Maternal Data Center
Supplemental Data Submissions
Oregon and Washington Hospitals
Updated October 15, 2015

In addition to the required discharge and clinical files, hospitals also have the *option* to submit supplemental files. Optional fields (see list below) may be derived from internal systems (e.g. EMR, core measure vendor system) and might be used to:

- Replace erroneous data already in the MDC system from your required file submissions
- Add data for records that are missing values (e.g. for Gestational Age, Parity or Apgar Score)
- Pre-populate the "chart-review" data elements (e.g. labor, SROM or Prior Uterine Surgery) in the MDC system.
- Submit the Delivering Provider ID that allows the generation of provider-level metrics.

As long as you have already submitted the required discharge and clinical data elements for the reporting period, 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" in one submission and a second "maternal file" that includes missing data for "gestational age" in a different 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.

Creating the Supplemental Data File

- The Patient Number and Date of Discharge are REQUIRED in any supplemental data submission (so we can link to the data already in the system).
- All other data elements are optional in a supplemental data file.
- Please use CMQCC's designated column headers (see specifications below starting on page 3)
- Use CSV file format. This is essentially an Excel file saved as a ".csv" file.

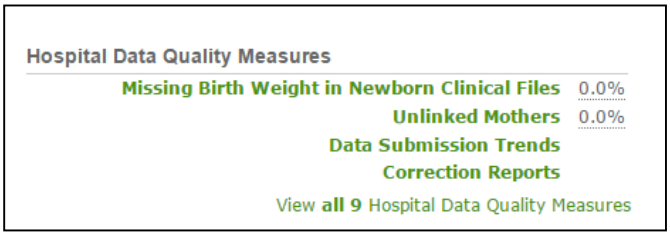
List of Optional Supplemental Data Elements

Maternal Supplemental File	**Newborn Supplemental File**
▪ Patient Number **(REQUIRED)** ▪ Date of Discharge **(REQUIRED)** ▪ Parity ▪ Gestational Age ▪ Number of Maternal ICU Days ▪ Blood Products Transfused (RBC, FFP) ▪ Labor ▪ Spontaneous Rupture of Membranes ▪ Prior Uterine Surgery ▪ Antenatal Steroid Therapy Initiated ▪ Reason for Not Initiating ANS Therapy ▪ DVT Prophylaxis - C-Section ▪ Sample Flag for Joint Commission PC measures ▪ Provider ID: Delivering Provider ▪ Maternal Diagnosis Codes ▪ Maternal Procedure Codes ▪ Patient Height-Feet ▪ Patient Height-Inches ▪ Patient Pre-Pregnancy Weight ▪ Transfer from Alternative Birth Setting ▪ Labor Management Process Measure Fields (17): *For WSHA MDC Hospitals as of July 15, 2015*	▪ Patient Number **(REQUIRED)** ▪ Date of Discharge **(REQUIRED)** ▪ Maternal Patient ID ▪ 5 Minute APGAR Score ▪ 10 Minute APGAR Score ▪ Bloodstream Infection Present on Admission ▪ NICU Admission ▪ Exclusive Breast Milk Feeding ▪ Reason for Not Exclusively Breastfeeding ▪ Bilirubin Screen: ▪ Bilirubin Screen: Parental refusal to test ▪ Sample Flag for Joint Commission PC-05 ▪ Sample Flag for Leapfrog Bilirubin Measure ▪ Newborn Diagnosis Codes ▪ Newborn Procedure Codes ▪ Newborn Discharge Status

