Oregon Maternal Data Center (OMDC)
Data Submission Guidelines and Specifications
Required Files (Core Files)
January 1, 2017

To generate perinatal performance metrics for the Oregon Perinatal Collaborative (OPC) quality improvement programs, hospitals may submit data to the Oregon Maternal Data Center (OMDC), an online data aggregation and quality improvement tool developed by the California Maternal Quality Care Collaborative (CMQCC) and housed at Stanford University School of Medicine.

Questions or Comments

Please contact Anne Castles of CMQCC at 626-639-3044 or support@oregonmaternaldatacenter.org

Summary Guidelines and Timelines

- Participating hospitals will submit patient discharge and clinical data files in CSV file format to the MDC on a monthly basis.
- Submissions should be based on discharge date for all files and are to be made on a calendar month basis, representing *inpatient* discharges from the first day of the month through the last day of the month for the given reporting period.
- You may submit multiple months in a single file, but please ensure the files represent the entire month for each month you are submitting (no partial-month data).
- The files should be submitted 45 days after the close of the reporting period. For example, data for March 1 - 31 is due on May 15.
- Hospital systems have the option to submit a *single* patient discharge data file for *all* hospitals in their system. Please contact CMQCC to learn more.
- All data submissions will be made via the MDC's secure web-based tool, housed in dedicated server environments maintained by Stanford University's School of Medicine, Information, Resources and Technology (Med-IRT) Group.
- Files should be in flat file format—using commas to separate values—with each case in a single row. A template CSV file format is also available at http://www.q-corp.org/OMDC.
- Column headers, as denoted in the specifications below, must be used for all fields you are submitting.
- If the field is optional and you are choosing not to submit it, please omit the column header/column. Optional fields are highlighted in blue.
- If a record value for an included field is missing, leave no space between the commas(,,)

Data Elements

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

- Patient Discharge Data (using UB-04 coding): See Section B.
- Maternal Clinical File. See Section C.
- Newborn Clinical File. See Section D.

Records to be Submitted

- The MDC is currently focused on generating performance metrics for the Delivery hospitalization. Hospitals may choose between submitting all *inpatient* records *or* limiting the submission to *inpatient delivery-related* discharges (the latter is recommended). If you choose to limit your submission to *inpatient* delivery-related discharges, please use the codes in Section A below to filter your data. If you submit all *inpatient* discharge records, the MDC will apply the filters for you.
- Some fields are optional; optional fields are highlighted in blue and marked with an "O". If you choose not to submit data for these fields, please omit the column headers.

Registering with the MDC Prior to Submitting Data

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

To register: Click on the colored box in the invitation e-mail addressed to you from support@oregonmaternaldatacenter.org. Enter a login name, personal password and phone numbers that you personally answer. *The phone numbers are part of the MDC security protocols: each time you access patient level information, MDC will transmit a computer-generated pin number through a call or text to your registered phone number. For hospitals that use extensions, you may use a cell phone or a Google App available for smart phones.*

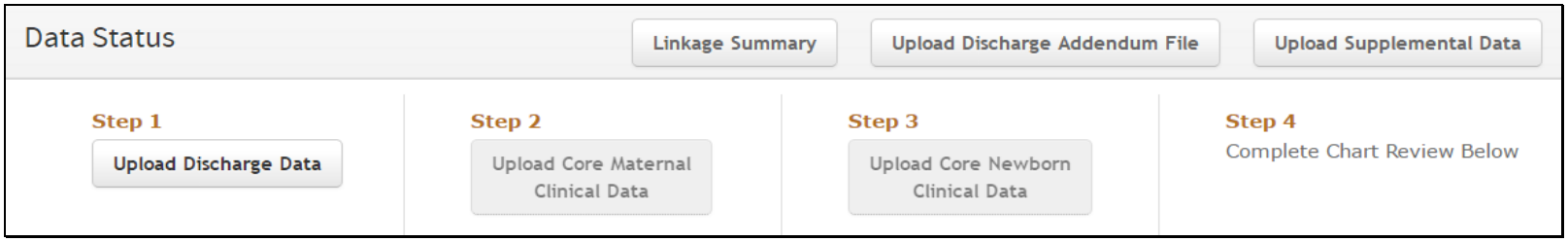
Uploading Data Files

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

https://oregonmaternaldatacenter.org

In order to submit a data file, you will:

- Enter your login name and personal password.
- In the upper right corner, click the button "Data Entry Status".
- Go through the 3 steps to upload the three data files (Discharge, Maternal Clinical, Newborn Clinical).



- You will receive a prompt for second factor authentication—the temporary pin required when submitting patient level data. Click "Call" or "Text" to select the phone number at which you wish to receive the pin number. Input the temporary pin provided via the call or text and click "Submit".
- Select "Choose File" to attach the file to be uploaded from your system.
- Click "Upload". The data may process for several minutes depending on the size of your file. Once the file is accepted, the word "Complete" will display for the month and file type that you submitted. If you hover over the word "Complete" you will see a count of the maternal and newborn discharge records imported into the MDC.

If errors are found, you will receive an error message. Please contact CMQCC if you need assistance in interpreting the message; within the MDC, click Support in the top black bar and then click Contact MDC Support. Your message will automatically include documentation of the page you were visiting when the Support link is selected. Or e-mail CMQCC directly at support@oregonmaternaldatacenter.org.

