

# **MIRCaI**

## **Edit Flag Description Guide**

### **INPATIENT DATA**

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**Version 28**



Medical Information Reporting for California

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## SUMMARY OF CHANGES VERSION 28

### Changes effective with discharges on and after January 1, 2015 (January – June 2015 Report Period)

Due to Patient Disposition code updates, the following error messages have been revised:

#### RE-ADMISSION EDITS

##### Page 33

###### **K014 Flag**

Patient Disposition: Patient expired and then was re-admitted

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###### **K044 Flag**

Patient Disposition on the first record is 02, 63, 82, or 91 (Acute Care) but Type of Care on the re-admit record is not 1 (Acute Care)

###### **K045 Flag**

Patient Disposition on the first record is 62, 65, 70, 90, 93, or 95 (Other Care), but Type of Care on the re-admit record is not 4, 5, or 6 (Psych, Chem Dep or Phys Rehab Care)

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###### **K046 Flag**

Patient Disposition on the first record is 03, 61, 64, 83, 89, or 92 (Skilled Nursing Care) but Type of Care on the re-admit record is not 3 (Your SN/IC)

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## I INTRODUCTION

There are currently eight (8) MIRCaI edit programs applied to inpatient data. Data submitted on MIRCaI, via file submission or manual record entry, are processed through the MIRCaI edit programs. Each record is edited, and any errors found within the record are identified by edit flags.

This guide provides detailed information about each edit program, the applicable Error Tolerance Levels, and a list of the edit flags and their descriptions.

MIRCaI Edit Programs:

Transmittal Validation

Licensing Check

Trend Edits

Comparative Edits

Records with a Blank or Invalid Principal Diagnosis

Standard Edits

Re-Admission Edits

Coding Edits

## II MIRCAL EDIT PROGRAMS AT-A-GLANCE

### UNDERSTANDING THE MIRCAL EDIT PROGRAMS

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

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

Program	Description	Likely Cause of Failure
Transmittal Validation	<p>Checks for proper file format and compares the "Expected" (based on the Transmittal Page information) to "Actual" data submitted.</p> <ul style="list-style-type: none"> <li>• Virus infected file</li> <li>• No data in file</li> <li>• Multiple files in a Zip file</li> <li>• Incorrect file format</li> <li>• Discrepancy in the number of records submitted vs. the number entered on the Transmittal screen.</li> <li>• One (1) or more records are reported with a Discharge Date that is blank, invalid, or outside the Report Period.</li> <li>• Incorrect Facility ID Number on one or more records</li> <li>• MIRCal Database errors.</li> </ul>	Your data did not pass one or more of the transmittal validations.
Licensing Check	<p>Checks to make sure your data includes all the types of care and services for which your facility is licensed. For example, if your facility is licensed for Acute care, but no records are reported as Acute type of care, then your data will fail this program.</p> <p>NOTE: This program does not check for records that include a type of care for which your facility is <u>not</u> licensed. The Standard Edit program identifies this type of error.</p>	Your facility is licensed for a specific type of care, but that type of care is not being reported on any of your records.
Trend Edit (T flag)	<p>Compares the data in the current report period to the facility's historical data to identify uncharacteristic increases or decreases in percentages reported for certain data elements/categories.</p> <p><u>EXAMPLE:</u> In the Current Report Period, your facility reported 65% Non-Hispanic patients, but in the previous two (2) report periods, you reported only 20% Non-Hispanic patients. If this percentage difference between report periods is outside the "Allowable Difference", then either a Critical or Non-Critical Trend flag is generated. Non-Critical flags will not cause your data to fail this program, but one or more Critical flags will.</p>	Your data caused the program to generate one or more Critical Trend flags.

<p>Comparative Edit (C flag)</p>	<p>Based on the TOTAL records reported, checks for reasonable distribution of categories within each data element for the Current Report Period. <u>EXAMPLE:</u> If 100% of your records are reported with Patient Disposition-Routine, this program will generate a Comparative Edit flag and your data will fail.</p>	<p>Your data caused the program to generate one or more Comparative Edit flags.</p>
<p>Records with a Blank or Invalid Principal Diagnosis</p>	<p>This program identifies records with a Principal Diagnosis that is blank, invalid, reported with an “old” diagnosis code after the effective End Date; or reported with a “new” diagnosis code before the effective Begin Date. The erroneous Principal Diagnosis code will receive a critical S-flag.</p>	<p>One or more records with a Blank or Invalid Principal Diagnosis</p>
<p>Standard Edit (S flag)</p>	<p>Checks for data entry errors and inconsistencies of data reported within each record. <u>EXAMPLE:</u> Admit Date is AFTER the Discharge Date.</p>	<p>More than 2% of your records contain standard edit errors.</p>
<p>Coding Edit (V flag)</p>	<p>Checks for illogical combinations of ICD-9-CM codes. <u>EXAMPLE:</u> It is illogical for a record to have a Principal Diagnosis code for a normal birth and a Procedure Code for a C-section.</p>	<p>More than 2% of your records contain coding edit errors.</p>
<p>Readmission Edit (K flag)</p>	<p>Groups records that contain identical Social Security Numbers (SSNs), and then checks for inconsistencies between the records. <u>EXAMPLE:</u> Two records with the same SSN cannot have different Dates of Birth; either the SSN or the Date of Birth is incorrect.  This program also checks for errors in transfers to a different type of care. <u>EXAMPLE:</u> A patient is transferred <b>within</b> your hospital from Acute Care to SN/IC on the same day. The Patient Disposition in record 1 is reported as "04 SN/IC within hospital", but the Source of Admission in record 2 is reported as "132 Home." This would cause a readmission error. The Source of Admission in record 2 should be reported as "51x Acute Inpatient within your hospital."</p>	<p>More than 2% of your records contain readmission edit errors.</p>

### III TRANSMITTAL VALIDATION

#### OVERVIEW

Transmittal Validation consists of two (2) levels of validation: The first level checks files for viruses and for empty, incomplete or multiple files. The second level checks for proper file format, discrepancies in the number of records submitted, blank and invalid discharge dates, and incorrect facility ID numbers.

**Error Tolerance Level:** Data must pass both levels of validation before continuing through the remaining MIRCal edit programs.

#### **How do I know if my data failed Transmittal Validation?**

Access the "Main Error Summary" to see if your data passed or failed Transmittal Validation. If the data failed Transmittal Validation, the Summary will display the error message(s) and record number(s) that contain the error.

- Up to 20 records are listed.
- If there more than 20 records with a transmittal error, then the following message will be displayed:  
**There are more than 20 records with a transmittal error.  
Only the first 20 records with errors are listed.**

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

#### FIRST LEVEL OF TRANSMITTAL EDITS

If the data fails any one of these transmittal edits, it will be rejected immediately and will not be processed through the Second Level of transmittal edits.

- Virus infected file
- Empty file (no data contained in the file)
- Multiple files in a Zip file

Once data passes the first level of edits, it will continue on to the second level of Transmittal Validation.

#### SECOND LEVEL OF TRANSMITTAL EDITS

Data will be rejected if it fails one or more of the following edits. Data must pass Transmittal Validation before continuing on to the remaining MIRCal edit programs.

- Incorrect File Format
- Non-ASCII character
- Discrepancy in Number of Records submitted
- Blank and Invalid Discharge Dates
- Incorrect Facility ID Number
- MIRCal Database capacity error

**TRANSMITTAL ERROR MESSAGES**

**NOTE:** For additional information on Transmittal Errors and how to correct them, please see the *Troubleshooting Guide for Transmittal Errors, Rev 11/08* which can be found on the MIRCal website at <http://www.oshpd.ca.gov/HID/MIRCal/ManualsGuides.html>.

