MIRCal
Edit Description Guide

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VERSION 6 - SUMMARY OF CHANGES
to the MIRCal Edit Description Guide

The following changes were made to the Edit Description Guide (EDG), Version 6.

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Added “Expected Source of Payment Categories” and “Invalid Social Security Number Ranges” under Section VIII – Standard Edit Program. Now you can click on the Page Number and go directly to these two items.

PAGE 18:

DRG 470 Edit Program:
The Guide now provides a more informative description of the DRG 470 Edit Program as well as a brief overview of the DRG Grouper process.

PAGE 19

The Critical and Warning/Non-Critical DRG 470 flags are now listed in separate tables.

PAGE 22

S006 – Deleted the second part of the Description (Source of Admission is not “712” (Newborn), but the Principal Diagnosis indicate Newborn). There are 3 different program logic rules for S006: #0035, #0036, and #0037, and this scenario only applies to Rule 0037.

S010 – Deleted the second part of the Description (Source of Admission is reported as “511” or “512” (from your Acute Care), but the Principal Diagnosis indicates Newborn. There are 2 different program logic rules for S010: #0038 and #0039, and this scenario only applies to Rule 0038.

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I INTRODUCTION

There are currently nine (9) MIRCal edit programs applied to discharge data. These programs have been developed to promote reliable, clean, quality data. All facility data are processed through the MIRCal edit programs in the following order: Transmittal Validation, Licensing Check, DRG Grouper, Standard, Coding, Readmissions, Trend, Comparative and Exception Edits. This guide provides detailed program information about each individual edit process applied to discharge data.

II MIRCAL EDIT PROGRAMS AT-A-GLANCE

UNDERSTANDING THE MIRCAL EDIT PROGRAMS

Your data will be rejected if it fails any of the edit programs. "Fail" means your data is not at or below the established Error Tolerance Level (ETL). Understanding the edit programs and the reasons your data might fail is very important when determining the best way to correct errors.

If your report fails either the Transmittal Validation or Licensing Check, it will be rejected and will not be processed through the remaining edit programs.

Program	Description	Likely Cause of Failure
Transmittal Validation	Checks for proper file format and compares the "Expected" (based on the Transmittal Page information) to "Actual" data submitted. • Virus infected file • No data in file • Multiple Files in the Zip File • Incorrect file format • Discrepancy in the number of records submitted • More than ten (10) Records with a Discharge Date outside the report period • Incorrect Facility ID Number on one or more records	Your data did not pass one or more of the transmittal validations.
Licensing Check	Checks to make sure your data includes all the types of care and services for which your facility is licensed. For example, if your facility is licensed for Acute care, but no records are reported as Acute type of care, then your data will fail this program. NOTE: This program does not check for records that include a type of care for which your facility is <u>not</u> licensed. The Standard Edit program identifies this type of error.	Your facility is licensed for a specific type of care, but that type of care is not being reported on any of your records.
Trend Edit (T flag)	Compares the data in the current report period to your facility's historical data to identify uncharacteristic increases or decreases in percentages reported for certain data element categories. <u>EXAMPLE</u>: In the Current Report Period, your facility reported 65% Non-Hispanic patients, but in the previous two (2) report periods, you reported only 20% Non-Hispanic patients. If this percentage difference between report periods is outside the "Allowable Difference", then either a Critical or Non-Critical Trend flag is generated. Non-Critical flags will not cause your data to fail this program, but one or more Critical flags will.	Your data caused the program to generate one or more Critical Trend flags.

Program	Description	Likely Cause of Failure
Comparative Edit (C flag)	Based on the TOTAL records reported, checks for reasonable distribution of categories within each data element for the Current Report Period. EXAMPLE: If 100% of your records are reported with Patient Disposition-Routine, this program will generate a Comparative Edit flag and your data will fail.	Your data caused the program to generate one or more Comparative Edit flags.
Ungroupable Records (DRG 470) (S flag)	Groups each record to the appropriate Diagnostic Related Group (DRG). If a record contains a blank, invalid, or illogical value in Date of Birth, Sex, Principal Diagnosis, Other Diagnoses, Procedures, and/or Patient Disposition, the record is ungroupable, and assigned to DRG 470.	One or more records grouped to DRG 470.
Standard Edit (S flag)	Checks for data entry errors and inconsistencies of data reported within each record. EXAMPLE: Admit Date is AFTER the Discharge Date.	More than 2% of your records contain standard edit errors.
Coding Edit (V flag)	Checks for illogical combinations of ICD-9-CM codes. EXAMPLE: It is illogical for a record to have a Principal Diagnosis code for a normal birth and a Procedure Code for a C-section.	More than 2% of your records contain coding edit errors.
Readmission Edit (K flag)	Groups records that contain identical Social Security Numbers (SSNs), and then checks for inconsistencies between the records. EXAMPLE: Two records with the same SSN cannot have different Dates of Birth; either the SSN or the Date of Birth is incorrect. This program also checks for errors in transfers to a different type of care. EXAMPLE: A patient is transferred **within** your hospital from Acute Care to SN/IC on the same day. The Patient Disposition in record 1 is reported as "04 SN/IC within hospital", but the Source of Admission in record 2 is reported as "132 Home." This would cause a readmission error. The Source of Admission in record 2 should be reported as "51x Acute Inpatient within your hospital."	More than 2% of your records contain readmission edit errors.
Exception Edit (X flag)	Identifies inconsistencies or reporting levels in your data that may indicate errors. EXAMPLE: An Exception Edit will be generated if no records are reported with a ZIP Code of ZZZZZ (Homeless). If your facility did not treat any homeless patients during the report period, then this is not an error. However, if your facility did treat homeless patients, then the ZIP Code must be reported as ZZZZZ. Do not use XXXXX (Unknown) for Homeless patients.	There is no pass or fail for this program.

III TRANSMITTAL VALIDATION

OVERVIEW

Transmittal Validation consists of two levels of editing: The first set of edits checks for viruses and proper file format. The second set checks for discrepancies in the number of records submitted, invalid discharge dates and incorrect facility identification (ID) numbers.

How do I know if my data failed Transmittal Validation?
Transmittal Validation Edits are identified by Error Messages. Access the "Main Error Summary for all Edit Programs" to see if your data passed or failed Transmittal Validation.
To access this Summary: click on "View Error Summary" on the Main Menu.

If the data fails the first set of Transmittal Edits, it will be rejected immediately and all further editing is terminated. It will not process through the second set of Transmittal edits.

FIRST SET OF TRANSMITTAL VALIDATION EDITS:

A Virus Infected File (Data is rejected immediately)
An Empty File (no data contained) (Data is rejected immediately)
A File (.txt or .zip) with an Incorrect Format (Data is rejected immediately)

Once data passes these 3 edits, it will continue through the second set of Transmittal Validation edits.

SECOND SET OF TRANSMITTAL VALIDATION EDITS:

If data fails **one or more** of the following transmittal edits, it will be rejected and all further data editing is terminated.

Discrepancy in Number of Records submitted
This edit compares the "number of records submitted" which is entered on the "Transmittal for File Submission" screen against the actual number of records submitted. If there is a difference of 20 or more records, then the data fails this edit.

"Invalid" Discharge Dates
Data fails this validation check if there are **more** than 10 records with an invalid Discharge Date. "Invalid" includes Blank, invalid date values, and Discharge Dates outside the Report Period.
Records with ten (10) or less invalid Discharge Dates will pass this Transmittal edit, but will flag as an error in the Standard Edit Program (S flag).

Incorrect Facility ID Number
If there are one or more records with an incorrect Facility ID number (does not match ID Number for your facility in the MIRCal database), then the data fails this edit.

Once the data passes the Transmittal Validation process, it will continue on to the Licensing Validation check.

TRANSMITTAL ERROR MESSAGES

Transmittal Edit	*Error Message*
Checks for Viruses	Virus infected file. Transmission of data was terminated
Does the file contain data? (Empty file)	No data contained in the file
Zip File	Zip File contains multiple files
Incorrect File Format	File is not ASCII character. Validation checks against first 60 records only
Incorrect File Format	Record length was more than 520 bytes.
Incorrect File Format	Record length was less than 520 bytes.
Incorrect File Format	No Carriage Control and Line Feed at bytes 521 and 522, respectively.
Incorrect File Format	No Carriage Control at byte 521
Incorrect File Format	No Line Feed at byte 522
Discrepancy in the Total Number of Records	Total number of records submitted does not match the number of discharges specified on the Transmittal Form. There is a difference of 20 or more records. The Main Error Summary will display the difference between the number of records on the actual file and the number of records entered on the "Transmittal for File Submission" screen.
Invalid Discharge Date	More than ten (10) records are reported with a Discharge Date outside the Report Period. The Main Error Summary will display the number of records with a "bad" Discharge Date.
Incorrect Facility ID Number	Incorrect Facility ID Number reported. The Main Error Summary will display the incorrect Facility ID and the number of records with the incorrect Facility ID,

IV LICENSING CHECK

OVERVIEW

The Licensing Check edits your data against OSHPD's Licensing File to verify that the data reported is consistent with the Types of Care and Services for which it is licensed. Please note that this validation will not edit records that include a Type of Care or Service for which your facility is not licensed. This type of error is checked in the Standard Edit Program and identified by an S flag.

