PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE THIRD QUARTER FY 2014 PATIENT ORIGIN SURVEY

MUST INCLUDE DISCHARGE DATA FOR APRIL, MAY, and JUNE 2014

FIELD NAME *(electronic & paper submissions)*	***INSTRUCTIONS (electronic & paper submissions)***	***FIELD LENGTH*** ***(for electronic submissions only)*** All fields should be numeric **Field Length Requirements**
Hospital ID #	SHPDA Hospital ID number	
Patient Number	Patient identification number. *This number may be a blind number assigned in sequential order.* Patient ID numbers **cannot** be duplicated.	**6**
Age	The numeric value of the patient's age, consisting of three (3) digits. For example, if the patient is 78, the entry would be 078. If the patient is 103, the entry would be 103. ***INCLUDE ALL NEWBORNS & PEDIATRICS, USING 000 FOR ALL INFANTS UNDER 1 YEAR OF AGE.***	**3**
Sex	Use the following values: ***MALE:*** **1** ***FEMALE:*** **2**	**1**
Race or National Origin	Use the following values: ***WHITE/CAUCASIAN*** ---------- **1** ***BLACK/AFRICAN AMERICAN/NEGRO*** ---------- **2** ***HISPANIC/SPANISH/LATINO*** ---------- **3** ***ASIAN*** ---------- **4** ***AMERICAN INDIAN/ALASKAN NATIVE*** ---------- **5** ***PACIFIC ISLANDER*** ---------- **6** ***INDIA*** ---------- **7** ***MIDDLE EASTERN*** ---------- **8** ***OTHER*** ---------- **9**	**1**
Zip Code	Patient's residence zip code. **5 digits only, report unknown zip codes as "99999".**	**5**

FIELD NAME *(electronic & paper submissions)*	***INSTRUCTIONS (electronic & paper submissions)***	***FIELD LENGTH (for electronic submissions only)*** <u>All fields should be numeric</u> **Field Length Requirements**
Length of Stay (LOS)	The number of days calculated from the date of admission until the date of <u>discharge</u> or <u>death</u>. **Discharges for this quarter** include any patients admitted in previous months and discharged during the months of **APRIL, MAY, and JUNE**. Patients must be in the hospital a minimum of 24 hours to be included in the Patient Origin Survey. ***Examples:*** A patient admitted on April 30th and discharged on May 4th would have a LOS of 004. A patient admitted on May 3rd and discharged on May 13th would have a LOS of 010. A patient admitted on June 28th and not discharged by June 30th would not be included.	**3**
Date of Discharge	For every discharge, Please include the date of discharge for that patient. This should be submitted in a **MM/DD/YYYY** format.	**10**
Service Code	Record only the ***PRIMARY*** service when more than one clinical service is provided during the hospital stay: ***MEDICINE:*** **01** ***SURGERY:*** **02** ***PEDIATRICS:*** **03** (use only if your facility has an organized pediatric unit and only for patients 17 <u>and under</u>). If your facility does not have an organized pediatric unit, report services under one of the remaining codes. For patients 18 and older, report under one of the remaining codes even if treatment occurred in an organized pediatric unit. ***GYNECOLOGY*** **04** <u>*(NO MALES)*</u>, (medicine or surgery)	**2**

FIELD NAME *(electronic & paper submissions)*	***INSTRUCTIONS (electronic & paper submissions)***	***FIELD LENGTH*** ***(for electronic submissions only)*** <u>All fields should be numeric</u> **Field Length Requirements**
Service code continued	***OBSTETRICS*** **05** *(<u>NO MALES</u>)* ***ORTHOPEDICS*** **06** (use only if your facility has an organized orthopedic unit.) Facilities without an organized orthopedic unit should report these patients under the appropriate service. ***PSYCHIATRIC*** **07** (include alcoholism and substance abuse treatments) ***REHABILITATION*** **08** ***OTHER*** **09**	**2**
DRG/CMG	Patient's ***DRG*** (Diagnosis Related Group) or ***CMG*** (Case Mix Group) code. **As a reminder, please indicate which version of DRG codes your facility is using.**	**4** (add leading 0's as necessary)
Payer Source	Use the following values: ***SELF PAY/PRIVATE PAY*** ---------- **1** ***WORKMAN'S COMPENSATION*** ---------- **2** ***MEDICARE*** ---------- **3** ***MEDICAID*** ---------- **4** ***TRI-CARE*** ---------- **5** ***BLUE CROSS/BLUE SHIELD*** ---------- **6** ***NO CHARGE/CHARITY*** ---------- **7** ***HMO*** ---------- **8** ***ALL KIDS*** ---------- **9** ***OTHER INSURANCE*** ---------- **10** ***HOSPICE*** ---------- **11** ***OTHER*** ---------- **12**	**2**

Note: Electronic submissions are requested; however, computer printouts or spreadsheets, ***in the same format***, are acceptable. SHPDA has a template available in Excel format. This template may be obtained by visiting the SHPDA website at www.shpda.alabama.gov, or contacting Bradford L. Williams at (334) 242-4103 or bradford.williams@shpda.alabama.gov

FOR ELECTRONIC SUBMISSIONS ONLY:

CD-ROMs and DVDs must carry an external label containing a data set name, the total number of records, and the type of file being submitted (Excel, text, CSV, etc.). E-Mail transmissions should include information regarding the total number of discharges, hospital name, and ID #, format of data, contact name, and telephone number. The data must contain only the fields indicated and **must** be in the order and format specified. Please transfer the data in Microsoft Excel or Microsoft Access 97 – 2007 only. If there are any special instructions concerning the data, they should be included with the submission. If data cannot be provided in one of these formats, please contact the agency using the information below.. Please send E-mailed submissions to data.submit@shpda.alabama.gov.

If there are any questions concerning submission of data, please contact Bradford L. Williams at (334) 242-4103 or bradford.williams@shpda.alabama.gov for clarification *PRIOR* to compiling the data.

THIRD QUARTER FY 2014 HOSPITAL PATIENT ORIGIN SURVEY

(*Include* newborns and pediatrics less than 1 year of age)

NOTE: Electronic submission of this information is preferred (see cover letter). If electronic submission is not possible, please make as many copies of this form as necessary in order to provide enough entries to cover all discharges for the months of **APRIL, MAY, and JUNE.**

Patient #	Age	Sex	Race	Zip Code	Length of Stay	Date of Discharge	Type of Service	DRG/CMG	Payer

Version of DRG Codes _____

Number of Discharge Entries Reported on this Page _____

THIRD QUARTER FY 2014
HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

Please attach this sheet as a cover to the THIRD QUARTER FY 2014 Hospital Patient Origin Survey for paper submissions. This survey is due by AUGUST 15, 2014.

Hospital Name _____

Hospital ID # _____

Total Number of Survey Sheets Enclosed _____

Total Number of Discharges Reported _____

Person submitting survey report: _____

Name _____

Title _____

Telephone Number _____

Version of **DRG** Codes: _____

Please only use this closeout record if the data is submitted on paper. Retain a copy for your records. Do not use this form if data is transmitted electronically.