WSHA Maternal Data Center (WSHA-MDC)
Data Submission Guidelines and Specifications
July 23, 2015

To generate perinatal performance metrics for the Washington State Hospital Association (WSHA) quality improvement programs, hospitals may submit data to the WSHA Maternal Data Center (WSHA-MDC), an online data aggregation and quality improvement tool developed by the California Maternal Quality Care Collaborative (CMQCC) and housed at Stanford University School of Medicine.

Questions or Comments

Please contact Anne Castles at 626-639-3044 or safedeliveries@cmqcc.org.

Summary Guidelines and Timelines

- Participating hospitals will submit administrative and clinical data files in CSV file format to the MDC on a monthly basis.
- Submissions should be based on discharge date for all files and are to be made on a calendar month basis, representing discharges from the first day of the month through the last day of the month for the given reporting period.
- You may submit multiple months in a single file, but please ensure the files represent the entire month for each month you are submitting (no partial-month data).
- The files should be submitted within 60 days of the close of the reporting period. For example, data for March 1 - 31 is due on May 30.
- Hospital systems have the option to submit a *single* patient discharge data file for *all* hospitals in their system. Please contact Anne Castles to learn more.
- All data submissions will be made via the MDC's secure web-based tool, housed in dedicated server environments maintained by Stanford University's School of Medicine, Information, Resources and Technology (Med-IRT) Group.
- Files should be in CSV file format—using commas to separate values—with each case in a single row. A template CSV file format is also available at http://www.wsha.org/0513.cfm%20.
- Column headers, as denoted in the specifications below, must be used for all fields you are submitting.
- If the field is optional and you are choosing not to submit it, please omit the column header/column. Optional fields are highlighted in blue.
- If a column value is missing, leave no space between the commas(,,)

Data Elements

The data elements to be submitted fall into three categories, which will be submitted via at least three separate files:

- Patient Discharge Data (in UB-04 format): See Section B.
- Maternal Clinical Data. See Section C.
- Newborn Clinical Data. See Section D.

Records to be Submitted

- Hospitals may choose between submitting all patient records *or* limiting the submission to delivery-related discharges. If you choose to limit your submission to delivery-related discharges, please use the codes in Section A below to filter your data. If you submit all discharge records, the MDC will apply the filters for you.
- Some fields are optional; optional fields are highlighted in blue and marked with an "O". If you choose not to submit data for these fields, please omit the column headers.

Registering with WSHA-MDC Prior to Submitting Data

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

- Click on the colored box in the invitation e-mail addressed to you from SafeDeliveries@cmqcc.org.
- Enter a login name, personal password and phone numbers that you personally answer.
  The phone numbers are part of the MDC security protocols: each time you access patient level information, MDC will transmit a computer-generated pin number through a call or text to your registered phone number. For hospitals that use extensions, please contact Anne Castles for special instructions.

Uploading Data Files

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

https://www.SafeDeliveries.org

In order to submit a data file, you will:

- Enter your login name and personal password.
- In the upper right corner, click the button "Data Entry Status".
- Go through the 3 steps to upload the three data files.
- You will receive a prompt for second factor authorization: the temporary pin required when submitting patient level data. Click "Call" or "Text" to select the phone number at which you wish to receive the pin number. Input the temporary pin provided via the call or text and click "Submit".
- In the left hand box, select the beginning and end dates of the data file you plan to upload. Please make sure the dates you choose are correct.
- If you are submitting separate files representing distinct months, please upload the files in chronological order (January data before February data).
- Select "Choose File" to attach the file to be uploaded from your system.
- Click "Upload". The data may process for several minutes depending on the size of your file. Once the file is accepted, the word "Complete" will display within the Patient Discharge Data bar.

If errors are found, you will receive an error message. Please contact CMQCC if you need assistance in interpreting the message. You may also use the Support link in the upper black bar to contact CMQCC. Your message will automatically include documentation of the page you were visiting when you click on Support and then select the "Contact WSHA MDC" button.

Summary of Changes to WSHA-MDC Data Specifications since June 2014

Changes since 7/15/15 Version

Section A2: Records to Include in MDC Data Submission

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

Changes since 2/9/15 Version

Section A: Records to Include in MDC Data Submission

Section A specifies the ICD codes to be used for identifying maternal and newborn records, and is now delineated in two sections.

- Section A1 provides the ICD-9 codes to be used for files that represent discharge dates before October 1, 2015.
- Section A2 provides the ICD-10 codes to be used for files that represent discharge dates on and after October 1, 2015.

Section C: Maternal Clinical File

There are new *OPTIONAL* Supplemental Data Elements:

- *Transfer from Alternative Birth Setting*. This data element allows the hospital to indicate, for any patient, whether labor management was initiated outside of the hospital, and if so, the alternative birth setting from which the mother was transferred.
- *Labor Management Process Measure*: There are 17 new data elements that represent the fields for the labor management process measures. If your hospital captures any of these data elements via an electronic system, you may wish to pre-populate the chart review boxes via a supplemental data submission.

Section D: Newborn Clinical File

There is a new *OPTIONAL* Supplemental Data Element: *Newborn Discharge Status*. This is the same data element submitted as part of the Discharge Data File. Including it as an optional field in the Supplemental Newborn Clinical File enables the hospital to make corrections to the original value in the Discharge Data File. This may be useful for the Unexpected Newborn Complications measure.

Changes since November 12, 2014 Version

Data element definitions used for The Joint Commission Perinatal Care measure set have been updated in alignment with the 2015A TJC Manual. The following data elements were modified:

- Admission to NICU
- Antenatal Steroid Therapy Initiated
- Birthweight
- Blood Stream Infection Present on Admission
- Exclusive Breast Milk Feeding
- Gestational Age
- Labor
- Parity
- Prior Uterine Surgery
- Reason for Not Exclusively Breast Milk Feeding
- Reason for Not Initiating Antenatal Steroid Therapy

Changes since October 1, 2014 Version

- Maternal Clinical File: Gestational Age Fields. The original data specifications called for gestational age to be broken down into two distinct fields: "Gestational Age-Weeks" (required) and "Gestational Age-Days" (optional). However, some hospitals clinical systems capture Gestational Age as a "combined" field that includes both completed weeks and days (e.g. 37+4). The MDC now has a new optional field called "Gestational Age_combined". If your hospital wishes to submit in the combined format, please use the column header "gestational age_combined". If you submit the combined form (e.g. 36 +3) in the "gestational age_weeks" column, you will receive an error message. See pages 15-16.

Changes since July 30, 2014 Version

- Admission Source Coding: Codes D,E,F available options for coding. See Page 7.
- Clarified instructions on selecting cases for clinical files are on pages 13 and 22.
- Information on how to submit Supplemental Files on pages 13 and 22.

Changes since Test Phase Draft of June 24, 2014

- Section A (page 4): Hospitals should not use DRGs or Major Diagnostic Categories (MDCs) to identify maternal and newborn records; use of these codes may inadvertently omit delivery-related cases with severe complications
- Section A (page 4): Typo corrected in the last ICD-9 code used for identifying maternal records (74.99 replaces 749.9).
- Patient Discharge Data (Pages 7-8): Wording has been clarified around use of Newborn Codes in *Source of Referral* field.

Section A1
Records to Include in MDC Data Submission
ICD-9 Codes
Pages 5-6

Please include all of the following records in you MDC Submission. Please apply these ICD-9 code filters to both the discharge and clinical files. If it is not possible to use ICD-9 codes as filters for the clinical files, then please attempt to include only maternal and newborn delivery hospitalizations in your clinical files (i.e. no antepartum or post-partum hospitalizations).

For the Patient Discharge Data, you may choose to submit the hospital's complete set of discharges; if so, MDC will apply this algorithm to your submission and discard all unnecessary records.

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

Infant Records	**Please include all newborn discharge records meeting ANY of the following criteria:**	
Dates of Admission and Birth	Admission Date – Date of Birth ≤ 28 days	
ICD-9-CM V-Codes: Neonatal observation and evaluation	V29.x	Observation for suspected condition
ICD-9-CM V-Codes: Live births (In-hospital and Out-of-Hospital)	V30.xx	Single liveborn
	V31.xx	Twin liveborn, mate liveborn
	V32.xx	Twin liveborn, mate stillborn
	V33.xx	Twin liveborn, mate unspecified
	V34.xx	Other multiple, mates all liveborn
	V35.xx	Other multiple, mates all stillborn
	V36.xx	Other multiple, mates live and stillborn
	V37.xx	Other multiple, mates unspecified
	V39.xx	Unspecified liveborn

Section A2
Records to Include in MDC Data Submission
ICD-10 Codes
Page 7

Include all discharge records meeting ANY of the following criteria

Mother Records

Outcome of Delivery

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

Delivery *(Letter "O" codes)*

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

Delivery Procedure Codes (Joint Commission Table Number 11.01.1)

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

Infant Records

Admission Date Criteria

Admission Date – Date of Birth ≤ 2 days

Liveborn Infants

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

Section B:
Patient Discharge Data Elements

Please note that while the MDC utilizes the same coding and definitions as CHARS, we do not utilize the CHARS File Format.