Data will fail the Licensing Edit Program if the data reported does not match OSHPD's licensing information for the facility. The data will be rejected and all further data editing is terminated.

How do I know if my data failed the Licensing Check?
Licensing edits are identified by Error Messages. Access the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Licensing Check.

To access this Summary: click on "View Error Summary" on the Main Menu.

Once the data passes the Licensing Check, it will continue processing through the remaining MIRCal Edit Programs.

NOTE: *If it is determined that the data submitted is correct as reported, please contact your OSHPD analyst to explain the licensing changes.*

LICENSING CHECK ERROR MESSAGES

Licensing Edit	*Error Message*
No Records Reported in Type of Care (TOC) 1	Hospital has licensed beds for Acute Care but there are no records reported in this type of care.
No Records Reported in TOC 3	Hospital has licensed beds for Skilled Nursing/Intermediate Care but there are no records reported in this type of care.
No Records Reported in TOC 4	Hospital has licensed beds for Psychiatric Care but there are no records reported in this type of care.
No Records Reported in TOC 5	Hospital has licensed beds for Chemical Dependency Care but there are no records reported in this type of care.
No Records Reported in TOC 6	Hospital has licensed beds for Physical Rehabilitation Care but there are no records reported in this type of care.
No Records Reported in Source of Admission (SOA) – Route: Your ER	Hospital is licensed as a Basic or Comprehensive Emergency Department but there are no admits through your ER.

V TREND EDIT PROGRAM

OVERVIEW

The Trend Edit Program compares the facility's current data against data submitted in two prior (historical) report periods. Trend Edits check for increases or decreases in the percentage of records reported in each data element category for the current report period by comparing them to the historical data. If the difference between the current data and the historical data is outside the "Allowable Difference" or a "fixed percentage", then a T or TW flag is applied to that data element category.

ALLOWABLE DIFFERENCE: The Allowable Difference is based on Facility Size. Only the T003/TW03 and T004/TW04 flags use an "Allowable Difference" when comparing the current data to historical data. For more information, please refer to "Facility Size" and "Allowable Differences" under the DEFINITIONS/REPORTS in this section.

FIXED PERCENTAGE: All other Trend Flags use **FIXED** Percentages regardless of facility size. Please refer to the "Trend Edit Flags and Descriptions" table in this guide for a complete description of the flags.

Data will fail the Trend Edit Program if one or more Critical Trend Flags (T) are identified in the data.

How do I know if my data failed the Trend Edit Program?
Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Trend Edits.
To access this Summary: click on "View Error Summary" on the Main Menu.

The Trend Edit Program will not apply edits to a data element if:

- A data element in the current report period has a Modification or Non-Compliance
- The current report period is less than 90 days. Conversely, an historical report period that is less than 90 days will not be used for trend analysis.
- There is no historical data for the facility (e.g., new facility)

DEFINITIONS/REPORTS

Critical Trend (T) Flag
A "T" flag, followed by a 3-digit number, identifies a Critical Trend Edit Flag.
A T-flag will result when the current data fails the Trend Edit in both historical report periods or it fails the Trend Edit against the only available historical report period. The affected data element category will receive the applicable T-Flag.

Trend Warning (TW) Flag (Non-Critical Error)
A "TW" flag, followed by a 2-digit number, identifies a Warning (Non-Critical) Trend Edit Flag.
A TW-flag will NOT cause the data to be rejected. These flags are "warnings" that alert the facility to possible errors in the data.

A TW-flag will result when the data FAILS the Trend Validation in the 1st historical report period but PASSES the Trend Validation in the 2nd historical report period, or vice-versa. In other words, a TW flag is applied when the current data Passes and Fails the same trend edit when compared to data in two (2) previous historical report periods.

IMPORTANT: Trend Flags on the Race, ZIP Code, and Prehospital Care and Resuscitation (DNR) data elements are always Warning Flags (TW01, TW02, TW03, and TW04) even if they fail trend edits in both the historical report periods.
These warning flags are provided to alert the facility to possible errors in these data elements.

Facility Size
This is the total number of records submitted by a facility for the current report period. OSHPD classifies facility size in nine (9) categories:

Hospital Size	Total Records Reported	Allowable Difference Applies only to T003/TW03 and T004/TW04 flags
Micro Small Hospital	1 to 50	40%
Very Very Small Hospital	51 to 100	20%
Very Small	101 to 250	15%
Small	251 to 500	12%
Medium	501 to 1000	10%
Large	1001 to 2500	8%
Very Large	2501 to 5000	7%
Super Large	5001 to 10000	6%
Ultra Large	10001 and up	5%

Allowable Difference

The amount of increase or decrease that the MIRCal System will allow between current data and historical data reported by a facility for a particular data element category.
IMPORTANT: For the T003/TW03 and T004/TW04 flags, the Allowable Difference is based on facility size— the larger the facility, the smaller the Allowable Difference.

How does MIRCal determine that a data element category failed a Trend Edit?
After MIRCal calculates the current and historical percentages for the data element category, it subtracts the Current Percentage reported from the Historical Percentage reported and compares the difference. If the calculated difference is outside the **"Allowable Difference"** (too high or too low), then a “T” or “TW” flag is applied. The Trend Edit Summary displays all the data element categories that have been flagged with a T or TW flag.

Use the Data Distribution Report in conjunction with the Trend Edit Summary Report, to help you determine if the data is in error or is correct as reported.

Trend Edit Summary Report

This report identifies the data element categories that have been flagged with a T or TW flag. It is listed in alphabetical order by Data Element and includes the percentage or number of records reported for the Current Report Period; the "Allowable Difference"; and the percentages or numbers from the corresponding historical report period(s).

To access this report: From the Main Menu, click on "View Error Reports", then under "Edit Programs-Trend Edits (T)", click on "View" under "Summary Report". You can print and/or save this PDF report.

Data Distribution Report

This is a 3-page summary that displays each data element and lists the numerical and percentage breakdown of records within each data element category. Use this report to compare the data element categories that have been flagged with a "T" or "TW" flag to those categories (within the same data element) that were not flagged. It also may be useful to compare the "current" Data Distribution Report to "historical" Data Distribution Report(s) and look for any questionable increases or decreases in data element categories.

To access this report: From the Main Menu, click on "View Error Reports", then under Informational Reports, click on "View" next to "Data Distribution Report". You can print and/or save this PDF report.

Report by Selected Data Element (custom report)

When reviewing the Trend Summary Report, you may need to review records associated with the Trend Edit Flag. For example, Type of Admission (TOA)-Scheduled has a T003 flag— "the percentage reported is lower than expected based on your historical data." In order to determine whether or not this is an error, you may want to review all records reported as TOA-**Unscheduled** to see if some of these records need to be corrected to TOA-Scheduled, or to confirm if your data is correct as reported.

If your facility does not have the capability to generate this type of report, contact your OSHPD analyst and request a "Report by Selected Data Element". This custom report, (all records reported as TOA-Unscheduled), can be generated and posted on MIRCal. It can then be accessed by the facility and used for Trend Edit error analysis. The report is only accessible by the requesting facility.

NOTE: *If it is determined that the current data is correct as reported, please contact your OSHPD analyst to explain.*

TREND EDIT FLAGS AND DESCRIPTIONS

Critical Flags identified as a T flag
Non-Critical or Warning flags identified as a TW flag

Trend Edit Flag	*Description*
T001	The current percentage reported for this data element category is ZERO, but your hospital's historical data shows data reported.
TW01	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T002	The current percentage reported for this data element category is greater than 2%, but your hospital's historical data shows ZERO records reported in this category.
TW02	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T003	The current percentage reported for this data element category is lower than expected, based on your hospital's historical data.
TW03	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T004	The current percentage reported for this data element category is greater than expected, based on your hospital's historical data reported.
TW04	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T005	Total number of records submitted **decreased** more than 20%, based on your hospital's historical data.
TW05	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T006	Total number of records submitted **increased** more than 20%, based on your hospital's historical data.
TW06	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T007	Average Number of Other Diagnoses per Record **decreased** more than 2 diagnoses per record, based on your hospital's historical data.
TW07	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T008	Average Number of Other Procedures per Record **decreased** more than 2 procedures per record, based on your hospital's historical data.
TW08	Same description as above, but data failed this Trend Edit in only one (1) historical report period.

