

**National Committee on Vital and Health Statistics**  
**Preliminary Recommendations for**  
**Core Health Data Elements**

In 1994, the National Committee on Vital and Health Statistics (NCVHS), in its advisory capacity to the Department of Health and Human Services (DHHS), initiated a public-private collaborative process to identify a set of core health data elements on persons and encounters that can serve a variety of needs and would benefit from voluntary standardization. The goal of this process was to ascertain where some convergence among various constituencies and applications may be developing, at least with regard to very commonly used data elements; the objective was not to identify a data set for mandated reporting.

In 1995, NCVHS contracted for a Compendium of Core Data Elements frequently collected or proposed for collection regarding eligibility, enrollment, encounters and claims in the United States; sent a mailing to over 2,000 organizations, seeking feedback on the most commonly collected core health data elements; and held two special meetings in Oakland, CA and Washington, DC, to gather additional information from data users and developers. The Committee is now circulating this document to receive further feedback on a preliminary set of recommendations before submitting its conclusions to the DHHS Data Council.

The Committee recognizes that this is an iterative process and has included in these recommendations several elements that have been proposed for standardization, even though no consensus currently exists concerning appropriate or feasible definitions. The description of the element indicates this present lack of agreement. The Committee has chosen to include these elements (i.e., nos. 8, 9, 12, 28 and 29) because it believes that the type of information they contain increasingly will be needed. The Committee intends to encourage the Department and its partners to give high priority to conducting evaluation and research on such elements and also seeks to alert organizations developing standards or data sets to leave place holders for their inclusion.

The following list of data items and proposed definitions apply to persons seen in both ambulatory and inpatient settings, unless otherwise specified. Standard electronic formats are recommended to the extent that they have been developed. The NCVHS has undertaken parallel efforts to identify elements specific to mental health, substance abuse, disability and long-term care settings. Some recommendations in the area of mental health and substance abuse are included here. Other recommendations will be circulated for comment at a future time.

## **CORE HEALTH DATA ELEMENTS PROPOSED FOR STANDARDIZATION**

1. **Personal/Unique Identifier**
2. **Date of Birth**
3. **Gender**
4. **Race and Ethnicity**
5. **Residence**
6. **Living/Residential Arrangement**
7. **Marital Status**
8. **Self-Reported Health Status**
9. **Functional Status**
10. **Years of Schooling**
11. **Patient's Relationship to Subscriber/Person Eligible for Entitlement**
12. **Current or Most Recent Occupation/Industry**
13. **Type of Encounter**
14. **Admission Date (inpatient)**
15. **Discharge Date (inpatient)**
16. **Date of Encounter (ambulatory and physician services)**
17. **Facility Identification**
18. **Type of Facility/Place of Encounter**
19. **Provider Identification (ambulatory)**
20. **Provider Location or Address (ambulatory)**
21. **Attending Physician Identification (inpatient)**
22. **Operating Physician Identification (inpatient)**
23. **Provider Specialty**
24. **Principal Diagnosis (inpatient)**
25. **Primary Diagnosis (inpatient)**
26. **Other Diagnoses (inpatient)**
27. **Qualifier for Other Diagnoses (inpatient)**
28. **Patient's Stated Reason for Visit or Chief Complaint (ambulatory)**
29. **Physician's Tentative Diagnosis (ambulatory)**
30. **Diagnosis Chiefly Responsible for Services Provided (ambulatory)**
31. **Other Diagnoses (ambulatory)**
32. **External Cause of Injury**
33. **Birth Weight of Newborn (inpatient)**
34. **Principal Procedure (inpatient)**
35. **Other Procedures (inpatient)**
36. **Dates of Procedures (inpatient)**
37. **Services (ambulatory)**
38. **Medications Prescribed**
39. **Medications Dispensed (pharmacy)**
40. **Disposition of Patient (inpatient)**
41. **Disposition (ambulatory)**
42. **Patient's Expected Sources of Payment**
43. **Injury Related to Employment**
44. **Total Billed Charges**

## **Person/Enrollment Data**

The elements collected in this section refer to information collected on enrollment or at an initial visit to a health care provider or institution. It is anticipated that these elements will be collected on a one-time basis or updated on an annual basis. They do not need to be collected at each encounter.

