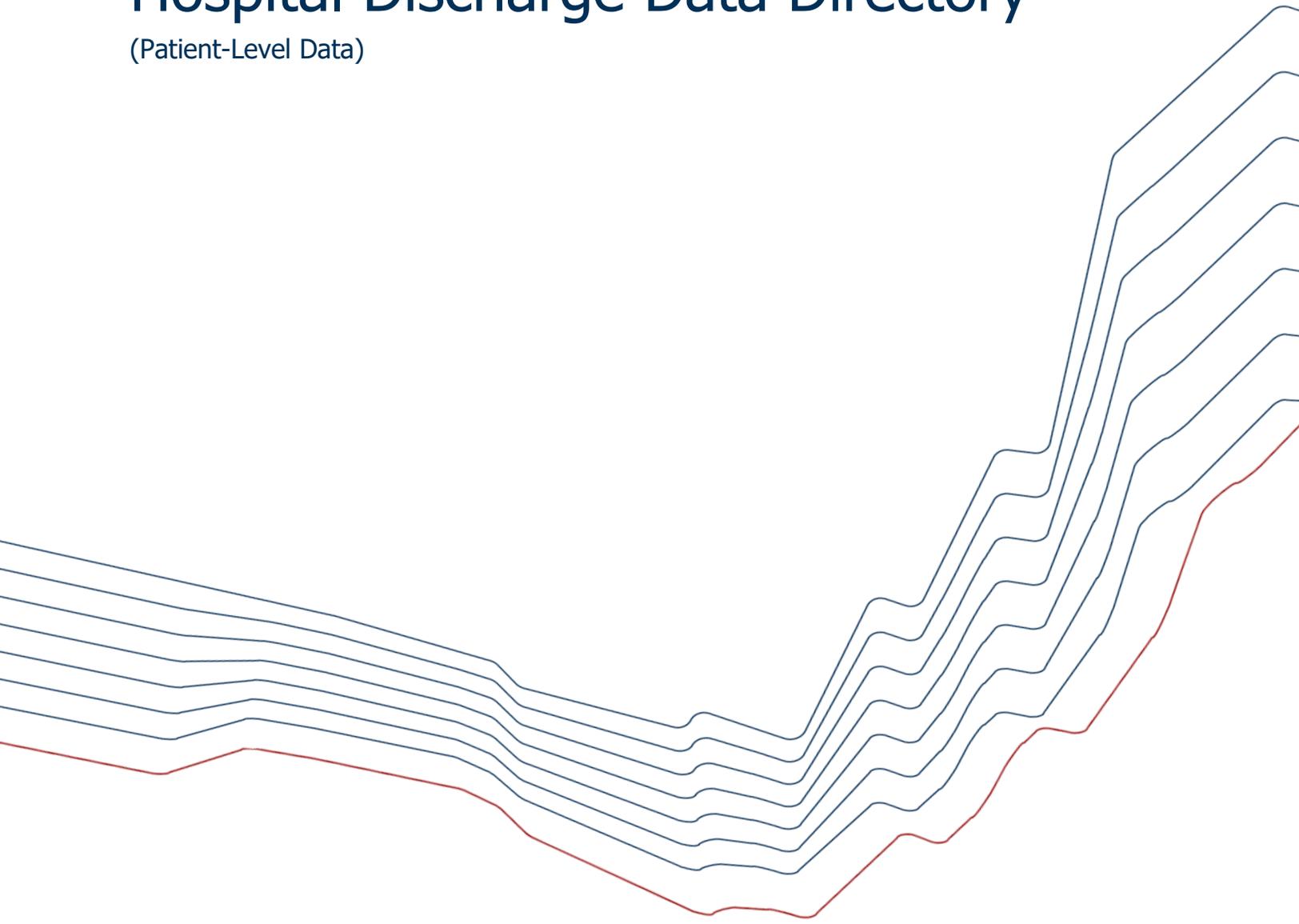


Last Updated: 2024-04-03



Hospital Discharge Data Directory

(Patient-Level Data)



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WELCOME TO VIRGINIA HEALTH INFORMATION!

VHI is the go-to for health information in Virginia and the only source for Virginia's complete publicly available inpatient discharge database. Since 1993 **VHI** has collected, analyzed and distributed the public use files (PUFs) as valuable health care information tools. Those who have used these flexible, easy-to-manipulate files under license by **VHI** have been satisfied with the results and many continue to obtain quarterly or yearly updates.

In addition, **VHI** also offers the Readmissions and Transfers Supplemental Data Set (RATs)—a significant enhancement to the hospital discharge data files. When linked to the PLD files, RATs offers the unique ability to track episodes of care through readmission cycles and transfer patterns. RATs enables development of more sophisticated performance measurements and comparative analyses when studying trends and assessing options. RATs is a powerful evaluation tool that facilitates sound, fact-based research and decision-making.

This product directory was designed to provide a brief background on the PLDB comprised of over 840,000 discharges annually. Included are:

- **Record layouts** of the PLD and RATs
- Detailed **data dictionaries** describing aspects of available fields
- A description and record layout of the **support files and**
- Licensing Agreement

Because many of **VHI's** customers have multiple staff, department and location needs, **VHI** offers multi-site licenses. Some users generate revenue from reports derived from **VHI's** PLD, so if you have potential multi-site or distribution opportunities, please see the appropriate section of the license agreement. **VHI** is proud to present the PLDB and RATs described herein and believes you will find this information important to you now and in the future.

DESCRIPTION OF PATIENT LEVEL DATA (PLD)

Licensed files contain all submitted, processed and verified inpatient hospital discharges in the Commonwealth of Virginia. Collected quarterly, the basis for these data are hospital-submitted billing claims forms adhering to the current National Uniform Billing Manual.

GENERAL TYPES OF DATA FOUND ON THE DISTRIBUTION FILES

ADMINISTRATIVE data includes from where the patient originated, the urgency of the admission, when the patient was treated and the hospital in which care was provided.

CLINICAL data available provides up to 18 diagnoses and 6 diagnostic or surgical procedures effective with discharges on and after January 1, 2011. **Virginia Health Information** calculates the patient's length of stay as well as the number of days a patient is hospitalized before and after the reported principal procedure. The field patient status reports whether the patient was discharged to return home, transferred to another hospital, expired or was discharged to another facility's care.

DEMOGRAPHIC data describe the patient's age; in days for newborns, years for patients one year or older. Information on the patient's gender and race (when available) are also collected. A five-digit patient zip code as well as the Virginia health planning region and district code, county code and state of the patient's residence is also provided.

FINANCIAL data includes total charges for the stay as well as a series of 14 calculated groupings by type of care. These groupings are as general as room and board and as specific as charges for anesthesiology.

PHYSICIAN data includes the National Provider Identifier (NPI) of the attending and operating (where principal procedure is reported) physicians who are primarily responsible for the care received by any individual patient.

CLASSIFICATION SYSTEMS

To facilitate meaningful analysis of this data, **Virginia Health Information** provides two types of classification systems. The first of these systems, Diagnosis Related Groups (DRGs), was developed under contract for the federal government for use in classifying Medicare patients by resource use for reimbursement purposes. DRGs are useful for the analysis of care provided to elderly patients. A DRG is assigned to each discharge.

The All Patient Refined DRG (APR-DRG) classification system developed by 3M Company differs from the DRG system in two key ways. First, the APR-DRGs were designed to classify patients of all age groups and contain more categories for children and infants. Second, 3M's APR-DRGs provide indicators of the patient's severity of illness and risk of mortality. These indicators further classify patients using reported co-morbid conditions, complications, age and other available data.

Both classification systems are provided to allow the user more flexibility in analysis of data. Major Diagnostic Categories (MDC) are also assigned and available. MDCs categorize patients into larger groups than either DRGs or APR-DRGs. *NOTE: APR-DRG is only available to health systems and government entities with an active and valid 3M APR-DRG license; otherwise, this field is populated as a filler.*

SUPPORT FILES

Support files are included with each order to facilitate the use of Virginia's patient level data. Prior to April 2015 (discharges prior to 2014q3), VHI provided all support information in separate SDF files for each quarter and version. VHI now provides support files in consolidated tables within a single Microsoft Access database named SUPPORT_YYYYqQ.

DRG SUPPORT TABLES

Multiple DRG key support files are consolidated and provided as a single table within the Access database. Field widths for each element are contained within parentheses.