Coding definitions can be found in the following manuals:

- NUBC UB-04 Data Specifications Manual: http://www.nubc.org/ **or**
- CHARS Procedure Manual for Submitting Discharge Data and CHARS Companion Guide:
- http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS/CHARS837I5010Transition.aspx#UB04%20837I%205010%20Manuals

Notes

- Use the patient's discharge date to filter the records for each reporting period.
- Each submission will include one or more months' worth of discharge data and should include the entire set of records for each month in the submission.
- For the "Medical/Health Record" field, please supply a patient record number that will enable authorized hospital staff to conduct record look-ups. The number will be encrypted upon receipt by MDC server, but will be re-constituted to true value by authorized hospital staff using private key.
- CSV File Format—using commas to separate values—with each case in a single row.
- Column headers, as denoted below, must be used for all fields you are submitting.
- If a column value is missing, leave no space between the commas (,,)
- You must submit all fields marked as "Required" with an "R". Optional fields are denoted by blue highlighting and the letter "O". If the field is optional and you are choosing not to submit it, please omit the column header/column.
- The file may be rejected if it does not include certain required fields (e.g. Principal Diagnosis). Although we encourage completeness, the file will not be rejected if some records are missing values in the required fields.

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
R	Facility ID	6-digit Medicare Provider ID https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/v287-28n3	facility_id	Medicare.gov
O	Federal Tax Number	The number assigned to the hospital by the federal government for tax reporting purposes. Also known as the tax identification number (TIN).	Tax_id	NUBC UB-04 Manual
O	Hospital Campus ID	Additional ID that distinguishes one hospital campus from another when two or more sites report under the same Medicare Provider ID number.	campus_id	Up to 3 digit internal code of hospital choice
R	Medical/Health Record Number	Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's medical records	medical_record_number	NUBC UB-04 Manual
R	Patient Address –Zip Code	Report the entire nine digits zip code if known. Use no dashes between zip and zip+4. If the Zip Code is unknown, use 99999. If the patient is homeless, use 99998.	zip_code	

<table>
<tr><th>Required (R) or Optional (O)</th><th>Data Element</th><th>Description</th><th>Column Header</th><th>Report Value According To</th></tr>
<tr><td>R</td><td>Patient Birth date</td><td>The date of birth of the patient. If unknown, use June 30 of the estimated year. (MMDDYYYY)</td><td>date_of_birth</td><td>CHARS Procedure Manual</td></tr>
<tr><td>R</td><td>Patient Sex</td><td>The sex of the patient as recorded at admission or start of care. Use “M” (Male), “F” (Female) or “U” (Unknown).</td><td>sex</td><td>NUBC UB-04 Manual</td></tr>
<tr><td>R</td><td>Admission/Start of Care Date</td><td>The start date for this episode of care. For inpatient services, this is the date of admission. (MMDDYYYY)</td><td>admitted_on</td><td>NUBC UB-04 Manual</td></tr>
<tr><td>R</td><td>Admission Hour</td><td>The code referring to the hour during which the patient was admitted for inpatient care.

<table>
<tr><th>Code</th><th>Time</th><th>-</th><th>AM</th><th></th><th>Code</th><th>Time</th><th>-</th><th>PM</th></tr>
<tr><td>00</td><td>12:00</td><td>–</td><td>12:59 Midnight</td><td></td><td>12</td><td>12:00</td><td>–</td><td>12:59 Noon</td></tr>
<tr><td>01</td><td>01:00</td><td>-</td><td>01:59</td><td></td><td>13</td><td>01:00</td><td>–</td><td>01:59</td></tr>
<tr><td>02</td><td>02:00</td><td>-</td><td>02:59</td><td></td><td>14</td><td>02:00</td><td>-</td><td>02:59</td></tr>
<tr><td>03</td><td>03:00</td><td>-</td><td>03:59</td><td></td><td>15</td><td>03:00</td><td>-</td><td>03:59</td></tr>
<tr><td>04</td><td>04:00</td><td>-</td><td>04:59</td><td></td><td>16</td><td>04:00</td><td>-</td><td>04:59</td></tr>
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<tr><td>11</td><td>11:00</td><td>-</td><td>11:59</td><td></td><td>23</td><td>11:00</td><td>-</td><td>11:59</td></tr>
</table></td><td>admit_hour</td><td>NUBC UB-04 Manual</td></tr>
<tr><td>R</td><td>Priority (Type) of Visit</td><td>A code indicating the priority of this admission/visit. Only values 1-5 or 9 are accepted.

1 Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions.
2 Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder.
3 Elective The patient’s condition permits adequate time to schedule the services.
4 Newborn: Use of this code necessitates the use of Special Source of Admission Code. See Form Locator 15 below.
5 Trauma: Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
9 Information: Information not available.</td><td>visit_type</td><td>NUBC UB-04 Manual</td></tr>
<tr><td>R</td><td>Source of Referral for Admission or Visit</td><td>A code indicating the point of origin for this admission or visit.
1 Non-Health Care Facility Point of Origin: The patient was admitted to this facility upon the order of a physician.
2 Clinic: The patient was admitted to this facility.
4 Transfer from a Hospital (Different Facility): The patient was admitted to this facility as a hospital transfer from an acute care facility.
5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from an SNF or ICF.</td><td>admit_source</td><td>NUBC UB-04 Manual</td></tr>
</table>

<table>
<tr><th>Required (R) or Optional (O)</th><th>Data Element</th><th>Description</th><th>Column Header</th><th>Report Value According To</th></tr>
<tr><td></td><td></td><td>6 Transfer from another Health Care Facility: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. (continued)
8 Court/Law Enforcement: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9 Information is Not Available: The means by which the patient was admitted to this hospital is not known.
D Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital: The patient was admitted to this facility as a transfer from hospital inpatient within the hospital resulting in a separate claim to the payer.
E Transfer from an Ambulatory Surgery Center: The patient was admitted to this facility as a transfer from an ambulatory surgery center.
F Transfer from Hospice and under Hospice Plan of Care: The patient was admitted to this facility as a transfer from hospice.

Code Structure for Newborn
If above field “Priority (Type) of Visit = 4, Newborn”, use these codes:
5 Born Inside Hospital: A baby born inside this hospital.
6 Born Outside this Hospital: A baby born outside of this hospital</td><td></td><td></td></tr>
<tr><td>R</td><td>Discharge Date</td><td>The date patient discharged from the hospital (MMDDYYYY).
Special Instructions: Single-digit months and days must include a preceding zero.</td><td>discharged_on</td><td></td></tr>
<tr><td>R</td><td>Discharge Hour</td><td>Discharge Hour: A code indicating the discharge hour of the patient from care.

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<tr><td>02</td><td>02:00</td><td>-</td><td>02:59</td><td></td><td>14</td><td>02:00</td><td>-</td><td>02:59</td></tr>
<tr><td>03</td><td>03:00</td><td>-</td><td>03:59</td><td></td><td>15</td><td>03:00</td><td>-</td><td>03:59</td></tr>
<tr><td>04</td><td>04:00</td><td>-</td><td>04:59</td><td></td><td>16</td><td>04:00</td><td>-</td><td>04:59</td></tr>
<tr><td>05</td><td>05:00</td><td>-</td><td>05:59</td><td></td><td>17</td><td>05:00</td><td>-</td><td>05:59</td></tr>
<tr><td>06</td><td>06:00</td><td>-</td><td>06:59</td><td></td><td>18</td><td>06:00</td><td>-</td><td>06:59</td></tr>
<tr><td>07</td><td>07:00</td><td>-</td><td>07:59</td><td></td><td>19</td><td>07:00</td><td>-</td><td>07:59</td></tr>
<tr><td>08</td><td>08:00</td><td>-</td><td>08:59</td><td></td><td>20</td><td>08:00</td><td>-</td><td>08:59</td></tr>
<tr><td>09</td><td>09:00</td><td>-</td><td>09:59</td><td></td><td>21</td><td>09:00</td><td>-</td><td>09:59</td></tr>
<tr><td>10</td><td>10:00</td><td>-</td><td>10:59</td><td></td><td>22</td><td>10:00</td><td>-</td><td>10:59</td></tr>
<tr><td>11</td><td>11:00</td><td>-</td><td>11:59</td><td></td><td>23</td><td>11:00</td><td>-</td><td>11:59</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table></td><td>discharge_hour</td><td>NUBC UB-04 Manual</td></tr>
<tr><td>R</td><td>Patient Discharge Status</td><td>An NUBC code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill as reported in FL6, Statement Covers Period. The following values are accepted by CHARS:
1 Discharged to Home or Self care (Routine Discharges)
2 Discharged/transferred to Short Term General Hospital for Inpatient Care
3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care.
4 Discharge /transferred to a Facility That Provides Custodial or Supportive Care (Includes ICF and Assisted Living Facilities)
5 Discharged/transferred to a Designated Cancer Center or Children’s Hospital
6 Discharged/transferred to Home under Care of Organized Home Health Service</td><td>discharge_status</td><td>CHARS Procedure Manual</td></tr>
</table>

