

## **Appendix A-7: Data Dictionary for MassHealth Chart-Based Measures**

**RY2025 (CY2025 Performance Period)  
Technical Specifications Manual for  
Clinical Quality Incentive Program (CQI) v3.0**

**Effective with Q1-2025 discharges (01/01/25)**

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## Enhancements to CQI Data Dictionary (v 3.0)

This Appendix contains the full set of clinical and administrative data element definitions to supplement the chart-abstracted measure technical specifications outlined under Section 4 of this manual. It also includes definitions for all patient identifier administrative data elements required in the MassHealth Crosswalk Files to supplement the MassHealth Payer Files for the nationally reported hospital quality measures data.

This version of the data dictionary contains changes to definitions for existing data elements and introduces new data elements effective with Q1-2025 data. These changes are summarized in the table below.

**Updates to Data Dictionary (CQI v3.0)**

Change to Data Element	Substance Use (SUB-2, 3)	Maternity and Newborn Measures (MAT-4, NEWB-3)	All MassHealth Records	Care Coordination Measures (CCM 1,2,3)
<b>Existing</b>	N/A	Gestational Age	<u>Episode of Care</u> <u>Hispanic Ethnicity</u> <u>Race</u>	N/A
<b>Add New</b>	N/A	N/A	N/A	N/A
<b>Retired</b>	N/A	N/A	<u>Sex (v2.1)</u>	<u>Advance Care Plan</u> <u>Contact Info 24/7</u> <u>Contact Info Studies Pending</u> <u>Current Med List</u> <u>Med Proc &amp; Tests</u> <u>Patient Instructions</u> <u>Patient Refusal of Transmission</u> <u>Plan for Follow-up Care</u> <u>Primary Physician for Follow-up</u> <u>Reason for Inpatient Admission</u> <u>Reconciled Medication List</u> <u>Studies Pending at DC</u> <u>Transition Record</u> <u>Transmission Date</u>

All updates to existing and/or new data elements are shown in *Emphasis* font style on the table of contents and throughout this data dictionary. The table of contents also shows which data element corresponds to the specific measure it is being collected for and the page number locator.

### Data Dictionary Format and Terms

This data dictionary contains detailed information necessary for defining and formatting the collection of all data elements, as well as the allowable values for each data element that uses the following format:

- *Data Element Name*: A short phrase identifying the data element.
- *Collected For*: Identifies the measure(s) requiring that data element to be collected.
- *Definition*: A detailed explanation of the data element.
- *Suggested Data Collection Question*: The wording for a data element question in a data abstraction tool.
- *Format: Length*: The number of characters or digits allowed for the data element.
- *Type*: The type of information the data element contains (e.g., numeric, alphanumeric, date, character, or time).
- *Occurs*: The number of times the data element occurs in a single episode of care record.
- *Allowable Values*: A list of acceptable responses for this data element.
- *Notes for Abstraction*: Notes to assist abstractor in the selection of appropriate value for a data element.
- *Suggested Data Sources*: Source document from which data may be identified such as administrative or medical record. Please note the data sources listed are not intended to reflect a comprehensive list.
- *Guidelines for Abstraction*: Notes to assist abstractors in determining how data element inclusions/exclusions should be answered.

Adherence to data dictionary definitions provided in this EOHHS manual are necessary to ensure that data element abstraction is accurate and reliable. This data dictionary should be used in conjunction with Section 6 (Table 6.1) of this EOHHS manual for a list of the data elements that are subject to data validation scoring.

<b>Data Element Name:</b>	Admission Date		
<b>Collected For:</b>	All MassHealth Records		
<b>Definition:</b>	The month, day, and year of admission to acute inpatient care.		
<b>Suggested Data Collection Question:</b>	What is the date the patient was admitted to acute inpatient care?		
<b>Format:</b>	<b>Length:</b>	10 – MM-DD-YYYY (includes dashes)	
	<b>Type:</b>	Date	
	<b>Occurs:</b>	1	
<b>Allowable Values:</b>	<b>MM</b>	<b>=</b>	Month (01-12)
	<b>DD</b>	<b>=</b>	Day (01-31)
	<b>YYYY</b>	<b>=</b>	Year (20xx)

**Notes for Abstraction:** For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The Admission Date would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.

The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The Admission Date would be abstracted 05-01-20xx.

If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.

For newborns that are born within this hospital, the Admission Date is the date the baby was born.

**Suggested Data Sources:** PRIORITY ORDER FOR THESE SOURCES

- Physician orders
- Face sheet

Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	Admit to observation Arrival date

<b>Data Element Name:</b>	Alcohol Use Status
<b>Collected For:</b>	SUB-2, SUB-3
<b>Definition:</b>	<p>Documentation of the adult patient's alcohol use status using a validated screening questionnaire for <b>unhealthy</b> alcohol use within the first day of admission (by end of Day 1). A validated screening questionnaire is an instrument that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). Validated screening questionnaires can be administered by pencil and paper, by computer or verbally. The screening questionnaire should be at a comprehension level or reading level appropriate for the patient population and in the appropriate language for non-English speaking patients.</p> <p>An example of a validated questionnaire for alcohol screening is the 10 item Alcohol Use Disorder Identification Tests (AUDIT). The first three questions of the AUDIT, the AUDIT-C, ask about alcohol consumption, and can be used reliably and validly to identify unhealthy alcohol use. The four-item CAGE questionnaire is generally inappropriate for screening general populations, as it aims to identify only severely alcohol dependent patients.</p>
<b>Suggested Data Collection Question:</b>	What is the patient's alcohol use status?
<b>Format:</b>	Length: 1 Type: Alphanumeric Occurs: 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"><li>1. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.</li><li>2. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.</li><li>3. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.</li><li>4. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.</li><li>5. The patient refused the screen for alcohol use within the first day of admission (by end of Day 1).</li><li>6. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) or unable to determine from medical record documentation.</li><li>7. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment.</li></ol>

**Notes for Abstraction:**

The alcohol use status screening must have occurred within the first day of admission (by end of Day 1). This includes the day of admission which is defined as Day 0 and the day after admission which is defined as Day 1.

**EXCEPTION:**

If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.

If patient has a blood alcohol test with a result of .08 g/dL or greater or the clinician documents the patient was acutely intoxicated per blood alcohol test results, select Value "2."

- The 0.08 limit is a blood alcohol concentration (BAC) reported in g/dL. If results are given in mg/dL, convert to g/dL by moving the decimal point 3 places to the left.

**Examples:**

- A 100 mg/dL serum ethanol level is equivalent to a 0.10 g/dL BAC.
- An 80 mg/dL serum ethanol level is equivalent to a 0.08 g/dL BAC.

Screening may be done with a "validated" Single Alcohol Screening Question (SASQ) in order to identify those patients with no risk or low risk or who do not drink. Further screening should be done with a validated tool for those patients with a positive result to determine if there is need for a brief intervention.