Trend Edit Flag	Description
T009	Average Number of Other E-Codes per Record **decreased** more than 2 E-Codes per record, based on your hospital's historical data.
TW09	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T010	Average Percentage of Principal Procedures **decreased** more than 5 percentage points, based on your hospital's historical data.
TW10	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T011	Average Percentage of Principal E-Codes **decreased** more than 5 percentage points, based on your hospital's historical data.
TW11	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T012	Average Length of Stay **decreased** more than expected. The decrease is more than 50%, based on your hospital's historical data.
TW12	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T013	Average Length of Stay **increased** more than expected. The increase is more than 50%, based on your hospital's historical data.
TW13	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T014	Adjusted Charge per Day **decreased** more than expected. The decrease is more than 50%, based on your hospital's historical data.
TW14	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T015	Adjusted Charge per Day **increased** more than expected. The increase is more than 50%, based on your hospital's historical data.
TW15	Same description as above, but data failed this Trend Edit in only one (1) historical report period.

VI COMPARATIVE EDIT PROGRAM

OVERVIEW

The Comparative Edit Program evaluates data for "reasonable" distribution of data within each data element category for the current report period. If the percentage reported is above the "Allowable Percentage", then the data element category will fail the Comparative Edit. Comparative Edits are not applied to Blank or Invalid data.

Data will fail the Comparative Edit Program if one or more Comparative Edit Flags are identified in the data.

A C-Flag, followed by a 3-digit number, identifies Comparative Edits.

How do I know if my data failed the Comparative Edit Program?
Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Comparative Edits.

To access this Summary: click on "View Error Summary" on the Main Menu.

DEFINITIONS/REPORTS

Allowable Percentage
This is the percentage of increase in a data element category that the MIRCal System allows before flagging it as a **possible error**. Depending on the Comparative Edit, the "Allowable Percentage" is either based on facility size; or is a "fixed" percentage that applies to all facilities regardless of size.

Facility Size
This is the total number of records submitted by a facility for the current report period. OSHPD classifies facility size in the following five (5) categories:

Hospital Size	Total Records Reported	Allowable Percentage
Very Small Hospital	1 to 100 discharges	25%
Small Hospital	101 to 500 discharges	20%
Medium Hospital	501 to 1,000 discharges	15%
Large Hospital	1,001 to 5,000 discharges	10%
Very Large Hospital	5,001 and more discharges	5%

How does MIRCal determine if a data element category failed a Comparative Edit?

- Based on the total records reported, MIRCal calculates the percentage of records reported in a data element category. If the reported percentage is above the Allowable Percentage, then a C-flag is applied to that data element category.
- The Comparative Edit Summary Report displays all the data element categories that have been flagged with a C flag.

Example of a Comparative Edit that uses an Allowable Percentage <u>based on Facility Size</u>:

The Total Records submitted by Facility A is 1,200 (Facility Size); therefore, their Allowable Percentage is 10%.

C005: This edit checks to see if the percentage of records with Unknown-Ethnicity is above the percentage <u>expected for the facility</u>. In this example 10% is the expected percentage for Facility A.

Facility A reported 12.5% of their records with an Unknown Ethnicity. Since their Allowable Percentage is 10%, this data element category will receive a C005 Flag.

Example of a Comparative Edit that is based on a fixed percentage:

C012: All records <u>(100%)</u> are reported in one data element category for Source of Admission.

If a facility reports 100% of their records as Source of Admission-Prison/Jail, then the data will receive a C012 flag. The Facility Size is irrelevant for this edit— facilities with either 100 records or 10,000 records will both fail this edit if 100% of their records are reported in one Source of Admission data element category.

Use the Data Distribution Report, in conjunction with the Comparative Edit Summary Report, to help you determine if data is in error or is correct as reported.

<u>Comparative Edit Summary Report</u>

This report identifies the data element categories that have been flagged with a C flag. It is listed in alphabetical order by Data Element and includes the data element category; the percentage of records reported (Current Report Period); the "Allowable Percentage" (if applicable); and the corresponding C-flag.

<u>To access this report</u>: From the Main Menu, click on "View Error Reports", then under "Edit Programs-Comparative Edits (C)", click on "View" under "Summary Report". You can print and/or save this PDF report.

Data Distribution Report

This is a 3-page summary that displays each data element and lists the numerical and percentage breakdown of records within each data element category. Use this report to compare the data element categories that have been flagged with a "C" flag to those categories (within the same data element) that were not flagged.

To access this report: From the Main Menu, click on "View Error Reports", then under Informational Reports, click on "View" next to "Data Distribution Report". You can print and/or save this PDF report.

Report by Selected Data Element (custom report)

When reviewing the Comparative Edit Summary Report, you may need to review records associated with a Comparative Edit Flag. For example, Type of Admission (TOA)-Unknown has a C014 flag— "the number of TOA-Unknown is above the percentage expected for your facility". In order to correct these records, it would be helpful to generate a report that lists all records reported as Type of Admission-Unknown.

If your facility does not have the capability to generate this type of report, contact your OSHPD analyst and request a "Report by Selected Data Element". A custom report (all records reported as TOA-Unknown sorted by Abstract Record Number) can be generated and posted on MIRCal. It can then be accessed by your facility and used for Comparative Edit error analysis. The report is only accessible by the requesting facility.

NOTE: *If it is determined that the current data submitted is accurate, please contact your OSHPD Analyst to explain.*

CRTICAL COMPARATIVE EDIT FLAGS AND DESCRIPTIONS

Comparative Edit Flag	Description
C001	All records (100%) are reported in one category for Sex: Male or Female
C002	Records reported as Sex-Other are more than 0.1% of total records reported.
C003	Records reported as Sex-Unknown are more than 0.1% of total records reported.
C004	All records (100%) are reported in one Ethnicity category: Hispanic, Non-Hispanic, or Unknown.
C005	Records reported as Ethnicity-Unknown are above the percentage expected for your hospital.
C006	All records (100%) are reported in one Race category: White, Black, Native American/Eskimo/Aleut, Asian/Pacific Islander/, Other, or Unknown.
C007	Records reported as Race-Unknown are above the percentage expected for your hospital
C008	Partial ZIP Code: Records reported are above the percentage expected for your hospital.
C009	Unknown ZIP Code (XXXXX): Records reported are above the percentage expected for your hospital.
C010	Foreign ZIP Code (YYYYY): Records reported are above the percentage expected for your hospital.
C011	Homeless ZIP Code (ZZZZZ): Records reported are above the percentage expected for your hospital.
C012	All records (100%) are reported in one category for Source of Admission - Site: Home, Residential Care, Ambulatory Surgery, Skilled Nursing, Acute Inpatient, Other Inpatient, Newborn, Prison, or Other.
C013	Records reported as Source of Admission-Other are above the percentage expected for your hospital.
C014	Records reported as Type of Admission-Unknown are above the percentage expected for your hospital.
C015	All records (100%) are reported in one Patient Disposition category: Routine, Acute-This Hosp, Other Inpatient Care-This Hosp, Skilled Nursing-This Hosp, Acute Care-Another Hospital, Other Inpatient Care-Another Hospital, Skilled Nursing-Another Hosp or Freestanding, Residential Care, Prison, Against Medical Advice, Died, Home Health Services or Other.
C016	Records reported as Patient Disposition-Other are above the percentage expected for your hospital.

Comparative Edit Flag	Description
C017	All records (100%) are reported in one "Payer" category for Expected Source of Payment (ESOP): Medicare, Medi-Cal, Private Coverage, Workers' Compensation, County Indigent Programs, Other Government, Other Indigent, Self-Pay, or Other Payer.
C018	Expected Source of Payment: All records (100%) with Type of Coverage "1" (Knox Keene-HMO) are reported with the same Plan Code number.
C019	Expected Source of Payment: More than 10% of records with Type of Coverage "1" (Knox Keene-HMO) are reported with Plan Code 8000.
C020	No Other Diagnoses Codes reported.
C021	No Principal Procedures reported.
C022	No Other Procedures reported on Type of Care "1" (Acute Care) records.
C023	No Other Procedures reported on Type of Care "3" (Skilled Nursing/Intermediate Care) records.
C024	No Other Procedures reported on Type of Care "4" (Psychiatric Care) records.
C025	Prehospital Care and Resuscitation (DNR): All records (100%) are reported as "YES".
C026	Prehospital Care and Resuscitation (DNR): All Type of Care "1" (Acute Care) records (100%) are reported as "NO".
C027	Prehospital Care and Resuscitation (DNR): All Type of Care "3" (Skilled Nursing/Intermediate Care) records (100%) are reported as "NO".
C028	Principal Diagnosis-Condition Present at Admission Indicator: The percentage of records reported with "NO" and/or "UNCERTAIN" is greater than 10% of the total number of all Principal Diagnosis Indicators reported (Yes, No, and Uncertain).
C029	Other Diagnosis-Condition Present at Admission Indicator: All records (100%) reported as "YES".
C030	Other Diagnosis-Condition Present at Admission Indicator: The percentage of "NO" and/or "UNCERTAIN" is greater than 20% of the total number of all ODX Indicators reported (Yes, NO, and Uncertain).
C031	Principal Diagnosis – 799.9 (Unspecified). The number of records reported with 799.9 as the Principal Diagnosis is greater than 5%.
C032	All records (100%) are reported in one Type of Admission category—Scheduled, Unscheduled, Infant under 24 Hours, or Unknown.

