



## Preserving Reported Procedures Through Error Corrections

This edition focuses on some of the corrections facilities can make to ensure the data quality of the procedures they report. Reporting facilities are likely aware that invalid procedures are deleted during final data standardization (data standardization is the process by which remaining errors are removed from the data set to prepare it for use). But did you know procedures are also removed during this process based on several other easily correctable errors? In 2014 there were 2,149 procedures removed from the patient discharge data (PDD) file because one of the following occurred (applicable edit flags noted in parentheses):

- (1) Invalid procedure (S002/S114/S119): n=42
- (2) Procedure date is missing or invalid (S001/S002): n=293
- (3) Procedure date occurs three days or more before the admission date (S024/S110): n=1,445
- (4) Procedure date occurs after the discharge date (S013/S097): n=369

Until recently, these deleted procedures were nearly indiscernible because the standardization process removes these procedures with one of the aforementioned errors and shifts the next valid procedure into its place. A new data validation process has allowed OSHPD to more easily quantify the number of procedures that are “lost” due to procedure date errors.

Of the 2,149 procedures removed from the PDD, 707 of them were principal procedure codes. This shift exacerbates the issue because many researchers rely on the principal procedure code in their analysis. When the secondary or tertiary procedure code becomes the principle procedure code, it has the potential of adversely affect their analysis.

In addition, the elimination of these uncorrected procedures and dates can affect a hospital's bottom-line because similar errors submitted to payers may reduce the number of procedures reported to the payer, thereby reducing the number of legitimate procedures reimbursed by payers.

In conclusion, your procedure data is highly desired and valued by researchers, hospitals, and other data users. Most of the 2,149 procedures that were deleted were due to an issue with the reported procedure date; deletion could have been easily prevented by correcting the date. You can find Procedure and Procedure Date errors noted above on your MIRCaI *Standard Edit Detail* report. Refer to [Section 97248](#) of MIRCaI Regulations for a description of Error Tolerance Level and default values.

## Ethnicity and Race Collection

Ethnicity and race data are highly utilized by healthcare researchers. We commend the efforts of your team in meeting requirements to report each patient's ethnic and racial background, and adhering to data quality by supporting patient ability to self-identify their own ethnicity and race. Currently there are five MIRCAl critical edit flags and three non-critical warning flags applied to validation of race or ethnicity.

OSHPD has updated our [Manuals & Guides page](#) with OSHPD-developed samples of race and ethnicity data collection tools for your use. These are made available as examples which can be models for your registration team's use but are not required.

### Reminders:

- Each patient should choose one ethnicity category and one race category. If a patient leaves one of the categories blank, please train registration staff to encourage them to complete each of the two sections.
- If a patient identifies with more than one of OSHPD's race categories, the patient may choose "Other."
- Each patient's self-reporting of their ethnicity and race supports integrity and quality of this vital data.
- When the patient is not capable of providing race and ethnicity information, the patient's family member or guardian may provide this information.
- A newborn's race and ethnicity should be reported separately from the mother. If the newborn's information is not found in the medical record, it may be appropriate to report the ethnicity and race of the mother.
- Unknown should only be reported to OSHPD when the patient's information is not in the medical record.

Please refer to the MIRCAl Data Reporting Manuals for more information.

## Inpatient Data Element Changes are Six Months Away – Are You Ready?

As discussed in Quick Notes issues #41 and #42, regulations were approved in October 2015 to update eight of the current Inpatient data elements to align them with National Standards. These changes take effect January 1, 2017. A summary of the changes includes:

- The reporting format was changed for Date of Birth, Admission Date, Discharge Date, and both Principal and Other Procedure Dates.
- "Other" was removed as an option when reporting Sex and values were changed from numeric to alpha characters.
- Substantial changes were made to the categories in Source of Admission and Type of Admission in order to adopt National Standards.

These changes can be viewed in the [Inpatient Data Reporting Manual](#) and in [Recently Approved Regulations](#). Further discussion will also be in the next edition of Quick Notes.

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## Regulatory Bulletin

The Patient Data Section submitted a nonsubstantive Section 100 regulatory package to the Office of Administrative Law (OAL) to remove obsolete regulatory language, incorrect cross-references, and inconsistent use of terminology.

All references to ICD-9 were removed and replaced with references to ICD-10. Additional language that is obsolete due to other regulatory changes was updated as well.

If you have any questions regarding these changes, please contact your MIRCAl analyst.