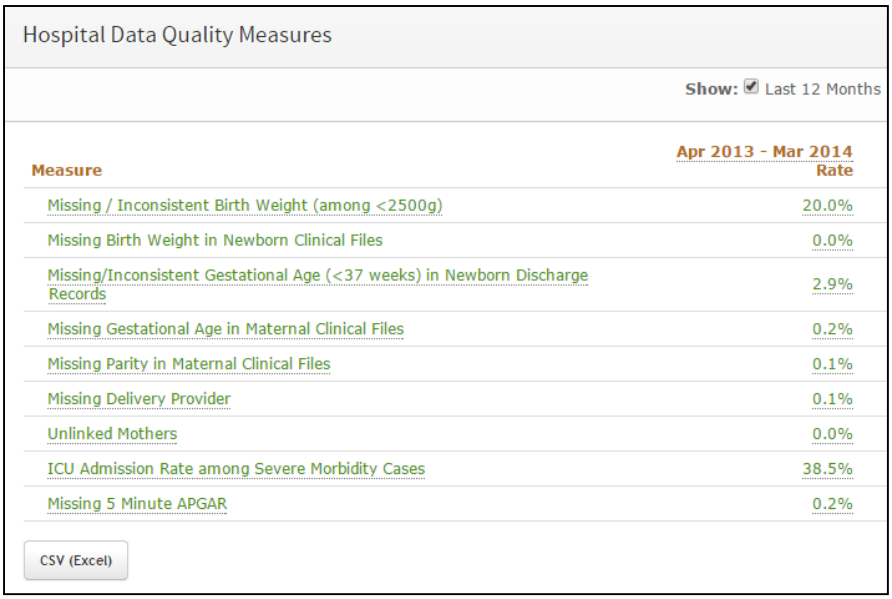
Using Supplemental Files to Replace Missing Data Elements (GA, Parity, 5-minute Apgar, Birthweight)

If you are submitting a supplemental file to fill in records with missing values for required fields (e.g. Gestational Age), you may find it easiest to download the cases that are missing data from the MDC, fill in the missing data, and then re-submit as a supplemental file. Below are specific steps:

1. From the Home Page, click on ***Hospital Data Quality Measures***

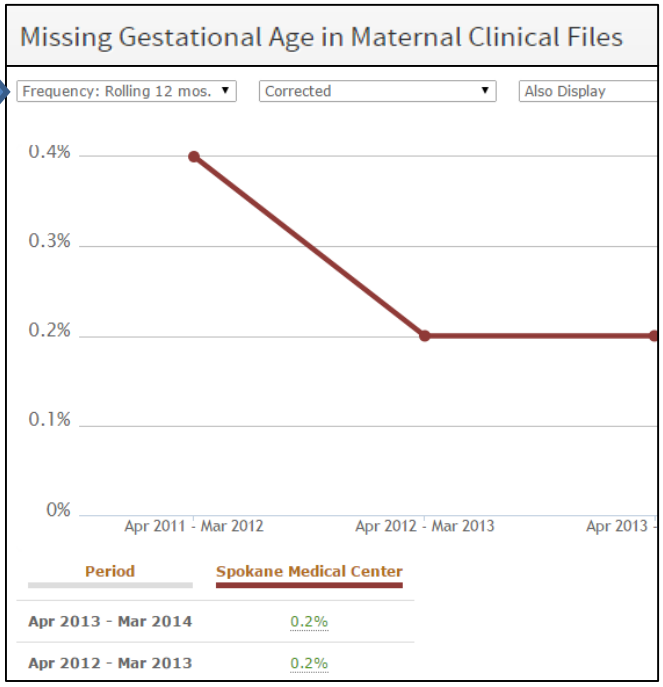


2. Determine if you have missing data for any of the required fields:
   - Missing Birthweight in Newborn Clinical Files
   - Missing Gestational Age in Maternal Clinical Files
   - Missing Parity in Maternal Clinical Files
   - Missing Delivery Provider
   - Missing APGAR in Newborn Clinical Files



3. Click into each measure with "missing" data

4. From the "Frequency" drop-down menu near the top of the screen, choose the time period for which you wish to correct missing data.



5. Click on the rate (e.g. 0.2%) for that period you wish to correct

6. You will now be on the patient-level drill down screen. Click "Download CSV/Excel".

7. The data will auto populate into an Excel spreadsheet (you may need to open the Excel download from a box at the bottom of your screen).

	A	B	C
1	Case Number	Discharge Date	Gestational Age Weeks
2	afd0ea5100	2/23/2014	
3			

8. Fill in the missing values for each record. As necessary, change out the column headers for each column so that they match the MDC-designated column headers (per data specs starting on page 5 below).