VII UNGROUPABLE RECORDS (DRG 470) EDIT PROGRAM

OVERVIEW

Before any edits are applied, your data is processed through a Diagnostic Related Group (DRG) assignment program. This program groups each record to a DRG based on principal diagnosis, secondary diagnoses, surgical procedures, age (date of birth), sex, and disposition status. If a record contains a blank, invalid or illogical value in any of these data element fields, then it is assigned a DRG 470 – Ungroupable Record.

Once the DRGs are assigned, the data is then processed through the Ungroupable Records (DRG 470) Edit Program. This program identifies records that grouped to DRG 470 and applies either a critical or non-critical DRG 470 Edit Flag to the affected data element(s) in that record.

Data will be rejected if any record groups to a DRG 470 and has a critical DRG 470 S-flag.

In order to pass this edit program, your data cannot have any records with a critical DRG 470 edit flag.

How do I know if my data failed the DRG 470 Edit Program?
Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Ungroupable Records (DRG 470) Edit Program.

To access this Summary: click on "View Error Summary" on the Main Menu.

DEFINITIONS/REPORTS

Critical DRG 470 Edit Flags
An S9XX flag identifies a critical DRG 470 edit. Currently, there are five (5) critical DRG 470 flags, see table on the following page. Your data will be rejected if there is one or more records with a critical DRG 470 edit flag.

DRG 470 Warning Flags (Non-Critical Error)
Currently, there is only one (1) warning flag for the "Ungroupable Records Edit Program"—SW13, see next page. The SW flag will not cause the data to be rejected since it is not applied towards the Error Tolerance Level. The SW13 flag identifies a **possible** error in the record, and therefore correction may not be needed.

Ungroupable Records (DRG 470) Edit Detail Report
This report displays all records that have been grouped to a DRG 470. Records will display an S9XX or SW13 flag on both the affected data element and the DRG field.
The report is sorted by Type of Care, and then by Discharge Date within each Type of Care.

To access this report: From the Main Menu, click on "View Error Reports", then under Informational Reports, click on "View" next to "Ungroupable Records (DRG 470) (S)".

NOTE: If making on-line corrections, use the **Search Records** function (on the Main Menu) to locate the record(s) with a DRG 470.

Critical DRG 470 Edit Flags

Critical DRG 470 Edit Flag	Description
S901	Principal Diagnosis is Blank, Invalid or a new/old code was reported before/after effective date
S902	Record does not match DRG criteria
S903	Sex is not Male or Female
S904	Patient Disposition is Invalid
S954	Age is less than zero or greater than 124 years old

Non-Critical or Warning DRG 470 Edit Flags

Non-Critical (Warning) DRG 470 Edit Flag	Description
SW13 (Warning Flag)	Principal Diagnosis is 765.09 Premature infant with birth weight 2500g or more is considered Ungroupable by the DRG Grouper. This record may not be in error and is not counted towards ETL. Please review this record for accuracy.

VIII STANDARD EDIT PROGRAM

OVERVIEW

The Standard Edit Program edits the data reported within each record. There are two (2) types of Standard Edits— Field Edits and Relational Edits. Field edits identify data elements that are blank, incomplete, or invalid. Relational edits identify illogical relationships between two or more data elements within the same record.

The Error Tolerance Level (ETL) for Standard Edits is 2% of records with one or more Critical Standard Edit flags, based on the total records reported. All edit flags in a record are counted as one (1) error.

How do I know if my data failed the Standard Edit Program?
Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Standard Edits.

To access this Summary: click on "View Error Summary" on the Main Menu.

DEFINITIONS/REPORTS

Critical Standard (S) Edit Flags
An "S" flag, followed by a 3-digit number, identifies a Critical Standard Edit Flag. Critical S-Flags are applied towards the ETL. If there are more than 2% of records with one or more S-flags, then the data will FAIL the Standard Edit Validation.

Standard Edit Warning (SW) Flag (Non-Critical Error)
An "SW" flag, followed by a 2-digit number, identifies a Warning Standard Edit Flag. SW-flags will not cause the data to be rejected since they are not applied towards the ETL. These warning flags are provided to alert the facility to possible errors in the data.

Standard Edit Summary Report
This Summary displays all data elements with Standard Edit flags. There are two (2) "tables" —one for data elements that have S-flags and one for data elements that have SW-flags. In each table, the data elements are listed in alphabetical order and include the number, flag, and percentage of S or SW-flag(s) within each data element. Use this Report to make sure that all errors are located and reviewed or corrected within each record.

Standard Edit Detail Report
This report displays all records that have one or more S or SW-flags. The report is sorted by Type of Care and then by Discharge Date, within each Type of Care.

EXPECTED SOURCE OF PAYMENT (ESOP)

The ESOP data element is made up of three components: Payer Category, Type of Coverage and Name of Plan. The MIRCal Standard Edit Program identifies records that have been reported with an "illogical combination" of ESOP, i.e., 2 or more of the ESOP components have been reported incorrectly.

Standard Edit Flags for Illogical combinations of ESOP:
Critical Flags: S062, S063, S064
Warning Flags: SW08, SW09, SW10

Below is a reference guide to assist you in making corrections to these errors:

Valid ESOP Combinations

For Payer Category:	**If Type of Coverage is:**	**Then HMO Plan Code Number is: (Knox-Keene or MCHOS Plans)**
01, 02, 03, 04, 05, 06	1 Knox-Keene (HMO) or MCOHS Plan	valid Plan Code Number *
01, 02, 03, 04, 05, 06	2 Managed Care - Other (PPO, IPO, POS, etc.)	0000
01, 02, 03, 04, 05, 06	3 Traditional Coverage (Fee for Service)	0000
07, 08, 09	0 No Coverage	0000

* **Refer to Table 1 (HMO Plan Codes) or Table 2 (MCOHS Plan Codes) in the Discharge Data Reporting Manual for a list of HMO Plan Code Numbers.**

INVALID SOCIAL SECURITY NUMBER RANGES

SSN's with the following numbers are flagged as invalid (S002).

- 7 or 8 identical numbers (except 000000001 – Unknown SSN)
- 9 identical numbers
- The first three (3) numbers are:
  - 000
  - 666
  - 729 through 749,
  - 773 through 999
- The last 4 numbers are 0000
- Alpha characters (no change)
- 4th and 5th digits are 00 (no change)

CRITICAL STANDARD EDIT FLAGS AND DESCRIPTIONS

Critical Standard Edit Flag	Description
S001	Blank. No data reported in the data element.
S002	Invalid. Data reported is not a valid OSHPD value.
S004	Date of Birth and Admit Date are not the same, but Type of Admission is "Infant, under 24 hours old".
S005	Type of Care is "3" (Skilled Nursing Care) and Source of Admission is reported as "SN/IC-This Hospital". This is an illogical combination.
S006	Admission Date and Date of Birth are the same, but the combination of Source of Admission and Principal Diagnosis is illogical on a newborn record.
S007	Date of Birth is AFTER the Admission Date. .
S008	Principal Diagnosis indicates Newborn, but the Type of Admission is not reported as "3" - Infant, under 24 hours old.
S009	Admission Date is AFTER the Discharge Date.
S010	The combination of Source of Admission and Principal Diagnosis is illogical on a Newborn record.
S011	Sex is illogical with Male Principal Diagnosis Code.
S012	Source of Admission is reported as "712" – Newborn, but the Type of Care is not reported as "1" – Acute Care.
S013	Discharge Date reported is before the Principal Procedure Date.
S016	Date of Birth and Admission Date are not the same, but Principal Diagnosis indicates Newborn (born in the hospital).
S017	Type of Care is reported as "SN/IC" and Patient Disposition is reported as "SN/IC". This is an illogical combination.
S018	Duplicate Other Diagnoses reported.
S019	Principal procedure is Blank, but Other Procedures are reported.
S020	Source of Admission "911" only applies to infants born before admission to the hospital.
S021	Age is illogical for the Principal Diagnosis reported.
S023	Place of Occurrence E-Code is required for the Principal E-Code reported.
S024	Principal Procedure Date reported is more than three days before the Admission Date.
S025	Principal Cause of Injury E-Code is required for the Principal Diagnosis reported.
S027	Expected Source of Payment: Medicare is illogical with patient's age. Patient is less than 15 years old.