### **1. Personal/Unique Identifier.**

A. Name - Last name, first name, middle initial, suffix (e.g., Jr., III, etc.)

B. Numerical identifier

Without a universal unique identifier or a set of data items that can form a unique identifier, it will be impossible to link data across the myriad of healthcare locations and arrangements. In the 1992 revision of the Uniform Hospital Discharge Data Set (UHDDS), the NCVHS recommended "using the Social Security Number(SSN), with a modifier as necessary, as the best option currently available for this unique and universal patient identifier." However, recent testimony has led the Committee to investigate this issue further, in light of perceived inadequacies of the SSN (e.g., lack of check digit, multiple SSN's, etc.), particularly when used alone, and impediments (legal and otherwise) to its use. New York State presented testimony that indicated that the last four digits of the SSN combined with the birth date were capable of linking data to a very high degree of probability. The State of California is testing the use of a series of data items that are readily known by individuals and which can be combined to link data. These data items include birth name, date of birth, place of birth, gender, and mother's first name. Those present at the November and December 1995 NCVHS regional meetings agreed that the establishment of a unique identifier is the most important core data item. A unique identifier such as the SSN in conjunction with at least one other data item or, alternatively, an identifier drawn from another distinct set of data items routinely collected presently would seem the most viable. The NCVHS recognizes the vital importance of maintaining patient confidentiality and emphasizes that any public use of a unique identifier should be in an encrypted form.

**2. Date of Birth** - Year, month and day - As recommended by the UHDDS and the Uniform Ambulatory Care Data Set (UACDS). It is recommended that the year of birth be reported in four digits to make the data element more reliable for the increasing number of persons of 100 years and older. It will also serve as a quality check as the date of birth approaches the new century mark.

**3. Gender** - Male, Female. As recommended by the UHDDS and the UACDS.

**4. Race and Ethnicity** - As recommended by the UHDDS and the UACDS and as currently defined by Office of Management and Budget (OMB) Directive 15:

- 4A. Race
  - 1. American Indian/Eskimo/Aleut
  - 2. Asian or Pacific Islander
  - 3. Black
  - 4. White
  - 5. Other race

- 4B. Ethnicity
  - 1. Hispanic Origin
  - 2. Not of Hispanic Origin

It is recommended that this item be self-reported, not based on visual judgment or surnames. Whenever possible, the Committee and participants recommended collecting more detailed information on Asian and Pacific Islanders, as well as persons of Hispanic Origin. OMB is currently investigating the possibility of changes to this classification, and the Committee will await the OMB recommendations. The Committee is concerned about the possible inclusion of a "multiracial" category, without an additional element requesting specific racial detail and/or primary racial identification, because of its anticipated impact on trend data and loss of specificity. The National Association of Health Data Organizations also has opposed such an inclusion.

**5. Residence** - Usual residence, full address and ZIP code - nine digit ZIP code, if available. This recommendation is in accord with the 1992 UHDDS and the UACDS, as well as recommendations by the NCVHS Subcommittee on State and Community Health Statistics. The Subcommittee determined that residential street address has the advantage of enabling researchers to aggregate the data to any level of geographic detail (block, census tract, ZIP Code, County, etc.) and is the best alternative to insure the availability of small area data. Some thought needs to be given to completing this item for persons with no known residence or persons whose residence is outside of the United States. Because the full residential address could serve as a proxy personal identifier, confidentiality of the complete information must be safeguarded in public use of the data.