**Examples** of SASQs include:

- "On any single occasion during the past 3 months, have you had more than 5 drinks containing alcohol?" ("Yes" response is considered positive.)
- "When was the last time you had more than X drinks in 1 day?" (X = 4 for women and 5 for men) (Within the last 3 months is considered positive.)
- "How many times in the past year have you had X or more drinks in a day?" (X = 5 men and 4 women) (Response of >1 is considered positive.)
- How often have you had 6 or more drinks on one occasion in the past year? (Ever in the past year considered positive.)
- How often do you have X or more drinks on one occasion? (X = 4 for women and 5 for men) (Ever in the past year considered positive.)

Refer to the Inclusion Guidelines for examples of commonly used validated screening tools; note that the CAGE, although a validated tool, is not recommended for this measure set.

If there is documentation in the medical record indicating the patient drinks alcohol and conflicting documentation indicating the patient does not drink alcohol, select Value "6" since alcohol use status is unable to be determined.

**EXCEPTION:**

If there is documentation of a validated questionnaire for alcohol screening completed within the first day of admission, select the appropriate Value 1 or 2 regardless of conflicting documentation.

When there is conflicting information in the record with regard to risk, for instance, the results from a validated screening tool are documented as both low AND moderate/high risk, select Value "2" indicating the highest risk.

Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the

impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).

If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis, e.g., hallucinating, non-communicative, catatonic, etc., must also be documented for the patient to be considered cognitively impaired.

If there is documentation to “rule out” a condition/diagnosis related to cognitive impairment, Value “7” cannot be selected unless there is documentation of symptoms.

**Examples:**

- Patient actively hallucinating, rule out psychosis. (Select Value “7”).
- Rule out psychosis. (Cannot select Value “7”).

If there is documentation within the first day of admission (by end of Day 1) of any of the examples below, select Value “7” regardless of conflicting documentation.

**Examples** of cognitive impairment include:

- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Cognitive impairment due to acute substance use, overdose, acute intoxication
- Confused
- Dementia
- Intubation and patient is intubated through the end of Day 1
- Memory loss
- Mentally handicapped
- Obtunded
- Psychotic/psychosis with documented symptoms
- Sedation

Documentation of cognitive impairment overrides documentation of an alcohol use screen and therefore would not be considered "conflicting documentation." Even if the family or others tell staff the patient uses alcohol, the patient could not be appropriately screened and subsequently counseled due to cognitive impairment. Select Value “7.”

**Suggested Data Sources:**

- Consultation notes
- Emergency department record
- History and physical
- Nursing admission assessment
- Nursing Admission Notes
- Physician Progress Notes

**Guidelines for Abstraction:**

Inclusion	Exclusion
<p>Validated Screening Tools for Unhealthy Alcohol Use: This list is not ALL Inclusive</p> <ul style="list-style-type: none"><li>• AUDIT</li><li>• AUDIT-C</li><li>• ASSIST</li><li>• CRAFFT</li><li>• G-MAST</li><li>• MAST</li><li>• TWEAK</li></ul>	<p>Any tool which specifically screens for alcohol use disorder, alcohol dependency or alcohol abuse. Examples include, but are not limited to:</p> <ul style="list-style-type: none"><li>• CAGE</li><li>• SASSI</li><li>• S2BI</li></ul>



**Data Element Name:** Birth Weight

**Collected For:** NEWB-3

**Definition:** The weight (in grams) of a newborn at the time of delivery.

**Note:**

453.5 grams = 1 pound

28.35 grams = 1 ounce

It is recommended to enter birth weight in either grams or pounds. However, all birth weights must be converted to grams prior to indicator calculation.

**Suggested Data Collection Question:**

What was the weight of the newborn at delivery?

**Format:**

**Length:** 4 or UTD

**Type:** Alphanumeric

**Occurs:** 1

**Allowable Values:**

150 through 8165 grams

UTD = Unable to Determine

**Note:** When converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams. Round to the nearest whole number after the conversion to grams.

**Notes for Abstraction:**

Newborns with birth weights less than 150 grams need to be verified that the baby has live born and for data quality purposes. Birth weights greater than 8165 grams need to be verified for data quality. Abstractors should review all of the suggested data sources to verify the accuracy of the data.

If the birth weight is unable to be determined from medical record documentation, enter "UTD".

The medical record must be abstracted as documented (taken at "face value"). When the value documented is not a valid number/value per the definition of this data element **and** no other documentation is found that provides this information, the abstractor should select "UTD."

Example:

Documentation indicates the *Birth Weight* was 0 grams. No other documentation in the medical record provides a valid value. Since the *Birth Weight* is not a valid value, the abstractor should select "UTD."

The NICU admission assessment or notes should be reviewed first for the birth weight. In the absence of admission to the NICU, the delivery record or operating room record should be reviewed next for the birth weight. In cases where there is conflicting data, use the document recording the birth weight closest to the time of delivery.

It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below.

For newborns received into the hospital as a transfer, the admission birth weight may be used if the original birth weight is not available.

If the birth weight is recorded in pounds and ounces and also in grams, abstract the value for grams.

- Suggested Data Sources:** In Order of Priority:
- NICU admission assessment or notes
  - Delivery record
  - Operating room record
  - History and physical
  - Nursing notes
  - Nursery record
  - Physician progress notes

**Additional Notes:**

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** Birthdate

**Collected For:** All MassHealth Records

**Definition:** The month, day, and year the patient was born.

NOTE: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate*. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.

**Suggested Data**

**Collection Question:** What is the patient's date of birth?

**Format:**

Length:	10 – MM-DD-YYYY (includes dashes)
Type:	Date
Occurs:	1

**Allowable Values:**

MM	=	Month (01-12)
DD	=	Day (01-31)
YYYY	=	Year (1907 – Current Year)

**Notes for Abstraction:** Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

**Suggested Data Sources:**

- Emergency department record
- Face sheet
- Registration form
- UB-04

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** Brief Intervention

**Collected For:** SUB-2

**Definition:** A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional or trained peer support person, following a positive screen for unhealthy alcohol use. The intervention includes motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at risk as well as a vehicle for engaging those in need of more extensive levels of care.

A brief intervention focuses on increasing the patient's understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

**Suggested Data Collection Question:** Did patients with a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence) receive a brief intervention prior to discharge?

**Format:**  
**Length:** 1  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:**

- 1 The patient received the components of a brief intervention
- 2 The patient refused/declined the brief intervention
- 3 Brief counseling was not offered to the patient during the hospital stay or Unable to Determine (UTD) if a brief intervention was provided from medical record documentation

**Notes for Abstraction:**

A qualified healthcare professional may be defined as a physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention.

A peer support person who has received specialized training in brief intervention may perform the brief intervention in lieu of a qualified healthcare professional.

If there is no documentation that a brief intervention was given to the patient, select value 3

Select value “3” if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if the intervention meets the intent of the measures.