Critical Standard Edit Flag	Description
S029	Place of Occurrence E-Code cannot be reported as the Principal E-Code.
S030	"Home-this Hospital" is an illogical combination for Source of Admission. HOME conflicts with Licensure of Site THIS HOSPITAL.
S031	"Home-Another Hospital" is an illogical combination for Source of Admission. HOME conflicts with Licensure of Site ANOTHER HOSPITAL
S032	"Residential Care-This Hospital" is an illogical combination for Source of Admission. RESIDENTIAL CARE conflicts with Licensure of Site THIS HOSPITAL
S033	"Residential Care-Another Hospital" is an illogical combination for Source of Admission. RESIDENTIAL CARE conflicts with Licensure of Site ANOTHER HOSPITAL
S034	"Acute Inpatient Care-Not a Hospital" is an illogical combination for Source of Admission. ACUTE INPATIENT conflicts with Licensure of Site NOT A HOSPITAL:
S035	"Other Inpatient Care-Not a Hospital" is an illogical combination for Source of Admission. OTHER INPATIENT conflicts with Licensure of Site NOT A HOSPITAL:
S036	"Newborn-Through your ER" is an illogical combination for Source of Admission. NEWBORN conflicts with Route YOUR ER.
S037	"Newborn-Another Hospital" is an illogical combination for Source of Admission. NEWBORN conflicts with Licensure of Site ANOTHER HOSPITAL.
S038	"Newborn-Not a Hospital" is an illogical combination for Source of Admission. NEWBORN conflicts with Licensure of Site NOT A HOSPITAL.
S039	"Prison/Jail-This Hospital" is an illogical combination for Source of Admission. PRISON/JAIL conflicts with Licensure of Site THIS HOSPITAL.
S040	"Prison/Jail-Another Hospital" is an illogical combination for Source of Admission. PRISON/JAIL conflicts with Licensure of Site ANOTHER HOSPITAL.

Critical Standard Edit Flag	Description
S041	"Other-This Hospital/Not your ER" is an illogical combination for Source of Admission. OTHER conflicts with Licensure of Site THIS HOSPITAL and with Route NOT YOUR ER.
S042	Source of Admission is "SN/IC-This Hospital". Your hospital is not licensed for SN/IC type of care.
S043	Source of Admission is "Acute Care-This Hospital". Your hospital is not licensed for this type of care.
S044	Source of Admission is "Other Care-This Hospital". Your hospital is not licensed for Psychiatric, Chemical Dependency or Physical Rehabilitation types of care.
S045	Patient Disposition is "Acute Care-Within This Hospital". Your hospital is not licensed for this type of care.
S046	Patient Disposition is "Other Care-This Hospital". Your hospital is not licensed for Psychiatric, Chemical Dependency, or Physical Rehabilitation types of care.
S047	Patient Disposition is "SN/IC-Within This Hospital". Your hospital is not licensed for this type of care.
S048	Type of Care: Your hospital is not licensed for Acute Care.
S049	Type of Care: Your hospital is not licensed for SN/IC Care.
S050	Type of Care: Your hospital is not licensed for Psychiatric Care.
S051	Type of Care: Your hospital is not licensed for Chemical Dep Care.
S052	Type of Care: Your hospital is not licensed for Physical Rehabilitation Care.
S053	Principal Condition Present at Admission Indicator should be "YES" for a Newborn diagnosis.
S054	Age of the patient is greater than 120 years old.
S055	Total Charges reported are less than $100 for Newborn. Principal Diagnosis indicates Newborn.
S056	There are no Other Diagnoses or Procedures reported on the Newborn record, but the Charge per Day is greater than $2,500. Principal Diagnosis indicates Newborn.
S057	Total Charges are blank on Newborn record. Are the charges included on the mother's record? Principal Diagnosis indicates Newborn.
S058	Discharge Date is Out-of-Range for the report period.
S059	New Diagnosis Code is reported BEFORE the Effective Beginning Date (October 1)
S060	Old Diagnosis Code is reported AFTER the Effective Ending Date (September 30)
S061	Expected Source of Payment: Invalid Plan Code reported.

Critical Standard Edit Flag	Description
S062	Expected Source of Payment: Plan Code is illogical with the Type of Coverage reported.
S063	Expected Source of Payment: Type of Coverage is illogical with the Payer category reported.
S064	Expected Source of Payment: Plan Code Number and/or Type of Coverage is illogical with the Payer category reported.
S069	Other Condition Present at Admission Indicator should be "YES" for Delivery Outcome diagnosis codes.
S070	Source of Admission is reported as "Ambulatory Surgery-This Hospital", but your hospital is not licensed for this service.
S071	Source of Admission-Route is reported as "Your ER", but your hospital is not licensed for Emergency Room Services.
S072	Expected Source of Payment: Worker's Compensation is illogical with age of patient (under 15 years old).
S073	Admission Date is not a reasonable date. Example: The Admission Date is more than 20 years before the Discharge Date.
S074	Principal Procedure Date is not reasonable date. Example: The Principal Procedure Date is more than 20 years before the Discharge Date.
S075	Other Procedure Date is not reasonable date. Example: The Other Procedure Date is more than 20 years before the Discharge Date.
S076	Type of Care is illogical with Type of Admission "Infant under 24 hrs old".
S077	Source of Admission "Acute Inpatient-This Hospital" is an illogical combination with Type of Care 1 (Acute Care) A patient cannot be admitted to your hospital's Acute Care if they are coming from your hospital's Acute Care.
S080	Date of Birth is after Discharge Date.
S081	Date of Birth is after the Principal Procedure Date.
S082	Date of Birth is after Other Procedure Date(s).
S083	Source of Admission indicates Newborn with an illogical Type of Admission. The Source of Admission is reported s '712', but Type of Admission is not '3' (Infant under 24 hours old).
S084	Date of Birth and Admit Date are the same, but Type of Admission is not equal to '3' (Infant under 24 hours old).
S086	Sex is illogical with Female Principal Diagnosis.

Critical Standard Edit Flag	Description
S087	Sex is illogical with Male Other Diagnoses Code.
S088	Sex is illogical with Female Other Diagnoses Code.
S089	Sex is illogical with Male Principal Procedure Code.
S090	Sex is illogical with Female Principal Procedure Code.
S091	Sex is illogical with Male Other Procedure Code.
S092	Sex is illogical with Female Other Procedure Code.
S093	Sex is illogical with Male Principal E-Code.
S094	Sex is illogical with Female Principal E-Code.
S095	Sex is illogical with Male Other E-Code
S096	Sex is illogical with Female Other E-Code.
S097	Other Procedure Date is after Discharge Date.
S099	Date of Birth and Admission Date are NOT the same, but Source of Admission is reported as Newborn (712).
S100	Type of Care "Acute" and Patient Disposition "Acute Care within this hospital" is an illogical combination A patient cannot be discharged to Acute Care within your hospital if they are already in your Acute Care.
S102	Duplicate E-Codes reported in Principal E-Code and Other E-Code fields.
S103	Duplicate Other E-Codes reported.
S104	Principal E-Code is blank, yet Other E-Codes are reported.
S105	Age is illogical with Other Diagnoses Code(s).
S106	Age is illogical with Principal Procedure
S107	Age is illogical with Other Procedure(s).
S108	Age is illogical with Principal E-Code.
S109	Age is illogical with Other E-Code(s).
S110	Other Procedure Date is more than three days <u>before</u> the Admission Date.
S114	New Procedure Code is reported <u>BEFORE</u> the Effective Beginning Date (October 1).
S116	New E-Code is reported <u>BEFORE</u> the Effective Beginning Date (October 1).
S119	Old Procedure Code is reported <u>AFTER</u> the Effective Ending Date (September 30).
S121	Old E-Code is reported <u>AFTER</u> the Effective Ending date (September 30).

WARNING STANDARD EDIT FLAGS AND DESCRIPTIONS
(Non-Critical Flags)

Standard Edit Warning Flag	*Description*
SW01	Partial Date of Birth reported. Only the Birth Year is reported for this patient.
SW02	Partial ZIP Code reported.
SW03	The Patient Length of Stay is longer than 180 days. Verify the Admission Date and Discharge Date.
SW04	The Type of Admission is "Scheduled", but the Source of Admission indicates that the patient was admitted through your ER. (Source of Admission-Route) This is an illogical combination.
SW05	Principal Diagnosis: HIV test result reported.
SW06	Other Diagnosis: HIV test result reported.
SW07	Expected Source of Payment: Medicare is reported with an Unknown Social Security Number.
SW08	Expected Source of Payment: Medicare and Type of Coverage "2" (Other Managed Care) is an unlikely combination.
SW09	Expected Source of Payment: Medi-Cal and Type of Coverage "2" (Other Managed Care) is an unlikely combination.
SW10	Expected Source of Payment: Other Government and Type of Coverage "2" (Other Managed Care) is an unlikely combination.
SW11	Based on the length of stay, the Charge per Day is less than $100 or greater than $40,000.
SW12	Prehospital Care and Resuscitation (DNR): DNR reported as "YES" is unlikely for Psychiatric, Chemical Dependency, or Physical Rehabilitation Type of Care.
SW13	Principal Diagnosis is 765.09. Record grouped to DRG 470. See the "Ungroupable Records" Section in this Guide for more info. Premature infant with birth weight 2500g or more is considered Ungroupable by the DRG Grouper. This record may not be in error and is not counted towards ETL. Please review this record for accuracy.