<i>Transmittal Edit</i>	<i>Error Message (Displayed on Main Error Summary)</i>
<b>I. FIRST LEVEL OF EDITING:</b>	
Checks for viruses	Virus infected file. Transmission of data was terminated.
Database failed to receive file submission	Database failed to receive file submission. Contact your OSHPD Analyst immediately. NOTE: This occurs when the Transmittal processor cannot access the database.
Does the file contain data? (Empty file)	No data contained in the file
Multiple files in a Zip file?	Zip file contains multiple files
No text file included in the Zip file	Zip file does not contain a file with a .txt file extension.
<b>II. SECOND LEVEL OF EDITING:</b>	
<b>To easily locate the error, the Main Error Summary will display the Record Number(s) that contain a transmittal error. Up to 20 records are listed.</b>	
Incorrect file format	File contains non-ASCII character(s)
Incorrect file format	Record length is more than 670 bytes
Incorrect file format	Record length is less than 670 bytes
Incorrect file format	No Carriage Control at byte 671
Incorrect file format	No Line Feed at byte 672
Discrepancy in the total number of records submitted. There is a difference of more than 20 records.	Total number of records submitted does not match the number of records entered on the Transmittal screen. On the Main Error Summary, the "Number of Records" column displays the number entered by the User.
Records with a Discharge Date outside the Report Period	One or more records are reported with a Discharge Date that is blank, invalid, or outside the Report Period.
Incorrect Facility ID Number	Incorrect Facility ID Number reported on one or more records. NOTE: On the Main Error Summary, the "Number of Records" column will display the Facility ID Number reported on the record in error.
MIRCal database capacity error	MIRCal Database error. The number of records in the MIRCal database does not match the number of records submitted. Contact your OSHPD analyst immediately.

## IV LICENSING CHECK

### OVERVIEW

The Licensing Check edits your facility's data against OSHPD's Licensing File to verify that the data reported is consistent with the Types of Care and Services for which it is licensed.

**Error Tolerance Level:** Data will fail the Licensing Check if it does not does not match OSHPD's licensing information, and all further editing is terminated.

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

**NOTE:** The Licensing Check does not edit records that include a Type of Care or Service for which your facility is not licensed. This is checked in the Standard Edit Program and is identified by an S flag.

### **How do I know if my data failed the Licensing Check?**

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Licensing Check. The Summary displays either "Pass" or "Fail" for this edit program. If data has failed, the applicable error message(s) is also be displayed.

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

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

**See next page for a list of the Licensing Check error messages and explanations...**

**LICENSING CHECK ERROR MESSAGES**

<b><i>Licensing Check (Message displayed on Main Error Summary)</i></b>	<b><i>Explanation</i></b>
No records reported in Type of Care 1	Hospital is licensed for Acute Care but there are no records reported in this type of care.
No records reported in Type of Care 3	Hospital is licensed for Skilled Nursing/Intermediate Care but there are no records reported in this type of care.
No records reported in Type of Care 4	Hospital is licensed for Psychiatric Care but there are no records reported in this type of care.
No records reported in Type of Care 5	Hospital is licensed for Chemical Dependency Care but there are no records reported in this type of care.
No records reported in Type of Care 6	Hospital is licensed for Physical Rehabilitation Care but there are no records reported in this type of care.
No records reported in Source of Admission – Your ER, but your facility is licensed for Emergency Department Services	Hospital is licensed as a Basic or Comprehensive Emergency Department, but there are no admits through "Your ER".
Discrepancy in licensing information between facility and OSHPD	The Types of Care and Services reported do not match OSHPD's records. Contact your OSHPD analyst to resolve this licensing issue.

## V TREND EDIT PROGRAM

### OVERVIEW

The Trend Edit Program is designed to check for inconsistencies in data by comparing data submitted in the current report period to data submitted in the last two (2) (historical) report periods. If the difference between the current data and the historical data is more than a specified percent, then a T (critical) or TW (non-critical) flag is applied to that data element or data element category. The facility must review any critical T flags in the data and verify whether or not the data is correct as reported.

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

**NOTE:** Facilities with 75 records or less are excluded from the T001, T002, T003 and T004 Trend edits.

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

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

### **How do I know if my data failed the Trend Edit Program?**

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Trend Edit Program. The Summary will display either "Pass" or "Fail" for this edit program. For "Fail" status, the Summary also displays the number of trend edit flags identified in the data.

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

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

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

### DEFINITIONS AND REPORTS

#### **Critical Trend (T) Flag**

A "T" flag, followed by a 3-digit number, identifies a Critical Trend Edit Flag.

A T-flag will result when the current data fails the Trend Edit in both historical report periods or it fails the Trend Edit against the only available historical report period.

The affected data element category will receive the applicable T-Flag.

#### **Trend Warning (TW) Flag (Non-Critical Error)**

A "TW" flag, followed by a 2-digit number, identifies a Warning (Non-Critical) Trend Edit Flag. A **TW-flag will NOT cause the data to be rejected**. These flags are

"warnings" that alert the facility to review possible errors in the data.

### When will the data get a TW flag?

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

Trend Flags on the Race, ZIP Code, and Prehospital Care and Resuscitation (DNR) data elements are always Warning Flags (TW01, TW02, TW03, and TW04), whether they fail the trend edit in one or both historical report periods.

### Facility Size

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

Hospital Size	Total Records Reported	Allowable Difference Applies only to T003 and T004 flags
Micro Small Hospital	1 to 75	Excluded
Very Very Small Hospital	76 to 100	20%
Very Small	101 to 250	15%
Small	251 to 500	12%
Medium	501 to 1000	10%
Large	1001 to 2500	8%
Very Large	2501 to 5000	7%
Super Large	5001 to 10000	6%
Ultra Large	10001 and up	5%

### Allowable Difference

This is the amount of increase or decrease that the MIRCal System will allow between current data and historical data for a particular data element category.

IMPORTANT: For the T003/TW03 and T004/TW04 flags, the Allowable Difference is based on facility size— the larger the facility, the smaller the Allowable Difference.

How does MIRCal determine that a data element category failed a Trend Edit?

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

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

### **Trend Edit Summary Report**

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

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

### **Data Distribution Report**

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

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

### **Report by Selected Data Element (custom report)**

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

You may need to contact your OSHPD analyst and request a “Report by Selected Data Element“. This custom report, (all records reported as TOA-Unscheduled), can be generated and posted on MIRCal. It can then be accessed by the facility and used for Trend Edit error analysis. The report can only be accessed by the requesting facility.

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

**TREND EDIT FLAGS AND DESCRIPTIONS**

**Critical Flags are identified as a T flag**  
**Warning (Non-Critical) flags are identified as a TW flag**

<i><b>Trend Edit Flag</b></i>	<i><b>Description</b></i>
T001	The current percent reported for this data element category is ZERO, but your hospital's historical data shows data reported.
TW01	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T002	The current percent reported for this data element category is greater than 2%, but your hospital's historical data shows ZERO records reported in this category.
TW02	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T003	The current percent reported for this data element category is lower than expected, based on your hospital's historical data.
TW03	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T004	The current percent reported for this data element category is greater than expected, based on your hospital's historical data reported.
TW04	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T005	<u>Total number of records submitted <b>decreased</b></u> more than 20%, based on your hospital's historical data.
TW05	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T006	<u>Total number of records submitted <b>increased</b></u> more than 20%, based on your hospital's historical data.
TW06	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T007	<u>Average Number of Other Diagnoses <b>decreased</b></u> more than 2 diagnoses per record, based on your hospital's historical data.
TW07	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T008	<u>Average Number of Other Procedures <b>decreased</b></u> more than 2 procedures per record, based on your hospital's historical data.
TW08	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T009	<u>Average Number of Other External Cause Codes <b>decreased</b></u> more than 2 External Cause Codes per record, based on your hospital's historical data.
TW09	Same description as above, but data failed this Trend Edit in only one (1) historical report period.

<b>Trend Edit Flag</b>	<b>Description</b>
T010	<u>Percent of Principal Procedures</u> reported <b>decreased</b> more than 5%, based on your hospital's historical data.
TW10	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T011	<u>Percent of Principal External Cause Codes</u> reported <b>decreased</b> more than 5%, based on your hospital's historical data.
TW11	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T012	<u>Average Length of Stay**</u> <b>decreased</b> more than 50%, based on your hospital's historical data.
TW12	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T013	<u>Average Length of Stay**</u> <b>increased</b> more than 50%, based on your hospital's historical data.
TW13	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T014	<u>Adjusted Charge per Day**</u> <b>decreased</b> more than 50%, based on your hospital's historical data.
TW14	Same description as above, but data failed this Trend Edit in only one (1) historical report period.
T015	<u>Adjusted Charge per Day**</u> <b>increased</b> more than 50%, based on your hospital's historical data.
TW15	Same description as above, but data failed this Trend Edit in only one (1) historical report period.

**\*\* Calculations for Average Length of Stay and Adjusted Charger per Day:**

Average Length of Stay (ALOS): The ALOS is calculated by dividing the total number of discharge days by the total number of discharges reported by the facility.

NOTE: Length of Stay equals Discharge Date minus Admit Date. If the Discharge Date is the same as the Admit Date, then the length of stay is one day.