NOTE: You also have the option to upload discharge data files via SFTP. See User Guide in the *MDC Support* Section **Automated File Submissions to the MDC**.

OPTIONAL *Supplemental Data File*

Your hospital has the option of submitting additional supplemental CSV data files derived from internal systems (e.g. EMR, core measure vendor system). The supplemental files might be used to:

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

See **Supplemental Data File Specifications** for more details.

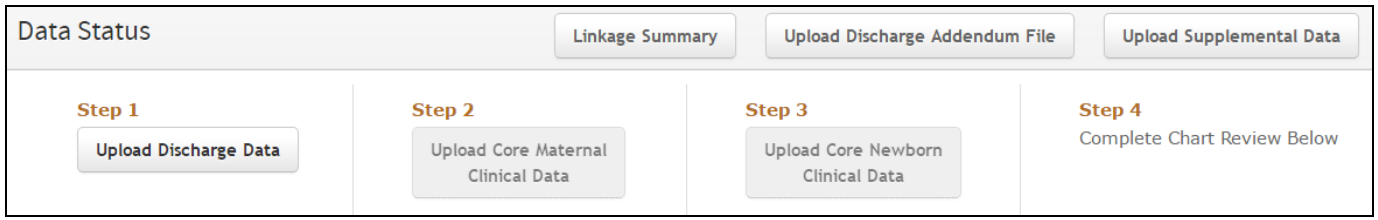
OPTIONAL *Discharge Data Addendum* Files

Ability to Add Cases to Previously-Submitted Discharge Data Files

If you discover that a case is missing from a monthly/quarterly Discharge Data file that you had *previously* submitted to the MDC, you can now add these individual discharge cases via a *Discharge Addendum* file. To submit these new "addendum" cases:

- Create your *Discharge Addendum File* using the same *Discharge Data* file specifications/format delineated in Section B below. All fields required for the standard Discharge Data file are also required for the Addendum Cases.
- From the MDC Home Page, click "Data Entry Status"
- Select "Upload Discharge Addendum File"
- Click "Choose File" to select the file you created, and click "Upload"

Note: This feature does ***not*** enable overwriting/replacement of the originally-submitted discharge records; i.e. any cases in the *Addendum File* that are duplicates of previously-submitted cases in the *Discharge Data File* will ***not*** replace the original record.


Data Status
Linkage Summary
Upload Discharge Addendum File
Upload Supplemental Data
Step 1
Upload Discharge Data
Step 2
Upload Core Maternal Clinical Data
Step 3
Upload Core Newborn Clinical Data
Step 4
Complete Chart Review Below

Summary of Changes to OMDC Data Specifications

Changes since 10/31/16 Version

Instructions

Information on two new MDC features:

- Users may now upload *Discharge Addendum Files*, which provides the ability to add new cases to previously-submitted monthly discharge files--in the event that *individual* discharge records were omitted from the original *Discharge Data File* submission. (*see Page 3: OPTIONAL Discharge Data Addendum Files*)
- Users have the option to submit *Discharge Data* and *Supplemental Data* Files (but not Core Clinical Files) via SFTP. See Page 3: *Automated File Submissions*.

Maternal Clinical File

Data element definitions used for The Joint Commission *Perinatal Care* measure set have been updated in alignment with the 2016B TJC Manual (effective with January 1, 2017 discharges). The following data elements were modified:

- Parity (used in PC-02)

There is a new *Optional* supplemental data element. *Labor Care Provider* can be submitted starting March 1, 2017. Hospitals may submit this field if they would like to calculate provider-level metrics for their *Labor Care Providers* (e.g. nurse-midwives) in addition to the provider-level metrics based on the *Delivering Provider*.

Changes since 12/15/15 Version

Throughout

- Clarification that the PDD file should only include *inpatient* discharge records, not ambulatory/outpatient records.
- The complete list of OPTIONAL supplemental data elements is no longer included in the Core File Specifications here. To see the full list of optional fields, see the document **Supplemental Data File Specifications** in the MDC Support Section.

Maternal Clinical File

Data element definitions used for The Joint Commission *Perinatal Care* measure set have been updated in alignment with the 2016A TJC Manual. The following data elements were modified:

- Parity (used in PC-02)

Newborn Clinical File

Data element definitions used for The Joint Commission Perinatal Care measure set have been updated in alignment with the 2016A TJC Manual. The following data elements were modified:

- The definition for NICU Admission has changed slightly to accommodate both Joint Commission and Leapfrog Group measures that require this data element. Specifically, the CMQCC definition no longer requires that the NICU Admission occur “at this hospital”. If there is documentation that the newborn was transferred directly from the birth hospital to a NICU at another hospital, you may still respond “yes” to “NICU Admission”

Changes since 7/23/15 Version

Section C: Maternal Clinical File

- Optional data element added: “Induced Y/N” given ICD-10 codes do not have a code that clearly identifies an induction procedure.

Changes since 7/15/15 Version

Section A2: Records to Include in MDC Data Submission

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

Changes since 2/9/15 Version

Section A: Records to Include in MDC Data Submission

Section A specifies the ICD codes to be used for identifying maternal and newborn records as delineated below:

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

Section A1
Inpatient Records to Include in MDC Data Submission
ICD-9 Codes

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

The MDC will transition to ICD-10 codes for discharges from October 2015; the ICD-10 filters are listed in Section A2 below.