**6. Living/Residential Arrangement** - The following definitions, as recommended by the NCVHS, should be used:

- 6A. Living Arrangement
  - 1. Alone
  - 2. With spouse (alternate: with spouse or unrelated partner)
  - 3. With children
  - 4. With parent or guardian
  - 5. With relatives other than spouse, children, or parents
  - 6. With nonrelatives

Multiple responses to this item are possible.

- 6B. Residential Arrangement
  - 1. Private residence/household

2. Homeless shelter
3. Housing with services or supervision (e.g., group home, assisted living facility)
4. Jail or correctional facility
5. Health care institutional setting (e.g., nursing home)
6. Homeless
7. Other residential setting

The key distinction to be ascertained in “residential arrangement” is whether organized care-giving services are being provided where the patient lives.

**7. Marital Status** - The following definitions, as recommended by the NCVHS, should be used. This item would be collected at first clinical visit and periodically updated, at least annually.

A. Married - A person currently married. Classify common law marriage as married.

- 1) living together
- 2) not living together

B. Never married - A person who has never been married or whose only marriages have been annulled.

C. Widowed - A person widowed and not remarried.

D. Divorced - A person divorced and not remarried.

E. Separated - A person legally separated.

**8. Self-Reported Health Status** - There was much interest in documenting health status, although there was no consensus on how its definition should be standardized. A commonly used measure is the person's rating of his or her own general health, as in the five-category classification, "excellent, very good, good, fair, or poor." Used in the National Health Interview Survey and many other studies, this item has been shown to be predictive of morbidity, mortality, and future medical care use. This item would be collected at first clinical visit and periodically updated, at least annually. Additional evaluation and research are needed on standardizing the health status element.

**9. Functional status** - The functional status of a person is an increasingly important health measure that has been shown to be strongly related to medical care utilization rates. A number of scales have been developed that include both a) self-report measures, such as the listings of limitations of Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) and the National Health Interview Survey age-specific summary evaluation of activity limitations, and b) clinical assessments, such as the International Classification of Impairments, Disabilities and Handicaps (ICIDH) and the Resident Assessment Instrument (RAI) (widely used in nursing homes). Self-report and clinician measurement are each valuable, and having both available is especially informative. Whichever method is used should be designated. Particular scales are more appropriate for measuring different functions or disabilities and should be selected on the basis of the needs of the patient population (such as, use of social functioning scales for those with mental disorders and substance abuse). Functional assessment scales also must be age-

appropriate. At present, there is no widely recognized instrument for measuring the functional status of children. Periodicity of assessment also is an issue. Consideration of these various issues and additional evaluation and research are needed before recommendations can be made for standardizing functional status measurement.

**10. Years of Schooling** - Years of schooling completed by the enrollee/patient has been recommended by the NCVHS and others as a proxy for socioeconomic status (SES). For children under the age of 18, the mother's years of schooling completed should be obtained. Years of schooling has been found to be highly predictive of health status and health care use.

Ideally, one would also collect income to more fully define socioeconomic status. However, income questions are often considered intrusive, whereas years of schooling are more acceptable to respondents. The NCVHS Subcommittee on Ambulatory and Hospital Care Statistics commented in the 1994 UACDS revision that years of schooling completed is the most feasible socioeconomic element to collect in the UACDS.

**11. Patient's relationship to subscriber/person eligible for entitlement -**

- A. Self
- B. Spouse
- C. Child
- D. Other

Respondents indicated that the relationship (i.e., self, spouse or child of subscriber) was of importance for payment and research purposes.

**12. Current or Most Recent Occupation/Industry** - This data item is very useful to track occupational diseases as well as to better define socioeconomic status. Standardized coding schemes, such as the Census Bureau's Alphabetical Listing of Occupation and Industry and the Standardized Occupation and Industry Coding (SOIC) software developed by the National Institute on Occupational Safety and Health, should be reviewed. The Committee feels that, over time, there will be increasing attention focused on this item and reaffirms its recommendations in the 1994 revisions to the UACDS that additional research be conducted on the feasibility and utility of collecting and periodically updating information on a person's occupation and industry.

