OSHPD
Office of Statewide Health Planning and Development

Patient Discharge Data (PDD)

Data Dictionary

Public Use File

For Data Years:

January – December 2010 – File Structure Revised 10/2013
January – December 2011 – File Structure Revised 10/2013
January – December 2012 – New File Specifications
January – December 2013
January – December 2014

File Formats Available:

Comma-Delimited Text File (.txt)
Comma-Delimited Text File with Labels (.txt)
SAS (Ver 9.3) File (.sas7bat)
SAS (Ver 9.3) Proc Format Program (to associate labels with SAS File)

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[1] Appendices not listed are not applicable to Public PDD data set.

INTRODUCTION

General Information

The California Office of Statewide Health Planning and Development (OSHPD) provides public data sets of inpatient data collected from California-licensed hospitals in California. The data set consists of a record for each inpatient discharged from a California-licensed hospital. Licensed hospitals include general acute care, acute psychiatric, chemical dependency recovery, and psychiatric health facilities. For more information see the documentation provided by the MIRCal (data submission) system: www.oshpd.ca.gov/HID/MIRCal/IPManual.html.

The public data is released yearly by OSHPD once it has been screened by the automated reporting software (MIRCal) and corrected by the reporting facilities. Because of the file size, the .txt version of the data is divided into three separate files based on the geographic location of the facility. See the readme file for the number of records per file.

Excluded and Masked Variables

The masking strategy used for Public Use Files has been revised to protect patient confidentiality, minimize the risk of disclosure of protected health information, and preserve the file's clinical information. See the "What's New" section and Appendix B – Risk Mitigation Specification for the masking specifications and Appendix E – Counts of Unique Records.

Facility Modification and Exception Reports

Some facilities have been granted "modifications" to standard data reporting requirements because they were unable to complete specific fields as required or were determined to be out of compliance at the time of reporting. Exceptions are reported for facilities with records that were initially flagged as wrong but were actually reported correctly. See Appendix C – Modifications and Exceptions for a listing of these facilities and affected variables.

Facility Openings, Closures, Ownership Changes, and Consolidated Status

Appendix D – Facility Status shows facility consolidated status and status changes (openings, closing, ownership) by year of data collection. When multiple facility locations operate under one hospital license, the licensed entity is considered a consolidated provider. These types of facilities can report patient-level data as either separate entities or aggregated, as one consolidated provider.

Importing Notes

There are several fields that, although they appear to contain numeric data, should be treated as text (character). This is particularly important when working with ICD-9-CM and CPT diagnosis and procedure codes (CPT codes are on emergency department/ambulatory surgery records only). Diagnosis and procedure codes are stored without decimals and many contain leading zeros. For example, the ICD-9-CM code for Salmonella Gastroenteritis is "003.0" (implied decimal following the third digit from the left). If not formatted as text, the leading zeros will be dropped and the code will appear as an invalid diagnosis code of "30".

File Format

The Public Use File is offered in two versions: SAS (.sas7bdat, created with SAS version 9.3) and comma-delimited (.txt). To assist SAS file users, the facility name variable (oshpd_name) has been added to the files and a proc format file is available to associate labels with variables.

For TXT file users, in addition to the "Code" format, a "Label" formatted file is available. In the "Label" file, alphanumeric values have been replaced by more descriptive "English" values. For example, for the variable "sev_code", the descriptive label "MS-DRG assignment is based on the presence of MCC" replaced the code value "1". In either version of the TXT file, for three variables (oshpd_id, MDC, MSDRG), the original variables, with "code" values, were retained and "label" variables were added (oshpd_name, mdc_name, msdrg_name). On the TXT files, the length of each field and the length of each record will vary according to the data reported. A header row identifying each data element is provided in sequence order on the first record.

Note that facility and MS-DRG codes and their associated labels potentially change across years and that year-specific code-label crosswalks must be used.

The attributes for each data field are provided on the following pages. Note that the variable length may differ across the Code/Label version of the file.

What's New

Revisions to the Public Use File to Protect Patient Confidentiality

Beginning in 2013, with the release of 2012 data, the Public Use File has been modified to protect patient confidentiality, minimize the risk of disclosure of confidential patient data, and preserve the file's clinical information.