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

Infant Records	**Include all newborn inpatient discharge records meeting <u>ANY</u> of the following criteria:**	
Dates of Admission and Birth	Admission Date – Date of Birth ≤ 2 days	
ICD-9-CM V-Codes: Live births (In-hospital and Out-of-Hospital)	V30.xx	Single liveborn
	V31.xx	Twin liveborn, mate liveborn
	V32.xx	Twin liveborn, mate stillborn
	V33.xx	Twin liveborn, mate unspecified
	V34.xx	Other multiple, mates all liveborn
	V35.xx	Other multiple, mates all stillborn
	V36.xx	Other multiple, mates live and stillborn
	V37.xx	Other multiple, mates unspecified
	V39.xx	Unspecified liveborn

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

Please include all of the following *inpatient* records in you MDC Submission. Apply these ICD-10 code filters to both the discharge and clinical files. If it is not possible to use ICD-10 codes as filters for the clinical files, then please attempt to include only maternal and newborn delivery hospitalizations in your clinical files (i.e. no antepartum or post-partum hospitalizations)

Include all *inpatient* discharge records meeting ANY of the following criteria

Mother Records

Outcome of Delivery

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

Delivery *(Letter "O" codes)*

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

Delivery Procedure Codes (Joint Commission Table Number 11.01.1)

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

Infant Records

Admission Date Criteria

Admission Date – Date of Birth ≤ 2 days

Liveborn Infants

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

Section B:
Patient Discharge Data Elements

Please note that while the MDC utilizes the same coding and definitions as OAHHS' Apprise system, we do not utilize the 837i File Format. Coding definitions can be found in the NUBC UB-04 Data Specifications Manual: http://www.nubc.org/ or the Apprise INFOH manual.

Notes

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

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
R	Facility ID	10-digit National Provider Identifier http://npidb.org/organizations/hospitals/general-acute-care-hospital_282n00000x/or/	facility_id	National Provider Identifier Database
O	Hospital Campus ID	Additional ID that distinguishes one hospital campus from another in the event that two or more sites report under the same National Provider Identifier.	campus_id	Up to 3 digit internal code of hospital choice
R	Medical/Health Record Number or Account Number	Patient's unique (alphanumeric) number assigned by the hospital to facilitate retrieval of the individual's medical records. MRNs are encouraged over Account Numbers in the event re-admissions are studied in the future.	medical_record_number OR account_number	
R	Patient Address –Zip Code	Report the entire nine digit zip code if known. Use no dashes between zip and zip+4. If the Zip Code is unknown, use 99999. If the patient is homeless, use 99998.	zip_code	NUBC UB-04 Manual Form Locator 9
R	Patient Date of Birth (DOB)	The date of birth of the patient. If unknown, use June 30 of the estimated year. (MMDDYYYY)	date_of_birth	NUBC UB-04 Manual Form Locator 10

<table>
<tr><th>Required (R) or Optional (O)</th><th>Data Element</th><th>Description</th><th>Column Header</th><th>Report Value According To</th></tr>
<tr><td>R</td><td>Patient Sex</td><td>The sex of the patient as recorded at admission or start of care. Use “M” (Male), “F” (Female) or “U” (Unknown).</td><td>sex</td><td>NUBC UB-04 Manual Form Locator 11</td></tr>
<tr><td>R</td><td>Date of Admission</td><td>The start date for this episode of care. For inpatient services, this is the date of admission. (MMDDYYYY)</td><td>admitted_on</td><td></td></tr>
<tr><td>R</td><td>Admission Hour</td><td>The code referring to the hour during which the patient was admitted for inpatient care.

<table>
<tr><th>Code</th><th>Time</th><th>-</th><th>AM</th><th></th><th>Code</th><th>Time</th><th>-</th><th>PM</th></tr>
<tr><td>00</td><td>12:00</td><td>–</td><td>12:59 Midnight</td><td></td><td>12</td><td>12:00</td><td>–</td><td>12:59 Noon</td></tr>
<tr><td>01</td><td>01:00</td><td>-</td><td>01:59</td><td></td><td>13</td><td>01:00</td><td>–</td><td>01:59</td></tr>
<tr><td>02</td><td>02:00</td><td>-</td><td>02:59</td><td></td><td>14</td><td>02:00</td><td>-</td><td>02:59</td></tr>
<tr><td>03</td><td>03:00</td><td>-</td><td>03:59</td><td></td><td>15</td><td>03:00</td><td>-</td><td>03:59</td></tr>
<tr><td>04</td><td>04:00</td><td>-</td><td>04:59</td><td></td><td>16</td><td>04:00</td><td>-</td><td>04:59</td></tr>
<tr><td>05</td><td>05:00</td><td>-</td><td>05:59</td><td></td><td>17</td><td>05:00</td><td>-</td><td>05:59</td></tr>
<tr><td>06</td><td>06:00</td><td>-</td><td>06:59</td><td></td><td>18</td><td>06:00</td><td>-</td><td>06:59</td></tr>
<tr><td>07</td><td>07:00</td><td>-</td><td>07:59</td><td></td><td>19</td><td>07:00</td><td>-</td><td>07:59</td></tr>
<tr><td>08</td><td>08:00</td><td>-</td><td>08:59</td><td></td><td>20</td><td>08:00</td><td>-</td><td>08:59</td></tr>
<tr><td>09</td><td>09:00</td><td>-</td><td>09:59</td><td></td><td>21</td><td>09:00</td><td>-</td><td>09:59</td></tr>
<tr><td>10</td><td>10:00</td><td>-</td><td>10:59</td><td></td><td>22</td><td>10:00</td><td>-</td><td>10:59</td></tr>
<tr><td>11</td><td>11:00</td><td>-</td><td>11:59</td><td></td><td>23</td><td>11:00</td><td>-</td><td>11:59</td></tr>
</table></td><td>admit_hour</td><td>NUBC UB-04 Manual Form Locator 13</td></tr>
<tr><td>R</td><td>Priority (Type) of Visit</td><td>A code indicating the priority of this admission/visit. Only values 1-5 or 9 are accepted.