IX RE-ADMISSION EDIT PROGRAM

OVERVIEW

The Re-Admission Edit Program edits for discrepancies between records for patients who had more than one inpatient stay within the Report Period. The records are sorted by Social Security Number in order to group together all inpatient stays for the same patient. Using the first record as the "base value", the data is then edited for discrepancies in Date of Birth, Sex, Race, and ZIP Code reported for the same patient. The Re-Admission Edits also identify possible errors in transfers between types of care within the facility; and admits from and discharges to sources outside the facility.

The Error Tolerance Level (ETL) for Re-Admission Edits is 2% of records with one or more Critical Re-Admission Edit flags, based on the total records reported. All errors in a record are counted as one (1) error.

How do I know if my data failed the Re-Admission Edit Program?
Check the "Main Error Summary for all Edit Programs" to see if you passed or failed the Re-Admission Edits.

To access this Summary: click on "View Error Summary" on the Main Menu.

DEFINITIONS/REPORTS

Critical Re-Admission (K) Edit Flags
A "K" flag followed by a 3-digit number identifies a Critical Re-Admission Edit. Critical K-Flags are applied towards the ETL. If there are more than 2% of records with one or more K-flags, then the data will FAIL the Re-Admission Edit Validation.

Re-Admission Warning (KW) Flag (Non-Critical Error)
A "KW" flag, followed by a 2-digit number, identifies a Warning Re-Admission Edit. KW-flags will not cause the data to be rejected since they are not applied towards the ETL. These warning flags are provided to alert the facility to possible errors in the data.

Re-Admission Summary Report
This summary provides a breakdown of the number and type of K and KW flags identified in the data. An additional table, for Critical K flags only, displays the data element and number of records within the data element that has a K flag. Use this summary to make sure that all errors are located and reviewed or corrected within each record

Re-Admission Edit Detail Report
This report displays all records that have one or more K or KW flags. The records are sorted by Social Security Number and then by Discharge Date, within each group of SSN's.

CRITICAL RE-ADMISSION EDIT FLAGS AND DESCRIPTIONS

Critical Re-Admission Edit Flag	Description
K002	Date of Birth does not match with the first record. Date of Birth on subsequent records for the same patient does not match the Date of Birth reported on the first record. Example: SSN DOB Same 03-11-1952 K002 (First Record) Same 03-11-1952 Same 05-11-1952 K002 Same 03-11-1952
K003	Sex does not match with the first record. Sex on subsequent records for the same patient does not match the Sex reported on the first record. Example: SSN SEX: Same 1 K003 (First Record) Same 2 K003 Same 1 Same 2 K003
K014	Patient Disposition: Patient died and then was re-admitted. Example: SSN Patient Disposition Same 01 (Home) Same 11 (Died) K014 Same 02 (Acute)
K025	ADMIT and DISCHARGE DATE OVERLAP for the same patient: Example: SSN Admit Date Discharge Date Same 04-20-2000 04-28-2000 Same 05-01-2000 05-10-2000 Same 06-11-2000 K025 06-19-2000 K025 Same 04-29-2000 K025 06-20-2000 K025
K026	Patient cannot be discharged from and then re-admitted to the same type of care within your hospital (Acute Care). Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 02 K026 1 K026 Same 05-26-2000 05-30-2000 512 K026 1 K026

Critical Re-Admission Edit Flag	Description
K027	Patient cannot be discharged from and then re-admitted to the same type of care within your hospital (SN/IC Care). Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 04 K027 3 K027 Same 05-26-2000 05-30-2000 411 K027 3 K027
K028	Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Psychiatric Care). Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 K028 4 K028 Same 05-26-2000 05-30-2000 612 K028 4 K028
K029	Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Chem Dep Care) Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 K029 5 K029 Same 05-26-2000 05-30-2000 611 K029 5 K029
K030	Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Physical Rehab Care) Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 K030 6 K030 Same 05-26-2000 05-30-2000 612 K030 6 K030
K032	Patient Disposition on the first record is 05 (Acute Care at another hospital) but Source of Admission on the re-admit records is not 521 or 522 (Acute Care at another hospital). Example: SSN Admit Date Discharge Date Source of Admission Pt Disposition Same 04-20-2000 05-26-2000 05 K032 Same 05-26-2000 05-30-2000 612 K032
K033	Patient Disposition on the first record is 06 (Other Care at another hospital) but Source of Admission on the re-admit records is not 621 or 622 (Other Care at another hospital). Example: SSN Admit Date Discharge Date Source of Admission Pt Disposition Same 04-20-2000 05-26-2000 06 K033 Same 05-26-2000 05-30-2000 612 K033

Critical Re-Admission Edit Flag	Description
K034	Patient Disposition on the first record is 07 (SN/IC at another hospital) but Source of Admission on the re-admit records is not 421, 422, 431 432 (SN/IC at another hospital/facility). Example: SSN Admit Date Discharge Date Source of Admission Pt Disposition Same 04-20-2000 05-26-2000 07 K034 Same 05-26-2000 05-30-2000 521 K034
K035	Patient Disposition on the first record is not 05 (Acute Care at another hospital) but Source of Admission on the re-admit records is 521 or 522 (Acute Care at another hospital). Example: SSN Admit Date Discharge Date Source of Admission Pt Disposition Same 04-20-2000 05-26-2000 01 K035 Same 05-26-2000 05-30-2000 522 K032
K036	Patient Disposition on the first record is not 06 (Other Care at another hospital) but Source of Admission on the re-admit records is 621 or 622 (Other Care at another hospital). Example: SSN Admit Date Discharge Date Source of Admission Pt Disposition Same 04-20-2000 05-26-2000 05 K036 Same 05-26-2000 05-30-2000 621 K036
K037	Patient Disposition on the first record is not 07 (SN/IC at another hospital) but Source of Admission on the re-admit records is 421, 22, 431, 432 (SN/IC at another hospital). Example: SSN Admit Date Discharge Date Source of Admission Pt Disposition Same 04-20-2000 05-26-2000 05 K037 Same 05-26-2000 05-30-2000 431 K037
K038	Type of Care on the first record is not 1 (Acute Care) but Source of Admission on the re-admit record is 511 or 512 (Your Acute Care). Example: SSN Admit Date Disch Date Source of Admission Type of Care Same 04-20-2000 05-26-2000 5 K038 Same 05-26-2000 05-30-2000 512 K038

Critical Re-Admission Edit Flag	Description
K039	Type of Care on the first record is not 3 (SN/IC) but Source of Admission on the re-admit record is 411 or 412 (Your SN/IC Care). Example: SSN Admit Date Disch Date Source of Admission Type of Care Same 04-20-2000 05-26-2000 5 K039 Same 05-26-2000 05-30-2000 411 K039
K041	Type of Care on the first record is 1 (Acute Care) but Source of Admission on the re-admit record is not 511 or 512 (Your Acute Care). Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 1 K041 Same 05-26-2000 05-30-2000 411 K041
K042	Type of Care on the first record is 3 (SN/IC) but Source of Admission on the re-admit record is not 411 or 412 (Your SN/IC Care). Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 3 K042 Same 05-26-2000 05-30-2000 921 K042
K043	Type of Care on the first record is 4, 5, or 6 (Psych, Chem Dep or Phys Rehab Care) but Source of Admission on the re-admit record is not 611 or 612 (Your Other Care). Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 02 6 K043 Same 05-26-2000 05-30-2000 411 K043
K044	Patient Disposition on the first record is 02 (Your Acute Care) but Type of Care on the re-admit record is not 1 (Acute Care) Example: SSN Admit Date Discharge Date Pt Disposition Type of Care Same 04-20-2000 05-26-2000 02 K044 Same 05-26-2000 05-30-2000 6 K044