These demographic and date variables were removed:

- Admission Quarter
- Admission Year
- Age in Years (at Admission)
- Age Range (20 categories)
- Age Range (5 categories)
- Do Not Resuscitate (DNR)
- Ethnicity
- Expected Source of Payment – Plan Code Number
- Gender
- Patient County
- Race

Two variables were modified: the 5-digit Patient ZIP Code was replaced with a 3-digit Patient ZIP Code and Total Charges was rounded to the nearest $1000.

A masking rule was applied: first, Principal Diagnosis, Principal Procedure, and Principal E-Codes were examined for a single occurrence of one of those codes for a given hospital. If, for the given hospital, a single instance of either a Principal Diagnosis or Principal Procedure was found, the Principal codes were preserved, but all E-Codes and secondary diagnoses and

related variables, and secondary procedures and related variables in the record were masked (*). If, for the given hospital, a single instance of a Principal E-Code was found, all E-Codes and E-Code Present on Admission (POA) variables on the record were masked (*). For each record that is the only record for a facility for a report year, all data elements other than hospital ID, hospital name, and discharge year were masked (*). No other masking of data elements was applied. In the 2012 PDD, 6.0% of the discharge records had secondary variables masked. See Appendix B – Risk Mitigation Specification for the masking specifications and Appendix E – Counts of Unique Records.

Files Split by Facility County, Not Service Date

Because of their size, previous .txt public use files were split into two six-month period files. To minimize the risk of disclosure based on service period, files are divided by the geographic location of the facility, not service date:

- Los Angeles
- Southern: Imperial, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, Ventura
- Northern: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba.

FILE DOCUMENTATION

Hospital Identification Number

Field Name: oshpd_id

Definition: A unique six-digit identifier assigned to each facility by the Office of Statewide Health Planning and Development. The first two digits indicate the county in which the facility is located. The last four digits are unique within each county. Appendix F - Counts by Facility (Discharges) (PDD) lists facility ID number, name, and number of discharges.

Variable Type: Character

SAS Length: 6

Hospital Name

Field Name: oshpd_name

Definition: The facility name documented on the official license issued by the California Department of Public Health (CDPH) Licensing and Certification Division and submitted to OSHPD's Licensed Facility Information System (LFIS). Displayed names use a standardized "doing business as" naming format. Note that names associated with facility IDs potentially change across years and year-specific code-label crosswalks must be used.

Variable Type: Character

SAS Length: 60

Type of Care

Field Name: typ_care

Definition: Defined by the California Health and Safety Code, this refers to the licensure of the bed occupied by an inpatient. The types of care are documented on the official license issued by CDPH Licensing and Certification Division.

Variable Type: Character

SAS Length: Code version: 1 Label version: 33

0 = Invalid/Blank

1 = Acute Care

3 = Skilled Nursing / Intermediate Care (includes GAC approved swing beds)

4 = Psychiatric Care

5 = Chemical Dependency Recovery Care

6 = Physical Rehabilitation Care

Patient 3-Digit ZIP Code

Field Name: patzip3

Definition: The patient's 3-digit ZIP Code of residence. If the ZIP Code is unknown, invalid, or blank, it is assigned a value of XXX. Foreign residents are assigned a ZIP Code of YYY and homeless are assigned a ZIP Code of ZZZ. If only the city of residence is known, the city's 3-digit ZIP is assigned to the record.

Variable Type: Character

SAS Length: 3

Discharge Year

Field Name: dschyear

Definition: The year the patient was discharged.

Variable Type: Character

SAS Length: 4

Length of Stay

Field Name: los

Definition: Total number of days from admission date to discharge date. Patients admitted and discharged on the same day are assigned a length of stay of "0" days.

Variable Type: Numeric

SAS Length: 8

Source of Admission

Field Name: adm_src

Definition: The site and licensure where the patient originated and the route by which the patient was admitted. For more information, see the documentation provided by the MIRCal (data submission) system: http://www.oshpd.ca.gov/HID/MIRCal/Text_pdfs/ManualsGuides/IPManual/SourceAdmission.pdf.