1 Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions.
2 Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder.
3 Elective The patient’s condition permits adequate time to schedule the services.
4 Newborn: Use of this code necessitates the use of Special Source of Admission Code. See Field “Point of Origin/Source of Admission” below.
5 Trauma: Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
9 Information: Information not available.</td><td>visit_type</td><td>NUBC UB-04 Manual Form Locator 14</td></tr>
<tr><td>R</td><td>Point of Origin / Source of Admission</td><td>A code indicating the point of origin for this admission or visit.
1 Non-Health Care Facility Point of Origin: The patient was admitted to this facility
2 Clinic: The patient was admitted to this facility.
4 Transfer from a Hospital (Different Facility): The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.
5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from an SNF, ICF or ALF where he or she was a resident.
6 Transfer from another Health Care Facility: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.</td><td>admit_source</td><td>NUBC UB-04 Manual Form Locator 15</td></tr>
</table>

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

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

<table>
<tr><td>Code</td><td>Time</td><td>-</td><td>AM</td><td></td><td>Code</td><td>Time</td><td>-</td><td>PM</td></tr>
<tr><td>00</td><td>12:00</td><td>–</td><td>12:59 Midnight</td><td></td><td>12</td><td>12:00</td><td>–</td><td>12:59 Noon</td></tr>
<tr><td>01</td><td>01:00</td><td>-</td><td>01:59</td><td></td><td>13</td><td>01:00</td><td>–</td><td>01:59</td></tr>
<tr><td>02</td><td>02:00</td><td>-</td><td>02:59</td><td></td><td>14</td><td>02:00</td><td>-</td><td>02:59</td></tr>
<tr><td>03</td><td>03:00</td><td>-</td><td>03:59</td><td></td><td>15</td><td>03:00</td><td>-</td><td>03:59</td></tr>
<tr><td>04</td><td>04:00</td><td>-</td><td>04:59</td><td></td><td>16</td><td>04:00</td><td>-</td><td>04:59</td></tr>
<tr><td>05</td><td>05:00</td><td>-</td><td>05:59</td><td></td><td>17</td><td>05:00</td><td>-</td><td>05:59</td></tr>
<tr><td>06</td><td>06:00</td><td>-</td><td>06:59</td><td></td><td>18</td><td>06:00</td><td>-</td><td>06:59</td></tr>
<tr><td>07</td><td>07:00</td><td>-</td><td>07:59</td><td></td><td>19</td><td>07:00</td><td>-</td><td>07:59</td></tr>
<tr><td>08</td><td>08:00</td><td>-</td><td>08:59</td><td></td><td>20</td><td>08:00</td><td>-</td><td>08:59</td></tr>
<tr><td>09</td><td>09:00</td><td>-</td><td>09:59</td><td></td><td>21</td><td>09:00</td><td>-</td><td>09:59</td></tr>
<tr><td>10</td><td>10:00</td><td>-</td><td>10:59</td><td></td><td>22</td><td>10:00</td><td>-</td><td>10:59</td></tr>
<tr><td>11</td><td>11:00</td><td>-</td><td>11:59</td><td></td><td>23</td><td>11:00</td><td>-</td><td>11:59</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table></td><td>discharge_hour</td><td>NUBC UB-04 Manual Form Locator 16</td></tr>
<tr><td>R</td><td>Patient Discharge Status</td><td>An NUBC code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill as reported in FL6, Statement Covers Period. The following values are accepted:
01 Discharged to Home or Self care (Routine Discharges)
02 Discharged/transferred to Short Term General Hospital for Inpatient Care
03 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care.
04 Discharge /transferred to a Facility That Provides Custodial or Supportive Care (Includes ICF and Assisted Living Facilities)
05 Discharged/transferred to a Designated Cancer Center or Children’s Hospital
06 Discharged/transferred to Home under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care.
07 Left Against Medical Advice or Discontinued Care</td><td>discharge_status</td><td>NUBC UB-04 Manual Form Locator 17</td></tr>
</table>