A brief intervention includes, at a minimum, the following three components:

- Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
- Feedback linking alcohol use and health, including:
  - Personalized feedback (i.e., explaining how alcohol use can interact with patient’s medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])
  - OR
  - General feedback on health risks associated with drinking.
- Advice:
  - To abstain (if there are contraindications to drinking)
  - OR
  - To drink below recommended limits (specified for patient).

**Suggested Data Sources:**

Consultation notes  
Nursing notes  
Progress notes  
Physician Progress Notes

**Additional Notes:****Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

<b>Data Element Name:</b>	Comfort Measures Only
<b>Collected For:</b>	SUB-2, SUB-3
<b>Definition:</b>	Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).
<b>Suggested Data Collection Question:</b>	When is the earliest physician/APN/PA documentation of comfort measures only?
<b>Format:</b>	Length: 1 Type: Alphanumeric Occurs: 1
<b>Allowable Values:</b>	<p>1 Day 0 or 1: The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).</p> <p>2 Day 2 or after: The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).</p> <p>3 Timing unclear: There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.</p> <p>4 Not Documented/UTD: There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.</p>
<b>Notes for Abstraction:</b>	<p><b>Only accept terms identified in the list of inclusions. No other terminology will be accepted.</b></p> <p>Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:</p> <ul style="list-style-type: none"> <li>○ Comfort measures only recommendation</li> <li>○ Order for consultation or evaluation by a hospice care service</li> <li>○ Patient or family request for comfort measures only</li> <li>○ Plan for comfort measures only</li> <li>○ Referral to hospice care service</li> <li>○ Discussion of comfort measures</li> </ul> <p>Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value "1," "2," or "3" accordingly.</p> <p>Examples:        "Discussed comfort care with family on arrival" noted in day 2 progress note — Select "2."</p> <p>State-Authorized Portable Orders (SAPOs).</p> <ul style="list-style-type: none"> <li>○ SAPOs are specialized forms or identifiers authorized by state law that translate a patient's preferences about specific end-of-life treatment decisions into portable medical orders</li> </ul>

## Examples:

- DNR-Comfort Care form
  - MOLST (Medical Orders for Life-Sustaining Treatment)
  - POLST (Physician Orders for Life-Sustaining Treatment)
  - Out-of-Hospital DNR (OOH DNR)
- If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select value "1."
  - If a SAPO lists different options for CMO and any CMO option is checked, select value "1," "2," or "3" as applicable.
  - If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
  - For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.  
Example:  
Patient has a POLST dated prior to arrival in his chart and ED physician states in current record "Patient is refusing comfort measures, wants to receive full treatment and be a full code."

Documentation of an inclusion term in the following situations should be **disregarded**. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the **ONLY** documentation found is an inclusion term in the following situations, select value "4."

- Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.  
Examples:
  - Comfort measures only order in previous hospitalization record
  - "Pt. on hospice at home" in MD ED note.
- Inclusion term clearly described as negative or conditional.  
Examples:
  - "No comfort care"
  - "Not appropriate for hospice care"
  - "Comfort care would also be reasonable - defer decision for now"
  - "DNRCCA" (Do Not Resuscitate — Comfort Care Arrest)
  - "Family requests comfort measures only should the patient arrest."
- Documentation of "CMO" should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., "hx dilated CMO" — Cardiomyopathy context).

If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value "1," "2," or "3" for this data element.

## Examples:

- Physician documents in progress note on day 1 "The patient has refused Comfort Measures" AND then on day 2 the physician writes an order for a Hospice referral. Select value "2."

- ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select value “1.”

**Suggested Data Sources:****PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTBLE SOURCES:**

- Consultation notes
- Discharge summary
- DNR/MOLST/POLST forms
- Emergency department record
- History and physical
- Physician orders
- Progress notes

**Excluded Data Sources:**

Restraint order sheet

**Guidelines for Abstraction:**

Inclusion	Exclusion
Brain dead Brain death Comfort care Comfort focused treatment Comfort measures Comfort measures only (CMO) Comfort only Compassionate extubation DCD DNR-CC Donation after Cardiac Death Donation after Circulatory Death End of life care Hospice Hospice care Organ harvest Terminal care Terminal extubation	None



<b>Data Element Name:</b>	Discharge Date		
<b>Collected For:</b>	All MassHealth Records		
<b>Definition:</b>	The month, day, and year the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.		
<b>Suggested Data Collection Question:</b>	What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?		
<b>Format:</b>	<b>Length:</b>	10 – MM-DD-YYYY (includes dashes)	
	<b>Type:</b>	Date	
	<b>Occurs:</b>	1	
<b>Allowable Values:</b>	MM	=	Month (01-12)
	DD	=	Day (01-31)
	YYYY	=	Year (20xx)
<b>Notes for Abstraction:</b>	Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.		
<b>Suggested Data Sources:</b>	<ul style="list-style-type: none"> <li>• Face sheet</li> <li>• Progress notes</li> <li>• Physician orders</li> <li>• Discharge summary</li> <li>• Nursing discharge notes</li> <li>• Transfer note</li> <li>• UB-04</li> </ul>		

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	Discharge Disposition
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	The final place or setting to which the patient was discharged on the day of discharge.
<b>Suggested Data Collection Question:</b>	What was the patient's discharge disposition on the day of discharge?
<b>Format:</b>	Length: 1 Type: Alphanumeric Occurs: 1
<b>Allowable Values:</b>	1 Home  2 Hospice- Home  3 Hospice- Health Care Facility.  4 Acute Care Facility  5 Other Health Care Facility  6 Expired  7 Left Against Medical Advice / AMA  8 Not Documented or Unable to Determine (UTD)

**Notes for Abstraction:**

**Only use documentation written on the day prior to discharge through 30 days after discharge** when abstracting this data element.

**Example:**

Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5" (Other Health Care Facility).

The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.

If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.

**Examples:**

- Discharge summary dictated 2 days after discharge states patient went "home". Physician note on day of discharge further clarifies that the patient will be going home with hospice". Select value "2" ("Hospice - Home").
- Discharge planner note from day before discharge states "XYZ Nursing Home". Discharge order from day of discharge states "Discharge home". Contradictory documentation, use latest. Select value "1" ("Home").
- Physician order on discharge states "Discharge to ALF". Discharge instruction sheet completed after the physician order states patient discharged to "SNF".

Contradictory documentation, use latest. Select value “5” (“Other Health Care Facility”).

If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.

- Acute Care Facility
- Hospice — Health Care Facility
- Hospice — Home
- Other Health Care Facility
- Home

Hospice (values “2” and “3”) includes discharges with hospice referrals and evaluations.

If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value “4” (“Acute Care Facility”).

If the patient is being discharged to assisted living care or an assisted living facility (ALF) that is located within a skilled nursing facility, and documentation in the medical record also includes nursing home, intermediate care or skilled nursing facility, select Value “1” (“Home”).

If the medical record states the patient is being discharged to nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value “5” (“Other Health Care Facility”).

If the medical record identifies the facility the patient is being discharged to by name only (e.g., “Park Meadows”), and does not reflect the type of facility or level of care, select value “5” (“Other Health Care Facility”).