The APR CMS DRG KEY YYYYqQ table contains the following elements:

DRG_TYPE (6): -- which will contain either APRDRG or CMSDRG

VERSION (3): -- contains V36, V37, V38, etc.

VHIKEY (10): -- the corresponding VHIKEY located in the patient data file

DX1 (7): -- This Primary Diagnosis field is use as a validator with the VHIKEY for the other values

DRG (3): -- APRDRG or CMSDRG

APR_SEVERITY (1): -- APRDRG only

APR_RISK (1): -- APRDRG only

MDC (2): -- APRDRG or CMSDRG

The APRDRG Desc YYYYqQ contains:

VERSION (3): -- contains V36, V37, V38, etc.

APRDRG_VALUE (3): -- 001 through 956

APRDRG_DESC (89): text field containing the English description of the respective APRDRG value

APR_MDC_VALUE (2): -- 01 through 25 -- of the respective MDC value and 99 representing unknown and/or ungroupable

The CMSDRG Desc YYYYqQ contains:

VERSION (3): – contains V36, V37, V38, etc.

CMS_DRG_VALUE (3): – 001 through 999

CMS_DESC (68): text field containing the English description of the respective CMSDRG value

CMS_MDC_VALUE (2): – 01 through 25 – of the respective MDC value and 98 representing pre-MDC MS-DRGs which include organ transplants, bone marrow transplants and tracheostomy cases and 99 representing unknown and/or ungroupable

CMS_DRG_WEIGHT (7): -- value of the CMS DRG weight

The MDC Desc YYYYqQ contains:

DRG_TYPE (6): -- contains either APRDRG or CMSDRG

VERSION (3): -- contains V36, V37, V38, etc.

MDC_VALUE (2): – 01 through 25 and 98 representing pre-MDC MS-DRGs which include organ transplants, bone marrow transplants and tracheostomy cases and 99 representing DRGs 981-999

MDC_DESC (88): -- text field containing the English description of the respective MDC value

GEOG SUPPORT TABLE

The Geog support table connects zip codes to their corresponding health planning regions and districts and city/county codes and is used in geographic analyses. This file is useful in studying patient origin or geographic differences in patterns of care. **The GEOG YYYYqQ contains:**

ZIP_CODE (5): -- USPS valid Virginia zip code for respective quarter of patient discharges

DISTRICT_CODE (2): -- 01 through 23 – containing the Virginia Health Planning District code

REGION_CODE (1): – 1 through 5 – containing the Virginia Health Planning Region code

COUNTY_CODE (3): – 001 through 840 – containing Virginia’s county code. (Virginia’s state code is 51.)

HPD_DESC (20): -- English text description of Virginia’s Health Planning District

REGION_DESC (22): -- English text description of Virginia’s Health Planning Region

COUNTY_DESC (25): -- English text description of Virginia’s city and/or county

NOTE: Some Virginia zip codes may cross county and or health planning districts or regions

PROVIDER TABLE

The Provider table supplies basic hospital demographic information. **PROVIDER YYYYqQ contains:**

MPN (50): -- current Medicare Provider Number

All_MPNs (255): -- all known Medicare Provider Numbers previously assigned to hospitals

NPI (50): - current National Provider Identifier

All_NPIs: - all known National Provider Identifier previously assigned to hospitals

Facility Name (100): -- current text name of each hospital

DBA Name (255): - name of facility “doing business as”

Address1 (100), City (100), State (100): -- street address, city and state for each hospital

Zip (100): -- USPS valid zip code for each hospital

Entity (255): -- valid values include acute, children’s, critical access, LTACH, psych and rehab

Tax Status (255): -- valid values are “Proprietary” or “Not-for-profit”

Teaching Status (100): -- valid values are “None, Council of Teaching Hospitals and Accreditation

Council of Graduate Medical Education”

Licensed_Beds (255): -- The number of beds licensed for use

Staffed_Beds (255): -- The number of licensed beds that the hospital staffs for patient care

Provider POA Exempt Status (255): -- Y or N indicates whether the hospital is exempt from reporting present on admission

Submitted (11): -- the number of records a hospital submitted

InFile (22): -- the number of records without fatal errors that are contained in the distribution file

Trauma Level (255): - the level of Trauma designation as identified by the Virginia Department of Health

Comments: -

PAYER TABLE

Lists the **VHI** payer code with its associated English description for the field. **PAYER YYYYqQ contains:**

PAYER_VALUE (2): -- VHI unique values – 1 through 99 – of the responsible payer

DESCRIPTION (25): -- English text description of Virginia Health Information’s PAYER_VALUE

Current Payer Codes are:

1 Medicare	21 Black Lung
2 Medicaid	25 Research/Donor
3 Anthem BC/BS	26 Foreign
4 Tricare	27 Hospice-Unspecified
5 Self Pay	31 Medicaid Out-of-State
6 Aetna	32 BC/BS Out-of-State
7 United Healthcare	34 Kaiser Permanente
8 Cigna	38 Optima
9 Other Commercial	40 Dual Medicare/Medicaid <i>*added 2016q4</i>
10 Indigent/Charity	41 CareFirst <i>*added 2022q1</i>
11 Worker’s Comp	42 Piedmont Community Health Plan <i>*added 2022q1</i>
16 Local Government	
18 Other Government	43 Humana <i>*added 2022q1</i>
19 Govt Assistance	99 Unknown
20 Jail/Detention	

COMORBID TABLE **ADDED 2022q1*

The Comorbid support table utilizes the [Agency for Health Quality and Research \(AHRQ\) Elixhauser Comorbidity software](#), which assigns variables using the ICD diagnosis codes that identify coexisting conditions for hospital discharge records. These conditions are not the primary reason for the hospital stay but have been found to influence the length of time the patient is hospitalized, total charges and other factors. A complication indicator is also calculated based on a range of diagnosis codes related to complications of surgical and medical care. Prior to January 1, 2021, discharges, these fields were present in the Patient Level Data Public Use Files. **The COMORBID YYYYqQ contains:**

VHIKEY (10): -- the corresponding VHIKEY located in the patient data file

COMP: -- COMPLICATION -- Effective with discharges on and after October 1, 2015, a value of 1 is assigned if any diagnosis field contains an ICD-10 value in the range of T80 to T88 which indicates the presence of a complication. Otherwise, the default value is 0.

CHF: -- CONGESTIVE HEART FAILURE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

VALVE: -- VALVULAR DISEASE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

PULMCIRC: --PULMONARY CIRCULATION DISORDERS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

PERIVASC: --PERIPHERAL VASCULAR DISEASE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

HTN_C_FILLER: -- HYPERTENSION (COMBINED UNCOMPLICATED AND COMPLICATED) -- filler beginning with discharges on and after January 1, 2021

PARALYSIS: -- PARALYSIS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

NEURO_FILLER: -- NEUROLOGICAL DISORDERS -- filler beginning with discharges on and after January 1, 2021

LUNG_CHRONIC: --CHRONIC PULMONARY DISEASE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

DIAB_UNCX: --DIABETES WITHOUT CHRONIC COMPLICATIONS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

DIAB_CX: -- DIABETES WITH CHRONIC COMPLICATIONS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

THYROID_HYPO: -- POSTPROCEDURAL HYPOTHYROIDISM -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

RENFAIL_FILLER: -- RENAL FAILURE -- filler beginning with discharges on and after January 1, 2021

LIVER_FILLER: -- LIVER DISEASE -- filler beginning with discharges on and after January 1, 2021

ULCER_PEPTIC: -- PEPTIC ULCER DISEASE WITH BLEEDING -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

AIDS: -- ACQUIRED IMMUNE DEFICIENCY SYNDROME -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

CANCER_LYMPH: -- LYMPHOMA -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

CANCER_METS: -- METASTATIC CANCER -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

TUMOR_FILLER: -- SOLID TUMOR WITHOUT METASTASIS -- filler beginning with discharges on and after January 1, 2021

ARTH: -- ARTHROPATHIES -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

COAG: --COAGULOPATHY -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

OBESE: -- OBESITY -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

WGHTLOSS: --WEIGHT LOSS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

LYTES_FILLER: -- FLUID AND ELECTROLYTE DISORDERS -- filler beginning with discharges on and after January 1, 2021

BLDLOSS: -- CHRONIC BLOOD LOSS ANEMIA -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

ANEMDEF: -- DEFICIENCY ANEMIAS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

