

**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE  
FIRST QUARTER FY 2014 PATIENT ORIGIN SURVEY**  
***MUST INCLUDE DISCHARGE DATA FOR October, November, and December 2013***

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

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<b>Length of Stay (LOS)</b>	<p>The number of days calculated from the date of admission until the date of <u>discharge</u> or <u>death</u>. <b>Discharges for this quarter</b> include any patients admitted in previous months and discharged during the months of <b>OCTOBER, NOVEMBER, and DECEMBER..</b> <i>DO NOT</i> include any patients admitted during this period but not discharged by September 30<sup>th</sup>. Patients must be in the hospital a minimum of 24 hours to be included in the Patient Origin Survey.</p> <p><b>Examples:</b> A patient admitted on September 30<sup>th</sup> and discharged on October 4<sup>th</sup> would have a LOS of 004. A patient admitted on October 3<sup>rd</sup> and discharged on October 13<sup>th</sup> would have a LOS of 010. A patient admitted on December 28<sup>th</sup> and not discharged by December 31<sup>st</sup> would not be included.</p>	<b>3</b>
<b>Date of Discharge</b>	<p>For every discharge, Please include the date of discharge for that patient. This should be submitted in a <b>MM/DD/YYYY</b> format.</p>	<b>10</b>
<b>Service Code</b>	<p>Record only the <b>PRIMARY</b> service when more than one clinical service is provided during the hospital stay:</p> <p><b>MEDICINE:</b>           <b>01</b></p> <p><b>SURGERY:</b>           <b>02</b></p> <p><b>PEDIATRICS:</b>       <b>03</b> (use only if your facility has an organized pediatric unit and only for patients <u>17 and under</u>). If your facility does not have an organized pediatric unit, report services under one of the remaining codes. For patients 18 and older, report under one of the remaining codes even if treatment occurred in an organized pediatric unit.</p> <p><b>GYNECOLOGY</b>       <b>04</b> (<u>NO MALES</u>), (medicine or surgery)</p>	<b>2</b>

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

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

**FOR ELECTRONIC SUBMISSIONS ONLY:**

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

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



# FIRST QUARTER FY 2014 HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

Please attach this sheet as a cover to the FIRST QUARTER FY 2014 Hospital Patient Origin Survey for paper submissions. This survey is due by February 28, 2014.

Hospital Name \_\_\_\_\_

Hospital ID # \_\_\_\_\_

Total Number of Survey Sheets Enclosed \_\_\_\_\_

Total Number of Discharges Reported \_\_\_\_\_

Person submitting survey report: \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Telephone Number \_\_\_\_\_

Version of **DRG**  
Codes: \_\_\_\_\_

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