If the medical record states only that the patient is being “discharged” and does not address the place or setting to which the patient was discharged, select value “1” (“Home”).

When determining whether to select value “7” (“Left Against Medical Advice/AMA”):

- Explicit “left against medical advice” documentation is not required. E.g., “Patient is refusing to stay for continued care” — Select value “7”.
- Documentation suggesting that the patient left before discharge instructions could be given does not count.
- A signed AMA form is not required for the purposes of this data element.
- Do not consider AMA documentation and other disposition documentation as “contradictory”. If any source states the patient left against medical advice, select value “7”, regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states “Discharged home with belongings” — Select “7”.

For NEWB-3 only:

Hospitals are encouraged to utilize a data source that reduces unnecessary medical record review e.g., using vital records, delivery logs or clinical information systems as a data source. Mapping from electronic administrative sources to the allowable values is acceptable.

If a newborn is transferred to another acute care facility for purposes other than medical treatment or the need for a higher level of care, and mother and baby remain together, abstract allowable value 8. Examples include transfers:

- To another facility covered by their health plan
- For disaster evacuation
- Full census

Suggested Data Sources:

- Consultation notes
- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Discharge planning notes
- Discharge summary
- Nursing discharge notes
- Social service notes
- Transfer record

Excluded Data Source: Any documentation prior to the last two days of hospitalization.  
Guidelines for Abstraction:

Inclusion	Exclusion
<p>For Value 1:</p> <ul style="list-style-type: none"> <li>Assisted Living Facilities (ALFs)- includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities</li> <li>Court/Law Enforcement- includes detention facilities, jails, prison</li> <li>Home- includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters</li> <li>Home with Home Health Services</li> <li>Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization</li> </ul> <p>For Value 2:</p> <ul style="list-style-type: none"> <li>Hospice in the home (or other “Home” setting as above in Value 1)</li> </ul> <p>For Value 3:</p> <ul style="list-style-type: none"> <li>Hospice- General Inpatient and Respite</li> <li>Hospice- Residential and Skilled Facilities</li> <li>Hospice- Other Health Care Facilities</li> </ul> <p>For Value 4:</p> <ul style="list-style-type: none"> <li>Acute Short Term General and Critical Access Hospitals</li> <li>Cancer and Children’s Hospitals</li> <li>Department of Defense and Veteran’s Administration Hospitals</li> </ul> <p>For Value 5:</p> <ul style="list-style-type: none"> <li>Extended or Immediate Care Facility (ECF/ICF)</li> <li>Long Term Acute Care Hospital (LTACH)</li> <li>Nursing Home or Facility including Veteran’s Administration Nursing Facility</li> <li>Psychiatric Hospital or Psychiatric Unit of a Hospital</li> <li>Rehabilitation Facility including but not limited to: Inpatient Rehabilitation Facility/ Hospital, Rehabilitation Unit of a Hospital, Chemical Dependency/Alcohol Rehabilitation Facility</li> <li>Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed</li> <li>Transitional Care Unit (TCU)</li> <li>Veterans Home</li> </ul>	None

**Data Element Name:** Episode of Care

**Collected For:** All MassHealth Records

**Definition:** The measure code for the data that is being submitted.

**Suggested Data**

**Collection Question:** What is the measure code for the data being submitted?

**Format:**

<b>Length:</b>	22
<b>Type:</b>	Alphanumeric
<b>Occurs:</b>	1

**Allowable Values:**

MAT-4	Cesarean Delivery
NEWB-3	Unexpected Complications in Term Newborns
SUB	Substance Use Treatment (SUB-2, SUB-3)

**Notes for Abstraction:** None

**Suggested Data Sources:** Not Applicable

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** First Name

**Collected For:** All MassHealth Records

**Definition:** The patient's first name.

**Suggested Data Collection Question:** What is the patient's first name?

**Format:** Length: 30  
Type: Alphanumeric  
Occurs: 1

**Allowable Values:** Enter the patient's first name.

**Notes for Abstraction:** None

**Suggested Data Sources:** Emergency department record  
Face sheet  
History and physical

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

**Data Element Name:** Gestational Age

**Collected For:** MAT-4

**Definition:** The weeks of gestation completed at the time of delivery.

Gestational age is defined as the best obstetrical estimate (OE) of the newborn's gestation in completed weeks based on the birth attendant's final estimate of gestation, irrespective of whether the gestation results in a live birth or a fetal death. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the newborn exam. Ultrasound taken early in pregnancy is preferred (source: American College of Obstetricians and Gynecologists reVITALize Initiative).

**Suggested Data**

**Collection Question:** How many weeks of gestation were completed at the time of delivery?

**Format:**

Length:	3 or UTD
Type:	Alphanumeric
Occurs:	1

**Allowable Values:** 1-50  
UTD= Unable to Determine

**Notes for Abstraction:** Gestational age should be rounded off to the nearest completed week, not the following week.

- For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.

Gestational age should be documented by the clinician as a numeric value between 1-50. Gestational age (written with both weeks and days, eg. 39 weeks and 0 days) is calculated using the best obstetrical Estimated Due Date (EDD) based on the following formula:

- $\text{Gestational Age} = (280 - (\text{EDD} - \text{Reference Date})) / 7$  (source: American College of Obstetricians and Gynecologists reVITALize Initiative).

The clinician, not the abstractor, should perform the calculation to determine gestational age.

The delivery or operating room record should be reviewed first for gestational age; documentation of a valid number should be abstracted.

If the gestational age in the delivery or operating room record is missing, obviously incorrect (in error, e.g. 3.6), or there is conflicting data, then continue to review the following data sources, starting with the document completed closest to or at the time of the delivery until a positive finding for gestational age is found:

- History and physical
- Clinician admission progress note
- Prenatal forms

Gestational age documented closest to or at the time of delivery (not including the newborn exam) should be abstracted.

The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

If no gestational age was documented (e.g. the patient has not received prenatal care), select allowable value UTD.

Documentation in the acceptable data sources may be written by the following clinicians:

- Physician
- Certified nurse midwife (CNM)
- Advanced practice nurse/physician assistant (APN/PA)
- Registered nurse (RN)

It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.

The EHR takes precedence over a handwritten entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:

- Delivery or Operating room record, note or summary
- History and physical
- Admission clinician progress notes
- Prenatal forms

Guidelines for Abstraction:

Inclusion	Exclusion
None	None



**Data Element Name:** Hispanic Ethnicity

Collected For: All MassHealth Records

Definition: Documentation that the patient is of Hispanic, Latino, or Spanish ethnicity.

Suggested Data Collection Question: Is the patient of Hispanic, Latino, or Spanish Ethnicity?

Format: Length: 1  
Type: Character  
Occurs: 1

Allowable Values: Y (Yes) Patient is of Hispanic, Latino, or Spanish ethnicity.  
N (No) Patient is not of Hispanic, Latino, or Spanish ethnicity or unable to determine from medical record documentation.