Variable Type: Character

SAS Length: 3

The source code consists of three digits. The first digit represents the site from which the patient originated:

1 = Home	6 = Other Inpatient Hospital Care
2 = Residential Care Facility	7 = Newborn (born in admitting hospital)
3 = Ambulatory Surgery	8 = Prison/Jail
4 = Skilled Nursing / Intermediate Care	9 = Other
5 = Acute Inpatient Hospital Care	0 = Invalid/Blank

The second digit describes the license of site from which the patient originated:

1 = The admitting hospital

2 = Another hospital

3 = Not a hospital

0 = Invalid/Blank

The third digit describes the route by which the patient was admitted:

1 = The admitting hospital's Emergency Room (ER)

2 = No ER or another facility's ER

0 = Invalid/Blank

Type of Admission

Field Name: adm_type

Definition: When the patient's admission was arranged.

Variable Type: Character

SAS Length: Code version: 1 Label version: 21

1 = Scheduled (arranged with the hospital at least 24 hours prior to the admission)

2 = Unscheduled (not arranged with the hospital at least 24 hours prior to the admission)

3 = Infant (under 24 hrs old)

4 = Unknown

0 = Invalid/Blank

Disposition

Field Name: disp

Definition: The consequent arrangement or event ending a patient's stay in the hospital. For more information, see the documentation provided by the MIRCal (data submission) system: http://www.oshpd.ca.gov/HID/MIRCal/Text_pdfs/ManualsGuides/IPManual/Disposition.pdf.

Variable Type: Character

SAS Length: Code version: 2 Label version: 44

01 = Routine (home)

02 = Acute Care within the admitting hospital

03 = Other Care within the admitting hospital

04 = Skilled Nursing / Intermediate Care (SN/IC) within the admitting hospital

05 = Acute Care at another hospital

06 = Other Care (not SN/IC) at another hospital

07 = Skilled Nursing / Intermediate Care (SN/IC) at another facility

08 = Residential Care Facility

09 = Prison/Jail

10 = Left Against Medical Advice

11 = Died

12 = Home Health Service

13 = Other

00 = Invalid/Blank

Expected Source of Payment – Payer Category

Field Name: pay_cat

Definition: The type of entity or organization expected to pay the greatest share of the patient's bill. For more information, see the documentation provided by the MIRCal (data submission) system: http://www.oshpd.ca.gov/HID/MIRCal/Text_pdfs/ManualsGuides/IPManual/ExpectedSourcePayment.pdf.

Variable Type: Character

SAS Length: Code version: 2 Label version: 23

01 = Medicare

02 = Medi-Cal

03 = Private Coverage

04 = Workers' Compensation

05 = County Indigent Programs

06 = Other Government

07 = Other Indigent

08 = Self Pay

09 = Other Payer

00 = Invalid/Blank

Expected Source of Payment – Type of Coverage

Field Name: pay_type

Definition: Indicates the type of coverage (HMO, non-HMO managed care, or Fee-for-Service) for the following reported categories: Medicare, Medi-Cal, Private Coverage, Workers' Compensation, County Indigent Programs, and Other Government. Type of coverage is not reported for the following categories: Other Indigent, Self Pay, or Other Payer. For more information, see the documentation provided by the MIRCal (data submission) system: http://www.oshpd.ca.gov/HID/MIRCal/Text_pdfs/ManualsGuides/IPManual/ExpectedSourcePayment.pdf.

Variable Type: Character

SAS Length: Code version: 1 Label version: 30

0 = Not Applicable

1 = Managed Care – Knox-Keene/Medi-Cal County Organized Health System (MCOHS)

2 = Managed Care – Other

3 = Traditional Coverage

Total Charges (Rounded)

Field Name: charge

Definition: Total Charges include all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates (before contractual adjustments). Charges include, but are not limited to, daily hospital services, ancillary services and any patient care services. Hospital-based physician fees are excluded. Prepayments (e.g., deposits and prepaid admissions) are not deducted from Total Charges.

