¹	Code	Description ¹

¹ Please note that *only* the ICD-10-CM/PCS diagnosis or procedure code(s) will need to be entered into the web-based tool. The description field is for your information only.