Notes for Abstraction: The data element, Race, is required in addition to this data element.

Suggested Data Sources: Emergency Department Record  
History and Physical  
Face sheet  
Nursing admission assessment  
Progress notes

## Guidelines for Abstraction:

Inclusion	Exclusion
<u>A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."</u> <u>Examples:</u> <u>Black-Hispanic</u> <u>Chicano</u> <u>Columbian</u> <u>Dominican</u> <u>Ecuadorian</u> <u>Guatemalan</u> <u>H</u> <u>Hispanic</u> <u>Latin American</u> <u>Latino/Latina</u> <u>Mexican-American</u> <u>Salvadorian</u> <u>Spaniard</u> <u>Spanish</u> <u>White-Hispanic</u>	None

<b>Data Element Name:</b>	ICD-10-CM Other Diagnosis Codes
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	The other or secondary ICD-10-CM codes associated with the diagnosis for this hospitalization.
<b>Suggested Data Collection Question:</b>	What were the ICD-10-CM other diagnosis codes selected for this medical record?
<b>Format:</b>	Length: 3-7 (without decimal point or dot) Type: Character (upper or lower case) Occurs: 24
<b>Allowable Values:</b>	Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order): <a href="https://www.cms.gov/Medicare/Coding/ICD10/index.html">https://www.cms.gov/Medicare/Coding/ICD10/index.html</a>
<b>Notes for Abstraction:</b>	None
<b>Suggested Data Sources:</b>	Discharge summary Face sheet UB-04

## Guidelines for Abstraction:

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	ICD-10-PCS Other Procedure Codes
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	The other or secondary ICD-10-PCS codes identifying all significant procedures other than the principal procedure.
<b>Suggested Data Collection Question:</b>	What were the ICD-10-PCS code(s) selected as other procedure(s) for this record?
<b>Format:</b>	Length: 3-7 (without decimal point or dot) Type: Character (upper or lower case) Occurs: 24
<b>Allowable Values:</b>	Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles): <a href="https://www.cms.gov/Medicare/Coding/ICD10/index.html">https://www.cms.gov/Medicare/Coding/ICD10/index.html</a>
<b>Notes for Abstraction:</b>	None
<b>Suggested Data Sources:</b>	Discharge summary Face sheet UB-04

## Guidelines for Abstraction:

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	ICD-10-PCS Other Procedure Dates
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	The month, day, and year when the associated procedure(s) was (were) performed.
<b>Suggested Data Collection Question:</b>	What were the date(s) the other procedure(s) were performed?
<b>Format:</b>	Length: 10 – MM-DD-YYYY (includes dashes) or UTD Type: Character Occurs: 24
<b>Allowable Values:</b>	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2001 – Current Year) UTD = Unable to Determine
<b>Notes for Abstraction:</b>	<p>If the procedure date for the associated procedure is unable to be determined from the medical record, select “UTD.”</p> <p>The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not valid format/range or outside of the parameters of care [after <i>Discharge Date</i>]) and no other documentation is found that provides this information, the abstractor should select “UTD.”</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>Documentation indicates the ICD-10-PCS Other Procedure Dates was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the ICD-10-PCS Other Procedure Dates is outside of the range listed in the Allowable Values for “Day”, It is not a valid date and the abstractor should select “UTD”</li> <li>Patient expires on 02-12-20xx and documentation indicates the ICD-10-PCS Other Procedure Dates was 03-12-20xx. Other documentation in the medical records supports the date of death as being accurate. Since the ICD-10-PCS Other Procedure Dates is after the Discharge Date (death), it is outside of the parameters of care and abstractor should select “UTD”</li> </ul>
<b>Suggested Data Sources:</b>	Consultation notes Diagnostic test reports Discharge summary Face sheet Operative notes Procedure notes Progress notes UB-04

## Guidelines for Abstraction:

Inclusion	Exclusion
None	None

<b>Data Element Name:</b>	ICD-10-CM Principal Diagnosis Code		
<b>Collected For:</b>	All MassHealth Records		
<b>Definition:</b>	The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.		
<b>Suggested Data Collection Question:</b>	What was the ICD-10-CM code selected as the principal diagnosis for this record?		
<b>Format:</b>	<b>Length:</b>	3-7 (without decimal point or dot)	
	<b>Type:</b>	Character (upper or lower case)	
	<b>Occurs:</b>	1	
<b>Allowable Values:</b>	Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order): <a href="https://www.cms.gov/Medicare/Coding/ICD10/index.html">https://www.cms.gov/Medicare/Coding/ICD10/index.html</a>		
<b>Notes for Abstraction:</b>	None		
<b>Suggested Data Sources:</b>	Discharge summary Face sheet UB-04		

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	ICD-10-PCS Principal Procedure Code
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.
<b>Suggested Data Collection Question:</b>	What was the ICD-10-PCS code selected as the principal procedure for this record?
<b>Format:</b>	Length: 3-7 (without decimal point or dot) Type: Character (upper or lower case) Occurs: 1
<b>Allowable Values:</b>	Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles): <a href="https://www.cms.gov/Medicare/Coding/ICD10/index.html">https://www.cms.gov/Medicare/Coding/ICD10/index.html</a>
<b>Notes for Abstraction:</b>	None
<b>Suggested Data Sources:</b>	Discharge summary Face sheet UB-04

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	ICD-10-PCS Principal Procedure Date
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	The month, day, and year when the principal procedure was performed.
<b>Suggested Data Collection Question:</b>	What was the date the principal procedure was performed?
<b>Format:</b>	Length: 10-MM-DD-YYYY (includes dashes) or UTD Type: Date Occurs: 1
<b>Allowable Values:</b>	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2001-Current Year) UTD = Unable to Determine
<b>Notes for Abstraction:</b>	<p>If the principal procedure date is unable to be determined from medical record documentation, select "UTD."</p> <p>The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid date/format or is outside of the parameters of care [after Discharge Date]) and no other documentation is found that provides this information, the abstractor should select "UTD."</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>Documentation indicates the ICD-10-PCS Principal Procedure Date was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the ICD-10-PCS Principal Procedure Date is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD"</li> <li>Patient expires on 02-12-20xx and documentation indicates the ICD-10-PCS Principal Procedure Date was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the ICD-10-PCS Principal Procedure Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select "UTD".</li> </ul>
<b>Suggested Data Sources:</b>	Consultation notes Diagnostic test reports Discharge summary Face sheet Operative notes Procedure notes Progress notes UB-04