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
		Organization in Anticipation of Covered Skilled Care. 7 Left Against Medical Advice or Discontinued Care 9 Admitted as an inpatient to this hospital 20 Expired 21 Discharged/transferred to Court/Law Enforcement 30 Still patient 43 Discharged/transferred to a Federal Health Care Facility 50 Hospice-Home 51 Hospice – Medical Facility (Certified) Providing Hospice Level of Care 61 Discharged/transferred to a Hospital Based Medicare Approved Swing Bed 62 Discharged/transferred to an Inpatient Rehabilitation Facility(IRF) including Rehabilitation Distinct Part Units of a Hospital 63 Discharged/transferred to a Medicare-Certified Long Term Care Hospital (LTCH) 64 Discharged/transferred to a Nursing Facility Certified under Medicaid but not certified under Medicare 65 Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital 66 Discharged/transferred to a Critical Access Hospital (CAH) 69 Discharges/transferred to Designated Disaster Alternative Care Site 70 Discharged/transferred to another Type of HealthCare Institution Not Defined Elsewhere in this Codes List 81 Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission 82 Discharged/Transferred to Short Term General Hosp for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission 83 Discharged/Transferred to SNF with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission 84 Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission 85 Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission 86 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission 87 Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission 88 Discharged/Transferred to Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission. 89 Discharged/Transferred to a Hospital Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission 90 Discharged/Transferred to Inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission 91 Discharged/Transferred to Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission. 92 Discharged/Transferred to A Nursing Facility Certified Under Medicaid but not Medicare with a Planned Acute Care Hospital Inpatient Readmission		

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
		93 Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission 94 Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission 95 Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in the Code List with a Planned Acute Care Hospital Inpatient Readmission		
O	Value Codes	Code structure to relate amounts or values to identify data elements necessary to process this claim (worker's comp, information noted below) *May include up to 100 value codes*	value_code_1, value_code_2, ……	NUBC UB-04 Manual
R	Revenue Code	Codes that identify a specific accommodation, or ancillary service or unique billing calculation or arrangement. Discharges should include accommodation codes and these are identified in the 010x to 021x series. Ancillary codes are identified in the 022x to 099x series. Bill type 131 discharges will include observation revenue codes 0760, 0761, or 0762. Legitimate outpatient charges on inpatient discharges shall be mapped to the corresponding inpatient revenue codes. For the list of accepted revenue codes see Appendix C in CHARS procedure manual. *Please include <u>all</u> revenue codes (max of 100 fields)*	revenue_code_1, revenue_code_2, revenue_code_3…..revenue_code_100	CHARS Procedure Manual
O	HCPCS/Rates/HIPPS Rate Codes	The Healthcare Common Procedure Coding System (HCPCS) codes are applicable to ancillary service and outpatient bills. Refer to the most recent AMA Medicare's National Level II Codes HCPCS and AMA CPT Coding Manual. *May include up to 100 HCPCS codes*	HCPCS_1, HCPCS_2, …..	NUBC UB-04 Manual
R	Service Units	A quantitative measure of services rendered by revenue category (i.e., revenue code) to the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. *Please include <u>all</u> service units associated with the revenue codes provided (max of 100 fields)*	service_unit_1, servce_unit_2, …. service_unit_100	NUBC UB-04 Manual
R	Payer Name	Name of the health plan that the provider might expect some payment for the bill. Payer_1=Primary Payer Payer_2=Secondary Payer	payer_1, Payer_2	NUBC UB-04 Manual
R	Health Plan Identification Number	Payer Identification Number identifying each payer group from which the hospital may expect some payment of the bill. Report all payers that are applicable (up to three). Values for CHARS are: 001 Medicare: Medicare and Medicare Managed Care (Secure Horizons, Advantage) 002 Medicaid: State or Federal, Healthy Options, SCHIP, Medicaid Managed Care, Basic Health Plan, etc 004 Health Maintanence Organizaion (HMO): Kaiser, Group Health, etc. 006 Commercial Mutual of Omaha, AARP, Safeco, etc. 008 Worker's Compensation Workers Compensation (L&I), Crime Victims, self insured	payer_type_1, payer_type_2	CHARS Procedure Manual

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
		employers, etc. 009 Self-Pay: Patient or family balance not covered under other catagories 610 Health Service Contractors: Premera, Premera/Blue Cross, KPS, etc. 625 Other Government Sponsored Patients: TRI-CARE's, CHAMPUS, Indian Health, Corrections, County, etc. 630 Charity Care: Charity Care as defined by Revised Code of Washington 70.170		
R	Principal Diagnosis Code	The ICD-9-CM/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.) To ensure codes stay intact within the CSV format, include periods after the third digit for all ICD-9 OR ICD-10 diagnosis codes.	principal_diagnosis	NUBC UB-04 Manual
R	Present on Admission Code for Principal Diagnosis	The five reporting options for all POA reporting are as follows: Y: Yes N: No U: No Information in the Record W: Clinically Undetermined Blank: Exempt from POA reporting	poa	
R	Other Diagnoses Codes and Present on Admission Codes	All additional ICD-9-CM/ICD-10-CM diagnosis codes. To ensure codes stay intact within the CSV format, include periods after the third digit for all ICD-9 OR ICD-10 diagnosis codes. *Please include <u>all</u> "other diagnosis" and associated "poa" codes (max of 100 fields)*	other_diagnosis_1, poa_1, other_diagnosis_2, poa_2, …..	CHARS Procedure Manual
R	Principal Procedure Code	The ICD-9-CM/ICD-10CM-PCS code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill To ensure codes stay intact within the CSV format, include periods after the second digit for all ICD-9 procedure codes.	principal_procedure	NUBC UB-04 Manual
R	Principal Procedure Date	The corresponding date (MMDDYYYY) of the principal procedure.	principal_procedure_date	
R	Other Procedure Codes and Dates	All ICD-9-CM /ICD-10CM-PCS procedure codes. To ensure codes stay intact within the CSV format, include periods after the second digit for all ICD-9 procedure codes. *Please include <u>all</u> "other procedure codes" and "other procedure dates" (max of 100 fields)*	other_procedure_1, other_procedure_1_date, other_procedure_2, other_procedure_2_date,…	CHARS Procedure Manual
R	Attending Provider Identifier	The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Provide the National Provider Identifier (NPI).	Attending_provider	NUBC UB-04 Manual

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
R	Patient Race	The code which best describes the race and ethnicity of the patient. The Federal Office of Management and Budget (OMB) Standard titles are used. 1 White 2 Black or African-American 3 American Indian or Alaska Native 4 Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, etc.) 5 Native Hawaiian or Pacific Islander (including Chamorro, Samoan, etc.) 8 Patient refused 9 Unknown	race _omb	CHARS Procedure Manual
R	Patient Ethnicity	1 Hispanic Origin (including Spanish, Mexican, Puerto Rican, Cuban, etc.) 2 Not Hispanic 8 Patient refused 9 Unknown	Ethnicity_omb	

Section C:
Maternal Clinical Data File:
Core and Supplemental

Instructions and File Format

- If possible, use ICD-9 OR ICD-10 codes in Section A to filter the records to submitted to the MDC. If that is not possible for the clinical file, include only records for *delivery-related hospitalizations* in the clinical file (i.e. do not include antepartum or postpartum records).
- The "Core" Maternal Clinical File must include the following required data fields: Maternal ID, Maternal DOB, Maternal Date of Discharge, Gestational Age, Parity as specified below. **If any required data fields are missing from the "Core" Maternal File, the file will be rejected**. (Although we encourage completeness for required data fields, the file will not be rejected if some records are missing values in the required fields.)
- In addition to the required "Core Maternal File" you also have the *option* to submit additional data, either as part of the core file or in separate supplemental files. As long as you have already submitted the "Core Maternal File" you can submit multiple supplemental files with different data elements and at different points in time. For example, you might submit one "supplemental maternal file" that includes values solely for "prior uterine surgery" 75 days after your initial submission and a second "maternal file" that includes data for "patient weight" 90 days after your initial submission. If two supplemental files are submitted that contain the same field for the same reporting period, the last submitted will represent the "final" value.
- CSV File Format with each case in a single row.
- Column headers, as denoted below, must be used for all fields you are submitting.
- You must submit all fields marked as "Required" with an "R". Optional fields are denoted by blue highlighting and the letter "O". If the field is optional and you are choosing not to submit it, please omit the column header/column.
- If a column value is missing, leave no space between the commas (,,)
- Use the patient's discharge date to filter the records for each reporting period (each submission will include one or more months' worth of data; please use complete calendar months.)
- Please submit separate clinical files for "Maternal" Data Elements and "Newborn" Data Elements

OPTIONAL Fields

Some fields are optional, and are denoted by the letter "O" in the "Required or Optional Column".
These optional fields may be derived from internal systems (e.g. EMR, core measure vendor system) and might be used to:

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

SUPPLEMENTAL Files

You may also choose to submit *optional* fields at later points in time via supplemental files. All supplemental files must include the fields: Patient ID/Medical Record Number, Date of Discharge and the Optional field(s) you're submitting*, using the designated column headers* in the specifications below. For more information, please see the document "Supplemental Data Submissions" at https://www.safedeliveries.org/support.