5	medical_record_number	Discharge_Date	Gestational Age_Weeks
6	afd0ea5100	2/23/2014	39
7			

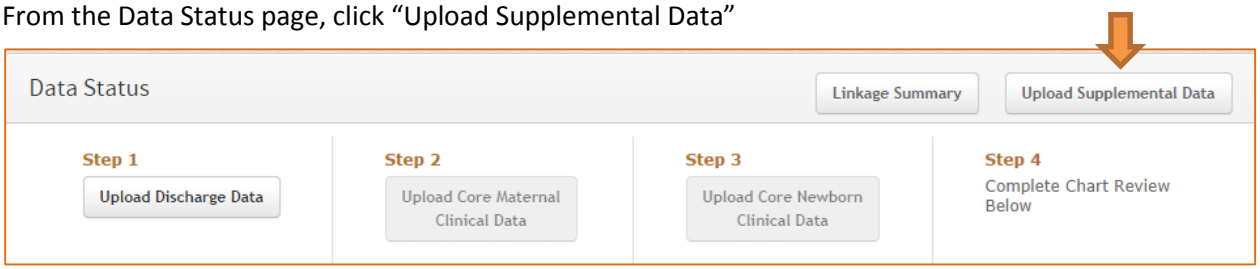
9. Save your file as a "____.csv".

Steps for Submitting Supplemental Files

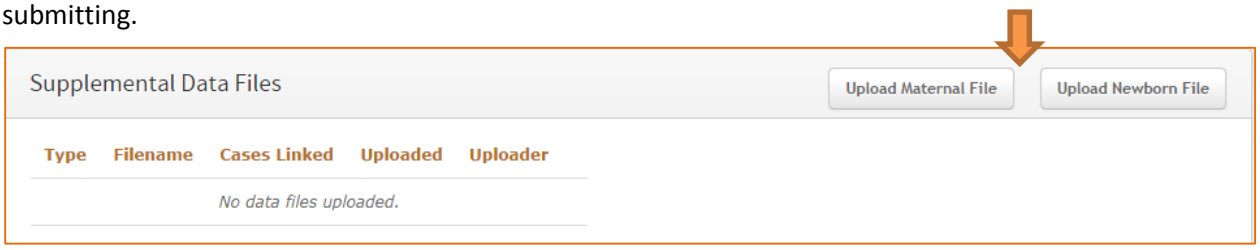
Once you have saved your supplemental file, follow the steps below to upload. The file must:

- Use CSV file format.
- Use the designated column headers for the data elements you are submitting (per data specs below)
- Include the same Patient Case Number/MRN and the Date of Discharge that were submitted as part of the required files (so CMQCC can link the supplemental data to the existing data).

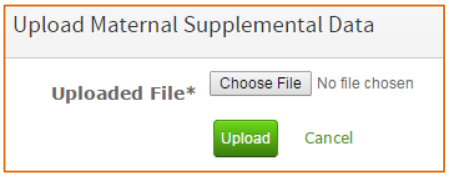
1. From the Data Status page, click "Upload Supplemental Data"