### **Encounter Data**

**13. Type of Encounter** (facility-based care) -

- A. Inpatient
- B. Outpatient
- C. Emergency Department
- D. Observation
- E. Ambulatory Surgery
- F. Other

**14. Admission Date** (inpatient)- Year, month, and day of admission as currently recommended in the UHDDS and by ANSI ASC X12. An inpatient admission begins with the formal acceptance by a hospital of a patient who is to receive physician or other services while receiving room, board, and continuous nursing services. It is recommended that the year of admission contain 4 digits to accommodate problems surrounding the turn of the century.

**15. Discharge Date** (inpatient) - Year, month, and day of discharge as currently recommended in the UHDDS and by ANSI ASC X12. An inpatient discharge occurs with the termination of the room, board, and continuous nursing services, and the formal release of an inpatient by the hospital. Four digits are recommended for the discharge year.

**16. Date of encounter** (ambulatory and physician services) - Year, month, and day of encounter, visit, or other health care encounter, as recommended by the UACDS and ANSI ASC X12. Each encounter generates a date of service that can be used to link encounters for the same patient over time. Grouping of similar services provided on different dates, as is often the case under batch billing, can be problematic if specificity of data elements is lost; the objective is to encourage identifying a unique date of record for each encounter. For services billed on a global basis, the range of dates from beginning of all treatments included under the global code to the end should be reported.

**17-23. Provider identifiers** - Each provider should have a universal unique number across data systems. The National Provider Identifier and National Provider File (NPI/NPF), currently under development by the Health Care Financing Administration (HCFA) and intended for implementation in 1997, could and should meet this need, if all providers are included. The NPI/NPF will provide a common means of uniquely identifying health care providers, including institutions, individuals, and group practices, both Medicare providers and those in other programs. Participation in the system will be voluntary for non-HCFA providers at first. Currently some states are using state facility identifiers, but the Committee recommends that this system be superseded by the NPI/NPF.

The immediate goal of the NPI/NPF project is to support HCFA's Medicare Transaction System initiative by providing a single, universal method for enumerating the providers who serve Medicare beneficiaries. It will do so by assigning a unique identifier to each provider. In the future, the system will integrate non-HCFA subscribers. It is planned that enumeration of Medicare providers will begin in the second quarter of calendar year 1996. The draft systems requirement definition was issued in January, 1995. It is recommended that the NPF be the source of all unique provider identifiers, for institutions and individuals. Systems may also choose to collect other identifiers (e.g., tax number), which they can link to the NPI. Items shown below with an asterisk (\*) indicate that this type of information can be obtained from linking the NPI with the National Provider File and may not need separate collection.

**17. Facility identification** - The unique HCFA identifier as described above. This identifier includes hospitals, ambulatory surgery centers, nursing homes, hospices, etc. If the HCFA system does not have separate identification numbers for parts of a hospital (i.e.,

Emergency Department, Outpatient Department), an additional element (such as element 13) will need to be collected along with the facility ID to differentiate these settings.

**18. Type of facility/place of encounter.\*** As part of the NPI/NPF system, described above, HCFA is defining a taxonomy for type of facility. This taxonomy builds on previous NCVHS and departmental work and should be reviewed by the NCVHS and standards organizations.

**19. Provider identification (ambulatory)** - The unique national identification number assigned to the provider of record for each encounter. There may be more than one provider identified:

- A. The provider professionally responsible for the services, including ambulatory procedures, delivered to the patient (provider of record)
- B. The provider of each clinical service received by the patient, including ambulatory procedures

Initial enumeration by HCFA will focus on individual providers covered by Medicare and Medicaid; however, the system will enable enumeration of other providers, as identified by system users.