If you choose NOT to include any of the optional fields, you must omit the column header/column for those fields.

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
CORE Fields				
Maternal Medical Record Number	R	Unique code identifying a particular patient record within reporting facility	medical_record_number	Medical record number or any patient identification number assigned by the facility. Use a number that matches the record number for the mother provided in the patient discharge data file submission to MDC. The number will be encrypted upon receipt by the MDC server, but will be re-constituted to true value by authorized hospital staff using private key.
Discharge Date	R	The date patient discharged from the hospital.	discharge_date	MMDDYYYY
Parity	R	The number of live deliveries the patient experienced prior to current hospitalization.	parity	**Allowable Values**: 0-50 or UTD=Unable to Determine **Notes for Abstraction:** The delivery or operating room record should be reviewed first for parity. If parity is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for parity is found. In cases where there is conflicting data, parity found in the first document according to the order listed above should be used. If parity entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number or two different numbers are listed in the first document and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered. If parity is not documented and GTPAL terminology is documented where G= Gravida, T= Term, P= Preterm, A= Abortions and L= Living, all previous term and preterm deliveries prior to this hospitalization should be added together to determine parity. If parity is not documented and gravidity is documented as one, parity should be considered zero. The previous delivery of twins or any multiple gestation is considered one parous event. Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below. If the number for parity documented in the EHR includes the delivery for the current hospitalization, parity should be answered as one number less than the number documented. If primagravida is documented select zero for parity.

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				Additional Notes: ***Inclusions***: The following descriptor must precede the number when determining parity: • Para • Parity • P Examples: parity=2 or g3p2a1 ***Exclusions***: A string of three or more numbers without the alpha designation of "p" preceding the second number cannot be used to determine parity. Example: 321 When GTPAL terminology is documented, G= Gravida, T= Term, P= Preterm, A= Abortions, L= Living, P does not equal parity. **Suggested Data Sources:** ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE: • Delivery room record • Operating room record • History and physical • Prenatal forms • Admission clinician progress notes • Discharge summary
Gestational Age-Weeks	R	The weeks of gestation completed at the time of delivery. The number of weeks that have elapsed between the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery, irrespective of whether the gestation results in a live birth or a fetal death.	gestational_age_weeks	**Allowable values:** 1-50 or UTD=Unable to Determine **Notes for Abstraction:** Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age. If the patient has not received prenatal care, select allowable value UTD. When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date. Gestational age should be documented by the clinician as a numeric value between 1-50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery. Ultrasound-based dating is also an acceptable method of determining gestational age. If the gestational age entered by the clinician in the first document listed above is obviously

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				incorrect (in error) but it is a valid number or two different numbers are listed in the first document and the correct number can be supported with documentation in the other acceptable data sources in the medical record, the correct number may be entered. Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below. **Suggested Data Sources:** ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE: • Delivery room record • Operating room record • History and physical • Prenatal forms • Admission clinician progress notes • Discharge summary
Optional				
Gestational Age-Days (OPTIONAL)	O	The additional number of days of gestation elapsed after the last completed week.	gestational_age_days	**Allowable values:** 0-6 or blank if unknown
Gestational Age-Combined (OPTIONAL)	O	Gestational age in weeks plus days, in a combined format.	gestational_age_combined	For hospitals with clinical systems that combine the completed weeks of gestational age with the days. Allowable forms include: • 37 • 37+3 • 37.3 • 37 3/7 • 37w 3d • 37 weeks 3 days
Number of Maternal ICU Days	O	Total number of days the mother spent in ICU during delivery hospitalization	ICU_days	Allowable Values: 0-180 or UTD=Unable to Determine **If there was no ICU stay, use a "0"; not a blank. Blanks indicate missing information.** *Required to calculate CMS Partnership for Patients metric*

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Red Blood Cell Blood Products Transfused	O	Total Number of Red Blood Cell (RBCs) blood product units transfused	Number_rbc_products	**Allowable Values:** Allowable Values: 0-100 or UTD=Unable to Determine **If there was no transfusion of this blood product type, use a "0"; not a blank. Blanks indicate missing information.** **Suggested Data Sources:** • Nursing notes • Discharge summary • Physician progress notes • Chargemaster data • Blood bank data *Required to calculate new CMS Partnership for Patients metric*
Fresh Frozen Plasma Blood Products Transfused	O	Total number of Fresh Frozen Plasma (FFP) blood product units transfused.	Number_ffp_products	**Allowable Values:** Allowable Values: 0-100 or UTD=Unable to Determine **If there was no transfusion of this blood product type, use a "0"; not a blank. Blanks indicate missing information.** **Suggested Data Sources:** • Nursing notes • Discharge summary • Physician progress notes • Chargemaster data • Blood bank data *Required to calculate new CMS Partnership for Patients metric*
Platelet Pack Blood Products Transfused	O	Total number of Platelet Pack blood product units transfused	Number_pp_products	**Allowable Values:** Allowable Values: 0-100 or UTD=Unable to Determine **If there was no transfusion of this blood product type, use a "0"; not a blank. Blanks indicate missing information.** **Suggested Data Sources:** • Nursing notes • Discharge summary • Physician progress notes • Chargemaster data • Blood bank data *Required to calculate new CMS Partnership for Patients metric*
Number of Cryoprecipitate Blood Products Transfused	O	Total number of cryoprecipitate blood product units transfused (Cryo)	Number_cryo_products	**Allowable Values:** Allowable Values: 0-100 or UTD=Unable to Determine **If there was no transfusion of this blood product type, use a "0"; not a blank. Blanks indicate missing information.** **Suggested Data Sources:** • Nursing notes • Discharge summary • Physician progress notes • Chargemaster data • Blood bank data *Required to calculate new CMS Partnership for Patients metric*
Total Number of Blood Products Transfused	O	Total number of blood product units transfused (summary of RBCs, FFP, Platelet Packs, Cyro)	total_blood_products	**Allowable Values:** Allowable Values: 0-100 or UTD=Unable to Determine **If there was no transfusion, use a "0"; not a blank. Blanks indicate missing information.**

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				Suggested Data Sources: • Nursing notes • Discharge summary • Physician progress notes • Chargemaster data • Blood bank data
Labor	O	Documentation by the clinician that the patient was in labor	labor_present	**Allowable Values:** Y (Yes) There is documentation by the clinician that the patient was in labor. N (No) There is no documentation by the clinician that the patient was in labor OR unable to determine from medical record documentation. Leave blank (,,) if the information is missing/not collected for a specific case **Notes for Abstraction:** A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). • Documentation of labor by the clinician should be abstracted at face value. There is no requirement for acceptable descriptors to be present in order to answer "yes" to labor. • Documentation of regular contractions or cervical change without mention of labor cannot be used to answer "yes" to labor ***Include***: The following are acceptable descriptors for labor: •Active • Early • Spontaneous ***Exclude***: The following are not acceptable descriptors for labor: •Latent • Prodromal **Suggested Data Sources**: History and physical, Nursing notes, Physician progress notes
Spontaneous Rupture of Membranes	O	Documentation that the patient had spontaneous rupture of membranes (SROM) *before* medical induction and/or cesarean section.	srom_before	**Allowable Values:** Y (Yes) There is documentation that the patient had spontaneous rupture of membranes before medical induction and/or c-section. N (No) There is no documentation that the patient had spontaneous rupture of membranes before medical induction and/or cesarean section OR unable to determine from medical record documentation. Leave blank (,,) if the information is missing/not collected for a specific case **Notes for Abstraction:** If the patient's spontaneous rupture of membranes is confirmed before medical induction and/or cesarean section by one of the following methods, select allowable value "Yes": • Positive ferning test • Positive nitrazine test • Positive pooling (gross fluid in vagina) • Positive Amnisure ROM test or equivalent • Patient report of SROM prior to hospital arrival **Suggested Data Sources**: History and physical, Nursing notes, Physician progress notes

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Prior Uterine Surgery	O	Documentation that the patient had undergone prior uterine surgery.	prior_uterine_surgery	**Allowable Values:** Y (Yes) The medical record contains documentation that the patient had undergone prior uterine surgery. N (No) The medical record does not contain documentation that the patient had undergone a prior uterine surgery OR unable to determine from medical record documentation. Leave blank (,,) if the information is missing/not collected for a specific case **Notes for Abstraction:** The only prior uterine surgeries considered for the purposes of the measure are: • Prior classical cesarean section which is defined as a vertical incision into the upper uterine segment • Prior myomectomy • Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury • History of a uterine window or thinning of the uterine wall noted during prior uterine surgery or during ultrasound • History of uterine rupture requiring surgical repair • History of a cornual ectopic pregnancy **Exclude from definition of "prior uterine surgery":** • Prior low transverse cesarean section • Prior cesarean section without specifying prior classical cesarean section **Suggested Data Sources:** History and physical, Nursing admission assessment, progress notes, physician's notes, prenatal forms
Antenatal Steroid Therapy Initiated	O	Documentation that antenatal steroid therapy was initiated before delivery. Initial antenatal steroid therapy is 12mg betamethasone IM or 6mg dexamethasone IM. *Note: Data used to populate both Joint Commission and Leapfrog versions of Antenatal Steroids measure*	antenatal_steroid_administered	**Allowable Values:** Y (Yes) There is documentation that antenatal steroid therapy was initiated before delivery. N (No) There is no documentation that antenatal steroid therapy was initiated before delivery OR unable to determine from medical record documentation. Leave blank (,,) if the information is missing/not collected for a specific case **Notes for Abstraction:** If there is documentation that antenatal steroid therapy was initiated prior to current hospitalization in another setting of care, i.e., doctor's office, clinic, birthing center, hospital before delivery, select allowable value "yes". If antenatal steroid therapy was initiated in the hospital, the name of the medication must be documented in the medical record in order to select allowable value "yes". Refer to Appendix C, Table 11.0 Antenatal Steroid Medications **Suggested Data Sources:** • History and physical • Progress notes • Medication administration record (MAR) • Prenatal forms