Adjusted Charge per Day (Adj C/D): The sum of the Adjusted Total Charges divided by Total Discharge Days

NOTE: Adjusted Total Charges: OSHPD regulations require that only the total charges for the last 365 days are to be reported. This is calculated by dividing the Total Charges by 365 to **determine the average** charge per day. This average charge per day is then multiplied by the patient's actual length of stay. The result is the Adjusted Total Charges.

## VI COMPARATIVE EDIT PROGRAM

### OVERVIEW

The Comparative Edit Program evaluates data for “reasonable” distribution of data within each data element category for the current report period. If the percent reported is greater than expected, then the data element category will fail the Comparative Edit. Comparative Edits are not applied to blank or invalid data.

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

**Error Tolerance Level:** Data will fail the Comparative Edit Program if one or more critical Comparative Edit Flags are identified in the data.

#### **How do I know if my data failed the Comparative Edit Program?**

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Comparative Edits. The Summary displays either “Pass” or “Fail” for this edit program. For “Fail” status, the Summary also displays the number of comparative edit flags identified in the data.

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

### DEFINITIONS AND REPORTS

#### **Critical Comparative (C) Flag**

A “C” flag, followed by a 3-digit number, identifies a Critical Comparative Edit Flag. A C-flag will result when the percent of data reported within a particular data element category is greater than expected. The affected data element category will receive the applicable C-Flag.

#### **Comparative Warning (CW) Flag (Non-Critical Error)**

A “CW” flag, followed by a 2-digit number, identifies a Warning (Non-Critical) Comparative Edit Flag. **A CW-flag will NOT cause the data to be rejected.** These flags are “warnings” that alert the facility to review possible errors in the data.

#### **Allowable Percentage**

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

## Facility Size

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

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

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

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

## Example of a Comparative Edit that uses an Allowable Percentage based on Facility Size:

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

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

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

## Example of a Comparative Edit that is based on a fixed percent:

C012: All records (100%) are reported in one category for Source of Admission - Site.

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

### **Comparative Edit Summary Report**

This report identifies the data element categories that have been flagged with a C flag. The report is in alphabetical order by data element and includes the data element category; percent of records reported (Current Report Period); the “Allowable Percentage” (if applicable); and the corresponding C flag.

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

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

### **Data Distribution Report**

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

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

### **Report by Selected Data Element (custom report)**

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

You may need to contact your OSHPD analyst and request a “Report by Selected Data Element”. This custom report, (all records reported as TOA-Unknown, sorted by Abstract Record Number), can be generated and posted on MIRCal. It can then be accessed by the facility and used for Trend Edit error analysis. The report can only be accessed by the requesting facility.

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

**CRITICAL COMPARATIVE EDIT FLAGS AND DESCRIPTIONS**

<b>Comparative Edit Flag</b>	<b>Description</b>
C001	All records are reported in one Sex category: Male or Female
C002	Percent of records reported as Sex-Other is more than 0.1%.
C003	Percent of records reported with Unknown Sex is greater than 0.1%.
C004	All records are reported in one Ethnicity category.
C005	Records reported as Ethnicity-Unknown are above the percent expected for your hospital.
C006	All records are reported in one Race category.
C007	Records reported as Race-Unknown are above the percent expected for your hospital.
C008	Percent of records with a partial ZIP Code is greater than 2%.
C009	Percent of records with Unknown ZIP Code (XXXXX) is greater than 1%.
C010	Foreign ZIP Code (YYYYY): Records reported are above the percent expected for your hospital.
C011	Homeless ZIP Code (ZZZZZ): Records reported are above the percent expected for your hospital.
C012	All records are reported in one category for Source of Admission – Site.
C013	Percent of records with Source of Admission-Other is greater than 2%. Excludes Source of Admission 931 and 932.
C014	Percent of records with Type of Admission-Unknown is greater than 0.5%.
C015	All records are reported in one Patient Disposition category.
C016	Percent of records with Patient Disposition-Other is greater than 1%.
C017	All records are reported in one “Payer” category for Expected Source of Payment.
C018	Expected Source of Payment: All records reported with a Type of Coverage “1” (HMO) have the same Plan Code.
C019	Expected Source of Payment: More than 10% of records with Type of Coverage “1” (HMO) are reported with Plan Code 8000.
C020	No Other Diagnoses Codes reported.
C021	No Principal Procedure reported on any records.
C022	No Other Procedures reported on Acute Care records (Type of Care 1).
C023	No Other Procedures reported on Skilled Nursing/Intermediate Care records (Type of Care 3).
C024	No Other Procedures reported on Psychiatric Care records (Type of Care 4).
C025	Prehospital Care and Resuscitation (DNR): All records are reported as Yes.
C026	Prehospital Care and Resuscitation (DNR): 100% of Acute Care records (Type of Care 1) are reported as No.

<b>Comparative Edit Flag</b>	<b>Description</b>
C027	Prehospital Care and Resuscitation (DNR): 100% of Skilled Nursing/Intermediate Care records (Type of Care 3) is reported as No.
C028	Principal Diagnosis Present on Admission: The percent of records reported with No (N), Unknown (U), or Clinically Undetermined (W) is greater than 10% of the total number of PDX-POA Indicators equal to Y, N, U, W. Excludes principal diagnoses 664.01 thru 664.44
C029	Other Diagnosis Present on Admission Indicators are reported as 100% Yes (Y). Excludes POA reported as 'blank', 1 or E for exempt diagnosis codes.
C030	Other Diagnosis-Present on Admission: The percent of POA's reported as No (N), Unknown (U), or Clinically Undetermined (W) is greater than 30% of the total number of ODX-POA Indicators equal to Y, N, U, W.
C031	Percent of records with 799.9 as the Principal Diagnosis is greater than 0.1%.
C032	All records are reported in one Type of Admission category.
C040	Principal External Cause Code Present on Admission Indicator is reported as 100% NO (N). Excludes exempt values 1, E and "blank".
C041	Principal External Cause Code Present on Admission Indicator is reported as 100% Unknown (U). Excludes exempt values 1, E and "blank".
C042	Principal External Cause Code Present on Admission Indicator is reported as 100% Clinically Undetermined (W). Excludes exempt values 1, E and "blank".
C043	Other External Cause Code Present on Admission Indicator is reported as 100% No (N). Excludes exempt values 1, E and "blank".
C044	Other External Cause Code Present on Admission Indicator is reported as 100% UNKNOWN (U). Excludes exempt values 1, E and "blank".
C045	Other External Cause Code Present on Admission Indicator is reported as 100% Clinically Undetermined (W). Excludes exempt values 1, E and "blank".
C046	100% of records reported with the same Preferred Language Spoken Code.
C047	Percent of records with Unknown Preferred Language Spoken (999) is greater than 0.5%.
C048	Percent of records with an SW14 flag is greater than 1%. These records are reported with a PLS write-in that is questionable and requires verification by the facility.
C049	The percentage of records with PLS UND (Undetermined) is greater than 0.5%.
C050	The percentage of records with PLS ZXX (No linguistic/language content) is greater than 0.1%.
C052	Percent of records with Source of Admission 931 or 932 (Other-Not a Hospital) is greater than 0.1%. Note: Infants born outside the hospital and reported with SOA 931 or 932 are excluded from this edit.

**WARNING (NON-CRITICAL) COMPARATIVE EDIT FLAGS AND DESCRIPTIONS**

<b><i>Warning Edit Flags</i></b>	<b><i>Description</i></b>
CW07	More than 50% of the total number of Place of Occurrence codes is reported as E849.9 (Unspecified). Please review records and correct to a more specific place of occurrence, if available in the medical record.
CW08	No ZZZZZ (Homeless) ZIP Codes reported.
CW09	Facility is licensed for Ambulatory Surgery, but there are no records reported in Source of Admission 311 or 312 (Ambulatory Surgery-This Hospital). Please verify that this is correct.
CW10	The number of Unknown SSN's reported is greater than 10%. Excludes records with age less than 1 year old.

## VII RECORDS WITH A BLANK OR INVALID PRINCIPAL DIAGNOSIS

### **OVERVIEW**

The “Records with a Blank or Invalid Principal Diagnosis” edit program identifies records with a Principal Diagnosis that is blank, invalid, reported with an “old” diagnosis code after the effective End Date (September 30); or reported with a “new” diagnosis code before the effective Begin Date (October 1). The erroneous Principal Diagnosis code will receive a critical S-flag.