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
		09 Admitted as an inpatient to this hospital 20 Expired 21 Discharged/transferred to Court/Law Enforcement 30 Still patient 43 Discharged/transferred to a Federal Health Care Facility 50 Hospice-Home 51 Hospice – Medical Facility (Certified) Providing Hospice Level of Care 61 Discharged/transferred to a Hospital Based Medicare Approved Swing Bed 62 Discharged/transferred to an Inpatient Rehabilitation Facility(IRF) including Rehabilitation Distinct Part Units of a Hospital 63 Discharged/transferred to a Medicare-Certified Long Term Care Hospital (LTCH) 64 Discharged/transferred to a Nursing Facility Certified under Medicaid but not certified under Medicare 65 Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital 66 Discharged/transferred to a Critical Access Hospital (CAH) 69 Discharges/transferred to Designated Disaster Alternative Care Site 70 Discharged/transferred to another Type of HealthCare Institution Not Defined Elsewhere in this Codes List 81 Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission 82 Discharged/Transferred to Short Term General Hosp for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission 83 Discharged/Transferred to SNF with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission 84 Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission 85 Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission 86 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission 87 Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission 88 Discharged/Transferred to Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission. 89 Discharged/Transferred to a Hospital Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission 90 Discharged/Transferred to Inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission 91 Discharged/Transferred to Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission. 92 Discharged/Transferred to A Nursing Facility Certified Under Medicaid but not Medicare with a Planned Acute Care Hospital Inpatient Readmission 93 Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission		

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
		94 Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission 95 Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in the Code List with a Planned Acute Care Hospital Inpatient Readmission		
0 Optional BUT Highly Recommended for ICU Metrics	Revenue Code	Codes that identify revenue categories, such as a specific accommodation, or ancillary service or unique billing calculation or arrangement. Discharges should include accommodation codes and these are identified in the 010x to 021x series. Ancillary codes are identified in the 022x to 099x series. *Please include all revenue codes (minimum of 10 fields and max of 100 fields)*	revenue_code_1, revenue_code_2, revenue_code_3…..revenue_code_100	NUBC UB-04 Manual Form Locator 42
0 Optional BUT Highly Recommended for ICU Metrics	Service Units	A quantitative measure associated with each revenue code (above). A quantitative measure of services rendered by revenue category (i.e., revenue code) to the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. *Please include all service units associated with the revenue codes provided (minimum of 10 fields and max of 100 fields)*	service_unit_1, servce_unit_2, …. service_unit_100	NUBC UB-04 Manual Form Locator 46
R	Payer Name	Text name of the health plan that the provider might expect some payment for the bill. Payer_1=Primary Payer Payer_2=Secondary Payer	payer_1, Payer_2	NUBC UB-04 Manual
R	Payer Type (aka Expected Source of Payment/Payer ID/ Health Plan Identification Number)	The code(s) identifying the health plan(s), either primary or secondary that might be expected to pay the hospital bill. Self-pay or no-pay claims must be included. Source of Payment codes need to be mapped from hospital system to this two-digit code. 11 Medicare Managed Care 12 Medicare Fee-for-Service 21 Medicaid Managed Care 22 Medicaid Fee-for-Service 31 Department of Defense 311 Tricare (Champus) 32 Department of Veterans Affairs 33 Indian Health Service of Tribe 34 HRSA Program 36 State Government 37 Local Government 39 Other Federal 51 HMO/Managed Care 511 Kaiser Permanente 522 Self Insured 52 Private Health Insurance/Indemnity 521 Commercial Indemnity	payer_type_1, payer_type_2	Apprise INFOH Submission Manual: Appendix VII Expected Source of Payment

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
		522 Self Insured 61 Regence Blue Cross Managed Care 62 Regence Blue Cross indemnity 81 Self Pay 82 No Charge 84 Hill Burton free care 95 Worker's Compensation 98 Other		
O	Payer Group	Insurance Groups defined as the ID#, control # or code assigned by the insurance carrier or plan administrator to identify the group under which the individual is covered. Payer_group_1=Primary Payer Group Payer_group_2=Secondary Payer Group	Payer_group_1, payer_group_2	NUBC UB-04 Manual Form Locator 62
R	Principal Diagnosis Code	The ICD-9-CM/ICD-10 code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.) To ensure codes stay intact within the CSV format, include periods after the third digit for all ICD-9 OR ICD-10 diagnosis codes.	principal_diagnosis	NUBC UB-04 Manual Form Locator 67
R	Present on Admission Code for Principal Diagnosis	The five reporting options for all POA reporting are as follows: Y: Yes N: No U: No Information in the Record W: Clinically Undetermined Blank: Exempt from POA reporting	poa	NUBC UB-04 Manual Form Locator 67
R	Other Diagnosis Codes and Present on Admission Codes	All additional ICD-9 OR ICD-10 diagnosis codes. To ensure codes stay intact within the CSV format, include periods after the third digit for all ICD-9 diagnosis codes. *Please include all "other diagnosis" and associated "poa" codes (min of 10 fields and max of 100 fields)*	other_diagnosis_1, poa_1, other_diagnosis_2, poa_2, …..	NUBC UB-04 Manual Form Locator 67
R	Principal Procedure Code	The ICD-9-CM/ICD-10CM-PCS code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill To ensure codes stay intact within the CSV format, include periods after the second digit for all ICD-9 procedure codes.	principal_procedure	NUBC UB-04 Manual Form Locator 74
R	Principal Procedure Date	The corresponding date (MMDDYYYY) of the principal procedure.	principal_procedure_date	NUBC UB-04 Manual Form Locator 74