**20. Provider location or address\*** (ambulatory) - The full address and Zip Code (nine digits preferred) for the location of the provider of record (see 19A.) that is the usual or principal place of practice. As recommended by the UACDS, address should be in sufficient detail (street name and number, city or town, county, State, and Zip Code) to allow for the computation of county and metropolitan statistical area.

**21. Attending physician identification (inpatient)** - The unique national identification number assigned to the clinician of record at discharge who is responsible for the discharge summary, as recommended by the 1992 UHDDS.

**22. Operating physician identification (inpatient)** - The unique national identification number assigned to the clinician who performed the principal procedure, as recommended by the UHDDS.

**23. Provider specialty\*** (inpatient and ambulatory) - As part of the NPI/NPF system, HCFA has identified an exhaustive list of specialties. This listing should be reviewed by the NCVHS and standards organizations and, if found acceptable, recommended for use.

**24. Principal Diagnosis (inpatient)** - As recommended by the UHDDS, the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. The currently recommended coding instrument is the ICD-9-CM.

**25. Primary Diagnosis (inpatient)** - The diagnosis that is responsible for the majority of the care given to the patient or resources used in the care of the patient. In most instances,



the principal and primary diagnoses will be the same. This diagnosis is not part of the UHDDS. Respondents have indicated a mixed use of this item for inpatients. There is, however, concern that medical personnel may be confusing the definitions/uses of principal versus primary diagnosis. Some respondents incorrectly interpreted this item as a means of classifying primary site for cancer, utilizing ICD-O (oncology). The NCVHS notes that the Department of Veterans Affairs routinely collects this element.

**26. Other diagnoses (inpatient)** - As recommended by the UHDDS, all conditions that coexist at the time of admission, or develop subsequently, which affect the treatment received and/or the length of stay. Diagnoses that refer to an earlier episode that have no bearing on the current hospital stay are to be excluded. Conditions should be coded that affect patient care in terms of requiring:

1. Clinical evaluation, or
2. Therapeutic treatment, or
3. Diagnostic procedures, or
4. Extended length of hospital stay, or
5. Increased nursing care and/or monitoring.

**27. Qualifier for other diagnoses (inpatient)** - The following list of qualifiers should be applied to each diagnosis coded under "other diagnoses," as was recommended in the 1992 revision of the UHDDS:

- A. Onset prior to admission
- B. Onset not prior to admission
- C. Onset uncertain

This qualifier is currently being collected by California and New York hospital discharge data systems; testimony indicates that use of this qualifier can contribute significantly to quality assurance monitoring, risk-adjusted outcome studies, and reimbursement strategies.

**28-31. Ambulatory Conditions** - The elements for ambulatory conditions contain information on the Patient's Stated Reason for Visit and the Problems, Diagnosis, or Assessment, both of which were recommended by the UACDS. The latter element, which describes all conditions requiring evaluation and/or treatment or management at the time of the encounter as designated by the provider, has been divided into two elements: 1) the diagnosis chiefly responsible for services provided, and 2) other diagnoses. A new element, "Physician's Tentative Diagnosis," as discussed below, is also proposed.

During the NCVHS review of core health data elements, discussion arose regarding the specificity of diagnoses reported in the Problems, Diagnosis and Assessment element (now elements 30 and 31). The official national outpatient/physician coding and reporting guidelines provide instruction that a suspected or rule out condition not be reported as though it is a confirmed diagnosis. The instruction clarifies that only what is known to the highest level of specificity should be reported. In some instances this may be a symptom or an abnormal finding. Medicare and many other payers adhere to these guidelines. Some third party payers, however, have ignored the guidelines and required facilities and

physicians to report a diagnosis that justifies the performance of services being provided. This has resulted in inconsistent data found in many ambulatory databases and has skewed patient outcome studies.

The NCVHS recommendation is to create a new element called "Physician's Tentative Diagnosis" (element 29), that would include impression, presumptive, rule out, suspected, and differential diagnoses. This would be beneficial to individuals who need this type of information without circumventing existing coding guidelines and negatively affecting longitudinal data.