#### **Error Tolerance Level (ETL): Zero Records**

Data will be rejected if one or more records fail this edit program.

#### **How do I know if my data failed the “Records with a Blank or Invalid Principal Diagnosis” Edit Program?**

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed this edit program. The Summary will display either “Pass” or “Fail”. If data has failed, the summary will display the number of records reported with a blank or invalid Principal Diagnosis.

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

### **DEFINITIONS AND REPORTS**

#### **Critical (S) Flag**

An ‘S’ flag followed by a 3-digit number identifies a critical error. Critical S-flags are applied towards the ETL. If there are one or more records with an S-flag for this edit program, then the data will FAIL the “Records with a Blank or Invalid Principal Diagnosis” edit program and your data will be rejected.

#### **Warning (SW) Flag (Non-Critical Error)**

Currently, there are no warning flags for this edit program.

#### **Edit Detail Report of Records with a Blank or Invalid Principal Diagnosis**

This report displays all records that received an S001, S002, S059, or S060 on the Principal Diagnosis. The report is sorted by Type of Care, and then by Discharge Date within each Type of Care.

To access this report: From the Main Menu, click on “Error Reports”, then under Informational Reports, click on “View” next to “Records with a Blank/Invalid Principal Diagnosis (S).”

**RECORDS WITH A BLANK OR INVALID PRINCIPAL DIAGNOSIS**

<b><i>Critical Edit Flag</i></b>	<b><i>Description</i></b>
S001	Principal Diagnosis is Blank.
S002	Principal Diagnosis is invalid.
S059	New Diagnosis Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S060	Old Diagnosis Code is reported <u>AFTER THE</u> Effective End Date (September 30).

## VIII STANDARD EDIT PROGRAM

### OVERVIEW

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

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

### **How do I know if my data failed the Standard Edit Program?**

Check the "Main Error Summary for all Edit Programs" to see if your data passed or failed the Standard Edits. The Summary displays either "Pass" or "Fail" and the number and percent of records with an "S" flag.

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

### DEFINITIONS AND REPORTS

#### **Critical Standard (S) Edit Flag**

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

#### **Standard Edit Warning (SW) Flag (Non-Critical Error)**

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

#### **Standard Edit Summary Report**

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

#### **Standard Edit Detail Report**

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

To access these reports: Click on "Error Reports" on the Main Menu.

**EXPECTED SOURCE OF PAYMENT (ESOP)**

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

Standard Edit Flags for Illogical combinations of ESOP:

Critical Flags: S062, S063, S064

Warning Flags: none

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

**Valid ESOP Combinations**

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

**INVALID SOCIAL SECURITY NUMBER RANGES**

- Identical numbers repeated 7 or 8 times (except 000000001 – Unknown SSN). Numbers do not have to be in consecutive order
- 9 identical numbers
- Alpha characters
- The last 4 numbers are 0000
- 4th and 5th digits are 00
- The first three (3) numbers are:
  - ✓ 000
  - ✓ 666
  - ✓ 900 through 999
- Reported as ‘100101000’ or ‘001010001’

**CRITICAL STANDARD EDIT FLAGS AND DESCRIPTIONS**

<b><i>Critical Standard Edit Flag</i></b>	<b><i>Description</i></b>
S001	Blank. No data reported.
S002	Invalid. Data reported is not a valid OSHPD value. For <b>Preferred Language Spoken</b> : Valid values include alpha characters; '(apostrophe), - (hyphen), and 999. All other special characters and numeric values are invalid.
S003	Total Charges is reported as \$1 (No Charge), but Expected Source of Payment is not equal to 09 0 0000 (Other Payer).
S004	Date of Birth and Admission Date are not the same, but Type of Admission is INFANT UNDER 24 HRS OLD.
S005	Source of Admission SN/IC THIS HOSPITAL is an illogical combination for Type of Care-SN/IC.
S006	Admission Date and Date of Birth are the same, but the combination of Source of Admission and Principal Diagnosis is illogical on a newborn record.
S007	Date of Birth is AFTER the Admission Date.
S008	Principal Diagnosis indicates Newborn, but the Type of Admission is <u>not</u> reported as "3" - Infant, under 24 hours old.
S009	Admission Date is AFTER the Discharge Date.
S010	The combination of Source of Admission and Principal Diagnosis is illogical on a Newborn record.
S011	Sex is illogical with Male Principal Diagnosis Code.
S012	Source of Admission is reported as "712" – Newborn, but the Type of Care is not reported as "1" – Acute Care.
S013	Principal Procedure Date is AFTER the Discharge Date.
S016	Date of Birth and the Admission Date are not the same but Principal Diagnosis indicates Newborn born in the Hospital.
S018	Duplicate Diagnoses codes reported.
S019	Principal procedure is Blank, yet Other Procedures are reported.
S020	Source of Admission '911' applies to infants born in your ER, before admission to your hospital.
S021	Age is illogical with Principal Diagnosis Code.
S023	Place of Occurrence Code is required.
S024	Principal Procedure Date reported is more than three days <u>before</u> the Admission Date.

<b>Critical Standard Edit Flag</b>	<b>Description</b>
S025	<p>Missing Principal Cause of Injury External Cause Code. The Cause of Injury External Cause Code is required for the reported Principal Diagnosis.</p> <p><b>NOTE:</b> If your facility is the first episode of care* for this injury, poisoning, or adverse effect being treated or diagnosed, then the Principal External Cause Code must be reported on the record. If your facility is not the first episode of care*, then do not report the External Cause Code.</p> <p><i>*First episode of care includes ED or AS encounter, or hospital admission (discharge record). It does not include doctor's office.</i></p>
S029	Place of Occurrence Code cannot be the Principal External Cause Code.
S030	"Home-this Hospital" is an illogical combination for Source of Admission. HOME conflicts with <u>Licensure of Site</u> THIS HOSPITAL.
S031	"Home-Another Hospital" is an illogical combination for Source of Admission. HOME conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL.
S032	"Residential Care-This Hospital" is an illogical combination for Source of Admission. RESIDENTIAL CARE conflicts with <u>Licensure of Site</u> THIS HOSPITAL.
S033	"Residential Care-Another Hospital" is an illogical combination for Source of Admission. RESIDENTIAL CARE conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL
S034	"Acute Inpatient Care-Not a Hospital" is an illogical combination for Source of Admission. ACUTE INPATIENT conflicts with <u>Licensure of Site</u> NOT A HOSPITAL.
S035	"Other Inpatient Care-Not a Hospital" is an illogical combination for Source of Admission. OTHER INPATIENT conflicts with <u>Licensure of Site</u> NOT A HOSPITAL.
S036	"Newborn-Through your ER" is an illogical combination for Source of Admission. NEWBORN conflicts with <u>Route</u> YOUR ER.
S037	"Newborn-Another Hospital" is an illogical combination for Source of Admission. NEWBORN conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL.
S038	"Newborn-Not a Hospital" is an illogical combination for Source of Admission. NEWBORN conflicts with <u>Licensure of Site</u> NOT A HOSPITAL.
S039	"Prison/Jail-This Hospital" is an illogical combination for Source of Admission. PRISON/JAIL conflicts with <u>Licensure of Site</u> THIS HOSPITAL.