Total charges are reported in whole numbers and are rounded to the nearest thousand dollars ($1000). A zero amount is shown when the charges were less than $499.99, when there were no charges, when the charge is unknown, or when an invalid value is reported. Facilities with approved modifications to not report Total Charges are listed in Appendix C – Modifications and Exceptions. Total Charges of $9,999,999 indicates the actual charges exceed the maximum seven digit input field size. When a patient's length of stay is more than 1 year (365 days), only the last 365 days of charges are reported. Use the following formula to adjust total charges to reflect stays more than 1 year in length:

Adjusted Total Charges = (Total Charges / 365 days) x Length of Stay

For more information, see the documentation provided by the MIRCal (data submission) system: http://www.oshpd.ca.gov/HID/MIRCal/Text_pdfs/ManualsGuides/IPManual/TotalCharges.pdf.

Variable Type: Numeric

SAS Length: 8

Major Diagnostic Category (MDC)

Field Name: mdc

Definition: MDC code (for example, “22”). The Major Diagnostic Categories (MDC) are formed by dividing all possible principal diagnoses (from ICD-9) into 25 mutually exclusive diagnosis groupings. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. MDC 1 to MDC 23 are grouped according to principal diagnosis. Patients are assigned to MDC 24 (Multiple Significant Trauma) with at least two significant trauma diagnosis codes (either as principal or secondary) from different body site categories. Patients assigned to MDC 25 (HIV Infections) must have a principal diagnosis of an HIV Infection or a principal diagnosis of a significant HIV related condition and a secondary diagnosis of an HIV Infection. Some discharges are associated with procedures that are resource intensive and may be associated with multiple diagnosis domains (for example, transplants, MS-DRG 001-017), or procedures that are unrelated to the principal diagnosis (MS-DRG 981-989). These records are assigned to a variety of MDCs, based on the principal diagnosis instead of the MDC associated with the designated DRG. A MDC of “00” is assigned to records that are ungroupable. Ungroupable records include those where the principal diagnosis is not an existing ICD-9-CM code or the sex code does not logically relate to the diagnosis or procedure. For a list of MDC codes and labels see Appendix I - Major Diagnostic Categories (MDC). Note that MDC codes and their associated labels potentially change across years and year-specific code-label crosswalk lists must be used.

Variable History: Beginning with 2008 data, the new Medicare Severity DRG (MS-DRG) grouper was used. Coinciding with this change, OSHPD applies each new grouper verion to discharges based on the federal release date for the MS-DRG grouper (usually October 1 of each year).

Variable Type: Character

SAS Length: 2

Major Diagnostic Category Name (MDC Name)

Field Name: mdc_name

Definition: MDC descriptive label (for example, “Burns”). This variable is included in the “Label”, but not the “Code” version of the file. To assist users of the “Code” file, a proc format file is available to associate the variable’s code values with labels.

Variable Type: Character

SAS Length: 50

Medicare Severity-Diagnosis Related Group (MS-DRG)

Field Name: msdrg

Definition: MS-DRG code (for example, "028"). One MS-DRG is assigned to each inpatient stay. The MS-DRGs are assigned using the principal diagnosis and additional diagnoses, the principal procedure and additional procedures, sex, and discharge status. For a list of MS-DRG codes and labels see Appendix J - Medicare Severity-Diagnosis Related Groups (MS-DRG). Also see the MS-DRG Grouper Version variable ("grouper").

Variable History: Beginning with 2008 data, the new Medicare Severity DRG (MS-DRG) grouper was used. Coinciding with this change, OSHPD applies each new grouper version to discharges based on the federal release date for the MS-DRG grouper (usually October 1 of each year).

Variable Type: Character

SAS Length: 3

Medicare Severity-Diagnosis Related Group Name (MS-DRG Name)

Field Name: msdrg_name

Definition: MS-DRG descriptive label (for example, "Spinal Procedures W/MCC"). This variable is included in the "Label", but not the "Code" version of the file. To assist users of the "Code" file, a proc format file is available to associate the variable's code values with labels. Note that MS-DRG codes and their associated labels potentially change across years and year-specific code-label crosswalk lists must be used.

Variable Type: Character

SAS Length: 70

MS-DRG Category

Field Name: cat_code

Definition: Each MS-DRG is categorized into one of three codes: Medical, Surgical, or Ungroupable.