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Reason for Not Initiating Antenatal Steroid Therapy	O	Reasons for not initiating antenatal steroid therapy before delivery are clearly documented in the medical record. Reasons for not initiating antenatal steroid therapy may include fetal distress, imminent delivery or other reasons documented by physician/advanced practice nurse (APN)/physician assistant (PA)/certified nurse midwife (CNM). Initial antenatal steroid therapy is 12mg betamethasone IM or 6mg dexamethasone IM. *Note: Data used to populate both Joint Commission and Leapfrog versions of Antenatal Steroids measure*	antenatal_steroid_exclusion	**Allowable Values:** Y (Yes) There is documentation by physician/APN/PA/CNM that the patient has one or more reasons for not initiating antenatal steroid therapy before delivery. N (No) There is no documentation by physician/APN/PA/CNM of a reason for not initiating antenatal steroid therapy before delivery or unable to determine from medical record documentation. Leave blank (,,) if the information is missing/not collected for a specific case **Notes for Abstraction:** When determining whether there is a reason documented by a physician/APN/PA or CNM for not initiating antenatal steroid therapy, reasons must be explicitly documented (e.g., "patient had an adverse reaction to the medication in the past - unable to initiate antenatal steroid therapy") or clearly implied (i.e., there is documentation of an imminent delivery which occurs within 2 hours after admission to the hospital, there is documentation the fetus has anomalies which are not compatible with life, there is documentation that the patient has chorioamnionitis). **Suggested Data Sources:** PHYSICIAN/APN/PA/CNM DOCUMENTATION ONLY • History and physical • Physician progress notes • Prenatal forms
DVT Prophylaxis - C-Section	O	Documentation that patient received either fractionated or unfractionated heparin or heparinoid, or pneumatic compression devices prior to surgery	dvt_prophylaxis_administered	**Allowable Values:** Y (Yes) There is documentation that the patient received either fractionated or unfractionated heparin or heparinoid, or pneumatic compression devices prior to surgery N (No) There is no documentation that the patient received either fractionated or unfractionated heparin or heparinoid, or pneumatic compression devices prior to surgery Leave blank (,,) if the information is missing/not collected for a specific case
Sample Flag for Joint Commission PC-01	O	Flag to indicate that the record was included in the hospital's Joint Commission sample (drawn via the core measure vendor system) for PC-01: Elective Delivery < 39 Weeks.	pc_01_sample	**Allowable values:** Y (Yes): Record is part of Joint Commission Sample for this measure. N (No) or Blank: Record is not part of Joint Commission sample for this measure or sample inclusion is unknown
Sample Flag for Joint Commission PC-02	O	Flag to indicate that the record was included in the hospital's Joint Commission sample (drawn via the core measure vendor system) for PC-02: NTSV C-section Rate.	pc_02_sample	**Allowable values:** Y (Yes): Record is part of Joint Commission Sample for this measure. N (No) or Blank: Record is not part of Joint Commission sample for this measure or sample inclusion is unknown

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Sample Flag for Joint Commission PC-03	O	Flag to indicate that the record was included in the hospital's Joint Commission sample (drawn via the core measure vendor system) for PC-03: Antenatal Steroids.	pc_03_sample	**Allowable values:** Y (Yes): Record is part of Joint Commission Sample for this measure. N (No) or Blank: Record is not part of Joint Commission sample for this measure or sample inclusion is unknown
Sample Flag for Leapfrog DVT Prophylaxis Measure	O	Flag to indicate that the record was included in the hospital's Leapfrog sample for DVT Prophylaxis.	lf_dvt_sample	**Allowable values:** Y (Yes): Record is part of Leapfrog Sample for this measure. N (No) or Blank: Record is not part of Leapfrog sample for this measure or sample inclusion is unknown
Provider ID: Delivering Provider	O	The National Provider Identifier (NPI) of the person delivering the baby	prov_delivering	**Allowable values:** 10-digit alphanumeric. The NPI is issued to health care providers by CMS. This field will be used to generate physician-level metrics for the hospital's internal use; it is the hospital's choice as to which provider constitutes the "delivering provider" in order to make attributions around the delivery.
Maternal Diagnosis Codes	O	All conditions (primary and other) that coexist at time of admission, that develop during hospital stay or that affect treatment received or length of stay	Principal_diagnosis _ diagnosis_1, diagnosis_2, diagnosis_3…….	ICD-9 OR ICD-10-CM Codes Include periods after the third digit for all ICD-9 OR ICD-10 diagnosis codes greater than three digits. THE ONLY REASON TO SUBMIT THIS FIELD AS PART OF THE CLINICAL FILE IS TO CORRECT CODES PREVIOUSLY SUBMITTED IN THE PATIENT DISCHARGE DATA FILE. SUBMISSION OF THIS FIELD WILL OVERWRITE PREVIOUSLY SUBMITTED DATA IN THE PDD FILE.
Maternal Procedure Codes	O	All procedures (primary and other) related to patient's stay	Principal_procedure , procedure_1, procedure_2, ….	ICD-9 OR ICD-10-CM Code and MMDDYYYY Date Format. Include periods after the second digit for all ICD-9 procedure codes greater than two digits. THE ONLY REASON TO SUBMIT THIS FIELD AS PART OF THE CLINICAL FILE IS TO CORRECT CODES ORIGINALLY SUBMITTED IN THE PATIENT DISCHARGE DATA FILE. SUBMISSION OF THIS FIELD WILL OVERWRITE PREVIOUSLY SUBMITTED DATA IN THE PDD FILE.
Patient Height-Feet	O	Mother's Height (Feet)	Mom_height_feet	Allowable values: 2-7 (N) THE ONLY REASON TO SUBMIT THIS FIELD IS TO USE AS A SUBSTITUTE FOR SAME FIELD FROM THE BIRTH CERTIFICATE FILE.
Patient Height-Inches	O	Patient's Height (inches)	Mom_height_inches	Allowable values: 0-11 (NN) THE ONLY REASON TO SUBMIT THIS FIELD IS TO USE AS A SUBSTITUTE FOR SAME FIELD FROM THE FUTURE BIRTH CERTIFICATE FILE.
Patient Pre-Pregnancy Weight	O	Mother's pre-pregnancy weight	Mom_prepreg_weight	Allowable values: 0-500 (NNN) THE ONLY REASON TO SUBMIT THIS FIELD IS TO USE AS A SUBSTITUTE FOR SAME FIELD FROM THE FUTURE BIRTH CERTIFICATE FILE.

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Transfer from Alternative Birth Setting	O	If labor management was initiated outside of the hospital, the alternative birth setting from which the mother was transferred.	Alt_birth_setting	Allowable Values **N**: None **home**: Home **birth_center**: Birth Center
Admission to L&D in Labor with Intact Membranes	O	Documentation that the patient was admitted to Labor and Delivery with Intact membranes.	admitted_for_labor_with_intact_membranes	Allowable Values: **Y** (Yes) **N** (No) Respond "no" for any cases with a planned or scheduled cesarean—regardless of labor status or ruptured membranes. If ruptured membranes are present guidelines allow admission with cervical dilation less than 4cm per provider clinical judgment (therefore these cases do not require further chart review).
Dilation ≥ 4cm at Admission Decision	O	Documentation that the patient's cervical dilation at admission was greater than or equal to 4 cm.	dilation_at_admission_gte_4cm	Allowable Values: **Y** (Yes) **N** (No)
Concern for Maternal/Fetal Status	O	Documentation that, at the time of the admission, there was a clinical concern regarding maternal or fetal status which prompted admission of the patient prior to 4 cm dilation.	clinical_concern_at_admission	Allowable Values: **Y** (Yes) **N** (No)
Inadequate Pain Control	O	Documentation that, at the time of the admission, the patient required pain control which prompted admission of the patient prior to 4 cm dilation.	inadequate_pain_control_at_admission	Allowable Values: **Y** (Yes) **N** (No)
Primary Reason for Induction	O	Provider documentation of the primary reason for electing to perform an induction. If there is a "Provider Documented Medical Indication", that option should trump all other options as the "Primary Reason".	induction_reason	**Allowable values in bold text below:** **provider_documented** : Provider documented medical indication **history_of_fast_labor** : History of fast labor **distance_from_hospital** : Distance from hospital **suspected_macrosomia** : Suspected macrosomia (without history of shoulder dystocia) **psychosocial** : Psychosocial (e.g. partner's deployment date, family or significant relation availability, adoption, etc.) **maternal_discomfort :** Mother in severe discomfort during final weeks of pregnancy **advanced_cervical_dilation** : Advanced cervical dilation, GBS negative **not_documented** : No Documented Indication If there is a "Provider Documented Medical Indication", that option should trump all other options as the "Primary Reason".