<b>Critical</b>	
<b>Standard Edit Flag</b>	<b>Description</b>
S040	“Prison/Jail-Another Hospital” is an illogical combination for Source of Admission. PRISON/JAIL conflicts with <u>Licensure of Site</u> ANOTHER HOSPITAL.
S041	“Other-This Hospital/Not your ER” is an illogical combination for Source of Admission. OTHER conflicts with <u>Licensure of Site</u> THIS HOSPITAL and with <u>Route</u> NOT YOUR ER.
S042	Source of Admission is “SN/IC-This Hospital”. Your hospital is <u>not licensed</u> for SN/IC type of care.
S043	Source of Admission is “Acute Care-This Hospital”. Your hospital is <u>not licensed</u> for this type of care.
S044	Source of Admission is “Other Care-This Hospital”. Your hospital is <u>not licensed</u> for Psychiatric, Chemical Dependency or Physical Rehabilitation types of care.
S048	Type of Care: Your hospital is <u>not licensed</u> for Acute Care.
S049	Type of Care: Your hospital is <u>not licensed</u> for SN/IC Care.
S050	Type of Care: Your hospital is <u>not licensed</u> for Psychiatric Care.
S051	Type of Care: Your hospital is <u>not licensed</u> for Chemical Dep Care.
S052	Type of Care: Your hospital is <u>not licensed</u> for Physical Rehabilitation Care.
S054	Age of the patient is greater than 120 years old.
S055	Total Charges reported are less than \$100 for Newborn. Principal Diagnosis indicates Newborn.
S056	There are no Other Diagnoses or Other Procedures reported on the Newborn record, but the <u>Charge per Day</u> is greater than \$3,200. Principal Diagnosis indicates Newborn.
S057	Total Charges are blank on Newborn record. Are the charges included on the mother’s record? Principal Diagnosis indicates Newborn.
S058	Discharge Date is Out of Range for the Report Period.
S059	New Diagnosis Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S060	Old Diagnosis Code is reported <u>AFTER</u> the Effective End Date (September 30).
S061	Expected Source of Payment: For Payer categories 01 thru 06 reported with Type of Coverage 1, the Plan Code cannot be blank or all zeroes.
S062	Expected Source of Payment: Do not report a Plan Code with Type of Coverage ‘0’, ‘2’ or ‘3’. (Example: 01 3 0000)
S063	Expected Source of Payment: Type of Coverage cannot be “0” for Payer categories 01 through 06. It must be reported as ‘1’, ‘2’, or ‘3’. (Example: 01 2 0000)

<b>Critical</b>	
<b>Standard Edit Flag</b>	<b>Description</b>
S064	Expected Source of Payment: For Payer categories 07, 08, and 09, Plan Code and Type of Coverage must be reported as all zeroes or left blank. (Example: 07 0 0000)
S070	Source of Admission is reported as "Ambulatory Surgery-This Hospital", but your hospital is <u>not licensed</u> for this service.
S071	Source of Admission-Route is reported as "Your ER", but your hospital is <u>not licensed</u> for Emergency Department Services.
S072	Expected Source of Payment: Worker's Compensation is illogical with age of patient (under 15 years old).
S073	Admission Date is not a reasonable date. Example: The Admission Date is more than 20 years before the Discharge Date.
S074	Principal Procedure Date is not a reasonable date. Example: The Principal Procedure Date is more than 20 years before the Discharge Date.
S075	Other Procedure Date is not a reasonable date. Example: The Other Procedure Date is more than 20 years before the Discharge Date.
S076	Type of Care is illogical with Type of Admission "Infant under 24 hrs old".
S077	Source of Admission "Acute Inpatient-This Hospital" is an illogical combination with Type of Care 1 (Acute Care). A patient cannot be admitted to your hospital's Acute Care if they are coming <u>from</u> your hospital's Acute Care.
S080	Date of Birth is after the Discharge Date.
S081	Date of Birth is after the Principal Procedure Date.
S082	Date of Birth is after Other Procedure Date(s).
S083	Source of Admission indicates Newborn with an illogical Type of Admission. The Source of Admission is reported s '712', but Type of Admission is not '3' (Infant under 24 hours old).
S084	Date of Birth and Admit Date are the same, but Type of Admission is not equal to '3' (Infant under 24 hours old).
S086	Sex is illogical with Female Principal Diagnosis Code.
S087	Sex is illogical with Male Other Diagnoses Code.
S088	Sex is illogical with Female Other Diagnoses Code.
S089	Sex is illogical with Male Principal Procedure Code.
S090	Sex is illogical with Female Principal Procedure Code.
S091	Sex is illogical with Male Other Procedure Code.
S092	Sex is illogical with Female Other Procedure Code.
S097	Other Procedure Date is after Discharge Date.

<b>Critical</b>	
<b>Standard Edit Flag</b>	<b>Description</b>
S099	Date of Birth and the Admission Date are not the same but Source of Admission indicates a Newborn (712).
S102	Duplicate External Cause Codes reported in Principal and Other External Cause Code fields.
S103	Duplicate Other External Cause Codes reported.
S104	Principal External Cause Code is blank, yet Other External Cause Codes are reported.
S105	Age is illogical with Other Diagnoses Code(s).
S106	Age is illogical with Principal Procedure Code.
S107	Age is illogical with Other Procedure(s).
S108	Age is illogical with Principal External Cause Code.
S109	Age is illogical with Other External Cause Code(s).
S110	Other Procedure Date is more than three days <u>before</u> the Admission Date.
S114	New Procedure Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S116	New External Cause Code is reported <u>BEFORE</u> the Effective Begin Date (October 1).
S119	Old Procedure Code is reported <u>AFTER</u> the Effective End Date (September 30).
S121	Old External Cause Code is reported <u>AFTER</u> the Effective End Date (September 30).
S129	Principal Diagnosis code is exempt, but POA Indicator is not blank, or not reported as 1 or E.
S130	Other Diagnosis code is exempt, but POA Indicator is not blank, or not reported as 1 or E.
S131	Principal External Cause Code is exempt, but POA Indicator is not blank, or not reported as 1 or E.
S132	Other External Cause Code is exempt, but POA Indicator is not blank, or not reported as 1 or E.
S134	Principal Diagnosis Code is <u>not exempt</u> , but POA indicator is reported as 1 or E.
S135	Other Diagnosis Code is <u>not exempt</u> , but POA indicator is reported as 1 or E.
S136	Principal External Cause Code is <u>not exempt</u> , but POA indicator is reported as 1 or E.
S137	Other External Cause Code is <u>not exempt</u> , but POA indicator is reported as 1 or E.
S138	The PLS Code or language reported is <u>AFTER</u> its removal from OSHPD Regulations.
S139	Charge per Day is greater than \$450,000.

**WARNING (SW) Non-Critical Flags**

<b>Warning Edit Flag</b>	<b>Description</b>
SW01	Partial Date of Birth reported. Only the Birth Year is reported for this patient.
SW02	Partial ZIP Code.
SW03	The Patient Length of Stay is greater than 180 days. Verify the Admission Date and Discharge Date.
SW04	The Type of Admission is “Scheduled”, but the Source of Admission indicates that the patient was admitted through your ER. (Source of Admission-Route) This is an illogical combination.
SW05	Principal Diagnosis: HIV test result reported.
SW06	Other Diagnosis: HIV test result reported.
SW07	Expected Source of Payment: Medicare is reported with an Unknown Social Security Number.
SW11	Based on the length of stay, the Charge per Day is less than \$100 or greater than \$150,000. Excludes records with SOA-Your ER <b>and</b> Patient Disposition 11 (Died).
SW12	Prehospital Care and Resuscitation (DNR): DNR reported as “YES” is unlikely for Psychiatric, Chemical Dependency, or Physical Rehabilitation Type of Care.
SW14	Questionable PLS write-in reported. Please review and verify the Preferred Language Spoken.

## IX RE-ADMISSION EDIT PROGRAM

### OVERVIEW

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

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

#### **How do I know if my data failed the Re-Admission Edit Program?**

Check the “Main Error Summary for all Edit Programs” to see if your data passed or failed the Re-Admission Edits. The Summary will display either “Pass” or “Fail” and the number and percent of records with a “K” flag.

To access this Summary: click on “Main Error Summary” on the Main Menu.

### DEFINITIONS AND REPORTS

#### **Critical Re-Admission (K) Edit Flag**

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

#### **Re-Admission Warning (KW) Flag (Non-Critical Error)**

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

#### **Re-Admission Summary Report**

This report provides a breakdown of the number and type of K and KW flags identified in the data. Another summary in this report displays the type and number of K flags by data element. Use this report to make sure that all errors are located and reviewed or corrected within each record

#### **Re-Admission Edit Detail Report**

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

To access these reports: click on “ Error Reports” on the Main Menu.