Critical Re-Admission Edit Flag	Description
K045	Patient Disposition on the first record is 03 (Your Other Care), but Type of Care on the re-admit record is not 4, 5, or 6 (Psych, Chem Dep or Phys Rehab Care) Example: SSN Admit Date Discharge Date Pt Disposition Type of Care Same 04-20-2000 05-26-2000 03 K045 Same 05-26-2000 05-30-2000 1 K045
K046	Patient Disposition on the first record is 04 (Your SN/IC Care) but Type of Care on the re-admit record is not 3 (SN/IC Care Example: SSN Admit Date Discharge Date Pt Disposition Type of Care Same 04-20-2000 05-26-2000 04 K046 Same 05-26-2000 05-30-2000 4 K046
K048	Patient Disposition on the first record is not 03 (Your Other Care) but Type of Care on the re-admit record is 4, 5 or 6 (Psych, Chem Dep or Phys Rehab Care) Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 02 K048 Same 05-26-2000 05-30-2000 411 6 K048
K049	Patient Disposition on the first record is not 04 (Your SN/IC Care) but Type of Care on the re-admit record is 3 (SN/IC). Example: SSN Admit Date Discharge Date Pt Dispo TOC Same 04-20-2000 05-26-200 03 K049 Same 5-26-2000 05-30-2000 3 K049
K050	Type of Care on the first record and on the re-admit record is 4 (Psych Care). Patient cannot be discharged from and re-admitted to the same Type of Care. Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 02 K050 4 K050 Same 05-26-2000 05-30-2000 611 K050 4 K050

Critical Re-Admission Edit Flag	Description
K051	Type of Care on the first record and on the re-admit record is 5 (Chem Dep Care). Patient cannot be discharged from and re-admitted to the same Type of Care. Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 02 K051 5 K051 Same 05-26-2000 05-30-2000 612 K051 5 K051
K052	Type of Care on the first record and on the re-admit record is 6 (Phys Rehab Care). Patient cannot be discharged from and re-admitted to the same Type of Care. Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 04 K052 6 K052 Same 05-26-2000 05-30-2000 611 K052 6 K052
K053	Expected Source of Payment does not match on same day re-admit records. Example: SSN Admit Date Discharge Date Source of Payment Same 04-20-2000 05-26-2000 0800000 K053 Same 05-26-2000 05-30-2000 0320000 K053
K054	Same Principal E-Code is reported on re-admit record. Example: SSN Admit Date Discharge Date Principal E-Code Same 04-20-2000 05-26-2000 E989 K054 Same 05-26-2000 05-30-2000 E989 K054
K055	Source of Admission on the re-admit record indicates that patient was admitted from "your hospital", but the Discharge Date on the first record and the Admit Date on the re-admit record are not the same. Example: SSN Admit Date Discharge Date Source of Admission/ **Licensure of Site** Same 05-31-2000 06-01-2000 K055 1**3**2 Same 06-03-2000 K055 06-15-2000 5**12** K055

Critical Re-Admission Edit Flag	Description
K056	Type of Care on the first record and on the re-admit record is 4 (Psych Care). Patient cannot be discharged from and re-admitted to the same Type of Care. Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 K056 4 K056 Same 05-26-2000 05-30-2000 511 K056 4 K056
K057	Type of Care on the first record and on the re-admit record is 5 (Chem Dep Care). Patient cannot be discharged from and re-admitted to the same Type of Care. Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 K057 5 K057 Same 05-26-2000 05-30-2000 412 K057 5 K057
K058	Type of Care on the first record and on the re-admit record is 6 (Phys Rehab Care). Patient cannot be discharged from and re-admitted to the same Type of Care. Example: SSN Admit Date Disch Date Source of Admission Pt Dispo TOC Same 04-20-2000 05-26-2000 03 K058 6 K058 Same 05-26-2000 05-30-2000 132 K058 6 K058

WARNING RE-ADMISSION EDIT FLAGS AND DESCRIPTIONS
(Non-Critical Flags)

Warning Re-Admission Edit Flag	*Description*
KW01	Ethnicity and/or Race does not match **with the first record.** Ethnicity and/or Race on re-admit records for the same patient does not match the Ethnicity and/or Race reported on the first record. NOTE: Psychiatric Type of Care records are excluded from this edit, EXCEPT for "Same Day Re-Admits"— the Discharge Date on the first record is the same as the Admit Date on the re-admit record. Example: The Ethnicity and/or Race reported on the third record is not the same and is flagged based on the Ethnicity and/or Race reported on the first record. SSN / RACE / ADMIT DATE / DISCHARGE DATE / TOC Same / 11 KW01 / 5-1-2000 / 5-2-2000 / 1 Same / 21 / 5-3-2000 / 5-5-2000 / 4 Same / **31 KW01** / 5-5-2000 / 6-6-2000 / 1 Same / 32 / 7-9-2000 / 7-11-2000 / 4
KW02	ZIP Code does not match with the first record. ZIP Code on subsequent records for the same patient does not match the ZIP Code reported on the first record. NOTE: Psychiatric Type of Care records are excluded from this edit, EXCEPT for "Same Day Re-Admits"— the Discharge Date on the first record is the same as the Admit Date on the re-admit record. Example: The ZIP Code reported for this patient is not the same and is flagged based on the ZIP Code reported on the first record. SSN / ZIP CODE / ADMIT DATE / DISCHARGE DATE / TOC Same / 95608 KW02 / 5-1-2000 / 5-2-2000 / 1 Same / 95864 / 5-3-2000 / 5-5-2000 / 4 Same / 95608 / 6-1-2000 / 6-4-2000 / 1 Same / 95864 KW02 / 6-5-2000 / 6-6-2000 / 1 Same / 95825 / 6-6-2000 / 6-8-2000 / 4

X CODING EDITS

REFER TO THE CODING EDIT MANUAL FOR CODING EDIT FLAGS AND DESCRIPTIONS

GO TO:
www.oshpd.state.ca.us/hid/HID/patient/discharges/indexCode.htm

XI EXCEPTION EDIT PROGRAM

OVERVIEW

Exception edits are non-critical and are not applied to the ETL. Data cannot be rejected due to Exception Edits. Exception Edits identify the possible over-reporting or under-reporting of certain data element values. For example, an Exception Edit will alert the facility that there are no records reported with Homeless ZIP Codes (ZZZZZ); or that 15% or more of the records are reported with an Unknown Social Security Number. The facility may want to review the data to determine if errors exist in the data.

An X-flag followed by a 3-digit number identifies an Exception Edit.

How do I know if I have Exception Edits?
Check the "Main Error Summary for all Edit Programs" to see if you have any Exception Edits.
To access this Summary: click on "View Error Summary" on the Main Menu.

DEFINITIONS/REPORTS

Exception Edit Summary Report
This lists the Exception Edit Flags and descriptions that identify possible errors in the data.

Exception Edit Detail Report
For the applicable Exception Edits, this report lists the records that have been flagged with an X-flag. The X009 and X010 edits do not flag records. These edits are based on the logic: "no records reported", and therefore there are no records to flag.

Data Distribution Report
The Data Distribution Report is a 3-page summary report that displays each data element and lists the numerical and percentage breakdown of records within each data element category. This report may be helpful in determining if corrections are needed to the Exception Edit flags.
To access this report: From the Main Menu, click on “View Error Reports”, then under Informational Reports, click on “View” next to “Data Distribution Report”. You can print and/or save this PDF report.

EXCEPTION EDIT FLAGS AND DESCRIPTIONS

Exception Edit Flag	Description
X003	No E-Code reported on Skilled Nursing Care records, Type of Care 3. Record includes one or more of the following ICD-9 codes in "Other Diagnoses": 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89. Did patient sustain an injury or adverse effect during their skilled nursing care stay?
X004	No E-Code reported on Psychiatric Care records, Type of Care 4. Record includes one or more of the following ICD-9 codes in "Other Diagnoses": 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89. Did patient sustain an injury or adverse effect during their psychiatric care stay?
X005	No E-Code reported on Chemical Dependency Care records, Type of Care 5. Record includes one or more of the following ICD-9 codes in "Other Diagnoses": 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89. Did patient sustain an injury or adverse effect during their chemical dependency care stay?
X006	No E-Code reported on Physical Rehabilitation Care records, Type of Care 6. Record includes one or more of the following ICD-9 codes in "Other Diagnoses": 800.00 thru 904.09, 910.9 thru 994.9, 995.50 thru 995.59, or 995.80 thru 995.89. Did patient sustain an injury or adverse effect during their physical rehabilitation care stay?
X007	Place of Occurrence E-Code: 50% or more of all Place of Occurrence E-Codes reported are E849.9 (Unspecified). Please review records with an E849.9 and correct to a more specific place of occurrence, if available in the medical record.
X008	Unknown SSN's: The number of records reported with an Unknown SSN is 15 % or more. Please review these records and provide a valid SSN, if available in the medical record. This percentage excludes Unknown SSN's reported on **Newborn records.**
X009	Source of Admission: Ambulatory Surgery-This Hospital. Your facility is licensed for Ambulatory Surgery, but there are NO RECORDS reported as 311 or 312 in Source of Admission. Please verify that this is correct as reported.
X010	There are NO RECORDS reported with a Homeless ZIP Code. If your facility provides inpatient care to Homeless patients, the ZIP Code must be reported as "ZZZZZ". Do not use the Unknown ZIP Code, XXXXX, for homeless patients.