ALCOHOL: -- ALCOHOL ABUSE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

DRUG_ABUSE: -- DRUG ABUSE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

PSYCHOSES: -- PSYCHOSES -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

DEPRESS: --DEPRESSION -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after October 1, 2015

CANCER_LEUK: -- LEUKEMIA -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

CANCER_NSITU: -- SOLID TUMOR W/O METASTASIS, IN SITU -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

CANCER_SOLID: -- SOLID TUMOR W/O METASTASIS, MALIGNANT -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

CBVD: -- CEREBROVASCULAR DISEASE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

HTN_UNCX: -- HYPERTENSION, UNCOMPLICATED -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

HTN_CX: -- HYPERTENSION, COMPLICATED -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

LIVER_MLD: -- LIVER DISEASE, MILD -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

LIVER_SEV: -- LIVER DISEASE, MODERATE TO SEVERE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

DEMENCIA: -- DEMENCIA -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

NEURO_MOVT: -- NEUROLOGICAL DISORDERS AFFECTING MOVEMENT -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

NEURO_OTH: -- OTHER NEUROLOGICAL DISORDERS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

NEURO_SEIZ: -- SEIZURES AND EPILEPSY -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

RENFL_MOD: -- RENAL FAILURE, MODERATE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

RENFL_SEV: -- RENAL FAILURE, SEVERE -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

THYROID_OTH: -- OTHER THYROID DISORDERS -- 0 = Co-Morbidity NOT Present; 1 = Co-Morbidity Present; Beginning with discharges on and after January 1, 2021

RISK_READMISSION: -- RISK OF 30-DAY, ALL-CAUSE READMISSION -- Index for risk of 30-day, all-cause readmissions based on the comorbidity measures; Beginning with discharges on and after January 1, 2022

RISK_MORTALITY: -- RISK OF IN-HOSPITAL MORTALITY -- Index for risk of in-hospital mortality based on the comorbidity measures; Beginning with discharges on and after January 1, 2022

DATA QUALITY

VHI edits all data at the record level for integrity. Certain records are automatically excluded from distribution files. These are records which contain a “fatal” error in:

- admission date
- discharge date
- patient status at discharge
- date of birth
- principal diagnosis or
- principal procedure.

Duplicate records are also excluded. For other fields in error, VHI has collapsed invalid entries into “unknown” or designated error values. We believe this allows for maximum use of the data while affording exclusions of records with serious errors.

ORDERING VHI PATIENT LEVEL DATA

To order the inpatient data Public Use File (PUF) or the supplemental Readmissions and Transfers (RATs) file, complete the license agreement found in Appendix C. Download and complete the Order Form for PLD and RATs Quarterly Hospital Data in Adobe Acrobat Format available at www.vhi.org/pld. Enclose payment in full and mail to **Virginia Health Information**.

DESCRIPTION OF READMISSION AND TRANSFER FILES (RATS)

GENERAL TYPES OF DATA FOUND ON THE SUPPLEMENTAL FILES

VHI defines a readmission as a hospital stay that follows an earlier hospitalization by at least one day but within 90 days. Transfers are defined as a hospital stay in which the discharge date of the first admission is the same as the admission date of the second admission. A transfer may take place within a hospital (generally between specialty units) or across hospitals. **VHI** provides detailed information on each hospital stay to allow the user to define a related readmission according to their own criteria of time between hospital stays, diagnoses, procedures, All Patient Refined-Diagnostic Related Groups (APR-DRGs) or other criteria.

HOW A READMISSION OR TRANSFER IS IDENTIFIED

The Readmission and Transfer (RATs) file is an optional supplement to the PLD file that facilitates longitudinal analysis of multiple episodes of inpatient hospital care through readmission cycles and transfer patterns. When a patient has been admitted into a facility more than once within the reporting timeframe, they will be part of the RATs database. If a patient is admitted to a facility on the same day they are discharged, it is considered a transfer. If there are one or more days between discharge from one facility to admission to another or same facility, it is considered a readmission. **VHI** uses social security number, age, and gender to identify an individual patient across multiple admissions.

TIMEFRAME

VHI patient level data is based on the discharge date within a quarterly period. In order for a patient record to be included in the RATs file, the patient must have had an admission in that time period and a readmission or transfer in that quarterly period or following quarter.

Each quarter **VHI** takes the most recent file and looks forward 90 days within that quarter and up to 90 days in the following quarter. So, for any discharge between October and December 2020, we would look within that quarter and in the following quarter's discharges between January and March 2021. Although this spans nine months, we only look 90 days forward for each discharge. Patients must match on Social Security Number (SSN), date of birth and patient sex. Because **VHI** does not require SSN for patients three years old or younger, RATs information is not complete even though some hospitals do provide this information when available. Since **VHI** looks in the following quarter, RATs data is always released one quarter later than the quarterly patient level data.

RECORD LAYOUT AND NAMING CONVENTION

The RATs table contains information pertaining to current quarter's discharges as well as subsequent discharges. "VHIKEY" and "QTR_IND" are the only fields in the database that refer to the current discharge. The VHIKEY beginning with a "0" in the RATs table will match exactly one record in **VHI**'s Patient Level Database (PLD). All of the other fields relate to a discharge that took place after (*fieldname_after*) the discharge from the VHIKEY. Therefore, the field

“*VHIKEY_after*” will link to a record in the PLD that had a discharge *after* the date of the discharge of the record associated with *VHIKEY*. “After” records will show up in the current and next quarter of PLD.

The field “*RT1_flag*” will contain either the value “T1” or “R1” that indicates that the record (*VHIKEY*) is the first admission of a readmission (R1) or transfer (T1). This means that all the fields related to an “After” record will be filled in. i.e.: the patient who was discharged in the record related to *VHIKEY*, was subsequently readmitted to the record related to “*VHIKEY_after*.”

The field “*DAYS_AFTER*” will be the number of days after that a transfer (0 days) or readmission (1 or more days) occurred. This will be the number of days from the discharge date of the first record to the admission date of the next record. For example, if “*RT1_flag*” has a value of “R1,” then “*Days_after*” will contain the number of days from when the patient was discharged (*VHIKEY*) to when they were admitted (*VHIKEY_after*).

LINKING RATs TO PATIENT LEVEL DATA (PLD)

To utilize the RATs files, you must first obtain **VHI** quarterly patient level data (PLD) files. The PLD files provide the denominator for calculating percentages of patients readmitted or transferred. You then obtain a RAT file for the same quarter. By linking this information, you can develop profiles at the state, region, county, hospital, physician or zip code level. These profiles may be by disease or any other variable you choose that is in the data file.

In order to properly link RATs to PLD, you must first link the *VHIKEY* field from the PLD table to the *VHIKEY* in the RATs table. Once linked, you can use the RATs principal diagnosis codes (*DX1_after*), principal procedure codes (*PX1_after*), APRDRG codes, and Medicare provider number (*MPN_after*) to analyze the data.

If you need additional information pertaining to a patient’s discharge, you would need to link PLD to *VHIKEY_after*. For instance, to analyze readmission and transfers that occurred after the discharge in the PLD, link the *VHIKEY_after* to both the “current” quarter and the next quarter of the PLD in order to get all extra discharge data needed.