**CRITICAL RE-ADMISSION EDIT FLAGS AND DESCRIPTIONS**

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

<b>Critical Re-Admission Edit Flag</b>	<b>Description</b>															
K027	<p>Patient cannot be discharged from and then re-admitted to the same type of care within your hospital (SN/IC Care).</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>3 K027</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>411 K027</td> <td>3 K027</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		3 K027	Same	05-26-2000	05-30-2000	411 K027	3 K027
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		3 K027												
Same	05-26-2000	05-30-2000	411 K027	3 K027												
K028	<p>Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Psychiatric Care).</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>4 K028</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>612 K028</td> <td>4 K028</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		4 K028	Same	05-26-2000	05-30-2000	612 K028	4 K028
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		4 K028												
Same	05-26-2000	05-30-2000	612 K028	4 K028												
K029	<p>Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Chem Dep Care)</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>5 K029</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>611 K029</td> <td>5 K029</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		5 K029	Same	05-26-2000	05-30-2000	611 K029	5 K029
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		5 K029												
Same	05-26-2000	05-30-2000	611 K029	5 K029												
K030	<p>Patient cannot be discharged to and then re-admitted from the same Type of Care within your hospital (Physical Rehab Care)</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>6 K030</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>612 K030</td> <td>6 K030</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		6 K030	Same	05-26-2000	05-30-2000	612 K030	6 K030
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		6 K030												
Same	05-26-2000	05-30-2000	612 K030	6 K030												
K038	<p>Type of Care on the first record is not 1 (Acute Care) but Source of Admission on the re-admit record is 511 or 512 (Your Acute Care).</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>5 K038</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>512 K038</td> <td></td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		5 K038	Same	05-26-2000	05-30-2000	512 K038	
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		5 K038												
Same	05-26-2000	05-30-2000	512 K038													
K039	<p>Type of Care on the first record is not 3 (SN/IC) but Source of Admission on the re-admit record is 411 or 412 (Your SN/IC Care).</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>5 K039</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>411 K039</td> <td></td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		5 K039	Same	05-26-2000	05-30-2000	411 K039	
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		5 K039												
Same	05-26-2000	05-30-2000	411 K039													

<b>Critical Re-Admission Edit Flag</b>	<b>Description</b>															
K041	<p>Type of Care on the first record is 1 (Acute Care) but Source of Admission on the re-admit record is not 511 or 512 (Your Acute Care).</p> <p>Example:</p> <table border="0"> <tr> <td>SSN</td> <td>Admit Date</td> <td>Discharge Date</td> <td>Admit Source</td> <td>TOC</td> </tr> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>1 K041</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>411 K041</td> <td></td> </tr> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		1 K041	Same	05-26-2000	05-30-2000	411 K041	
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		1 K041												
Same	05-26-2000	05-30-2000	411 K041													
K042	<p>Type of Care on the first record is 3 (SN/IC) but Source of Admission on the re-admit record is not 411 or 412 (Your SN/IC Care).</p> <p>Example:</p> <table border="0"> <tr> <td>SSN</td> <td>Admit Date</td> <td>Discharge Date</td> <td>Admit Source</td> <td>TOC</td> </tr> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>3 K042</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>921 K042</td> <td></td> </tr> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		3 K042	Same	05-26-2000	05-30-2000	921 K042	
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		3 K042												
Same	05-26-2000	05-30-2000	921 K042													
K043	<p>Type of Care on the first record is 4, 5, or 6 (Psych, Chem Dep or Phys Rehab Care) but Source of Admission on the re-admit record is not 611 or 612 (Your Other Care).</p> <p>Example:</p> <table border="0"> <tr> <td>SSN</td> <td>Admit Date</td> <td>Discharge Date</td> <td>Admit Source</td> <td>TOC</td> </tr> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>6 K043</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>411 K043</td> <td></td> </tr> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2000	05-26-2000		6 K043	Same	05-26-2000	05-30-2000	411 K043	
SSN	Admit Date	Discharge Date	Admit Source	TOC												
Same	04-20-2000	05-26-2000		6 K043												
Same	05-26-2000	05-30-2000	411 K043													
K044	<p>Patient Disposition on the first record is 02, 63, 82, or 91 (Acute Care) but Type of Care on the re-admit record is not 1 (Acute Care)</p> <p>Example:</p> <table border="0"> <tr> <td>SSN</td> <td>Admit Date</td> <td>Discharge Date</td> <td>Pt Disposition</td> <td>TOC</td> </tr> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td>02 K044</td> <td></td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td></td> <td>6 K044</td> </tr> </table>	SSN	Admit Date	Discharge Date	Pt Disposition	TOC	Same	04-20-2000	05-26-2000	02 K044		Same	05-26-2000	05-30-2000		6 K044
SSN	Admit Date	Discharge Date	Pt Disposition	TOC												
Same	04-20-2000	05-26-2000	02 K044													
Same	05-26-2000	05-30-2000		6 K044												
K045	<p>Patient Disposition on the first record is 62, 65, 70, 90, 93, or 95 (Other Care), but Type of Care on the re-admit record is not 4, 5, or 6 (Psych, Chem Dep or Phys Rehab Care)</p> <p>Example:</p> <table border="0"> <tr> <td>SSN</td> <td>Admit Date</td> <td>Discharge Date</td> <td>Pt Disposition</td> <td>TOC</td> </tr> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td>62 K045</td> <td></td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td></td> <td>1 K045</td> </tr> </table>	SSN	Admit Date	Discharge Date	Pt Disposition	TOC	Same	04-20-2000	05-26-2000	62 K045		Same	05-26-2000	05-30-2000		1 K045
SSN	Admit Date	Discharge Date	Pt Disposition	TOC												
Same	04-20-2000	05-26-2000	62 K045													
Same	05-26-2000	05-30-2000		1 K045												

<b>Critical Re-Admission Edit Flag</b>	<b>Description</b>																		
K046	<p>Patient Disposition on the first record is 03, 61, 64, 83, 89, or 92 (Skilled Nursing Care) but Type of Care on the re-admit record is not 3 (Your SN/IC)</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Pt Disposition</th> <th>Type of Care</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td>03 K046</td> <td></td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td></td> <td>4 K046</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care	Same	04-20-2000	05-26-2000	03 K046		Same	05-26-2000	05-30-2000		4 K046			
SSN	Admit Date	Discharge Date	Pt Disposition	Type of Care															
Same	04-20-2000	05-26-2000	03 K046																
Same	05-26-2000	05-30-2000		4 K046															
K053	<p>Expected Source of Payment does not match on same day re-admit records.</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Source of Payment</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td>0800000 K053</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>0320000 K053</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Source of Payment	Same	04-20-2000	05-26-2000	0800000 K053	Same	05-26-2000	05-30-2000	0320000 K053						
SSN	Admit Date	Discharge Date	Source of Payment																
Same	04-20-2000	05-26-2000	0800000 K053																
Same	05-26-2000	05-30-2000	0320000 K053																
K054	<p>Same Principal External Cause Code is reported on re-admit record.</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Principal E-Code</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td>E989 K054</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>E989 K054</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Principal E-Code	Same	04-20-2000	05-26-2000	E989 K054	Same	05-26-2000	05-30-2000	E989 K054						
SSN	Admit Date	Discharge Date	Principal E-Code																
Same	04-20-2000	05-26-2000	E989 K054																
Same	05-26-2000	05-30-2000	E989 K054																
K055	<p>Source of Admission on the re-admit record indicates that patient was admitted from "your hospital", but the Discharge Date on the first record and the Admit Date on the re-admit record are not the same.</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Source of Admission/ Licensure of Site</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>05-31-2000</td> <td>06-01-2000 K055</td> <td>132</td> </tr> <tr> <td>Same</td> <td>06-03-2000 K055</td> <td>06-15-2000</td> <td>512 K055</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Source of Admission/ Licensure of Site	Same	05-31-2000	06-01-2000 K055	132	Same	06-03-2000 K055	06-15-2000	512 K055						
SSN	Admit Date	Discharge Date	Source of Admission/ Licensure of Site																
Same	05-31-2000	06-01-2000 K055	132																
Same	06-03-2000 K055	06-15-2000	512 K055																
K056	<p>Type of Care on the first record and on the re-admit record is 4 (Psych Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>Pt Dispo</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>65 K056</td> <td>4 K056</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>511 K056</td> <td></td> <td>4 K056</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		65 K056	4 K056	Same	05-26-2000	05-30-2000	511 K056		4 K056
SSN	Admit Date	Discharge Date	Admit Source	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		65 K056	4 K056														
Same	05-26-2000	05-30-2000	511 K056		4 K056														