XII AGE AND SEX EDIT TABLES

AGE EDIT TABLE

ICD-9-CM Diagnosis Code	Age at Admission Invalid if . . .
V20.0 - V20.2	- Age greater than 18
V22.0 - V23.7	- Age less than 10 or greater than 70
V23.81 - V23.82	- Age less than 35 or greater than 70
V23.83 - V23.84	- Age greater than 15
V23.89 - V24.2	- Age less than 10 or greater than 70
V25.01 - V25.1	- Age less than 10
V25.3 - V25.5	- Age less than 10
V26.0	- Age less than 1 year
V26.1 - V26.2	- Age less than 10
V26.8 - V26.9	- Age less than 10
V27.0 - V28.9	- Age less than 10 or greater than 70
V29.0 - V29.9	- Age greater than 1
V30.00 - V30.1	- Age greater than 1
V31.00 - V31.1	- Age greater than 1
V32.00 - V32.1	- Age greater than 1
V33.00 - V33.1	- Age greater than 1
V34.00 - V34.1	- Age greater than 1
V35.00 - V35.1	- Age greater than 1
V36.00 - V36.1	- Age greater than 1
V37.00 - V37.1	- Age greater than 1
V39.00 - V39.1	- Age greater than 1
V61.6 - V61.7	- Age less than 10 or greater than 55
V71.01	- Age less than 15
V71.02	- Age greater than 18
V72.4	- Age less than 10
259.1	- Age greater than 18
277.01	- Age greater than 2
303.00 - 303.03	- Age less than 5
303.90 - 304.93	- Age less than 10
305.00 - 305.03	- Age less than 5
305.1	- Age less than 10
305.20 - 305.43	- Age less than 5
305.50 - 305.53	- Age less than 10
305.60 - 305.93	- Age less than 5
313.89 - 313.9	- Age greater than 18
331.81	- Age greater than 18
335.20	- Age less than 15
340	- Age less than 11
366.10 - 366.19	- Age less than 15
374.01	- Age less than 15
374.11	- Age less than 15
410.00 - 414.05	- Age less than 15
429.2	- Age less than 15
429.71 - 429.79	- Age less than 15

AGE EDIT TABLE (cont'd)

ICD-9-CM Diagnosis Code	Age at Admission Invalid if . . .
435.8 - 436	- Age less than 11
437.0	- Age less than 15
440.0 - 440.9	- Age less than 15
441.00 - 442.9	- Age less than 11
454.0 - 454.9	- Age less than 15
457.0	- Age less than 15
496 - 501	- Age less than 15
571.0 - 571.3	- Age less than 15
600 - 602.9	- Age less than 15
606.0 - 606.9	- Age less than 15
607.84	- Age less than 15
610.1	- Age less than 15
630. - 659.43	- Age less than 10 or greater than 70
659.50 - 659.63	- Age less than 35 or greater than 70
659.70 - 676.94	- Age less than 10 or greater than 70
690.11 - 690.12	- Age greater than 18
722.0 - 722.93	- Age less than 15
724.00 - 724.09	- Age less than 15
728.6	- Age less than 15
751.1 - 751.2	- Age greater than 18
751.61	- Age greater than 18
780.91 - 789.92	- Age greater than 2
790.93	- Age less than 15
792.3	- Age less than 10
798.0	- Age greater than 18
995.50 - 995.59	- Age greater than 18
995.80 - 995.85	- Age less than 15

ICD-9-CM Procedure Code	**Age at Admission Invalid if . . .**
72.0 - 75.99	- Age less than 10 or greater than 55

ICD-9-CM E-Code	**Age at Admission Invalid if . . .**
E800.0	- Age less than 14
E801.0	- Age less than 14
E802.0	- Age less than 14
E803.0	- Age less than 14
E804.0	- Age less than 14
E805.0	- Age less than 14
E806.0	- Age less than 14
E807.0	- Age less than 14
E810.0	- Age less than 2
E810.2	- Age less than 2

AGE EDIT TABLE (cont'd)

ICD-9-CM E-Code	Age at admission Invalid if . . .
E811.0	- Age less than 2
E811.2	- Age less than 2
E812.0	- Age less than 2
E812.2	- Age less than 2
E813.0	- Age less than 2
E813.2	- Age less than 2
E814.0	- Age less than 2
E814.2	- Age less than 2
E815.0	- Age less than 2
E815.2	- Age less than 2
E816.0	- Age less than 2
E816.2	- Age less than 2
E817.0	- Age less than 2
E817.2	- Age less than 2
E818.0	- Age less than 2
E818.0	- Age less than 2
E818.2	- Age less than 2
E819.0	- Age less than 2
E819.2	- Age less than 2
E820.0	- Age less than 2
E820.2	- Age less than 2
E821.0	- Age less than 2
E821.2	- Age less than 2
E822.0	- Age less than 2
E822.2	- Age less than 2
E823.0	- Age less than 2
E823.2	- Age less than 2
E824.0	- Age less than 2
E824.2	- Age less than 2
E825.0	- Age less than 2
E825.2	- Age less than 2
E826.2	- Age less than 2
E827.2	- Age less than 2
E828.2	- Age less than 2
E830.4	- Age less than 2
E830.6	- Age less than 14
E831.4	- Age less than 2
E831.6	- Age less than 14
E832.4	- Age less than 2
E832.6	- Age less than 14

AGE EDIT TABLE (cont'd)

ICD-9-CM E-Code	Age at admission Invalid if . . .
E833.4	- Age less than 2
E833.6	- Age less than 14
E834.4	- Age less than 2
E834.6	- Age less than 14
E835.4	- Age less than 2
E835.6	- Age less than 14
E836.4	- Age less than 2
E836.6	- Age less than 14
E837.4	- Age less than 2
E837.6	- Age less than 14
E838.4	- Age less than 2
E838.6	- Age less than 14
E840.2	- Age less than 14
E840.7	- Age less than 2
E840.8	- Age less than 14
E841.2	- Age less than 14
E841.7	- Age less than 2
E841.8	- Age less than 14
E842.7	- Age less than 2
E842.8	- Age less than 14
E843.2	- Age less than 14
E843.7	- Age less than 2
E843.8	- Age less than 14
E844.2	- Age less than 14
E844.7	- Age less than 2
E844.8	- Age less than 14
E845.8	- Age less than 14
E950.0 - E959	- Age less than 2

SEX EDIT TABLE

ICD-9-CM Diagnosis Code	Sex Specific
V07.4	Female
V10.40 - V10.44	Female
V10.45 - V10.49	Male
V13.1	Female
V22.0 - V25.01	Female
V25.1	Female
V25.3	Female
V25.41 - V25.43	Female
V25.5	Female
V26.1	Female
V27.0 - V28.9	Female
V45.51	Female
V50.2	Male
V50.42	Female
V52.4	Female
V61.6 - V61.7	Female
V72.3 - V72.4	Female
V76.11	Female
V76.2	Female
016.40 - 016.56	Male
016.60 - 016.76	Female
054.11 - 054.12	Female
054.13	Male
072.0	Male
098.12 - 098.14	Male
098.15 - 098.17	Female
098.32 - 098.34	Male
098.35 - 098.37	Female
112.1	Female
131.01	Female
131.03	Male
174.0 - 174.9	Female
175.0 - 175.9	Male
179. - 184.9	Female
185. - 187.9	Male
198.6	Female
214.4	Male
218.0 - 221.9	Female
222.0 - 222.9	Male
233.1 - 233.3	Female
233.4 - 233.6	Male
236.0 - 236.3	Female

SEX EDIT TABLE (cont'd)

ICD-9-CM Diagnosis Code	Sex Specific
236.4 - 236.6	Male
256.0 - 256.9	Female
257.0 - 257.9	Male
302.73	Female
302.74 - 302.75	Male
302.76	Female
306.51 - 306.52	Female
456.4	Male
456.6	Female
600. - 608.9	Male
614.0 - 677	Female
716.30 - 716.39	Female
752.0 - 752.49	Female
752.51 - 752.69	Male
758.7	Male
788.32	Male
790.93	Male
792.2	Male
792.3	Female
795.00 - 795.02	Female
795.09	Female
867.4 - 867.5	Female
878.0 - 878.3	Male
878.4 - 878.7	Female
902.55 - 902.56	Female
902.81 - 902.82	Female
939.1 - 939.2	Female
939.3	Male
947.4	Female
996.32	Female

ICD-9-CM Procedure Code	Sex Specific
60.0 - 64.99	Male
65.0 - 75.99	Female
87.81 - 87.89	Female
87.91 - 87.99	Male
88.46	Female
88.78	Female
89.26	Female
91.41 - 91.49	Female
92.17	Female

SEX EDIT TABLE (cont'd)

ICD-9-CM Procedure Code	Sex Specific
96.14 - 96.18	Female
96.44	Female
97.24 - 97.26	Female
97.71 - 97.75	Female
98.16 - 98.17	Female
98.23	Female
98.24	Male
99.94 - 99.96	Male
99.98	