PLD RECORD LAYOUTS AND DATA DICTIONARY

PLD RECORD LAYOUT PUBLIC USE FILE FOR USE WITH DISCHARGES 2022Q2 TO PRESENT

Public Use File-PUF1 PLD Record Layout for Discharges 2022q2 to Present updated 2024-04-03							
Field	Name	Label	Length	Format	From	To	Description
1	MPN	Hospital ID Number	6	A	1	6	Medicare Provider Number
2	ProvNPI	Provider's NPI	10	N	7	16	National Provider Identifier for the hospital
3	Ageday	Age in Days	3	N	17	19	Age in Days up to 365 Days
4	Age	Age in Years	3	N	20	22	Age in Years for Individuals >= 1 Year Old
5	Sex	Sex	1	A	23	23	Values: M (Male), F (Female), U (Unknown)
6	Race	Race	1	A	24	24	Values: 0 (White), 1 (Black), 2 (Other), 3 (Asian), 4 (Am. Indian), 5 (Hispanic), 6 (Blk. Hispanic), 9 (Unknown)
7	QYA	Quarter/Year of Admission	3	A	25	27	Example: 320 = Third Quarter 2020
8	QYD	Quarter/Year of Discharge	3	A	28	30	Example: 121 = First Quarter 2021
9	Asrce	Admit Source	1	A	31	31	Values: 1 (Non Health Care Facility), 2 (Clinic or Physician's office), 4 (Transfer from Hospital), 5 (Transfer from SNF, ICF or ALF), 6 (Transfer from other Health Care Facility), 8 (Court/Law Enforcement), 9 (Information not available) **Please obtain a UB manual for a current and complete listing of codes
10	Atype	Admit Type	1	A	32	32	Values: 1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma), 9 (Unknown) **Please obtain a UB manual for a current and complete listing of codes
11	Zip	Patient Zip Code of Residence	9	A	33	41	U.S. Postal Service Zip Codes
12	LOS	Length of Stay	3	N	42	44	Note: If Adate = Ddate, LOS = 0; Subtract Units from Rcode 180-189
13	Pstat	Patient Status	2	A	45	46	Values: 1 = Discharged to home or self care, 2 = Discharged/ Transferred to another short term general hospital, 3 = Discharged/Transferred to a skilled nursing facility, 6 = Discharged/Transferred to home under the care of an organized home health service organization, 7 = Left against medical advice or discontinued care, 20 = Expired, 50 = Hospice-Home, 51 Hospice-Medical Facility. **Please obtain a UB manual for a current and complete listing of codes
14	DX1	Principal Diagnosis Code	7	A	47	53	ICD-10-CM code

Public Use File-PUF1 PLD Record Layout for Discharges 2022q2 to Present updated 2024-04-03							
Field	Name	Label	Length	Format	From	To	Description
15	DX1_POA	Present on Admission for DX1	1	A	54	54	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
16	DX2	1st Secondary Diagnosis Code	7	A	55	61	ICD-10-CM code
17	DX2_POA	Present on Admission for DX2	1	A	62	62	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
18	DX3	2nd Secondary Diagnosis Code	7	A	63	69	ICD-10-CM code
19	DX3_POA	Present on Admission for DX3	1	A	70	70	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
20	DX4	3rd Secondary Diagnosis Code	7	A	71	77	ICD-10-CM code
21	DX4_POA	Present on Admission for DX4	1	A	78	78	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
22	DX5	4th Secondary Diagnosis Code	7	A	79	85	ICD-10-CM code
23	DX5_POA	Present on Admission for DX5	1	A	86	86	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
24	DX6	5th Secondary Diagnosis Code	7	A	87	93	ICD-10-CM code
25	DX6_POA	Present on Admission for DX6	1	A	94	94	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
26	DX7	6th Secondary Diagnosis Code	7	A	95	101	ICD-10-CM code
27	DX7_POA	Present on Admission for DX7	1	A	102	102	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
28	DX8	7th Secondary Diagnosis Code	7	A	103	109	ICD-10-CM code

Public Use File-PUF1 PLD Record Layout for Discharges 2022q2 to Present updated 2024-04-03							
Field	Name	Label	Length	Format	From	To	Description
29	DX8_POA	Present on Admission for DX8	1	A	110	110	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
30	DX9	8th Secondary Diagnosis Code	7	A	111	117	ICD-10-CM code
31	DX9_POA	Present on Admission for DX9	1	A	118	118	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
32	DX10	9th Secondary Diagnosis Code	7	A	119	125	ICD-10-CM code
33	DX10_POA	Present on Admission for DX10	1	A	126	126	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
34	DX11	10th Secondary Diagnosis Code	7	A	127	133	ICD-10-CM code
35	DX11_POA	Present on Admission for DX11	1	A	134	134	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
36	DX12	11th Secondary Diagnosis Code	7	A	135	141	ICD-10-CM code
37	DX12_POA	Present on Admission for DX12	1	A	142	142	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
38	DX13	12th Secondary Diagnosis Code	7	A	143	149	ICD-10-CM code
39	DX13_POA	Present on Admission for DX13	1	A	150	150	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
40	DX14	13th Secondary Diagnosis Code	7	A	151	157	ICD-10-CM code
41	DX14_POA	Present on Admission for DX14	1	A	158	158	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
42	DX15	14th Secondary Diagnosis Code	7	A	159	165	ICD-10-CM code

Public Use File-PUF1 PLD Record Layout for Discharges 2022q2 to Present updated 2024-04-03							
Field	Name	Label	Length	Format	From	To	Description
43	DX15_POA	Present on Admission for DX15	1	A	166	166	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
44	DX16	15th Secondary Diagnosis Code	7	A	167	173	ICD-10-CM code
45	DX16_POA	Present on Admission for DX16	1	A	174	174	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
46	DX17	16th Secondary Diagnosis Code	7	A	175	181	ICD-10-CM code
47	DX17_POA	Present on Admission for DX17	1	A	182	182	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
48	DX18	17th Secondary Diagnosis Code	7	A	183	189	ICD-10-CM code
49	DX18_POA	Present on Admission for DX18	1	A	190	190	Indicates diagnosis was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
50	PX1	Principal Procedure Code	7	A	191	197	ICD-10-CM code
51	PX2	1st Secondary Procedure Code	7	A	198	204	ICD-10-CM code
52	PX3	2nd Secondary Procedure Code	7	A	205	211	ICD-10-CM code
53	PX4	3rd Secondary Procedure Code	7	A	212	218	ICD-10-CM code
54	PX5	4th Secondary Procedure Code	7	A	219	225	ICD-10-CM code
55	PX6	5th Secondary Procedure Code	7	A	226	232	ICD-10-CM code
56	PRLOS	Pre-Op LOS	3	N	233	235	PX1date - Adate
57	PSLOS	Post-Op LOS	3	N	236	238	Ddate - PX1date
58	DRG	DRG Code	3	A	239	241	DRG as per CMS
59	MDC	MDC Code	2	A	242	243	MDC as per CMS
60	APRDRG or Filler4	APRDRG Code	5	A	244	248	3M All Patient Refined DRG Code NOTE: APR-DRG is only available to health systems and government entities with an active and valid 3M APR-DRG license. Otherwise, this field is populated as a filler.
61	Tchg	Total Charges	7	N	249	255	NOTE: For all charges, if value is > 7 digits, default to 9999999
62	RBchg	Room and Board Charges	7	N	256	262	100-171
63	RCchg	Routine Care Charges	7	N	263	269	176-199,220-232,235-239,500-529,550-569,650-659, 910-919, 990-999

Public Use File-PUF1 PLD Record Layout for Discharges 2022q2 to Present updated 2024-04-03							
Field	Name	Label	Length	Format	From	To	Description
64	SCchg	Special Care (Intensive Care)	7	N	270	276	172-175, 200-219, 233-234
65	Aneschg	Anesthesiology Charges	7	N	277	283	370-379
66	Phrchg	Pharmacy Charges	7	N	284	290	250-269
67	Radchg	Radiology Charges	7	N	291	297	320-339, 400-409
68	MRICT	MRI/CT Charges	7	N	298	304	350-359, 610-619
69	NMchg	Nuclear Medicine Charges	7	N	305	311	340-349
70	CLchg	Clinical Lab Charges	7	N	312	318	300-319
71	LDchg	Labor/Delivery Room Charges	7	N	319	325	720-729
72	ORchg	Operating Room Charges	7	N	326	332	360-369, 490-499, 710-719
73	Oncchg	Oncology Charges	7	N	333	339	280-289
74	MSSchg	Med/Surg Supplies Charges	7	N	340	346	270-279
75	Othchg	Other Charges	7	N	347	353	All Other Revenue Codes
76	Payer	Payer Type 1	2	A	354	355	VHI Payer Codes
77	Cnty	County Code	3	A	356	358	U.S. Postal Service County Code
78	HPR	Health Planning Region	1	A	359	359	Va. Health Planning Region Codes
79	HPD	Health Planning District	2	A	360	361	Va. Health Planning District Codes
80	Comp_Filler	Complication Code_Filler	1	A	362	362	filler beginning w/2022q1
81	CCA_Filler	CCA_Filler	1	A	363	363	filler beginning w/2015q4
82	CCV_Filler	CCV_Filler	1	A	364	364	filler beginning w/2015q4
83	CLV_Filler	CLV_Filler	1	A	365	365	filler beginning w/2015q4
84	CRN_Filler	CRN_Filler	1	A	366	366	filler beginning w/2015q4
85	CDI_Filler	CDI_Filler	1	A	367	367	filler beginning w/2015q4
86	COP_Filler	COP_Filler	1	A	368	368	filler beginning w/2015q4
87	CCE_Filler	CCE_Filler	1	A	369	369	filler beginning w/2015q4
88	Filler1	Filler1	9	A	370	378	
89	State	Patient State	2	A	379	380	Not available for discharges prior to July 1, 1994
90	Ecode1	1 st External Injury Code	7	A	381	387	ICD-10-CM Diagnosis Code; not available for discharges prior to July 1, 1994
91	Ecode1_POA	Present on Admission for Ecode1	1	A	388	388	Indicates Ecode was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
92	Ecode2	2 nd External Injury Code	7	A	389	395	ICD-10-CM Diagnosis Code; not available for discharges prior to January 1, 2007
93	Ecode2_POA	Present on Admission for Ecode2	1	A	396	396	Indicates Ecode was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)