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
R	Other Procedure Codes and Dates	All ICD-9-CM /ICD-10CM-PCS procedure codes. To ensure codes stay intact within the CSV format, include periods after the second digit for all ICD-9 procedure codes. *Please include all "other procedure codes" and "other procedure dates" (minimum of 10 field and max of 100 fields)*	other_procedure_1, other_procedure_1_date, other_procedure_2, other_procedure_2_date,…	NUBC UB-04 Manual Form Locator 74
R	Attending Clinician NPI	The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Provide the National Provider Identifier (NPI). **NOTE**: This field is not currently used within the MDC for provider attribution, but may be used in the future. (Currently, the *Maternal Clinical File* field "Delivering Provider" will be used to generate the provider-level metrics within the MDC).	Attending_provider	NUBC UB-04 Manual
O	Referring Physician NPI	Provider ID number of the referring physician or ordering physician for ancillary services. Provide the National Provider Identifier (NPI). **NOTE**: This field is not currently used within the MDC for provider attribution, but may be used in the future. (Currently, the *Maternal Clinical File* field "Delivering Provider" will be used to generate the provider-level metrics within the MDC).	Referring_provider	NUBC UB-04 Manual
O	Operating Clinician NPI	The Operating Provider is the individual with primary responsibility for performing the surgical procedures. Provide the National Provider Identifier (NPI). **NOTE**: This field is not currently used within the MDC for provider attribution, but may be used in the future. (Currently, the *Maternal Clinical File* field "Delivering Provider" will be used to generate the provider-level metrics within the MDC).	Operating_provider	NUBC UB-04 Manual
O	Other Operating Physician NPI	The Other Operating Provider is the individual performing a secondary surgical procedure or assisting the Operating Provider. Provide the National Provider Identifier (NPI). **NOTE**: This field is not currently used within the MDC for provider attribution, but may be used in the future. (Currently, the *Maternal Clinical File* field "Delivering Provider" will be used to generate the provider-level metrics within the MDC).	Operating_provider_other	NUBC UB-04 Manual
R	Patient Race	The code which best describes the race of the patient. **Hospitals may choose between two coding options per below:** **Option 1 codes** 1 White 2 Black or African-American 3 American Indian or Alaska Native 4 Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, etc.) 5 Native Hawaiian or Pacific Islander (including Chamorro, Samoan, etc.) 8 Patient refused 9 Unknown	race _omb	NUBC UB-04 Manual Form Locator 74

Required (R) or Optional (O)	Data Element	Description	Column Header	Report Value According To
		Option 2 codes (used for Apprise submission by Oregon hospitals) R1 American Indian or Alaska Native R2 Asian R3 Black or African American R4 Native Hawaiian or Pacific Islander R5 White R7 Patient Refused R8 Unknown R9 Other A person having origins not already mentioned in the above stated categories.		
R	Patient Ethnicity	The code which best describes the ethnicity of the patient. **Hospitals may choose between two coding options per below:** **Option 1 codes** 1 Hispanic Origin (including Spanish, Mexican, Puerto Rican, Cuban, etc.) 2 Not Hispanic 8 Patient refused 9 Unknown **Option 2 codes (used for Apprise submission for Oregon hospitals)** E1 Hispanic Origin (including Spanish, Mexican, Puerto Rican, Cuban, etc.) E2 Not Hispanic E8 Patient refused E9 Unknown	Ethnicity_omb	NUBC UB-04 Manual Form Locator 74

Section C:
Maternal Clinical File:
Core Required Data

Instructions and File Format

- If possible, use ICD-9 OR ICD-10 codes in Section A to filter the records submitted to the MDC. If that is not possible for the clinical file, include only records for *inpatient delivery-related hospitalizations* in the clinical file (i.e. do not include antepartum or postpartum records).
- The "Core" Maternal Clinical File must include the following required data fields: Maternal ID, Maternal DOB, Maternal Date of Discharge, Gestational Age, Parity, Delivering Provider ID as specified below. **If any required data fields are missing from the "Core" Maternal File, the file will be rejected.** (Although we encourage completeness for required data fields, the file will not be rejected if some records are missing values in the required fields.)
- CSV File Format with each case in a single row.
- Column headers, as denoted below, must be used for all fields you are submitting.
- You must submit all fields marked as "Required" with an "R". Optional fields are denoted by blue highlighting and the letter "O". If the field is optional and you are choosing not to submit it, please omit the column header/column.
- If a record value is missing, leave no space between the commas (,,)
- Please submit separate clinical files for "Maternal" Data Elements versus "Newborn" Data Elements
- Use the patient's discharge date to filter the records for each reporting period. This applies even to mother-baby pairs discharged in different months. For example, for a mother-baby pair in which the mother was discharged in April, but the baby discharged in May, the mother's discharge and clinical records would be included in the April submission, while the newborn discharge and clinical records would be included in the May submission.
- In addition to the required "Core Maternal Clinical File" you also have the option to submit additional data. Optional data elements may be submitted either as part of the *Core File* or in separate *Supplemental Files*. Supplemental files should only be submitted after all Core / Required Files have been submitted. See more below.