**28. Patient's Stated Reason for Visit or Chief Complaint** (ambulatory) - Includes the patient's stated reason at the time of the encounter for seeking attention or care. This item attempts to define what actually motivated the patient to seek care. The NCVHS has recommended this as an optional item in the UACDS but that high priority should be given to conducting additional research as to the feasibility, ease and practical utility of collecting the patient's reason for encounter, in as close to the patient's words as possible. There is not one agreed-upon coding system for this item; the International Classification of Primary Care, and the Reason For Visit Classification used by the National Ambulatory Medical Care Survey are two such systems. Additional evaluation and demonstration are warranted for this important information.

**29. Physician's Tentative Diagnosis** (ambulatory) - Contains the code(s) for the condition(s) or problem(s) that explain the clinician's assessment of the presenting symptoms/problems and corresponds to the tests or services provided. This assessment (opinion) may be a suspected diagnosis or a rule-out diagnosis and is based on the patient's presenting history and physical and the physician's review of systems. This element should be maintained separately and not merged with Elements 30 and 31. An established diagnosis should not be reported here, but rather in Element 30 and 31. Additional fields would be needed to capture multiple tentative diagnoses. The ICD-9-CM is the recommended coding convention. A qualifier, if desired, could take the form of:

- A. Presumptive
- B. Rule out

**30-31. Problem, Diagnosis or Assessment** (ambulatory)

**30. Diagnosis Chiefly Responsible for Services Provided** (ambulatory) - Contains the code(s) for the diagnosis, condition, problem, or the reason for encounter/visit chiefly responsible for the services provided. Code the condition(s) to the highest documented level of specificity, such as symptoms, signs, abnormal test results, or other reason for visit, if a definitive diagnosis has not been established at the end of the visit/encounter. The ICD-9-CM is the recommended coding convention.

**31. Other Diagnoses** (ambulatory) - Contains the additional code(s) that describe any coexisting conditions (chronic conditions or all documented conditions that coexist at the time of the encounter/visit, and require or affect patient management). The ICD-9-CM is the recommended coding convention.

**32. External Cause-of-Injury** - As recommended by the UHDDS and the UACDS and as included in the HCFA UB-92, the ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect. This item should be completed whenever there is a diagnosis of an injury, poisoning, or adverse effect. The priorities for recording an E-code are:

1. Principal diagnosis of an injury or poisoning
2. Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis.
3. Other diagnosis with an external cause.

The information that will be provided on hospitalized injury patients with this item is considered essential for the development of intervention, prevention and control strategies for injuries.

**33. Birth Weight of Newborn** (inpatient) - The specific birth weight of the newborn, recorded in grams or in pounds and ounces. Specify which unit of measure is being used.

**34-36. Procedures** (inpatient) - All significant procedures, and dates performed, are to be reported. A significant procedure is one that is:

1. Surgical in nature, or
2. Carries a procedural risk, or
3. Carries an anesthetic risk, or
4. Requires specialized training.

Surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation. A qualifier element is recommended to indicate the type of coding structure used, i.e., ICD, CPT, etc.

**34. Principal procedure** - As recommended by the UHDDS, the principal procedure is 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 should be selected as the principal procedure. ICD-9-CM Vol. 3 is required; however NCVHS has strongly advocated for a single procedure classification for inpatient and ambulatory care.

**35. Other procedures** - All other procedures that meet the criteria described above.

**36. Dates of Procedures** - Year, month, and day, as recommended in the UHDDS and by ANSI ASC X12 must be reported for each significant procedure.