Public Use File-PUF1 PLD Record Layout for Discharges 2022q2 to Present updated 2024-04-03							
Field	Name	Label	Length	Format	From	To	Description
94	Ecode3	3 rd External Injury Code	7	A	397	403	ICD-10-CM Diagnosis Code; not available for discharges prior to January 1, 2007
95	Ecode3_POA	Present on Admission for Ecode3	1	A	404	404	Indicates Ecode was Present on Admission; required from non-exempt acute hospitals; values include Y (yes), N (no), U (unknown), W (clinically undetermined), 1 (unreported, not used)
96	InfBWT	Infant Birth Weight	4	N	405	408	Weight in Grams not available for discharges prior to July 1, 1994
97	VHIKey	Key Number	10	A	409	418	Unique Record Identifier not available for discharges prior to July 1, 1994
98	APHY	Attending Physician ID	10	A	419	428	Attending Physician UPIN not available for discharges prior to April 1, 1996; both UPINs and NPIs were submitted 2007q1 through 2008q2; NPIs only beginning with 2008q3
99	OPHY	Operating Physician ID	10	A	429	438	Attending Physician UPIN not available for discharges prior to April 1, 1996; both UPINs and NPIs were submitted 2007q1 through 2008q2; NPIs only beginning with 2008q3
100	OthPHY1	Other Physician 1	10	A	439	448	Attending Physician UPIN not available for discharges prior to April 1, 1996; both UPINs and NPIs were submitted 2007q1 through 2008q2; NPIs only beginning with 2008q3
101	OthPHY2	Other Physician 2	10	A	449	458	Attending Physician UPIN not available for discharges prior to April 1, 1996; both UPINs and NPIs were submitted 2007q1 through 2008q2; NPIs only beginning with 2008q3
102	PLEGSTAT	Patient Legal Status	1	A	459	459	Legal status applies to voluntary or involuntary psychiatric admissions of minors and adults per Virginia Code. Value: 1 - Parental admission of minors < 14 and non-objecting minors 14 years of age or older; 2 - Parental admission of objecting minor 14 years of age or older; 3 - Involuntary TDO (minor); 4 - Involuntary commitment (minor); 5 - Voluntary admission (adult); 6 - Involuntary TDO (adult); 7 - Sexually violent predators (prisoners or defendants); PLEGSTAT only beginning with 2022q2
103	Filler2	Filler 2	8	A	460	467	
104	Filler3	Filler 3	8	A	468	475	

Public Use File-PUF1 PLD Record Layout for Discharges 2022q2 to Present updated 2024-04-03							
Field	Name	Label	Length	Format	From	To	Description
105	APHYWRN	Attending Phys ID Warning	1	A	476	476	Values: 0=UPIN/NPI is valid format and in CMS UPIN/NPI table, 1= UPIN/NPI is valid format only
106	OPHYWRN	Operating Phys ID Warning	1	A	477	477	Values: 0=UPIN/NPI is valid format and in CMS UPIN/NPI table, 1=UPIN/NPI is valid format only
107	OthPHY1WRN	Other Phys 1 ID Warning	1	A	478	478	Values: 0=UPIN/NPI is valid format and in CMS UPIN/NPI table, 1=UPIN/NPI is valid format only
108	OthPHY2WRN	Other Phys 2 ID Warning	1	A	479	479	Values: 0=UPIN/NPI is valid format and in CMS UPIN/NPI table, 1=UPIN/NPI is valid format only
109	RAT	Readmission and Transfer	1	A	480	480	1=Record is eligible for inclusion in the Readmission and Transfer File
	CRLF		2	N	481	482	End of Record

PLD DICTIONARY OF DATA ELEMENTS

The following information describes each data element contained in the patient level data public use files. These descriptions can be used with the above record layout for information pertaining to VHI data elements. For complete and updated information, VHI recommends subscribing to the National Uniform Billing Committee to obtain updates to the UB Data Specifications Manual. More information may be found at www.nubc.org

MPN--MEDICARE PROVIDER NUMBER Pseudo numbers have been assigned where a hospital is not a Medicare provider. Records are excluded if there is a known error in this field. A Provider support table containing the MPN, hospital’s name, address, number of licensed and staffed beds, teaching status, hospital type and tax status is provided.

PROVNPI--PROVIDER NPI NUMBER National provider identifier for the hospital as assigned by the federal government.

AGEDAY--AGE IN DAYS Calculated in days for children up to one year old. The calculation is based on date of birth and date of admission. Age in days is equal to zero if the admission date and date of birth are the same. This field is blank for patients one year of age or older. Records are excluded if there is a known error in any of the fields used for this calculation.

AGE--AGE IN YEARS Calculated for individuals one year of age or older. The calculation is based on date of birth and date of admission. Records are excluded if there is a known error in any of the fields used for this calculation; however, some questionable ages may still result.

SEX--PATIENT SEX Values are: M = Male, F = Female, U = Unknown. Records with a missing or known invalid entry are assigned a default value of U.

RACE--PATIENT RACE Values are: 0 = White, 1 = Black, 2 = Other, 3 = Asian, 4 = American Indian, 5 = Hispanic, 6 = Black Hispanic, 9 = Unknown. Records with a missing or known invalid entry are assigned a default value of 9.

QYA--QUARTER/YEAR OF ADMISSION Admission date is converted to the calendar quarter and year the patient was admitted. Records are excluded if there is a known error in the admission date.

QYD--QUARTER/YEAR OF DISCHARGE Discharge date is converted to the calendar quarter and year the patient was discharged. Records are excluded if there is a known error in the discharge date.

ASRCE--ADMISSION SOURCE (POINT OF ORIGIN FOR ADMISSION OR VISIT) Values for patients other than newborns are: 1 (Non Health Care Facility), 2 (Clinic or Physician's office), 4 (Transfer from Hospital), 5 (Transfer from SNF, ICF or ALF), 6 (Transfer from other Health Care Facility), 8 (Court/Law Enforcement), 9 (Information not available) However, if the admission is a newborn, the values are: 5 (Born inside this Hospital) and 6 (Born Outside of this Hospital). Any record with a missing or known invalid entry is assigned a default value of 9. **Please obtain a UB manual for a current and complete listing of codes.

ATYPE--ADMISSION TYPE Priority of the admission. Values are: 1 = Emergency, 2 = Urgent, 3 = Elective, 4 = Newborn, 5 = Trauma, 9 = Unknown. Records with a missing or known invalid entry are assigned a default value of 9. **Please obtain a UB manual for a current and complete listing of codes.

ZIP--UNITED STATES POSTAL SERVICE ZIP CODE OF PATIENT RESIDENCE A 5-digit zip code of patient residence is provided. A value of XXXXX indicates an unknown zip code and a value of YYYYY indicates a foreign zip code. Records with a missing or known invalid value are assigned a default value of blanks.

LOS--LENGTH OF STAY Calculated by subtracting the admission date from the discharge date. If the admission date is the same as the discharge date, the length of stay is defined to be 0. You may wish to exclude cases with a length of stay equal to 0 from average length of stay calculations or other analyses. Furthermore, if a patient took a leave of absence, indicated by a revenue center code of 180-189, those days are subtracted from the length of stay. Records with a known error in either the admission date or discharge date are excluded from the data base.