Variable Type: Character

SAS Length: Code version: 1 Label version: 17

M = Medical MS-DRG

S = Surgical MS-DRG

X = Ungroupable MS-DRG

MS-DRG Severity Code

Field Name: sev_code

Definition: MS-DRGs are assigned based on the presence/absence of a complication/comorbidity (CC) or major complication/comorbidity (MCC). MCCs are reserved for the more severely ill patients with life-threatening conditions. The revised CCs are reserved for patients with significant acute diseases, acute exacerbation of chronic diseases, advanced or end stage chronic diseases, or chronic diseases associated with extensive debility. The lists of ICD-9 codes for CC or MCC are mutually exclusive.

Variable Type: Character

SAS Length: Code version: 1 Label version: 38

M = Medical MS-DRG

S = Surgical MS-DRG

X = Ungroupable MS-DRG

MS-DRG Grouper Version

Field Name: grouper

Definition: The MS-DRG grouper version used for any given record corresponds to the federal fiscal year.

Variable Type: Character

SAS Length: 4

31.0 = includes discharges from October 1, 2013, through September 30, 2014

30.0 = includes discharges from October 1, 2012, through September 30, 2013

29.0 = includes discharges from October 1, 2011, through September 30, 2012

28.0 = includes discharges from October 1, 2010, through September 30, 2011

27.0 = all discharges between October 1, 2009, through September 30, 2010

External Cause of Injury – Principal E-Code

Field Name: ecode_p

Definition: The external cause of injury or poisoning or adverse effect code (E800-E999) which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect related to the admission. An E-Code is to be reported on the record for the first episode of care reportable to OSHPD during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. They are coded according to the ICD-9-CM. This variable is masked (*) on records where only one instance of a Principal Diagnosis, Principal Procedure, or Principal E-Code was reported for a facility.

Variable Type: Character (implied decimal after the 4th character from the left)

SAS Length: 5

External Cause of Injury – Other E-Code (up to 4)

Field Name(s): ecode1 – ecode4

Definition: The additional external cause of injury or poisoning or adverse effect codes (E800-E999) that completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect. Up to 4 other E-Codes should be included for the first reported episode of care for which the injury, poisoning, or adverse effect was first diagnosed and/or treated only. They are coded according to the ICD-9-CM. This variable is masked (*) on records where only one instance of a Principal Diagnosis, Principal Procedure, or Principal E-Code was reported for a facility.

Variable Type: Character (implied decimal after the 4th character from the left)

SAS Length: 5

Present on Admission (POA) – Principal E-Code

Field Name(s): epoa_p

Definition: An External Cause of Injury is considered present on admission (POA) if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes). Facilities were required to begin POA reporting on principle E-Codes for all reported discharges on or after July 1, 2008. POA values E and 1 were discontinued as a national standard as of July 1, 2011, however OSHPD continues to accept them. This variable is masked (*) on records where only one instance of a Principal Diagnosis, Principal Procedure, or Principal E-Code was reported for a facility.

Variable Type: Character

SAS Length: Code version: 1 Label version: 25

Y = Present at admission

N = Not present at admission

W = Clinically undetermined (discontinued)

U = Unknown

0 = Invalid/Missing/Blank

Present on Admission (POA) – Other E-Codes (up to 4)

Field Name(s): epoa1-epoa4

Definition: An External Cause of Injury is considered present on admission (POA) if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes). Facilities were required to begin POA reporting on other E-Codes for all reported discharges on or after July 1, 2008. POA values E and 1 were discontinued as a national standard as of July 1, 2011, however OSHPD continues to accept them. This variable is masked (*) on records where only one instance of a Principal Diagnosis, Principal Procedure, or Principal E-Code was reported for a facility.

Variable Type: Character

SAS Length: Code version: 1 Label version: 25

Y = Present at admission

N = Not present at admission

W = Clinically undetermined (discontinued)

U = Unknown

0 = Invalid/Missing/Blank

Principal Diagnosis

Field Name(s): diag_p

Definition: The condition established, after study, to be the chief cause of the admission of the patient to the hospital for care. Diagnoses are coded according to the ICD-9-CM.