<b>Critical Re-Admission Edit Flag</b>	<b>Description</b>																		
K057	<p>Type of Care on the first record and on the re-admit record is 5 (Chem Dep Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>Pt Dispo</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>70 K057</td> <td>5 K057</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>412 K057</td> <td></td> <td>5 K057</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		70 K057	5 K057	Same	05-26-2000	05-30-2000	412 K057		5 K057
SSN	Admit Date	Discharge Date	Admit Source	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		70 K057	5 K057														
Same	05-26-2000	05-30-2000	412 K057		5 K057														
K058	<p>Type of Care on the first record and on the re-admit record is 6 (Phys Rehab Care). Patient cannot be discharged from and re-admitted to the same Type of Care.</p> <p>Example:</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>Pt Dispo</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2000</td> <td>05-26-2000</td> <td></td> <td>62 K058</td> <td>6 K058</td> </tr> <tr> <td>Same</td> <td>05-26-2000</td> <td>05-30-2000</td> <td>132 K058</td> <td></td> <td>6 K058</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	Pt Dispo	TOC	Same	04-20-2000	05-26-2000		62 K058	6 K058	Same	05-26-2000	05-30-2000	132 K058		6 K058
SSN	Admit Date	Discharge Date	Admit Source	Pt Dispo	TOC														
Same	04-20-2000	05-26-2000		62 K058	6 K058														
Same	05-26-2000	05-30-2000	132 K058		6 K058														
K060	<p>Missing Record? Source of Admission on the first record is 411, 412, 511, 512, 611, or 612 (admitted from care within your hospital) but there is no previous record with a matching Discharge Date that indicates the previous inpatient stay.</p> <p>Example 1</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> </tr> </thead> <tbody> <tr> <td>Valid</td> <td>04-20-2012 K060</td> <td>04-26-2012</td> <td>512 K060</td> </tr> </tbody> </table> <p>Example 2</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> </tr> </thead> <tbody> <tr> <td>Valid</td> <td>05-26-2012 K060</td> <td>05-30-2012</td> <td>411 K060</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	Valid	04-20-2012 K060	04-26-2012	512 K060	SSN	Admit Date	Discharge Date	Admit Source	Valid	05-26-2012 K060	05-30-2012	411 K060		
SSN	Admit Date	Discharge Date	Admit Source																
Valid	04-20-2012 K060	04-26-2012	512 K060																
SSN	Admit Date	Discharge Date	Admit Source																
Valid	05-26-2012 K060	05-30-2012	411 K060																
K062	<p>Type of Care on the first record is <b>not</b> 4, 5, or 6 (Psych, Chem Dep, Phys Rehab) but the Source of Admission on the re-admit record is 611 or 612 (admitted from Other Inpatient Care within your hospital).</p> <p>Example</p> <table border="0"> <thead> <tr> <th>SSN</th> <th>Admit Date</th> <th>Discharge Date</th> <th>Admit Source</th> <th>TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>04-20-2012</td> <td>04-30-2012</td> <td>132</td> <td>3 K062</td> </tr> <tr> <td>Same</td> <td>04-30-2012</td> <td>05-30-2012</td> <td>611 K062</td> <td>1</td> </tr> </tbody> </table>	SSN	Admit Date	Discharge Date	Admit Source	TOC	Same	04-20-2012	04-30-2012	132	3 K062	Same	04-30-2012	05-30-2012	611 K062	1			
SSN	Admit Date	Discharge Date	Admit Source	TOC															
Same	04-20-2012	04-30-2012	132	3 K062															
Same	04-30-2012	05-30-2012	611 K062	1															

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

<b>Warning (Non-Critical) Re-Admission Edit Flag</b>	<b>Description</b>																														
KW01	<p>Ethnicity and/or Race does not match <b>with the first record</b>. Ethnicity and/or Race on re-admit records for the same patient does not match the Ethnicity and/or Race reported on the first record.</p> <p>NOTE: Psychiatric Type of Care records are excluded from this edit, EXCEPT for “Same Day Re-Admits”— the Discharge Date on the first record is the same as the Admit Date on the re-admit record.</p> <p>Example: The Ethnicity and/or Race reported on the third record is not the same and is flagged based on the Ethnicity and/or Race reported on the first record.</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">SSN</th> <th style="text-align: left;">Race</th> <th style="text-align: left;">Admit Date</th> <th style="text-align: left;">Discharge Date</th> <th style="text-align: left;">TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>11 KW01</td> <td>5-1-2000</td> <td>5-2-2000</td> <td>1</td> </tr> <tr> <td>Same</td> <td>21</td> <td>5-3-2000</td> <td><u>5-5-2000</u></td> <td><u>4</u></td> </tr> <tr> <td>Same</td> <td><b>31 KW01</b></td> <td><u>5-5-2000</u></td> <td>6-6-2000</td> <td>1</td> </tr> <tr> <td>Same</td> <td>32</td> <td>7-9-2000</td> <td>7-11-2000</td> <td>4</td> </tr> </tbody> </table>	SSN	Race	Admit Date	Discharge Date	TOC	Same	11 KW01	5-1-2000	5-2-2000	1	Same	21	5-3-2000	<u>5-5-2000</u>	<u>4</u>	Same	<b>31 KW01</b>	<u>5-5-2000</u>	6-6-2000	1	Same	32	7-9-2000	7-11-2000	4					
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Same	<b>31 KW01</b>	<u>5-5-2000</u>	6-6-2000	1																											
Same	32	7-9-2000	7-11-2000	4																											
KW02	<p>ZIP Code does not match with the first record. ZIP Code on subsequent records for the same patient does not match the ZIP Code reported on the first record.</p> <p>NOTE: Psychiatric Type of Care records are excluded from this edit, EXCEPT for “Same Day Re-Admits”— the Discharge Date on the first record is the same as the Admit Date on the re-admit record.</p> <p>Example: The ZIP Code reported for this patient is not the same and is flagged based on the ZIP Code reported on the <u>first</u> record.</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">SSN</th> <th style="text-align: left;">ZIP Code</th> <th style="text-align: left;">Admit Date</th> <th style="text-align: left;">Discharge Date</th> <th style="text-align: left;">TOC</th> </tr> </thead> <tbody> <tr> <td>Same</td> <td>95608 KW02</td> <td>5-1-2000</td> <td>5-2-2000</td> <td>1</td> </tr> <tr> <td>Same</td> <td>95864</td> <td>5-3-2000</td> <td>5-5-2000</td> <td>4</td> </tr> <tr> <td>Same</td> <td>95608</td> <td>6-1-2000</td> <td>6-4-2000</td> <td><u>1</u></td> </tr> <tr> <td>Same</td> <td>95864 KW02</td> <td>6-5-2000</td> <td><u>6-6-2000</u></td> <td>1</td> </tr> <tr> <td>Same</td> <td>95825</td> <td><u>6-6-2000</u></td> <td>6-8-2000</td> <td><u>4</u></td> </tr> </tbody> </table>	SSN	ZIP Code	Admit Date	Discharge Date	TOC	Same	95608 KW02	5-1-2000	5-2-2000	1	Same	95864	5-3-2000	5-5-2000	4	Same	95608	6-1-2000	6-4-2000	<u>1</u>	Same	95864 KW02	6-5-2000	<u>6-6-2000</u>	1	Same	95825	<u>6-6-2000</u>	6-8-2000	<u>4</u>
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## X CODING EDITS

# REFER TO THE CODING EDIT MANUAL FOR CRITICAL AND NON-CRITICAL CODING EDIT FLAGS AND DESCRIPTIONS

This manual is available on the MIRCaI website at:  
<http://www.oshpd.ca.gov/HID/MIRCaI/ICD9CodingManual.html>

**Error Tolerance Level (ETL):** 2% of records with one or more Critical Coding Edit flags, based on the total records reported. All errors in a record are counted as one (1) error.

### **DEFINITIONS AND REPORTS**

#### **Critical Coding Edit Flag (V)**

A “V” flag, followed by a 3-digit number, identifies a Critical Coding Edit Flag. Critical V flags are applied towards the ETL. If there are more than 2% of records with one or more V flags, then the data will FAIL the Coding Edit Validation.

#### **Warning (non-critical) Coding Edit Flag (VW)**

A “VW” flag, followed by a 2-digit number, identifies a Warning Coding Edit Flag. VW flags will not cause the data to be rejected since they are not applied towards the ETL. These warning flags are provided to alert the facility to review possible errors in the data.

#### **Coding Summary Report**

This report provides a breakdown of the number and type of V and VW flags identified in the data. Use this report to make sure that all errors are located and reviewed or corrected within each record.

#### **Coding Edit Detail Report**

This report displays all records that have one or more V or VW flags. The report is sorted by Type of Care, and then by Discharge Date within each Type of Care.

To access these reports on MIRCaI, on the Main Menu under Results, click on “Error Reports”.