PSTAT--PATIENT DISCHARGE STATUS Beginning October 1, 2001, allowable values include but are not limited to the following:

Values: 1 = Discharged to home or self care, 2 = Discharged/ Transferred to another short term general hospital, 3 = Discharged/Transferred to a skilled nursing facility, 4 = Discharged/Transferred to a facility providing custodial or supportive care, 5 = Discharged/Transferred to a designated cancer center or children's hospital, 6 = Discharged/Transferred to home under the care of an organized home health service organization, 7 = Left against medical advice or discontinued care, 20 = Expired, 43 = Discharged/transferred to Federal Facility, 50 = Hospice-Home, 51 Hospice-Medical Facility. Records with a missing or known invalid entry are excluded from the data base. **Please obtain a UB manual for a current and complete listing of codes.

DX1--PRINCIPAL DIAGNOSIS Based on the ICD-10-CM coding system beginning with discharges on and after October 1, 2015. Records with a missing or known invalid entry are excluded from the data base.

DX2-DX18--SECONDARY DIAGNOSIS FIELDS Based on the ICD-10-CM coding system beginning with discharges on and after October 1, 2015. Records with a known invalid entry are assigned a default value of “00000”.

DX1_POA TO DX18_POA—PRESENT ON ADMISSION POA indicates that the diagnosis was present at the time the order for inpatient admission occurred. POA Values from non-exempt acute hospitals include Y = Yes (present at the time of inpatient admission), N = No (not present at the time of inpatient admission), U = Unknown (documentation is insufficient to determine if condition was present at the time of admission), W = clinically undetermined (provider is unable to clinically determine whether a condition was present on admission), 1 = Unreported, not used. The diagnosis is exempt from POA reporting. POA values for exempt providers are blank. Exempt providers include critical access, long-term care, children’s, psychiatric and rehabilitation hospitals. The CMS website has more information on POA reporting.

http://www.cms.gov/HospitalAcqCond/01_Overview.asp#TopOfPage

PX1--PRINCIPAL PROCEDURE Based on the ICD-10-CM coding system beginning with discharges on and after October 1, 2015. Records with a known invalid value are excluded from the data base.

PX2-PX6--SECONDARY PROCEDURE FIELDS Based on the ICD-10-CM coding system beginning with discharges on and after October 1, 2015. Records with a known invalid value are assigned a default value of “0000”.

PRLOS--PREOPERATIVE LENGTH OF STAY Measured in days and calculated by subtracting the admission date from the date of the principal procedure. Records with a known invalid value in the principal procedure date field are assigned a default value of blanks. Note: Some software will convert blanks to zeros. If this occurs, various calculations and statistics you perform could be distorted. You should determine your software default and exercise caution.

PSLOS--POSTOPERATIVE LENGTH OF STAY Measured in days and calculated by subtracting the principal procedure date from the date of discharge. Records with a known invalid entry in the principal procedure date field are assigned a default value of blanks. PSLOS will be blank filled even though it is defined as a numeric field. Note: Some software will convert blanks to zeros. If this occurs, various calculations and statistics you perform could be distorted. You should determine your software default and exercise caution.

DRG--DIAGNOSIS RELATED GROUP Based on the CMS (Centers for Medicare & Medicaid Services) DRG grouping software. This software utilizes the principal diagnosis, secondary diagnoses, surgical procedures, age, sex and discharge status. A table in the quarterly support file containing the version number, value, CMS DRG English description, MDC value and weight is provided and labeled CMSDRG_DESC_yyyyQq.

MDC--MAJOR DIAGNOSTIC CATEGORY Assigned based on the CMS definition. A table in the quarterly support file containing the DRG type, version number, MDC value and MDC English description is provided and labeled MDC_DESC_yyyyQq.

APRDRG--ALL PATIENT REFINED-DRG Based on the 3M definition as follows:

4q16 - 3q17 is version 34.0

4q17 - 3q18 is version 35.0

4q18 - 3q19 is version 36.0

4q19 - 3q20 is version 37.0

Version numbers are updated annually with discharges beginning each October 1. A table in the quarterly support file containing the version number, value, APRDRG English description and MDC value is provided and labeled APRDRG_DESC_yyyyQq.

*NOTE: APR-DRG is only available to health systems and government entities with an active and valid 3M APR-DRG license. Otherwise, this field is populated as **Filler4**.*

TCHG--TOTAL CHARGE Determined by the revenue center code 0001. If this code is present, the corresponding revenue center charge is the total charge. There are 23 possible revenue center code and charge fields. Values are in whole dollar amounts. For ALL charges, if the amount is greater than 7 digits, the default value is 9999999. Records not reporting a revenue center code value of 001 or containing a missing or known invalid value in the required RCode1 field will have total charges reported as blanks. Note: Some software will convert blanks to zeros. If this occurs, various calculations and statistics you perform could be distorted. You should determine your software default and exercise caution. You may wish to exclude cases from charge analyses if total charges are equal to 0.

RBCHG--ROOM AND BOARD CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values: 100 - 171, inclusive.

RCCHG--ROUTINE CARE CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values: 176 -199, 220 - 232, 235 - 239, 500 - 529, 550 - 569, 650 - 659, 910 - 919 or 970 - 999.

SCCHG--SPECIAL CARE (INTENSIVE CARE) Calculated by summing revenue center charge fields that have associated revenue center code fields containing values: 172 - 175, 200 - 219 and 233 - 234.

ANESCHG--ANESTHESIOLOGY CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values: 370 - 379, inclusive.

PHRCHG--PHARMACY CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing any of the values: 250 - 269, inclusive.

RADCHG--RADIOLOGY CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values: 320 - 339 or 400 - 409.

MRICT--MRI/CT CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values: 350 - 359 or 610 - 619.

NMCHG--NUCLEAR MEDICINE CHARGES Calculated by summing the revenue center charge fields that have corresponding revenue center code fields containing values: 340 - 349, inclusive.

CLCHG--CLINICAL LAB CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values: 300 - 319, inclusive.

LDCHG--LABOR/DELIVERY ROOM CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values 720 - 729.

ORCHG--OPERATING ROOM CHARGES Calculated by summing revenue center charge fields that have corresponding revenue center code fields containing values: 360 - 369, 490 - 499, 710 - 719.

ONCHG--ONCOLOGY CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values 280 - 289, inclusive.

MSSCHG--MEDICAL/SURGICAL SUPPLIES CHARGES Calculated by summing revenue center charge fields that have associated revenue center code fields containing values 270 - 279, inclusive.

OTHCHG--OTHER CHARGES Calculated by summing remaining revenue center charge fields that have corresponding revenue center code fields containing any value not listed above.

PAYER--PAYER TYPE 1 A VHI assigned numeric value indicating the primary insurer responsible for reimbursing the hospital for the services provided. This field does not contain information about the type of plan. Values were calculated by converting text names of payers provided by hospitals to codes. A support table named Payer containing the English description is provided.

CNTY--COUNTY CODE The United States Postal Service county code derived from the patient's zip code of residence. A support table containing Virginia's county codes, zip codes, health planning regions and health planning districts is provided and named GEOG.

HPR--HEALTH PLANNING REGION Based on Virginia's Department of Health planning regions. A support table containing Virginia's county codes, zip codes, health planning regions and health planning districts is provided and named GEOG. Zip codes were mapped to the HPR by the Central Virginia Health Planning Agency (CVHPA). A value of 9 indicates that the patient resides outside Virginia or the zip code was invalid or unknown.

HPD--HEALTH PLANNING DISTRICT Based on Virginia's Department of Health planning districts. A support table containing Virginia's county codes, zip codes, health planning regions and health planning districts is provided and named GEOG. Zip codes were mapped to the HPD by the CVHPA. A value of 99 indicates that the patient resides outside Virginia or the zip code was invalid or unknown.

COMP_FILLER--COMPLICATION CODE filler beginning with discharges on and after January 1, 2022.

CCA_FILLER--CANCER COMORBID filler beginning with discharges on and after October 1, 2015.

CCV_FILLER--CHRONIC CARDIOVASCULAR DISEASE filler beginning with discharges on and after October 1, 2015.

CLV_FILLER--CHRONIC LIVER DISEASE filler beginning with discharges on and after October 1, 2015.

CRN_FILLER--CHRONIC RENAL DISEASE filler beginning with discharges on and after October 1, 2015.

CDI_FILLER--CHRONIC DIABETES filler beginning with discharges on and after October 1, 2015.

COP_FILLER--CHRONIC PULMONARY DISEASE filler beginning with discharges on and after October 1, 2015.

CCE_FILLER--CEREBROVASCULAR DEGENERATION filler beginning with discharges on and after October 1, 2015.