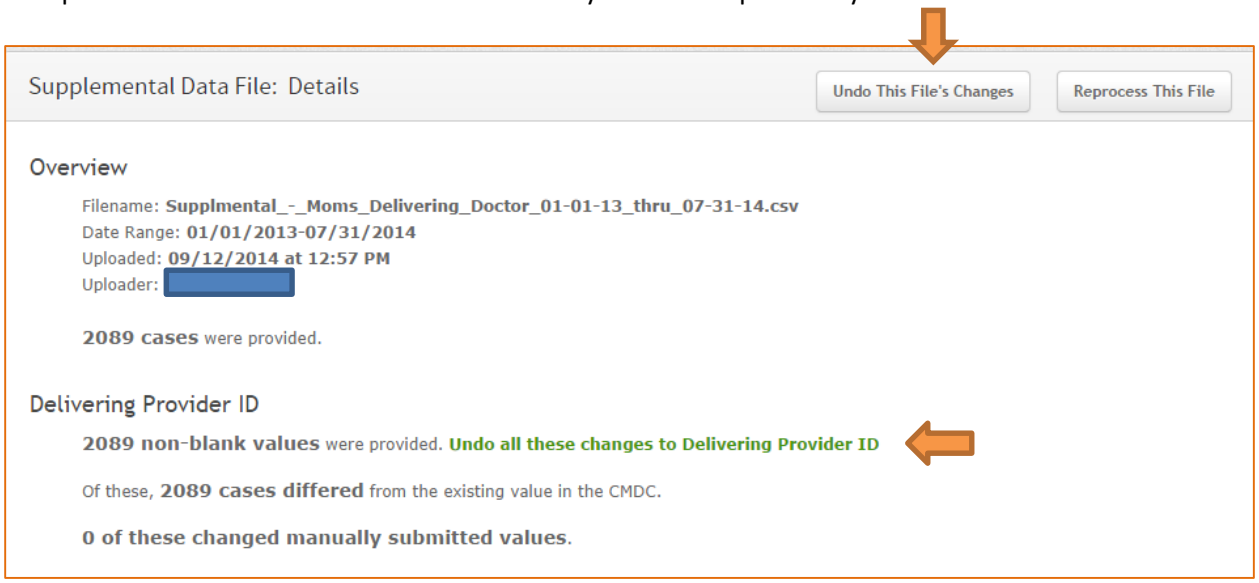
2. Click either "Upload Maternal File" or "Upload Newborn File" depending on which file type you're submitting.



3. Click "Choose File" to browse your computer and select the supplemental file you created. Click Upload.



4. Once the file uploads, you will see the file name and can click on "see details" to see which values changed. If needed, you will have the ability to "Undo Changes" to:
   - the entire file, or
   - specific fields in the event the file erroneously overwrites previously-submitted values.



Maternal Supplemental File Data Elements

For all data elements you are including in the supplemental file, please use the designated column header as listed below.
For fields you are not including, simply omit the column header/column.

Data Element	Definition	Column Header	Description
Maternal Medical Record Number or Account Number	Unique code identifying a particular patient record within reporting facility	medical_record_number OR account_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	The date patient discharged from the hospital.	discharge_date	MMDDYYYY
Parity	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,

Data Element	Definition	Column Header	Description
			parity should be answered as one number less than the number documented. If primagravida is documented select zero for parity. **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	The weeks of gestation completed at the time of delivery. Gestational age is defined as the best obstetrical estimate (OE) of the newborn's gestation in completed weeks based on the birth attendant's final estimate of gestation, irrespective of whether the gestation results in a live birth or a fetal death. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the newborn exam. Ultrasound taken early in	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 and no gestational age was documented, 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. Gestational age (written with both weeks and days, eg. 39 weeks and 0 days) is calculated using the best obstetrical

Data Element	Definition	Column Header	Description
	pregnancy is preferred (source: American College of Obstetricians and Gynecologists reVITALize Initiative).		Estimated Due Date (EDD) based on the following formula: Gestational Age = (280 - (EDD - Reference Date)) / 7 (source: American College of Obstetricians and Gynecologists reVITALize Initiative). The clinician, not the abstractor, should perform the calculation to determine gestational age. If the gestational age 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 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. The EHR takes precedence over a hand written entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary. **Suggested Data Sources:** ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE: • Delivery record, note or summary • Operating room record, note or summary • History and physical • Prenatal forms • Admission clinician progress notes • Discharge summary
Provider ID: Delivering Provider	The National Provider Identifier (NPI) of the provider 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 provider-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.
Gestational Age-Days	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	Gestational age in weeks plus days, in a combined format.	gestational_age_combined	This optional field can serve as a substitute for the above required field "Gestational Age-Weeks" for hospitals with clinical systems that combine the completed weeks of gestational age with the days. Allowable forms include: • 37 • 37+3 • 37.3