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Full Bishop Score	O	The Full Bishop Score indicting the odds of an induction resulting in a vaginal delivery. The Full Bishop Score is based on 5 elements: Cervical dilation, Cervical effacement, Cervical consistency, Cervical position, Fetal station	bishop_score	**Allowable values in bold text below:** **1**: 1 **2**: 2 **3**: 3 **4**: 4 **5**: 5 **6**: 6 **7**: 7 **8**: 8 **9**: 9 **10**: 10 **11**: 11 **12:** 12 **13**: 13 **deferred**: Deferred because of ROM or bleeding **unknown**: Unknown
Planned/Scheduled CS	O	Documentation at the time of admission that: a cesarean had been planned or scheduled OR an urgent/emergent cesarean was required.	scheduled_cs	**Allowable Values:** **Y** (Yes) **N** (No) "Yes" responses include both planned or scheduled cesareans prior to admission and immediate decisions for urgent/emergent cesareans upon admission
Maximum Cervical Dilation Documented Before C: Section	O	The maximum cervical dilation documented prior to the decision to perform the cesarean section.	maximum_cervical_dilation	**Allowable values in bold text below:** **complete**: 10cm/Complete **9**: 9cm **8**: 8cm **7**: 7cm **6**: 6cm **5**: 5cm **4**: 4cm **3**: 3cm **2**: 2cm **1**: 1cm **less_than_1cm**: Less than 1cm/FT
Primary Indication for Cesarean Birth	O	Documentation of the primary indication for the cesarean birth at the time the decision to perform the cesarean was made.	primary_indication_for_cs	**Allowable values in bold text below:** **labor_abnormality**: Labor Abnormality (labor dystocia, failure to progress, or failure to descend) **fetal_concern**: Fetal Status Concern **maternal_concern**: Maternal Status Concern
Fetal Status Concern	O	Documentation of the primary fetal status concern at the time the decision to perform the cesarean was made	fetal_indication_for_cs	**Allowable values in bold text below:** **category_3_fhr**: Category 3 FHR **persistent_category_2_fhr**: Persistent Category 2 FHR w/Minimal Variability and Significant Decelerations **category_2_fhr_pattern**: Category 2 FHR Pattern with Labor Abnormality **other_non_reassuring_fhr**: Other Non: reassuring FHR **other_fetal_concerns**: Other Fetal Concerns

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Maternal Clinical Concern	O	Documentation of the primary maternal clinical concern at the time the decision to perform the cesarean was made	maternal_indication_for_cs	**Allowable values in bold text below:** **preeclampsia_or_hellp_syndrome**: Preeclampsia/HELLP Syndrome **high_fever_remote_from_delivery**: High Fever Remote From Delivery **bleeding_or_other_coagulopathy**: Bleeding or Other Coagulopathy **other_abnormal_maternal_vital_signs**: Other Abnormal Maternal Vital Signs **other_severe_complication**: Other Severe Complication
Total Time in Second Stage to CS Decision	O	Documentation of the total time in second stage: from 10cm to delivery, including "laboring-down" time.	duration_second_stage_labor	**Allowable values in bold text below:** **second_stage_less_than_two_hours**: <2 hours **second_stage_less_than_three_hours**: 2 : <3 hours **second_stage_less_than_four_hours**: 3 : <4 hours **second_stage_less_than_five_hours**: 4 : <5 hours **second_stage_less_than_seven_hours**: 5 : <7 hours **second_stage_seven_or_more_hours**: >=7 hours
Total time in Active Phase Prior to CS Decision	O	Documentation of the total time in active phase stage: from 6 cm to the time a decision was made to perform the cesarean. The total time should include "laboring-down" time.	duration_active_phase_labor	**Allowable values in bold text below:** **active_phase_less_than_two_hours**: <2 hours **active_phase_less_than_three_hours**: 2 : <3 hours **active_phase_less_than_four_hours**: 3 : <4 hours **active_phase_less_than_five_hours**: 4 : <5 hours **active_phase_less_than_seven_hours**: 5 : <7 hour **active_phase_seven_or_more_hours**: >=7 hours
Oxytocin Administration	O	Documentation that there was at least 12 hours of oxytocin after rupture of membranes and prior to the CS delivery	twelve_hours_of_oxytocin_after_rom	Allowable Values: **Y** (Yes) **N** (No)
Ruptured Membranes at Arrest Time	O	Documentation that membranes had ruptured at or before arrest time	ruptured_membranes_before_labor_arrest	Allowable Values: **Y** (Yes) **N** (No)
Minimal Cervical Change	O	Documentation of the time interval in which there was no or minimal change in cervical dilation before the CS decision	duration_minimal_cervical_change_before_cs	**Allowable values in bold text below:** **minimal_cervical_change_before_cs_at_least_4h**: at least 4h with adequate uterine activity **minimal_cervical_change_before_cs_at_least_6h**: at least 6h with inadequate uterine activity and with oxytocin **minimal_cervical_change_less_than_4h**: Less than those times
Cervical Ripening	O	Documentation on whether cervical ripening was used	cervical_ripening_used	Allowable Values: **Y** (Yes) **N** (No)

Section D:
Newborn Clinical Data File

Instructions and File Format

- If possible, use the ICD-9 OR ICD-10 codes in Section A to filter the newborn records to submitted to the MDC. If that is not possible for the clinical file, include only records for *delivery-related hospitalizations* in the clinical file (i.e. do not include antepartum or postpartum records).
- The "Core" Newborn Clinical File must include the following required data elements: Newborn ID, Maternal ID, Newborn DOB, Newborn Date of Discharge, Birthweight, and Apgar Score as specified below. If any of these data fields are missing, the file will be rejected. (Although we encourage completeness, the file will not be rejected if some *records* are missing values in the required fields.)
- In addition to the required "Core Newborn File" you also have the option to submit additional data, either as part of the core file or in separate supplemental files. As long as you have already submitted the "Core Newborn File" you can submit as many supplemental files with different data elements as you wish. For example, you might submit one "supplemental newborn file" that includes solely data on bilirubin screening and a second "newborn file" that includes data on NICU admission. If two supplemental files are submitted that contain the same field for the same reporting period, the last submitted will represent the "final" value.
- **The Maternal MRN/ID must be included in the newborn file (as long as the newborn record reflects the birth hospitalization and not a transfer in).**
- CSV File Format with each case in a single row.
- Column headers, as denoted below, must be used for all fields you are submitting.
- The required data elements are denoted with an "R" in the "Required or Optional column".
- If a column value is missing, leave no space between the commas (,,)
- Use the patient's discharge date to filter the records for each reporting period (each submission will include one or more months' worth of data; please use complete calendar months.)
- Please submit separate clinical files for "Maternal" Data Elements and "Newborn" Data Elements

OPTIONAL Fields

Some fields are optional, and are denoted by blue highlighting and the letter "O" in the "Required or Optional Column".
These optional fields may be derived from internal systems (e.g. EMR, core measure vendor system) and might be used to:

- Replace data already in the MDC system from your administrative data submission
- Pre-populate the "chart-review" data elements (e.g. bilirubin screening) in the MDC system.
- Include a flag that denotes a record as part of the hospital's Joint Commission sample (from the core measure vendor system).

SUPPLEMENTAL Files

You may also choose to submit *optional* fields at later points in time via supplemental files. All supplemental files must include the fields: Patient ID/Medical Record Number, Date of Discharge and the Optional field(s) you're submitting*, using the designated column headers* in the specifications below. For more information, please see the document "Supplemental Data Submissions" at https://www.safedeliveries.org/support.

If you choose NOT to include any of the optional fields, you must omit the column header for those fields.