## XI AGE AND SEX EDIT TABLES

### AGE EDIT TABLE

<u>ICD-9-CM Diagnosis Code</u>	<u>Record will flag if Age at Admission</u>
V11.4	Age is less than 15
V20.0 - V20.2	Age is greater than 17
V22.0 – V22.2	Age is less than 12 or greater than 55
V23.0 - V23.7	Age is less than 12 or greater than 55
V23.81 - V23.82	Age is less than 35 or greater than 55
V23.83 - V23.84	Age is greater than 15
V23.85 – V23.9	Age is less than 12 or greater than 55
V24.0	Age is less than 12 or greater than 55
V27.0 - V28.89	Age is less than 12 or greater than 55
V29.0 - V29.9	Age is greater than 1
V30.00 - V30.1	Age is greater than 1
V31.00 - V31.1	Age is greater than 1
V32.00 - V32.1	Age is greater than 1
V33.00 - V33.1	Age is greater than 1
V34.00 - V34.1	Age is greater than 1
V35.00 - V35.1	Age is greater than 1
V36.00 - V36.1	Age is greater than 1
V37.00 - V37.1	Age is greater than 1
V39.00 - V39.1	Age is greater than 1
V49.81	Age is less than 15
V51.0	Age is less than 15
V59.71 - V59.72	Age is greater than 34
V59.73 - V59.74	Age is less than 35
V61.6 - V61.7	Age is less than 12 or greater than 55
V62.21 – V62.29	Age is less than 15
V69.5	Age is greater than 17
V71.01	Age is less than 15
V71.02	Age is greater than 17
V72.42	Age is less than 12 or greater than 55
V85.0 – V85.45	Age is less than 21
V85.51 – V85.54	Age is greater than 20
V89.01 - V89.09	Age is less than 12 or greater than 55
V91.00 – V91.99	Age is less than 12 or greater than 55
040.41	Age is greater than 17
058.10 – 058.12	Age is greater than 17
259.1	Age is greater than 17
277.01	Age is greater than 1
290.0 – 290.9	Age is less than 15
303.00 - 303.03	Age is less than 10
303.90 - 304.93	Age is less than 10
305.00 - 305.03	Age is less than 10
305.1	Age is less than 10
305.20 - 305.43	Age is less than 10
305.50 - 305.53	Age is less than 10
305.60 - 305.93	Age is less than 10
313.89 - 313.9	Age is greater than 17

**AGE EDIT TABLE (continued)**

<b><u>ICD-9-CM Diagnosis Code</u></b>	<b><u>Record will flag if Age at Admission is:</u></b>
331.81	Age is greater than 17
335.20	Age is less than 15
366.10 - 366.19	Age is less than 15
374.01	Age is less than 15
374.11	Age is less than 15
379.27	Age is less than 15
414.00 - 414.07	Age is less than 15
414.3	Age is less than 15
429.71 - 429.79	Age is less than 15
437.0	Age is less than 15
440.0 - 440.9	Age is less than 15
454.0 - 454.9	Age is less than 15
457.0	Age is less than 15
500 - 501	Age is less than 15
516.5	Age is less than 15
571.0 - 571.3	Age is less than 15
600.0 - 602.9	Age is less than 15
606.0 - 606.9	Age is less than 15
607.84	Age is less than 15
610.1	Age is less than 15
611.81 – 611.83	Age is less than 15
612.0 – 612.1	Age is less than 15
630. - 676.94	Age is less than 12 or greater than 55
678.00 - 679.14	Age is less than 12 or greater than 55
690.11 - 690.12	Age is greater than 17
728.6	Age is less than 15
747.83	Age is greater than 1
<del>751.1 - 751.2</del>	<del>Age is greater than 17<sup>1</sup></del>
<del>751.61</del>	<del>Age is greater than 17<sup>1</sup></del>
780.91	Age is greater than 1
780.92	Age is greater than 1
783.41 – 783.42	Age is greater than 17
783.7	Age is less than 15
786.31	Age is greater than 17
789.7	Age is greater than 17
790.93	Age is less than 15
792.3	Age is less than 12 or greater than 55
796.5	Age is less than 12 or greater than 55
796.6	Age is greater than 1
798.0	Age is greater than 17
799.81	Age is less than 15
799.82	Age is greater than 17
995.50 - 995.59	Age is greater than 17
995.80 - 995.85	Age is less than 15

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<sup>1</sup> CMS removed these from the list of pediatric codes since patients could have revision procedures as adults.

**AGE EDIT TABLE (continued)**

**ICD-9-CM Procedure Code**

72.0 - 75.99

**Age at Admission Invalid if . . .**

Age is less than 12 or greater than 55

**ICD-9-CM E-Code**

E000.1

E800.0

E801.0

E802.0

E803.0

E804.0

E805.0

E806.0

E807.0

E827.2

E828.2

E830.6

E831.6

E832.6

E833.6

E834.6

E835.6

E836.6

E837.6

E838.6

E840.2

E840.8

E841.2

E841.8

E842.8

E843.2

E843.8

E844.2

E844.8

E845.8

E950.0 - E959

**Record will flag if Age at Admission is:**

Age is less than 18

Age is less than 14

Age is less than 2

Age is less than 2

Age is less than 14

Age is less than 2

**SEX EDIT TABLE**

<b><u>ICD-9-CM Diagnosis Code</u></b>	<b><u>Sex Specific</u></b>
V07.4	Female
V10.40 - V10.44	Female
V10.45 - V10.49	Male
V12.21	Female
V13.1	Female
V13.21 - V13.29	Female
V13.61	Male
V15.21 - V15.22	Female
V22.0 - V25.01	Female
V25.1 - V25.13	Female
V25.3	Female
V25.41 - V25.43	Female
V25.5	Female
V26.1	Female
V26.34 - V26.35	Male
V26.39	Male
V26.51	Female
V26.52	Male
V27.0 - V28.9	Female
V45.51	Female
V49.81	Female
V50.2	Male
V50.42	Female
V52.4	Female
V59.70 - V59.74	Female
V61.6 - V61.7	Female
V65.11	Female
V67.01	Female
V72.3 - V72.42	Female
V76.11	Female
V76.2	Female
V76.44 - V76.45	Male
V76.46 - V76.47	Female
V84.02	Female
V84.03	Male
V84.04	Female
V88.01 - V88.03	Female
V89.01 - V89.09	Female
V91.00 - V91.99	Female
016.40 - 016.56	Male
016.60 - 016.76	Female
054.11 - 054.12	Female
054.13	Male
072.0	Male
098.12 - 098.14	Male
098.15 - 098.17	Female
098.32 - 098.34	Male
098.35 - 098.37	Female

**SEX EDIT TABLE (continued)**

<b><u>ICD-9-CM Diagnosis Code</u></b>	<b><u>Sex Specific</u></b>
112.1	Female
131.01	Female
131.03	Male
174.0 - 174.9	Female
175.0 - 175.9	Male
179. - 184.9	Female
185. - 187.9	Male
198.6	Female
214.4	Male
218.0 - 221.9	Female
222.0 - 222.9	Male
233.1 - 233.39	Female
233.4 - 233.6	Male
236.0 - 236.3	Female
236.4 - 236.6	Male
256.0 - 256.9	Female
257.0 - 257.1	Male
257.9	Male
302.73	Female
302.74 -302.75	Male
302.76	Female
306.51 - 306.52	Female
456.4	Male
456.6	Female
600.0 - 608.9	Male
614.0 - 679.16	Female
716.30 -716.39	Female
752.0 - 752.49	Female
752.51 - 752.69	Male
752.81	Male
758.7	Male
788.32	Male
790.93	Male
792.2	Male
792.3	Female
795.0 - 795.09	Female
795.10 - 795.19	Female
796.5	Female
867.4 - 867.5	Female
878.0 - 878.3	Male
878.4 - 878.7	Female
902.55 - 902.56	Female
902.81 - 902.82	Female
939.1 - 939.2	Female
939.3	Male
947.4	Female
959.13	Male
996.32	Female

**SEX EDIT TABLE (continued)**

<b><u>ICD-9-CM Procedure Code</u></b>	<b><u>Sex Specific</u></b>
60.0 - 64.99	Male
65.01 - 75.99	Female
85.70 - 85.79	Female
87.81 - 87.89	Female
87.91 - 87.99	Male
88.46	Female
88.78	Female
89.26	Female
91.41 - 91.49	Female
92.17	Female
96.14 - 96.18	Female
96.44	Female
97.24 - 97.26	Female
97.71 - 97.75	Female
98.16 - 98.17	Female
98.23	Female
98.24	Male
99.94 - 99.96	Male
99.98	Female