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

**Data Element Name:** Last Name

**Collected For:** All MassHealth Records

**Definition:** The patient's last name.

**Suggested Data Collection Question:** What is the patient's last name?

**Format:** Length: 60  
Type: Alphanumeric  
Occurs: 1

**Allowable Values:** Enter the patient's last name.

**Notes for Abstraction:** None

**Suggested Data Sources:** Emergency department record  
Face sheet  
History and physical

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None



<b>Data Element Name:</b>	MassHealth Member ID
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	The patient's MassHealth Member ID.
<b>Suggested Data Collection Question:</b>	What is the patient's MassHealth Member ID?
<b>Format:</b>	Length: 20 Type: Alphanumeric Occurs: 1
<b>Allowable Values:</b>	Any valid MassHealth Member ID number Alpha characters must be upper case No embedded dashes or spaces or special characters
<b>Notes for Abstraction:</b>	<p>The Provider Regulations define a valid MassHealth Member ID as a twelve (12) digit number that contains numeric characters only. This 12 digit member ID number applies to members enrolled within various Medicaid managed care or fee-for-service insurance programs.</p> <p>However, some MassHealth managed care insurance plans may issue different MassHealth member ID numbers that use alphanumeric type and exceed the 12 digit numeric requirement. For the purposes of measures reporting the "format length" was expanded to 20 fields within the portal environment only. This portal edit allows data files that may exceed the 12 characters to not be rejected by the portal. The change in the portal environment <b>does not</b> constitute a change to existing MassHealth Provider Regulation definitions of member ID number.</p> <p>Once a member is assigned a MassHealth ID number it will not change through the duration of their enrollment or if they change managed care plans (e.g.: coverage changed from fee-for-service to an MCO plan). Member ID numbers can be verified using the on-line Eligibility Verification System (EVS) at:</p> <p><a href="https://www.mass.gov/how-to/eligibility-verification-for-providers">https://www.mass.gov/how-to/eligibility-verification-for-providers</a>. EVS provides historical data on a member for any given point in time that can be reviewed by entering a particular date of service.</p> <p>The abstractor should NOT assume that their hospital's claim information for the patient's MassHealth Member ID number is correct. If the abstractor determines through chart review that the MassHealth Member ID number is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.</p>
<b>Suggested Data Sources:</b>	Emergency department record Face sheet

## Guidelines for Abstraction:

Inclusion	Exclusion
None	None

**Data Element Name:** National Provider ID

**Collected For:** All MassHealth Records

**Definition:** The provider's ten digit national provider identifier.

**Suggested Data**

**Collection Question:** What is the provider's ten digit national provider identifier?

**Format:**

Length:	10
Type:	Alphanumeric
Occurs:	1

**Allowable Values:** Any valid ten digit national provider ID.

**Notes for Abstraction:** Hospitals must submit either their valid Medicare or Medicaid Provider ID or their National Provider ID for all MassHealth measure files.

**Suggested Data Sources:** Administrative record

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** Patient Identifier

**Collected For:** All MassHealth Records

**Definition:** The identification number used by the Hospital to identify this patient.

**Suggested Data Collection Question:** What is the patient's hospital patient identification number?

**Format:**

Length:	40
Type:	Alphanumeric
Occurs:	1

**Allowable Values:** Up to 40 letters and / or numbers

**Notes for Abstraction:** When abstracting this data element for a clinical measure file, the data in this field must match the hospital patient ID number submitted in the corresponding crosswalk file.

**Suggested Data Sources:** Administrative record  
Face sheet

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

<b>Data Element Name:</b>	Payer Source																																																		
<b>Collected For:</b>	All MassHealth Records																																																		
<b>Definition:</b>	<p>The definition of Medicaid payer source as defined by the Massachusetts regulations noted in Section 2 of the RY23 EOHHS manual.</p> <p>The definition of the Medicaid payer source data element differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.</p>																																																		
<b>Suggested Data Collection Question:</b>	What is the patient's primary source of Medicaid payment for care provided?																																																		
<b>Format:</b>	<p>Length: 3</p> <p>Type: Alphanumeric</p> <p>Occurs: 1</p>																																																		
<b>Allowable Values:</b>	<p>Payment source code values assigned by Massachusetts regulations include:</p> <table> <tr><td>103</td><td>MassHealth FFS Network, MassHealth Limited Plans</td></tr> <tr><td>103</td><td>Primary Care Clinician Management (PCCM) Plan</td></tr> <tr><td>118</td><td>Medicaid Managed Care: Massachusetts Behavioral Health Partnership</td></tr> <tr><td>103</td><td>Medicaid Managed Care: Other (not listed elsewhere)</td></tr> <tr><td>288</td><td>Medicaid Managed Care: WellSense Health Plan</td></tr> <tr><td>7</td><td>Medicaid Managed Care: Tufts Health Plan</td></tr> <tr><td>311</td><td>Medicaid Other ACO</td></tr> <tr><td>4</td><td>Fallon Health-Atrius Health Care Collaborative</td></tr> <tr><td>4</td><td>Berkshire Fallon Health Collaborative</td></tr> <tr><td>4</td><td>Fallon 365 Care</td></tr> <tr><td>24</td><td>Be Healthy Partnership with Health New England</td></tr> <tr><td>288</td><td>East Boston Neighborhood Health WellSense Alliance</td></tr> <tr><td>288</td><td>WellSense Beth Israel Lahey Health (BILH) Performance Network ACO</td></tr> <tr><td>288</td><td>WellSense Boston Children's ACO</td></tr> <tr><td>288</td><td>WellSense Care Alliance</td></tr> <tr><td>288</td><td>WellSense Community Alliance</td></tr> <tr><td>288</td><td>WellSense Mercy Alliance</td></tr> <tr><td>288</td><td>WellSense Signature Alliance</td></tr> <tr><td>288</td><td>WellSense Southcoast Alliance</td></tr> <tr><td>320</td><td>Community Care Cooperative</td></tr> <tr><td>322</td><td>Mass General Brigham Health Plan with Mass General Brigham ACO</td></tr> <tr><td>323</td><td>Steward Health Choice (ACO)</td></tr> <tr><td>7</td><td>Tufts Health Together with UMass Memorial Health</td></tr> <tr><td>7</td><td>Tufts Health Together with Cambridge Health Alliance</td></tr> <tr><td>328</td><td>Tufts Medicine (ACO)</td></tr> </table>	103	MassHealth FFS Network, MassHealth Limited Plans	103	Primary Care Clinician Management (PCCM) Plan	118	Medicaid Managed Care: Massachusetts Behavioral Health Partnership	103	Medicaid Managed Care: Other (not listed elsewhere)	288	Medicaid Managed Care: WellSense Health Plan	7	Medicaid Managed Care: Tufts Health Plan	311	Medicaid Other ACO	4	Fallon Health-Atrius Health Care Collaborative	4	Berkshire Fallon Health Collaborative	4	Fallon 365 Care	24	Be Healthy Partnership with Health New England	288	East Boston Neighborhood Health WellSense Alliance	288	WellSense Beth Israel Lahey Health (BILH) Performance Network ACO	288	WellSense Boston Children's ACO	288	WellSense Care Alliance	288	WellSense Community Alliance	288	WellSense Mercy Alliance	288	WellSense Signature Alliance	288	WellSense Southcoast Alliance	320	Community Care Cooperative	322	Mass General Brigham Health Plan with Mass General Brigham ACO	323	Steward Health Choice (ACO)	7	Tufts Health Together with UMass Memorial Health	7	Tufts Health Together with Cambridge Health Alliance	328	Tufts Medicine (ACO)
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7	Tufts Health Together with Cambridge Health Alliance																																																		
328	Tufts Medicine (ACO)																																																		
<b>Notes for Abstraction:</b>	<p>As noted in Section 2.B.1 (Table 2.1) in the RY23 EOHHS manual is a revised list of included and excluded Medicaid payer codes resulting from Affordable Care Act requirements apply. The Massachusetts regulations outline the payer data reporting definitions and codes for Medicaid payment sources required when preparing MassHealth data files for submission.</p> <p>Primary source of payment is a MassHealth insurance program:</p> <ul style="list-style-type: none"> <li>• If Medicaid is the only payer listed (see payer codes above);</li> </ul>																																																		

- If Medicaid is primary and another secondary insurance is listed.