FILLER1

STATE--PATIENT STATE United States Postal Service assigned state code. Zip codes received are edited for validity. Valid zip codes are then assigned the appropriate state and county code. Records with a missing or known invalid zip code are assigned a default state value of XX. State codes are provided for discharges on and after July 1, 1994.

ECODE1-ECODE3--EXTERNAL CAUSE OF INJURY CODES Base on ICD-10-CM coding system. Ecode 1 provided for discharges on and after July 1, 1994; Ecodes 2-3 provided for discharges on and after January 1, 2007.

ECODE1_POA TO ECODE3_POA—Present on Admission POA indicates that the Ecode was present at the time the order for inpatient admission occurred. POA Values from non-exempt acute hospitals include Y = Yes (present at the time of inpatient admission), N = No (not present at the time of inpatient admission), U = Unknown (documentation is insufficient to determine if condition was present at the time of admission), W = clinically undetermined (provider is unable to clinically determine whether a condition was present on admission), 1 = Unreported, not used. The diagnosis is exempt from POA reporting. POA values for exempt providers are blank. Exempt providers include critical access, long-term care, children's, psychiatric and rehabilitation hospitals. The CMS website has more information on POA reporting.

http://www.cms.gov/HospitalAcqCond/01_Overview.asp#TopOfPage

INFBWT--INFANT BIRTH WEIGHT Recorded for newborns. The range included is 160-7999 grams; improbable weights have been changed to blanks. The user may wish to further restrict this range. Provided for discharges on and after July 1, 1994.

VHIKEY--VHI UNIQUE RECORD IDENTIFIER This field allows linking of records to other records if developed with adjunct information. Provided for discharges on and after July 1, 1994.

APHY--ATTENDING PHYSICIAN UPIN or NPI Federally assigned unique physician identification number. The attending physician is defined in the Virginia UB manual as the physician who has primary responsibility for the patient's medical care and treatment. Individual hospitals and their medical staffs determine how to make this determination. Provided for all hospitals on and after July 1, 1996.

OPHY--OPERATING PHYSICIAN UPIN OR NPI Federally assigned unique physician identification number. Provided for all hospitals on and after July 1, 1996.

OTHPHY1—OTHER PHYSICIAN 1 UPIN or NPI Federally assigned unique physician identification number.

OTHPHY2—OTHER PHYSICIAN 2 UPIN or NPI Federally assigned unique physician identification number.

PLEGSTAT—PATIENT LEGAL STATUS Legal status applies to voluntary or involuntary psychiatric admissions of minors and adults per Virginia Code. Value: 1 - Parental admission of minors < 14 and non-objecting minors 14 years of age or older; 2 - Parental admission of objecting minor 14 years of age or older; 3 - Involuntary TDO (minor); 4 - Involuntary commitment (minor); 5 - Voluntary admission (adult); 6 - Involuntary TDO (adult); 7 - Sexually violent predators (prisoners or defendants); PLEGSTAT only beginning with 2022q2

FILLER2

FILLER3

APHYWRN—ATTENDING UPIN OR NPI WARNING

OPHYWRN—OPERATING PHYSICIAN WARNING

OTHPHY1WRN—OTHER PHYSICIAN 1 WARNING

OTHPHY2WRN—OTHER PHYSICIAN 2 WARNING The addition of these fields allows the data user to determine whether the UPIN OR NPI will be included in an analysis. A value equal to "0" indicates that the submitted Attending Physician UPIN or NPI for a hospital discharge was on the CMS National UPIN or NPI table. A value of "1" indicates that the value was not on the CMS

National table but was in the proper UPIN or NPI format (Alpha character followed by five numbers). A value of "1" may indicate a physician recently assigned a UPIN or NPI, a physician who seldom submits claims for Medicare patients or a possible error. A blank (" ") reflects that no value was submitted or it was in an incorrect format. Available for discharges beginning with 4q98.

RAT--READMISSION AND TRANSFER Indicates whether the discharge is eligible to be used for Readmission and transfer calculations when valid SSN, Bdate, Adate, Ddate, MPN and sex are provided to VHI. When available, Readmission and Transfer (RAT) files can be used to accurately calculate readmission or transfer rates by determining which records in the patient level data file were considered a possible readmission/transfer record (e.g. met the listed criteria). A label of "1" indicates that the record met those criteria. Readmission and transfer information can be linked to the public use data files and correctly identify the denominator by including only those cases with a "1" in the RAT field. Populated beginning with discharges on and after January 1, 1999.

CRLF--CARRIAGE RETURN LINE FEED End of Record

SUPPLEMENTAL RATS RECORD LAYOUT AND DATA DICTIONARY

RECORD LAYOUT FOR READMISION AND TRANSFER (RATS) DATA (UPDATED 2018-01-23)

Virginia Health Information			
Record Layout for Readmission and Transfer (RATS) Data			
Field Name	Length	Format	Description
VHIKEY	10	text	10-digit Unique Record Identifier available for discharges after July 1, 1994; VHI assigns a unique identifier for every inpatient discharge in Virginia. The first digit indicates the VHI dataset source: 0=Inpatient Discharge. The second digit indicates the quarter of discharge, and the third and fourth digits are the two-digit year of discharge. The remaining 6 digits identify the unique record.
VHIKEY_AFTER	10	text	10-digit Unique Record Identifier available for discharges after July 1, 1994; VHI assigns a unique identifier for every inpatient discharge in Virginia. The first digit indicates the VHI dataset source: 0=Inpatient Discharge or 1-State Mental Health Institution Discharge. The second digit indicates the quarter of discharge, and the third and fourth digits are the two-digit year of discharge. The remaining 6 digits identify the unique record.
RT1_FLAG	2	text	RT1 identifies the VHIKey_After as either a readmission or transfer. The possible values are R1=a readmit and T1=a transfer.
DAYS_AFTER	3	text	Days_after contains the number of days between the patient discharges identified by the VHIKEY and the patient admission identified by the VHIKEY_AFTER.
DX1_AFTER	7	text	DX1_after contains the principal diagnosis code of the patient discharge identified by the VHIKEY_AFTER.
PX1_AFTER	7	text	PX1_after contains the principal procedure code of the patient discharge identified by the VHIKEY_AFTER.
MPN_AFTER	6	text	MPN_after contains the Medicare Provider Number of the patient discharge identified by the VHIKEY_AFTER.
APRDRG_AFTER	5	text	The first three digits of APRDRG_after contain the All Patient Refined Diagnostic Related Group (APRDRG) code, the fourth digit indicates the severity of illness and the last digit indicates the mortality subclass of the patient discharge identified by the VHIKEY_AFTER.
QTR_IND	4	text	QTR_ind contains the calendar quarter of the patient discharge identified by the VHIKEY.

RATS DICTIONARY OF DATA ELEMENTS

Key Number 10-digit Unique Record Identifier available for discharges after July 1, 1994; VHI assigns a unique identifier for every inpatient discharge in Virginia. The first digit indicates the VHI dataset source: 0=Inpatient Discharge. The second digit indicates the quarter of discharge, and the third and fourth digits are the two-digit year of discharge. The remaining 6 digits identify the unique record.

VHIKey_after 10-digit Unique Record Identifier available for discharges after July 1, 1994; VHI assigns a unique identifier for every inpatient discharge in Virginia. The first digit indicates the VHI dataset source: 0=Inpatient Discharge or 1-State Mental Health Institution Discharge. The

second digit indicates the quarter of discharge, and the third and fourth digits are the two-digit year of discharge. The remaining 6 digits identify the unique record.

RT1--RT1 Flag RT1 identifies the VHIKey_After as either a readmission or transfer. The possible values are R1=a readmit and T1=a transfer.

Days_after Days_after contains the number of days between the patient discharges identified by the VHIKEY and the patient admission identified by the VHIKEY_AFTER.

DX1_after-- DX1_after contains the principal diagnosis code of the patient discharge identified by the VHIKEY_AFTER.

PX1_after PX1_after contains the principal procedure code of the patient discharge identified by the VHIKEY_AFTER.

MPN_after MPN_after contains the Medicare Provider Number of the patient discharge identified by the VHIKEY_AFTER.

APRDRG_after The first three digits of APRDRG_after contain the All Patient Refined Diagnostic Related Group (APRDRG) code, the fourth digit indicates the severity of illness and the last digit indicates the mortality subclass of the patient discharge identified by the VHIKEY_AFTER.