SUPPLEMENTAL Files

You may also choose to submit *optional* fields at later points in time via supplemental files. These optional fields may be derived from internal systems (e.g. EMR, core measure vendor system) and might be used to:

- Replace data already in the MDC system from your Patient Discharge Data file submission
- Pre-populate the "chart-review" data elements (e.g. labor, SROM or Prior Uterine Surgery) in the MDC system.
- Include a flag that denotes a record as part of the hospital's Joint Commission sample (from the core measure vendor system).
- To see the full list of optional fields, see the document **Supplemental Data File Specifications** in the MDC *Support* Section or at http://www.q-corp.org/omdc.

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

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

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				hospitalization should be added together to determine the number of previous live births. If the number of previous live births entered by the clinician in the first document listed is obviously incorrect (in error) but it is a valid number or two different numbers are listed in the first document and the correct number can be supported with documentation in the other acceptable data sources in the medical record, the correct number may be entered. **Suggested Data Sources:** ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE: • Delivery record, note or summary • Operating room record, note or summary • History and physical • Prenatal forms • Admission clinician progress notes • Discharge summary **Guidelines for Abstraction:** Inclusion The following descriptor must precede the number when determining parity: Parity P Examples: parity=2 or g3p2a1 Exclusion A string of three or more numbers without the alpha designation of "p" preceding the second number can not be used to determine parity. Example: 321 When GTPAL terminology is documented, G= Gravida, T= Term, P= Preterm, A= Abortions, L= Living, P does not equal parity.
Gestational Age-Weeks	R	The weeks of gestation completed at the time of delivery. Gestational age is defined as the best obstetrical estimate (OE) of the newborn's gestation in completed weeks based on the birth attendant's final estimate of gestation , irrespective of whether the gestation results in a live birth or a fetal death. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the newborn exam. Ultrasound taken early in pregnancy is preferred (source: American College of Obstetricians and Gynecologists	gestational_age_weeks	**Allowable values:** 1-50 or UTD=Unable to Determine **Notes for Abstraction:** Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms,clinician admission progress note and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age. If the patient has not received prenatal care and no gestational age was documented, select allowable value UTD. When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date. Gestational age should be documented by the clinician as a numeric value between 1-50. Gestational age (written with both weeks and days, eg. 39 weeks and 0 days) is calculated

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
		reVITALize Initiative).		using the best obstetrical Estimated Due Date (EDD) based on the following formula: Gestational Age = (280 - (EDD - Reference Date)) / 7 (source: American College of Obstetricians and Gynecologists reVITALize Initiative). The clinician, not the abstractor, should perform the calculation to determine gestational age. If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number or two different numbers are listed in the first document and the correct number can be supported with documentation in the other acceptable data sources in the medical record, the correct number may be entered. Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below. The EHR takes precedence over a hand written entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary. **Suggested Data Sources:** ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE: • Delivery room record • Operating room record • History and physical • Prenatal forms • Admission clinician progress notes • Discharge summary
Delivering Provider ID	R	The National Provider Identifier (NPI) of the provider delivering the baby	prov_delivering	**Allowable values:** 10-digit alphanumeric. The NPI is issued to health care providers by CMS. This field is designed to identify the provider performing the delivery itself, and is used to generate provider-level metrics for the hospital's use.
Optional	**Optional fields can be submitted *either* as part of the Core File *or* as a Supplemental File. See the Supplemental File Specifications for the complete list of Optional Data Elements (the list below is a small subset).**			
Labor Care Provider ID	O	The National Provider Identifier (NPI) of the provider responsible for the majority of the labor management *Can be populated after 3/1/17*	prov_labor	**Allowable values:** 10-digit alphanumeric. The NPI is issued to health care providers by CMS. This field is designed to identify the provider responsible for the majority of the labor management and is used to generate provider-level metrics for the hospital's use.

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
Gestational Age-Days (OPTIONAL)	O	The additional number of days of gestation elapsed after the last completed week.	gestational_age_days	**Allowable values:** 0-6 or blank if unknown
Gestational Age-Combined (OPTIONAL)	O	Gestational age in weeks plus days, in a combined format.	gestational_age_combined	This optional field can serve as a substitute for the above required field "Gestational Age-Weeks" for hospitals with clinical systems that combine the completed weeks of gestational age with the days. Allowable forms include: • 37 • 37+3 • 37.3 • 37 3/7 • 37w 3d • 37 weeks 3 days
Induced	O	Documentation that labor was induced in the patient.	Induced	Allowable Values: **Y** (Yes) **N** (No)