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
CORE Data				
Newborn Medical Record Number	R	Unique code identifying a particular patient record within reporting facility	medical_record_number	Medical record number or any patient identification number assigned by the facility. Use a number that matches the medical record number for the newborn provided in the patient discharge data file submission. The number will be encrypted upon receipt by the MDC server, but will be re-constituted to true value by authorized hospital staff using private key.
Newborn Discharge Date	R	The date patient discharged from the hospital.	discharge_date	MMDDYYYY
Maternal Medical Record Number	R	Unique code identifying a particular patient record within reporting facility	mrn_mother_linked	Medical record number or any patient identification number assigned by the facility. Use a number that matches the record number for the mother provided in the patient discharge data file submission to MDC. The number will be encrypted upon receipt by the MDC server, but will be re-constituted to true value by authorized hospital staff using private key.
Birthweight	R	The weight (in grams) of a newborn at the time of delivery	birth_weight	**Allowable Values:** 150 through 8165 grams or UTD = Unable to Determine **Note:** When converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams. Round to the nearest whole number after the conversion to grams. **Notes for Abstraction:** • Newborns with birth weights less than 150 grams need to be verified that the baby was live born and for data quality purposes. Birth weights greater than 8165 grams need to be verified for data quality. Abstractors should review all of the suggested data sources to verify the accuracy of the data. • If the birth weight is unable to be determined from medical record documentation, enter "UTD". • The medical record must be abstracted as documented (taken at "face value"). When the value documented is not a valid number/value per the definition of this data element **and** no other documentation is found that provides this information, the abstractor should select "UTD." Example: Documentation indicates the *Birth Weight* was 0 grams. No other documentation in the medical record provides a valid value. Since the*Birth Weight* is not a valid value, the abstractor should select "UTD." *Note:* Transmission of a case with an invalid value as described above will be rejected from the Joint Commission's Data Warehouse. Use of "UTD" for *Birth Weight* allows the case to be accepted into the warehouse. • The NICU admission assessment or notes should be reviewed first for the birth weight. In the absence of admission to the NICU, the delivery record or operating room record should be reviewed next for the birth weight. In cases where there is conflicting data, use the document recording the birth weight closest to the time of delivery. • It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below. • For newborns received into the hospital as a transfer, the admission birth weight may be used if the original birth weight is not available. • If the birth weight is recorded in pounds and ounces and also in grams, abstract the value for grams. **Suggested Data Sources** (In Order of Priority): • NICU admission assessment or notes • Delivery record • Operating room record • History and physical • Nursing notes • Nursery record • Physician progress notes
5 Minute Apgar Score	R	The newborn's Apgar Score at 5 minutes after birth	Apgar_5	**Allowable Values:** 0-10 or UTD = Unable to Determine The newborn's Apgar Score at 5 minutes after birth. If you do not have a 5 minute Apgar Score the 10 Minute Apgar Score (per field below) will be required.
Optional				
10 Minute Apgar Score	O	The newborn's Apgar Score at 10 minutes after birth	Apgar_10	**Allowable Values:** 0-10 or UTD = Unable to Determine The newborn's Apgar Score at 10 minutes after birth, if available". If no 5-minute Apgar is available, a 10-minutes Apgar is required in order to calculate some newborn measures.
Bloodstream Infection Present on Admission	O	Documentation in the medical record within the first 48 hours after admission that the patient had a bloodstream infection present on admission. This includes patients with positive blood cultures or negative or inconclusive blood cultures when the patient is suspected of having a bloodstream infection or septicemia and is being treated for the condition. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia.	bsi_poa	**Allowable Values:** Y (Yes) There is documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission. N (No) There is no documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia present on admission or unable to determine from medical record documentation. **Notes for Abstraction:** The admission assessment and the NICU admission assessment or NICU notes should be reviewed first for documentation of a suspected or confirmed bloodstream infection present on admission or within the first 48 hours after admission. Documentation of the suspected bloodstream infection being present on admission should be taken at face value regardless of the blood culture results. Routine work up for sepsis for high risk newborns admitted to the NICU should not be considered a suspected bloodstream infection in the absence of positive blood culture results. There must be documentation from the clinician specifically stating that the newborn appeared septic or was showing signs and symptoms of sepsis in order to answer "yes". Signs and symptoms of sepsis include but are not limited to: body temperature changes, respiratory difficulty, diarrhea, hypoglycemia, reduced movements, reduced sucking, seizures, bradycardia, swollen/distended abdomen, vomiting and/or jaundice. The results of the initial blood cultures drawn within the first 48 hours of admission which are reported after the first 48 hours may be used to determine if the bloodstream infection was present on admission. Birth is considered the same as admission for patients who were born in the reporting hospital. If the present on admission (POA) indicator is present with the diagnosis code for septicemia or

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				bacteremia, answer "yes" to bloodstream infection present on admission. **Suggested Data Sources:** • History and physical • Laboratory report • Nursing notes • Nursing admission assessment • Progress notes • Admission assessment • Microbiology report • NICU admission assessment **Guidelines for Abstraction:** ***Include***: • Suspected bloodstream infection • Positive blood culture • Inconclusive blood culture under treatment • Staphylococcal septicemia • Staphylococcal bacteremia • Gram negative septicemia • Gram negative bacteremia ***Exclude:*** • Rule out sepsis • R/O sepsis • Work up for sepsis • Negative blood culture under treatment • Evaluation for sepsis
NICU Admission	O	Documentation that the newborn was admitted to the Neonatal Intensive Care Unit (NICU at this hospital any time during the hospitalization. *Note: Used for both Breastfeeding (PC-05) and Newborn Bilirubin Screening (Leapfrog) measures*	nicu_admission	**Allowable Values:** Y (Yes) There is documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization. N (No) There is no documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization or unable to determine from medical record documentation. **Notes for Abstraction:** A NICU is defined as a hospital unit providing critical care services which is organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness (source: American Academy of Pediatrics). Names of NICUs may vary from hospital to hospital. Level designations and capabilities also vary from region to region and cannot be used alone to determine if the nursery is a NICU. If the newborn is admitted to the NICU for observation or transitional care, select allowable value "no". Transitional care is defined as a stay of 4 hours or less in the NICU. If an order to admit to the NICU is not found in the medical record, there must be supporting documentation present in the medical record indicating that the newborn received critical care services in the NICU in order to answer "yes". Examples of supporting documentation include, but are not limited to the NICU admission assessment and NICU flow sheet. **Suggested Data Sources:** • Nursing notes • Discharge summary • Physician progress notes

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Exclusive Breast Milk Feeding	O	Documentation that the newborn was exclusively fed breast milk during the entire hospitalization. Exclusive breast milk feeding is defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.	exclusively_breastfed	**Allowable Values:** Y (Yes) There is documentation that the newborn was exclusively fed breast milk during the entire hospitalization. N (No) There is no documentation that the newborn was exclusively fed breast milk during the entire hospitalization OR unable to determine from medical record documentation. **Notes for Abstraction:** • If the newborn receives any other liquids including water during the entire hospitalization, select allowable value "No". • Exclusive breast milk feeding includes the newborn receiving breast milk via a bottle or other means beside the breast. • Sweet-Ease® or a similar 24% sucrose and water solution given to the newborn for the purpose of reducing discomfort during a painful procedure is classified as a medication and is not considered a supplemental feeding. • If the newborn receives donor breast milk, select allowable value "Yes". • If breast milk fortifier is added to the breast milk, select allowable value "Yes". • In cases where there is conflicting documentation and both exclusive breast milk feeding and formula supplementation is documented, select allowable value "No". • If the newborn received drops of water or formula dribbled onto the mother's breast to stimulate latching and not an actual feeding, select "yes". **Suggested Data Sources:** • Discharge summary • Feeding flow sheets • Individual treatment plan • Intake and output sheets • Nursing notes • Physician progress notes
Reason for Not Exclusively Feeding Breast Milk	O	Reasons for not exclusively feeding breast milk during the entire hospitalization are clearly documented in the medical record. These reasons are due to a maternal medical condition for which feeding breast milk should be avoided or due to mother's initial feeding plan which included formula feeding upon admission of the newborn. Exclusive breast milk feeding is defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.	reason_not_breastfeeding	**Allowable Values:** 1.) There is documentation by physician/advanced practice nurse(APN)/physician assistant (PA)/certified nurse midwife (CNM) /international board certified lactation consultant (IBCLC)/ certified lactation counselor (CLC) of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition with which breast milk feeding should be avoided 2.) There is documentation by physician/APN/PA/CNM/IBCLC/CLC/RN that the newborn's mother's initial feeding plan for the hospitalization included formula upon admission of the newborn. 3.) None of the above or unable to determine from medical record documentation. **Notes for Abstraction:** Admission is defined as the birth of the newborn. The mother's initial feeding plan or diet plan must be documented in the newborn's medical record and may only be used if it is documented prior to the first feeding. If the discussion of the mother's initial feeding plan occurred prior to birth of the newborn, this may be used provided the date and time of the discussion appears in the newborn's medical record. The date and time the discussion took place must also be prior to the date and time of the first feeding. Example: The discussion of the initial feeding plan with the mother was documented in the mother's medical record on 6-1-20xx at 10:00. The baby was born (admitted) on 6-1-20xx at 13:00. The first feeding was documented on 6-1-20xx at 13:30 in the newborn's medical record. The newborn's medical record should have documentation of the discussion of the initial feeding plan that took place with the mother, the content of the discussion and the mother's decision for the initial feeding plan along with the date and time of the discussion (6-1-20xx at 10:00). If the