Qtr_ind QTR_ind contains the calendar quarter of the patient discharge identified by the VHIKEY.

PLD AND RATS ORDERING INFORMATION

LICENSE AGREEMENT

**Virginia Health Information
Application for and Agreement to License Patient Level Data
(Public Use File - PUF1)
Revised as of April 3, 2024**

I. Name: _____
 Company: _____ (the "Contractor")
 Address: _____
 Telephone: _____
 Email: _____
 Check as Applicable: Business nonprofit (per IRS): _____ Business other: _____
 University: _____ Government: _____ Other: _____

II. State the reason the data is requested. _____

III. Will reports be created for sale to third parties using this data? If yes, please note target volume of expected reports using this data or extracts from this data and the file format of any such report.

IV. Will computer readable files be created for sale to third parties? If yes, please note the target volume and format of the files to be created.

V. Applicant desires the following license: (Please check only one)
 A. Individual License: _____ Allows Contractor to use data on a single computer belonging to the Contractor or the Contractor’s designated subcontractor. **Please note: Contractor may not generate revenue from the use of the data either via consulting fees, generation of reports or analysis, or incorporating data into software for distribution to third parties.**
 B. Site License: _____ Allows Contractor to make multiple copies of the data for use by individuals within the same organization of the Contractor or a single copy accessible by Contractor’s computer network by more than one individual within the same organization. **Please note: Contractor may not generate revenue from the use of the data either via consulting fees, generation of reports or analysis, or incorporating data into software for distribution to third parties.**
 C. Commercial and/or Government License: _____ Allows Contractor to make

multiple copies of the data for incorporation into computer software for subsequent resale and/or distribution of such computer software to third parties, subject to the condition that with respect to the data the third party is able only to access the data by queries that produce aggregated data reports. This license also allows Contractor to sell reports created from the database. Notwithstanding the forgoing, any subsequent resale and/or distribution by such third parties is expressly prohibited, and any distribution of data to third parties that enables third party access to data other than by aggregated reports is expressly prohibited.

VI. Virginia Health Information (VHI) hereby grants the Contractor indicated in Section I a non-exclusive, non-transferable, and perpetual license to use the Data Base described in Appendix A (or “data”) under the terms and subject to the restrictions of this Agreement, and the Contractor hereby accepts, subject to the terms and conditions set forth in this Agreement, the nonexclusive and nontransferable right to use the Data Base pursuant to the terms of this Agreement. VHI reserves all rights, title, and interest in and to the Data Base (including ownership of all copyrights and other intellectual property rights pertaining thereto), subject only to the license expressly granted to Contractor herein.

In accepting the usage granted by VHI, the Contractor agrees that it shall:

- A. Except as permitted under Section VI, Part F below, not license, rent, lease, distribute, or permanently transfer the Contractor’s rights to use the Data Base.
- B. Use the Data Base only for the expressed purpose stated by the Contractor in this application.
- C. Make no attempt, by commission or omission, to identify, disclose, discuss, release, or provide access to information on specific individual patients.
- D. Contractor agrees to include the following statement in any reports, publications, or secondary files created using the Data Base whether for internal use or for sale, presentation, or distribution to third parties:
“Virginia Health Information (VHI) has provided non-confidential patient level information used in this file, report, publication, or database which it has compiled in accordance with Virginia law but which it has no authority to independently verify. By using this file, report, publication, or database, the user agrees to assume all risks that may be associated with or arise from the use of inaccurate data. VHI cannot and does not represent that the use of VHI’s data was appropriate for this file, report, publication, or database or endorse or support any conclusions of inferences that may be drawn from the use of VHI’s data.”
For any reports, publications, or secondary files created using the Data Base for sale, presentation, or distribution to third parties under Section V., Part C., Contractor also agrees to include the following statement:
“The patient level information used in this file, report, publication, or database is provided for your sole, internal use only, and is non-transferable, and shall not be distributed to any third parties whatsoever.”
- E. Not resell or externally distribute to third parties the Data Base unless Contractor obtains a commercial license from Virginia Health Information as defined in Section

V., Part C above and incorporates the Data Base into a computer program that manipulates and analyzes or enables the user to manipulate and analyze the data as permitted under this License Agreement (the “Software”). Any such resale or external distribution shall be expressly limited to the internal use of such third party; Contractor shall not make any representation or attempt to authorize third parties to further resell or distribute the Data Base or patient level information therein. Contractor agrees to take all reasonable steps to limit such third party use to the sole use of making queries and generating reports of aggregated data, and as a condition of this license such third parties shall be expressly prohibited from accessing or exporting data or individual patient records.

F. Notwithstanding the restrictions set forth above if a multi-site license or commercial license as described in Section V., Parts B, or C is issued, Contractor shall be permitted to distribute the Data Base to entities or individuals that are directly or indirectly owned or controlled by Contractor or that are directly or indirectly owned or controlled by the same entity or individual that owns or controls Contractor, with any such distribution remaining subject to the terms and conditions herein.

G. Pay such additional licensing fees to VHI as may reasonably be demanded by VHI in the event that Contractor’s use of the Data Base exceeds the scope of this agreement.

Contractor further agrees that VHI shall be entitled to terminate all of Contractor’s rights to use the Data Base and Contractor shall return all copies of the Data Base to VHI, in the event Contractor violates the terms of this Agreement and fails to cure such violation within seven (7) days of the receipt of such notice. Notwithstanding the preceding sentence, if Contractor violates the terms of Section C above regarding patient identity, this license shall immediately terminate and Contractor shall immediately return all copies of the Data Base to VHI. The rights and remedies of VHI set forth herein with respect to Contractor’s failure to comply with the terms of this Agreement (including, without limitation, the right to terminate this Agreement) are not exclusive, the exercise thereof shall not constitute an election of remedies, and VHI shall be entitled to seek whatever additional remedies may be available in law or in equity.

Upon receipt of this application and Agreement, executed by the Contractor acceptance by VHI hereof, and receipt of the license fee, VHI shall execute the Agreement and furnish the Contractor the Data Base in computer-readable form, subject to the terms of this agreement.

All fees payable by Contractor under this Agreement are net of applicable taxes. Contractor is solely responsible for any taxes or assessed fees which are, or may become, due by reason of this Agreement.

Contractor does hereby indemnify and shall hold harmless VHI, and its directors, officers, and any employees and agents from and against all liability (including punitive damages) and costs (including reasonable attorneys’ fees) arising out of a claim or claims of third parties arising from the use by Contractor, in any manner, of the Data Base, including (but not limited to) the violation of any third party’s privacy rights.

CONTRACTOR AGREES THAT THE DATA BASE IS BEING PROVIDED AS IS AND ALL WARRANTIES,

WHETHER BY COMMON LAW, STATUTE, OR EQUITY, ARE EXCLUDED, INCLUDING THE WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE (WHETHER OR NOT VHI KNOWS, HAS REASON TO KNOW, HAS BEEN ADVISED, OR IS OTHERWISE IN FACT AWARE OF ANY SUCH PURPOSE). CONTRACTOR ACKNOWLEDGES THAT VHI ONLY COMPILES THE INFORMATION CONTAINED IN THE DATA BASE, AND DOES NOT INDEPENDENTLY VERIFY OR WARRANT THE ACCURACY OF SUCH INFORMATION.

CONTRACTOR AGREES THAT VHI SHALL NOT BE LIABLE FOR SPECIAL, INDIRECT, OR CONSEQUENTIAL DAMAGES EVEN IF IT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THE ABOVE INDEMNIFICATION, DISCLAIMER OF WARRANTIES, AND LIMITATION OF LIABILITY SHALL SURVIVE TERMINATION OF THIS AGREEMENT.

Contractor has read and agrees to abide by all terms and restrictions described regarding the use of Virginia Health Information (VHI) patient level data. Any change or waiver of any provision of this Agreement shall be only by signed writing of the parties to be effective.

VIRGINIA HEALTH INFORMATION

By: _____

Name: _____

Title: _____

Date: _____

CONTRACTOR

By: _____

Name: _____

Title: _____

Date: _____

VHI License No. _____

Valid for one year from the date of execution

Description of the Data Base

Public Use File-PUF1

The Public Use File-PUF1 is a data file of all hospital discharges in the Commonwealth of Virginia for the identified quarter. Claims data elements are included for patient demographics, diagnoses and procedures, charges, and revenue groupings. Co-morbid conditions have also been added to aid in determining variations in patient outcomes.