Data Element	Definition	Column Header	Description
			• 37 3/7 • 37w 3d • 37 weeks 3 days
Number of Maternal ICU Days	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.**
Red Blood Cell Blood Products Transfused	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
Fresh Frozen Plasma Blood Products Transfused	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
Labor	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***:

Data Element	Definition	Column Header	Description
			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	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
Prior Uterine Surgery	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,

Data Element	Definition	Column Header	Description
			physician's notes, prenatal forms
Antenatal Steroid Therapy Initiated	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
Reason for Not Initiating Antenatal Steroid Therapy	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.	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

Data Element	Definition	Column Header	Description
	Note: Data used to populate both Joint Commission and Leapfrog Group ANS measure		• Physician progress notes • Prenatal forms
DVT Prophylaxis - C-Section	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	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	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
Sample Flag for Joint Commission PC-03	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	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

Data Element	Definition	Column Header	Description
Maternal Diagnosis Codes	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, other_diagnosis_1, other_diagnosis_2, other_diagnosis_3… ….	ICD-9-CM Codes Include periods after the third digit for all ICD-9 diagnosis codes greater than three digits. THE ONLY REASON TO SUBMIT THIS FIELD 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	All procedures (primary and other) related to patient's stay	Principal_procedure, other_procedure_1, other_procedure_2, ….	ICD-9-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 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	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 ANY FUTURE BIRTH CERTIFICATE FILE.
Patient Height-Inches	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 ANY FUTURE BIRTH CERTIFICATE FILE.
Patient Pre-Pregnancy Weight	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 ANY FUTURE BIRTH CERTIFICATE FILE.
Transfer from Alternative Birth Setting	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	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

Data Element	Definition	Column Header	Description
			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	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	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	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	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".
*Full Bishop Score	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

Data Element	Definition	Column Header	Description
*Planned/Scheduled CS	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	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	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	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
*Maternal Clinical Concern	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	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

Data Element	Definition	Column Header	Description
			second_stage_seven_or_more_hours: >=7 hours
*Total time in Active Phase Prior to CS Decision	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	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	Documentation that membranes had ruptured at or before arrest time	ruptured_membranes_before_labor_arrest	Allowable Values: **Y** (Yes) **N** (No)
*Minimal Cervical Change	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	Documentation on whether cervical ripening was used	cervical_ripening_used	Allowable Values: **Y** (Yes) **N** (No)

***As of July 2015, these fields are only being used by WSHA-MDC hospitals.**

Newborn Supplemental File Data Elements

For all data elements you are including in the supplemental file, please use the designated column header as listed below.
For fields you are not including, simply omit the column header/column.

Data Element	Definition	Column Header	Description
Newborn Medical Record Number or Account Number	Unique code identifying a particular patient record within reporting facility	medical_record_number OR account_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	The date patient discharged from the hospital.	discharge_date	MMDDYYYY
Maternal Medical Record Number	Unique code identifying a particular patient record within reporting facility	mrn_mother_linked OR Account_number_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	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 available and are directly

Data Element	Definition	Column Header	Description
			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	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.
10 Minute Apgar Score	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 <u>is required</u> in order to calculate some newborn measures.
Bloodstream Infection Present on Admission	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 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

Data Element	Definition	Column Header	Description
			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	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
Exclusive Breast Milk Feeding	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	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

Data Element	Definition	Column Header	Description
	for drops or syrups consisting of vitamins, minerals, or medicines.		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	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 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"".

Data Element	Definition	Column Header	Description
			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 **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

Data Element	Definition	Column Header	Description
			• 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:	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	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	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
Sample Flag for Leapfrog Bilirubin Measure	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	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, other_diagnosis_1, other_diagnosis_2, other_diagnosis_3….	ICD-9-CM Codes Include periods after the third digit for all ICD-9 diagnosis codes greater than three digits. THE ONLY REASON TO SUBMIT THIS FIELD 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.

Data Element	Definition	Column Header	Description
Newborn Procedure Codes	All procedures (primary and other) related to patient's stay	Principal_procedure, other_procedure_1, other_procedure_2, ….	ICD-9-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 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	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 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

Data Element	Definition	Column Header	Description
			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