Primary source of payment is NOT a MassHealth insurance program:

- If Medicare is the only payer listed;
- If Medicare is primary and lists Medicaid as secondary (ex: dual eligible)
- If HMO/Commercial Plan is primary and lists Medicaid as secondary (TPL)

Suggested Data Sources:

Face sheet (Emergency Department / Inpatient)

UB-04, file location, 50A, B, C

MassHealth Eligibility Verification System (EVS)

<http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/eligibility-verification/>

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

<b>Data Element Name:</b>	Prescription for Alcohol or Drug Disorder Medication
<b>Collected For:</b>	SUB-3
<b>Definition:</b>	Documentation that an FDA-approved medication for alcohol or drug disorder was prescribed at hospital discharge.
<b>Suggested Data Collection Question:</b>	Was one of the FDA approved medications for alcohol or drug disorder prescribed at discharge?
<b>Format:</b>	Length: 1 Type: Alphanumeric Occurs: 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"> <li>1. A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge</li> <li>2. A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused</li> <li>3. The patient: <ul style="list-style-type: none"> <li>- is being discharged to a residence outside the USA</li> <li>- is released to a court hearing and does not return</li> <li>- is being discharged to jail/law enforcement</li> </ul> </li> <li>4. A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge; or unable to determine from medical record documentation.</li> </ol>
<b>Notes for Abstraction:</b>	<p>In determining whether a medication for alcohol or drug disorder was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Disulfiram but this is not included in any of the other discharge medications sources, e.g., discharge orders. All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.</p> <p>In cases where there is a medication for alcohol or drug disorder in one source and it is not mentioned on other sources, it should be interpreted as a discharge medication, select value "1" unless documentation elsewhere in the medical record suggests that it was not prescribed at discharge.</p> <p>If documentation is contradictory (physician noted "d/c Antabuse" or "hold Antabuse" in the discharge orders, but Antabuse is listed in the discharge summary's discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed unable to determine, select value "4"</p> <p>If the patient does not have a residence in the USA, Value "3" must be selected.</p>
<b>Suggested Data Sources:</b>	Discharge summary Transfer sheet Discharge Instruction Sheet

Medication Reconciliation Form  
Nursing Discharge notes  
Physician Order Sheets

**Guidelines for Abstraction:**

Inclusion	Exclusion
Refer to Appendix C, Table 9.2 for a comprehensive list of FDA-approved medications for alcohol and drug dependence	None

<b>Data Element Name:</b>	Previous Births
<b>Collected For:</b>	MAT-4
<b>Definition:</b>	Documentation that the patient experienced a birth $\geq 20$ weeks gestation regardless of the outcome (i.e. parity $> 0$ ) prior to the current hospitalization.
<b>Suggested Data Collection Question:</b>	Did the patient experience a birth prior to current hospitalization?
<b>Format:</b>	Length: 1 Type: Alphanumeric Occurs: 1
<b>Allowable Values:</b>	<p>Y (Yes) There is documentation that the patient experienced one or more births prior to the current hospitalization.</p> <p>N (No) There is no documentation that the patient experienced one or more births prior to the current hospitalization OR unable to determine from medical record documentation.</p>
<b>Notes for Abstraction:</b>	<p>The delivery or operating room record should be reviewed first for documentation of parity greater than zero. If documentation of parity greater than zero is not present or is conflicting in the delivery or operating room record, then continue to review the acceptable data sources in the following order: history and physical, clinician admission progress note, prenatal forms, and discharge summary until a positive finding for parity greater than zero is found.</p> <p>If there is conflicting documentation throughout the acceptable sources and it cannot be determined from the medical record if there were previous births, select No.</p> <p>Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).</p> <p>It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the Only Acceptable Sources listed below.</p> <p>In the absence of parity, documentation that the patient experienced a previous birth <math>\geq 20</math> weeks gestation regardless of the outcome may be used. If the number for parity documented is "one" and includes the delivery for the current hospitalization, do not include the current delivery to determine previous births.</p> <p>A string of three or more numbers without the alpha designation of "p" preceding the second number cannot be used to determine parity. Example: 321 When GTPAL terminology is documented, G= Gravida, T= Term, P= Preterm, A= Abortions, L= Living, P does not equal parity.</p>
<b>Suggested Data Sources:</b>	<p><b>ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE</b></p> <ul style="list-style-type: none"> <li>• Delivery or Operating room record, note or summary</li> </ul>



- History and physical
- Admission clinician progress note
- Prenatal forms
- Discharge summary

## Guidelines for Abstraction:

Inclusion	Exclusion
Select Yes: <ul style="list-style-type: none"><li>• Number of previous births is greater than 0</li><li>• Parity is greater than 0</li><li>• Term is greater than 0</li><li>• Preterm is greater than 0</li><li>• Living is greater than 0</li><li>• Documentation of multiparous</li></ul>	Select No: <ul style="list-style-type: none"><li>• Number of previous births equals 0</li><li>• Parity equals 0</li><li>• Gravidity equals 1</li><li>• Documentation of primigravida or nulliparous</li><li>• Preterm and term births equals 0</li></ul>

**Data Element Name:** Provider ID

**Collected For:** All MassHealth Records

**Definition:** The provider's ten-digit acute care Medicaid or six-digit Medicare provider.

**Suggested Data Collection Question:** What is the provider's ten-digit acute care Medicaid or six-digit Medicare ID?

**Format:**

Length:	10
Type:	Alphanumeric
Occurs:	1

**Allowable Values:** Any valid ten-digit Medicaid or six-digit Medicare provider ID.

**Notes for Abstraction:** Hospitals must submit either their valid Medicare or Medicaid Provider ID for all MassHealth measure files or crosswalk files.