**37. Services** (ambulatory) - As recommended by the UACDS, describe all diagnostic services of any type including history, physical examination, laboratory, x-ray or radiograph, and others that are performed pertinent to the patient's reasons for the encounter; all therapeutic services performed at the time of the encounter; and all

preventive services and procedures performed at the time of the encounter. Also, describe, to the extent possible, the provision of drugs and biologicals, supplies, appliances and equipment. The HCFA Common Procedure Coding System (HCPCS), based on CPT-4, is required for physician (ambulatory and inpatient), hospital outpatient department, and free-standing ambulatory surgical facility bills; however, NCVHS has strongly advocated for a single procedure classification for inpatient and ambulatory care.

**38. Medications Prescribed** - Describe all medications prescribed or provided by the health care provider at the encounter, including National Drug Code, dosage, strength, and total amount prescribed.

**39. Medications Dispensed** (pharmacy) - Describe all prescription medications dispensed by a pharmacy/pharmacist, including National Drug Code, dosage, strength, and total amount dispensed. This information is to be provided by the pharmacist. It is anticipated that linkage data such as name or unique identifier of the patient and the prescribing physician will be collected so this information can be linked to the patient record.

**40. Disposition of Patient** (inpatient) - As recommended by the 1992-93 UHDDS:

A. Discharge Status

1. Discharged Alive
2. Discharged Dead
3. Status not stated

B. Discharge Setting

1. Discharged to home or self care (Includes discharged to a correctional facility, board and care home, or other nonmedical custodial care.)
2. Discharged to acute care (medical/surgical) hospital
3. Discharged to a nursing facility
4. Discharged to other health care facility
5. Discharged home to be under the care of a home health services agency
6. Left against medical advice

**41. Disposition** (ambulatory) - The provider's statement of the next step(s) in the care of the patient. At a minimum, the following classification is suggested.

- A. No follow-up planned (return if needed, PRN)
- B. Follow-up planned or scheduled
- C. Referred elsewhere (including to hospital)

**42. Patient's Expected Sources of Payment** - The name of each source of payment should be provided (as free text) for primary and secondary sources:

42A. Primary Source - The primary source that is expected to be responsible for the largest percentage of the patient's current bill.

42B. Secondary Source - The secondary source, if any, that will be responsible for the next largest percentage of the patient's current bill.

Source of payment categories, as recommended in the past, are no longer sufficient. The continuing expansion of types of payments and the combination of payments within groups

is ever changing. HCFA is developing a new system, called the HCFA PAYERID project, which will assign a unique identifier to every payer of health care claims in the United States. Participation is voluntary, and HCFA, which is funding its development, has been working to get consensus about the kind of system that would be useful. The database will contain payer names, billing addresses and business information. The information, which is already in the public domain, will be accessible by names and ID numbers, and available in several formats. Who will have access to the database for research purposes, and to what data, has yet to be determined. "Payers" are defined as public and private entities that have contract responsibility for health care payment.

Medicare decided a PAYERID was needed because of the difficulty its contractors were having in transferring claims to other insurance companies, due to incomplete information or multiple names for payers. It is hoped that the system will improve the coordination of benefits, as well as providing access to information about health insurance and making it easier to track third party liability situations. HCFA, however, has estimated that there are approximately 30,000 individual payers in the U.S. They currently are not developing a system of categories to accompany the IDs. Such a system would be helpful to the extent that it is feasible in the current highly dynamic market.

**43. Injury Related to Employment** - Yes, No. During the discussion on including External Cause of Injury in the 1994 revision to the UACDS, CDC and labor and business groups urged collection of whether or not an injury occurred at work or was work-related. In addition, it was noted that a similar item is currently collected on the HCFA 1500.

**44. Total billed charges** - The UHDDS and UACDS have recommended the collection of all charges for procedures and services rendered to the patient during a hospitalization or encounter. Although there is agreement that "payments" or "costs" are needed, most participants agreed that it is virtually impossible to collect these items consistently across time and locations. Moreover, in the electronic format, in most instances, payments would not be available at the time that patient and medical data are entered. It might not be feasible to expect the record to be updated to include payment data when it becomes available. Therefore, billed charges should be collected, at a minimum.

April 2, 1996