Section D:
Newborn Clinical File
Core Required Data

Instructions and File Format

- If possible, use the ICD-9 OR ICD-10 codes in Section A to filter the newborn records to submitted to the MDC. If that is not possible for the clinical file, include only records for *delivery-related hospitalizations* in the clinical file (i.e. do not include postpartum records).
- The "Core" Newborn Clinical File must include the following required data elements: Newborn ID, Maternal ID, Newborn DOB, Newborn Date of Discharge, Birthweight, and Apgar Score as specified below. If any of these fields are missing, the file will be rejected. (Although we encourage completeness, the file will not be rejected if some *records* are missing values in the required fields.)
- **The Maternal MRN/ID must be included in the newborn file (as long as the newborn record reflects the birth hospitalization and not a postpartum transfer.)**
- CSV File Format with each case in a single row.
- Column headers, as denoted by CMQCC in the specifications below, must be used for all fields you are submitting.
- The required data elements are denoted with an "R" in the "Required or Optional column".
- If a record value is missing, leave no space between the commas (,,)
- Please submit separate clinical files for "Maternal" Data Elements versus "Newborn" Data Elements
- Use the patient's discharge date to filter the records for each reporting period. This applies even to mother-baby pairs discharged in different months. For example, for a mother-baby pair in which the mother was discharged in April, but the baby discharged in May, the mother's discharge and clinical records would be included in the April submission, while the newborn discharge and clinical records would be included in the May submission.
- In addition to the required "Core Newborn File" you also have the *option* to submit additional data. Optional data elements may be submitted either as part of the *Core File* or in separate *Supplemental Files*. *Supplemental files* should only be submitted after all *Core / Required Files* have been submitted. See more below.

SUPPLEMENTAL Files

You may also choose to submit *optional* fields at later points in time via supplemental files. These optional fields may be derived from internal systems (e.g. EMR, core measure vendor system) and might be used to:

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

As long as you have already submitted the "Core Newborn File" you can submit as many supplemental files with different data elements as you wish. For example, you might submit one "supplemental newborn file" that includes solely data on bilirubin screening and a second "newborn file" that includes data on NICU admission. If two supplemental files are submitted that contain the same field for the same reporting period, the last submitted will represent the "final" value.

To see the full list of optional fields, see the document **Supplemental Data File Specifications.**

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

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

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				• The NICU admission assessment or notes should be reviewed first for the birth weight. In the absence of admission to the NICU, the delivery record or operating room record should be reviewed next for the birth weight. In cases where there is conflicting data, use the document recording the birth weight closest to the time of delivery. • It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below. • For newborns received into the hospital as a transfer, the admission birth weight may be used if the original birth weight is not available. • If the birth weight is recorded in pounds and ounces and also in grams, abstract the value for grams. **Suggested Data Sources** (In Order of Priority): • NICU admission assessment or notes • Delivery record • Operating room record • History and physical • Nursing notes • Nursery record • Physician progress notes
5 Minute Apgar Score	R	The newborn's Apgar Score at 5 minutes after birth	Apgar_5	**Allowable Values:** 0-10 or UTD = Unable to Determine The newborn's Apgar Score at 5 minutes after birth. If you do not have a 5 minute Apgar Score the 10 Minute Apgar Score (per field below) will be required.
Optional	**Optional fields can be submitted either as part of the Core File or as a Supplemental File. See the Supplemental File Specifications for the complete list of Optional Data Elements (the list below is a small subset).**			
10 Minute Apgar Score	O	The newborn's Apgar Score at 10 minutes after birth	Apgar_10	**Allowable Values:** 0-10 or UTD = Unable to Determine The newborn's Apgar Score at 10 minutes after birth, if available". If no 5-minute Apgar is available, a 10-minutes Apgar is required in order to calculate some newborn measures.
NICU Admission	O	Documentation that the newborn was admitted to the Neonatal Intensive Care Unit (NICU at this hospital any time during the hospitalization. *Note: Used for both Breastfeeding (PC-05) and Newborn Bilirubin Screening (Leapfrog) measures*	nicu_admission	**Allowable Values:** Y (Yes) There is documentation that the newborn was admitted to the NICU at any time during this hospitalization. N (No) There is no documentation that the newborn was admitted to the NICU at any time during this hospitalization or unable to determine from medical record documentation. **Notes for Abstraction:** A NICU is defined as a hospital unit providing critical care services which is organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness (source: American Academy of Pediatrics). Names of NICUs may vary from hospital to hospital. Level designations and capabilities also vary from region to region and cannot be used alone to determine if the nursery is a NICU. If the newborn is admitted to the NICU for observation or transitional care, select allowable value "no". Transitional care is defined as a stay of 4 hours or less in the NICU. There is no time limit for admission to observation. If an order to admit to the NICU is not found in the medical record, there must be supporting documentation present in the medical record indicating that the newborn received critical care

Data Element	Required (R) or Optional (O)	Definition	Column Header	Description
				services in the NICU in order to answer "yes". Examples of supporting documentation include, but are not limited to the NICU admission assessment and NICU flow sheet. If your hospital does not have a NICU, and there is no documentation that the newborn was transferred to a NICU at a different hospital,* you must select Value "no" regardless of any reason a newborn is admitted to a nursery. *Additional Notes: The Joint Commission defines "Admission to NICU" to be limited to "NICU at this hospital". For the Breast Milk Feeding measure, the TJC will then exclude cases with ***either*** "Admission to NICU" or "Transfers to other Acute Care Facilities or Other Health Care Facility". In order to use this data element for both the TJC and Leapfrog Group measures, the MDC definition no longer requires that the NICU Admission occur "at this hospital". If there is documentation that the newborn was transferred directly from the birth hospital to a NICU at another hospital, you may still respond "yes" to "NICU Admission" within the MDC. **Suggested Data Sources:** • Nursing notes • Discharge summary • Physician progress notes