**Suggested Data Sources:** Administrative record

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** Provider Name

**Collected For:** All MassHealth Records

**Definition:** The name of the provider of acute care inpatient services.

**Suggested Data**

**Collection Question:** What is the name of the provider of acute care inpatient services?

**Format:** Length: 60  
Type: Alphanumeric  
Occurs: 1

**Allowable Values:** Provider name

**Notes for Abstraction:** The provider name is the name of the hospital.

**Suggested Data Sources:** Face sheet

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

<b>Data Element Name:</b>	Race
<b>Collected For:</b>	All MassHealth Records
<b>Definition:</b>	<u>Documentation of the patient's race.</u>
<b>Suggested Data Collection Question:</b>	<u>What is the patient's race?</u>
<b>Format:</b>	Length: <u>1</u> Type: <u>Character</u> Occurs: 1
<b>Allowable Values:</b>	Select one: Code  <u>1. <b>White:</b> Patient's race is White or the patient has origins in Europe, the MiddleEast, or North Africa.</u> <u>2. <b>Black or African American:</b> Patient's race is Black or African American.</u> <u>3. <b>American Indian or Alaska Native:</b> Patient's race is American Indian/AlaskaNative.</u> <u>4. <b>Asian or Pacific Islander:</b> Patient's race is Asian/Pacific Islander.</u> <u>5. RETIRED VALUE (effective 01-01-2021).</u> <u>6. RETIRED VALUE (effective 07-01-05 discharges)</u> <u>7. <b>UTD:</b> Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).</u>
<b>Notes for Abstraction:</b>	<u>The data element Hispanic Ethnicity is required in addition to this data element.</u>  <u>If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.</u>  <u>Although the terms "Hispanic," "Latino," and "Spanish" are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic, Latino, or Spanish select "White." If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic — select "Black"). Other terms for Hispanic, Latino, or Spanish include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, and South or Central American.</u>
<b>Suggested Data Sources:</b>	<u>Emergency department record</u> <u>History and physical</u> <u>Face sheet</u> <u>Nursing admission assessment</u> <u>Progress notes</u>

## Guidelines for Abstraction:

Inclusions	Exclusion
<p><b><u>Black or African American</u></b>  <i>A person having origins in any of the black racial groups of Africa. (e.g., Jamaican, Haitian, Nigerian, Ethiopian, Somali, Negro).</i></p> <p><b><u>American Indian or Alaska Native</u></b>  <i>A person having origins in any of the original peoples of North America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and Central America, Native American).</i></p> <p><b><u>Asian or Pacific Islander</u></b>  <i>A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, the Pacific Islands, Native Hawaiian, Guam, Samoa, Thailand, and Vietnam.</i></p> <p><b><u>White</u></b>  <i>A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., German, Irish, English, Italian, Lebanese, Egyptian).</i></p>	None

<b>Data Element Name:</b>	Referral for Addictions Treatment
<b>Collected For:</b>	SUB-3
<b>Definition:</b>	Documentation that a referral was made at discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor). A referral is defined as an appointment made by the provider either through telephone contact, fax or e-mail. The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow-up for substance use or addiction treatment, or to a medical or health professional for follow-up for substance use or addiction.
<b>Suggested Data Collection Question:</b>	Was a referral for addictions treatment made for the patient prior to discharge?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"> <li>1. The referral to addictions treatment was made by the healthcare provider or health care organization at any time prior to discharge.</li> <li>2. Referral information was given to the patient at discharge, but the appointment was not made by the provider or health care organization prior to discharge.</li> <li>3. The patient refused the referral for addictions treatment and the referral was not made.</li> <li>4. The patient: <ul style="list-style-type: none"> <li>- is being discharged to a residence outside the USA</li> <li>- is released to a court hearing and does not return</li> <li>- is being discharged to jail/law enforcement</li> </ul> </li> <li>5. A referral for addictions treatment was not offered anytime prior to discharge or Unable to Determine (UTD) from the medical record documentation</li> </ol>
<b>Notes for Abstraction:</b>	<p>If a patient is referred to an addictions treatment provider that does not schedule appointments and the patient was given a specific date and time to present for addictions treatment, select Value "1."</p> <p>Value "4" should be selected if the patient:</p> <ul style="list-style-type: none"> <li>○ is being discharged to a residence outside the USA</li> <li>○ is released to a court hearing and does not return</li> <li>○ is being discharged to jail/law enforcement</li> </ul> <p>A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure. Select Value "5."</p> <p>Select Value "5" if:</p> <ul style="list-style-type: none"> <li>○ it cannot be determined that a referral for addictions treatment was made or;</li> <li>○ it is unclear that the absence of the referral was due to a patient refusal or because the referral was not offered.</li> </ul>

Suggested Data Sources:

- Discharge summary
- Transfer sheet
- Instruction Sheet
- Discharge Nursing Discharge Notes
- Physician Order Sheet

**Guidelines for Abstraction:**

Inclusion	Exclusion
Group counseling Individual counseling <ul style="list-style-type: none"><li>○ Addictions counselor</li><li>○ Personal physician</li><li>○ Psychiatrist</li><li>○ Psychologist</li></ul>	Self help interventions in the form of printed/electronic/digital media  Support groups that are not considered treatment such as Alcoholics Anonymous (AA)

<b>Data Element Name:</b>	Term Newborn
<b>Collected For:</b>	NEWB-3
<b>Definition:</b>	Documentation that the newborn was at term or $\geq 37$ completed weeks of gestation at the time of birth.
<b>Suggested Data Collection Question:</b>	Is there documentation that the newborn was at term or $\geq 37$ completed weeks of gestation at the time of birth?
<b>Format:</b>	Length: 1 Type: Alphanumeric Occurs: 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"><li>1. Y (Yes) There is documentation that the newborn was at term or <math>\geq 37</math> completed weeks of gestation at the time of birth.</li><li>2. N (No) No, there is documentation that the newborn was not at term or <math>\geq 37</math> completed weeks of gestation at the time of birth.</li><li>3. UTD, unable to determine from medical record documentation.</li></ol>
<b>Notes for Abstraction:</b>	<p>Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. Estimated gestational age (EGA) may be used to determine gestational age, including a range of numbers that are 37 weeks or greater, e.g., 37-38 weeks gestation.</p> <p>It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.</p> <p>The mother's medical record ALONE cannot be used to determine the newborn's gestational age. This documentation must appear in the newborn's medical record without using the mother's medical record to perform the abstraction even if there is a link between the mother and newborn medical records in the EHR.</p> <p>In cases when there is conflicting documentation, e.g., both term and a gestational age of 36 weeks are documented, the gestational age takes precedence.</p> <p>In cases where there are two different values documented for gestational age and one is determined by examination and the other is determined by the best obstetrical estimate (OE) based on dates, abstract the value determined by dates.</p>
<b>Suggested Data Sources:</b>	History and physical Nursing notes Nursing admission assessment Progress notes Physician's notes



## Discharge summary

## Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"><li>• Gestational age of 37 weeks or more</li><li>• Early term</li><li>• Full term</li><li>• Late term</li><li>• Post term</li><li>• Term</li></ul>	<ul style="list-style-type: none"><li>• Gestational age of 36 weeks or less</li><li>• Preterm</li><li>• Early preterm</li><li>• Late preterm</li></ul>