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				date and time documented in the newborn's medical record does not match that of the original discussion documented in the mother's record and it turns out to be a another discussion and feeding plan taking place after the first feeding, this documentation cannot be used, e.g., discussion occurring at 6-1-20xx at 14:00. When determining whether there is a reason due to a medical maternal condition documented by a physician/APN/PA/CNM/IBCLC or CLC for not exclusively feeding breast milk, reasons must be explicitly documented (e.g., "mother is HIV positive - newborn will not be breast fed") or clearly implied (e.g., "mother is currently abusing alcohol - newborn will be fed formula"). If reasons are not mentioned in the context of newborn feeding, do not make inferences (e.g., do not assume that the newborn is not receiving breast milk because of the medications the mother is currently taking). RN or certified lactation educator (CLE) documentation is not acceptable for maternal medical conditions. If newborn medical conditions, i.e., hypoglycemia, weight loss, hyperbilirubinemia, etc. are documented as a reason for not exclusively feeding breast milk, select allowable value ""3"". A mother's initial feeding plan existing at the time of admission of the newborn that includes formula feeding during the hospitalization must be clearly documented in the newborn's medical record in the context of the newborn substance fed in order to select allowable value ""2"". Do not assume that the newborn was not exclusively fed breast milk due to the mother's initial feeding plan in the absence of such documentation. There is no evidence to support feeding both breast milk and formula, so the discussion of the mother's initial feeding plan should focus on the benefits of exclusive breast milk feeding and the risks of adding formula when breast feeding. If there is documentation in the newborn's medical record of the discussion and the mother's initial feeding plan for the hospitalization, and the mother still elected to feed both formula and breast milk upon admission select allowable value "2". If the mother's initial feeding plan was to exclusively feed breast milk upon admission, and the mother's feeding plan changed later in the hospitalization to include formula feeding select allowable value "3". Standing orders and check boxes listing the method of feeding to include formula based on the mother's initial feeding plan cannot be used alone to select allowable value "2". There must be additional supporting documentation from the physician/APN/PA/CNM/IBCLC/CLC that the initial feeding plan was discussed with the mother. RN documentation of the discussion and the mother's initial feeding plan to include formula discussed upon admission is acceptable ONLY if there is supporting documentation by the physician/APN/PA/CNM/IBCLC/CLC at some point during the hospitalization to corroborate the RN's initial discussion with the mother. If the mother decides to feed formula prior to the supporting documentation, only the initial feeding plan findings can be used. The mother''s medical record cannot be used to determine the mother''s initial feeding plan. This documentation must appear in the newborn''s medical record without using the mother's medical record to perform the abstraction even if there is a link between the mother and newborn medical records in the EHR. Bottle is a method of feeding and is not the same as formula. Bottle cannot be used interchangeably for formula, since breast milk can also be fed via a bottle.**Suggested Data Sources:** PHYSICIAN/APN/CNM/LACTATION CONSULTANT DOCUMENTATION ONLY • Clinician progress notes • History and physical Nursing assessment • Physician progress notes • Physician's orders

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				Additional Notes: These are the only acceptable maternal medical conditions for which breast milk feeding should be avoided which includes one or more of the following medical conditions: • HIV infection • Human t-lymphotrophic virus type I or II • Substance abuse and/or alcohol abuse • Active, untreated tuberculosis • Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications and other medications where the risk of morbidity outweighs the benefits of breast milk feeding • Undergoing radiation therapy • Active, untreated varicella • Active herpes simplex virus with breast lesions • Admission to Intensive Care Unit (ICU) post-partum • Newborn and mother will be separated after discharge from the hospital, and the mother will not be providing care for the newborn after the hospitalization. Some examples include, but are not limited to: adoption, foster home placement, surrogate delivery, incarceration of the mother • Previous breast surgery, i.e., bilateral mastectomy, bilateral breast reduction or augmentation where the mother is unable to produce breast milk • Breast abnormality, i.e., hypoplasia, tumor, etc. where the mother is unable to produce breast milk
Bilirubin Screen:	O	Documentation that the newborn had a serum or transcutaneous bilirubin screen prior to discharge to identify risk of hyperbilirubinemia according to the Bhutani Nomogram	bilirubin_screening_performed	**Allowable Values:** Y (Yes) There is documentation that the newborn had a serum or transcutaneous bilirubin screen prior to discharge N (No) There is no documentation that the newborn had a serum or transcutaneous bilirubin screen prior to discharge.
Bilirubin Screen: Parental refusal to test	O	Documentation that the newborn's parents refused to allow the hospital to perform a serum or transcutaneous bilirubin screen prior to discharge.	patient_refused_bili_screening	**Allowable Values:** Y (Yes) There is documentation that the newborn's parents refused to allow the hospital to perform a serum or transcutaneous bilirubin screen prior to discharge. N (No) There is no documentation that the newborn's parents refused to allow the hospital to perform a serum or transcutaneous bilirubin screen prior to discharge.
Sample Flag for Joint Commission PC-05	O	Flag to indicate that the record was included in the hospital's Joint Commission sample (drawn via the core measure vendor system) for PC-05: Exclusive Breastfeeding.	pc_05_sample	**Allowable values:** Y (Yes): Record is part of Joint Commission Sample for this measure. N (No) or Blank: Record is not part of Joint Commission sample for this measure or sample inclusion is unknown

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Sample Flag for Leapfrog Bilirubin Measure	O	Flag to indicate that the record was included in the hospital's Leapfrog sample for Newborn Bilirubin Screening.	lf_bili_sample	**Allowable values:** Y (Yes): Record is part of Leapfrog Sample for this measure. N (No) or Blank: Record is not part of Leapfrog sample for this measure or sample inclusion is unknown
Newborn Diagnosis Codes	O	All conditions (primary and other) that coexist at time of admission, that develop during hospital stay or that affect treatment received or length of stay	Principal_diagnosis _ diagnosis_1, diagnosis_2, diagnosis_3…….	ICD-9 OR ICD-10-CM Codes Include periods after the third digit for all ICD-9 OR ICD-10 diagnosis codes greater than three digits. THE ONLY REASON TO SUBMIT THIS FIELD AS PART OF THE CLINICAL FILE IS TO CORRECT CODES PREVIOUSLY SUBMITTED IN THE PATIENT DISCHARGE DATA FILE. SUBMISSION OF THIS FIELD WILL OVERWRITE PREVIOUSLY SUBMITTED DATA IN THE PDD FILE.
Newborn Procedure Codes	O	All procedures (primary and other) related to patient's stay	Principal_procedure , procedure_1, procedure_2, ….	ICD-9 OR ICD-10-CM Code and MMDDYYYY Date Format. Include periods after the second digit for all ICD-9 OR ICD-10 procedure codes greater than two digits. THE ONLY REASON TO SUBMIT THIS FIELD AS PART OF THE CLINICAL FILE IS TO CORRECT CODES ORIGINALLY SUBMITTED IN THE PATIENT DISCHARGE DATA FILE. SUBMISSION OF THIS FIELD WILL OVERWRITE PREVIOUSLY SUBMITTED DATA IN THE PDD FILE.
Newborn Discharge Status	O	The discharge disposition of the newborn	discharge_status	An NUBC code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill as reported in FL6, Statement Covers Period. THE ONLY REASON TO SUBMIT THIS FIELD AS PART OF THE CLINICAL FILE IS TO CORRECT CODES ORIGINALLY SUBMITTED IN THE PATIENT DISCHARGE DATA FILE. SUBMISSION OF THIS FIELD WILL OVERWRITE PREVIOUSLY SUBMITTED DATA IN THE PDD FILE. The following values are accepted: 01 Discharged to Home or Self care (Routine Discharges) 02 Discharged/transferred to Short Term General Hospital for Inpatient Care 03 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care. 04 Discharge /transferred to a Facility That Provides Custodial or Supportive Care (Includes ICF and Assisted Living Facilities) 05 Discharged/transferred to a Designated Cancer Center or Children's Hospital 06 Discharged/transferred to Home under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care. 07 Left Against Medical Advice or Discontinued Care 09 Admitted as an inpatient to this hospital 20 Expired 21 Discharged/transferred to Court/Law Enforcement 30 Still patient 43 Discharged/transferred to a Federal Health Care Facility 50 Hospice-Home 51 Hospice – Medical Facility (Certified) Providing Hospice Level of Care

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				61 Discharged/transferred to a Hospital Based Medicare Approved Swing Bed 62 Discharged/transferred to an Inpatient Rehabilitation Facility(IRF) including Rehabilitation Distinct Part Units of a Hospital 63 Discharged/transferred to a Medicare-Certified Long Term Care Hospital (LTCH) 64 Discharged/transferred to a Nursing Facility Certified under Medicaid but not certified under Medicare 65 Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital 66 Discharged/transferred to a Critical Access Hospital (CAH) 69 Discharges/transferred to Designated Disaster Alternative Care Site 70 Discharged/transferred to another Type of HealthCare Institution Not Defined Elsewhere in this Codes List 81 Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission 82 Discharged/Transferred to Short Term General Hosp for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission 83 Discharged/Transferred to SNF with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission 84 Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission 85 Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission 86 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission 87 Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission 88 Discharged/Transferred to Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission. 89 Discharged/Transferred to a Hospital Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission 90 Discharged/Transferred to Inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission 91 Discharged/Transferred to Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission. 92 Discharged/Transferred to A Nursing Facility Certified Under Medicaid but not Medicare with a Planned Acute Care Hospital Inpatient Readmission 93 Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission 94 Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission 95 Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in the Code List with a Planned Acute Care Hospital Inpatient Readmission