Variable Type: Character (implied decimal after the 3rd character from the left)

SAS Length: 5

Other Diagnoses (up to 24)

Field Name(s): odiag1-odiag24

Definition: All other conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are excluded. They are coded according to the ICD-9-CM. If the reported principal diagnosis code is invalid or missing, it is assigned a default value of 799.9. This variable is masked (*) on records where only one instance of a Principal Diagnosis or Principal Procedure code was reported for a facility.

Variable Type: Character (implied decimal after the 3rd character from the left)

SAS Length: 5

Present on Admission (POA) – Principal Diagnosis

Field Name(s): poa_p

Definition: A condition is considered present on admission (POA) if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes). Facilities were required to begin POA reporting for all discharges on or after July 1, 2008.

Variable History: Beginning October 1, 2007, the National Uniform Billing Committee (NUBC) adopted two additional indicators for a new standard claims data element Present on Admission (POA). "W" was reported for diagnoses if the physician was unable to clinically determine if the diagnosis was present at admission or not. A "1" was reported for diagnoses that are exempt from POA reporting. OSHPD allowed hospitals to report these two new national standards from October 1, 2007, through June 30, 2008, while regulatory action was pending. OSHPD required hospitals to begin POA reporting for all discharges on or after July 1, 2008. POA values E and 1 were discontinued as a national standard as of July 1, 2011, however OSHPD continues to accept them.

Variable Type: Character

SAS Length: Code version: 1 Label version: 25

Y = Present at admission

N = Not present at admission

W = Clinically undetermined (discontinued)

U = Unknown

0 = Invalid/Missing/Blank

Present on Admission (POA) – Other Diagnoses (up to 24)

Field Name(s): opoa1- opoa24

Definition: A condition is considered present on admission (POA) if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes). Facilities were required to begin POA reporting for all discharges on or after July 1, 2008. This variable is masked (*) on records where only one instance of a Principal Diagnosis code or Principal Procedure code was reported for a facility.

Variable Type: Character

SAS Length: Code version: 1 Label version: 25

Y = Present at admission

N = Not present at admission

W = Clinically undetermined (discontinued)

U = Unknown

0 = Invalid/Missing/Blank

Principal Procedure

Field Name(s): proc_p

Definition: The procedure that is the one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis was reported as principal procedure. When a patient is admitted within 72 hours (3 days) of a procedure performed in a licensed ambulatory surgery facility or as an outpatient in a hospital, the admitting hospital is required, under billing requirements, to add the procedure (and date) to the inpatient record. Therefore, procedures performed up to 3 days prior to admission are reported. Procedures are coded according to the ICD-9-CM.

Variable Type: Character (implied decimal after the 2nd character from the left)

SAS Length: 4

Other Procedures (up to 20)

Field Name(s): oproc1-oproc20

Definition: All other procedures, related to the patient's stay, which are surgical in nature, carry a procedural risk, carry an anesthetic risk or are needed for DRG assignment. When a patient is admitted within 72 hours (3 days) of a procedure performed in a licensed ambulatory surgery facility or as an outpatient in a hospital, the admitting hospital is required, under billing requirements, to add the procedure (and date) to the inpatient record. Therefore, procedures performed up to 3 days prior to admission are reported. Procedures are coded according to the ICD-9-CM. This variable is masked (*) on records where only one instance of a Principal Diagnosis code or Principal Procedure code was reported for a facility.

Variable Type: Character (implied decimal after the 2nd character from the left)

SAS Length: 4

Principal Procedure Days

Field Name(s): proc_pdy

Definition: The number of days between the patient's date of admission and date of the principal procedure. If the procedure was performed prior to admission, this value will be prefixed with a minus (-) sign. If no procedure was performed, the days to principal procedure were shown as (.).

Variable Type: Numeric

SAS Length: 8

Other Procedures Days (up to 20)

Field Name(s): procdy1-procdy20

Definition: The number of days between the patient's date of admission and date of the other procedure. If the procedure was performed prior to admission, this value will be prefixed with a minus (-) sign. If a secondary procedure is not reported then the number of days is assigned a value of (.). This variable is masked (*) on records where only one instance of a Principal Diagnosis code or Principal Procedure code was reported for a facility.

Variable Type: Numeric

SAS Length: 8