Utah healthcare facility data submission guide

General guidelines, file formats, record formats and layouts, and data element descriptions for submitting ambulatory surgery, emergency department, and inpatient discharge data

Version 2.1.1

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Introduction and general guidelines

Purpose

This document defines encounter types and data elements that must be reported and specifies the technical requirements for submission to the healthcare facility database. As used in this document, "encounter" means an inpatient hospital stay, an outpatient surgery or diagnostic procedure treatment, or a visit and treatment in an emergency room.

This document is effective and supersedes prior guides and manuals.

Tables in this document are also available as a spreadsheet, including an example of the file layout.

Administrative rules

General requirements related to submission of healthcare facility data can be found in Utah Administrative Code Title R428. Data suppliers are encouraged to become familiar with the requirements of the rule found online: https://rules.utah.gov/publicat/code/r428/r428.htm.

Required data sources and types

Healthcare facilities shall report ambulatory surgery data records for each outpatient surgical, or diagnostic patient treated at its facility. Covered encounters for ambulatory surgery data include surgical and diagnostic procedures that occur in:

- Hospital outpatient departments
- Hospital-affiliated ambulatory surgery centers
- Freestanding ambulatory surgery centers

All encounters are to be reported regardless of whether they were the principal procedure. Any other procedures performed at the same time as the reportable encounters must also be included.

All hospitals and freestanding emergency departments shall report emergency room data

for all emergency department patient records that indicate the patient was treated in the emergency department. Freestanding emergency department data must be submitted under a unique HCS-assigned facility ID (HFD002), separate from any parent or affiliated inpatient hospital.

All hospitals shall report healthcare facility data for each inpatient discharged from its facility.

For a patient with multiple discharges, each healthcare facility shall submit a single data record for each discharge. For a patient with multiple billing claims, each healthcare facility shall consolidate the multiple billings into a single data record for submission after the patient's discharge.

All facilities that generate only ambulatory surgery data and/or only inpatient encounter data shall submit data following the quarterly schedule outlined in Table 1 below.

All facilities that generate emergency department encounters shall submit all data—ambulatory surgery, inpatient, and emergency department encounter data — following the monthly schedule outlined in Table 2 below.

Data submission schedule

The deadlines for submitting healthcare facility data are specified in Tables 1 and 2.

For facilities required to submit data on a quarterly basis, data submissions are based on discharges occurring in a calendar quarter. If a patient has a bill generated during a quarter but has not yet been discharged by the end of the quarter, data for that stay should not be included in the quarter's data but should be included with quarterly data when the patient is discharged.

Table 1. Quarterly submission schedule

Person's date of discharge is between	**Data must be received by**
January 1 through March 31	May 15
April 1 through June 30	August 15

July 1 through September 30	November 15
October 1 through December 31	February 15 (following year)

For facilities required to submit data on a monthly basis, the following instructions apply:

As shown in the table below, each monthly submission will contain 2 months of data: a new month and an old month. The new month will be the first submission of that month's data. For this data, the facility will have had 15 days to clean-up and submit the data. The old month will be a resubmission of the prior month's data. The old data will have had 45-days for clean-up and submission. This should ensure that the final monthly data are consistent with the quarterly processing data.

Identification of month will occur based on the Statement Covers Period—Through Date (HFD026) field. For example, claims with a Statement Covers Period—Through Date between April 1, 2019 and April 30, 2019 have a month of April 2019. Prepared data with these dates of service will be submitted during the April and May monthly submissions.

The file upload process to Mercer Connect will not change.

The quarter portion of the file name will change for monthly submissions. Rather than 2019Q2 to indicate a second quarter submission, files for May 201904-201905, and June 201905-201906. This will allow the facilities, Mercer, and HCS to easily identify which months of data are submitted in each file.

Table 2. Monthly submission schedule

New month	Old month	Dates in submission	Due date	Example file name
May	April	4/1/2019–5/31/2019	June 15	000_ExampleFacility_201904-201905_20190615_1_PROD.txt
June	May	5/1/2019–6/30/2019	July 15	000_ExampleFacility_201905-201906_20190715_1_PROD.txt
July	June	6/1/2019–7/31/2019	Aug 15	000_ExampleFacility_201906-201907_20190815_1_PROD.txt

Data transfer

Each healthcare facility shall submit healthcare facility data via secure transmission method determined by HCS. Data not in compliance with these specifications will be rejected and must be resubmitted by the due date via a method that complies with these standards.

File format

Standards for text file format

All files will be formatted as standard text files complying with the following guidelines:

A. The first row of the submission file always contains the data element name for each column.
B. For encounters, always use 1 line item per row and repeat header record data elements for each line.
C. All fields are variable field length, delimited using the pipe character "|" (ASC=124). It is imperative that no pipes appear in the data itself. Alternate delimiters may be used only after review and approval by HCS.
D. Text fields are never demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data. The only exception is if an alternate delimiter is approved.
E. Numbers (ID numbers, account numbers) do not contain spaces, hyphens or other punctuation marks unless otherwise noted.
F. Text fields are never padded with leading or trailing spaces or tabs.
G. Financial fields are never padded with leading or trailing zeros.
H. Fields shall be left blank if the data are not available or not applicable unless otherwise noted. 'Blank' means do not supply any value or character at all between pipes including quotes or other characters.
I. No partial files or record replacements shall be submitted. Each file shall contain all records for a given data submission period.
J. Facilities with more than 1 data type (ambulatory surgery, emergency department, and/or inpatient) shall submit all data types within the same file. Exceptions may be made after review and approval by HCS.
K. If facilities need to submit multiple quarters of data, those quarterly files

need to be submitted separately, in other words, do not combine multiple quarters' data into one file.

File naming convention

Quarterly submissions

For each submission, the healthcare facility shall supply the following descriptive information in the name of the file, each separated by a single underscore "_":

1. HCS assigned hospital ID number
2. The name of data supplier without spaces or other separators
3. Quarter being submitted as YYYYQ#
4. Date of submission as YYYYMMDD
5. Version number if more than 1 file submitted on the same day
6. "Test" or "Prod" indicating if the file is a test or production file.
    a. "Test" should ***only*** be used while a facility is testing their data and submissions and that data file will not be used for production. After the testing is complete, 'Prod' must be used in the file name.

Example: 001_HOSPITALNAME_2017Q2_20170815_1_PROD.txt

Monthly submissions

For each submission, the healthcare facility shall supply the following descriptive information in the name of the file, each separated by a single underscore "_":

1. HCS assigned hospital ID number
2. The name of data supplier without spaces or other separators
3. The month(s) being submitted as YYYYMM-YYYYMM. In the case of the first month of the new process, YYYYMM (see Table 2 above for examples).
4. Date of submission as YYYYMMDD
5. Version number if more than 1 file submitted on the same day
6. "Test" or "Prod" indicating if the file is a test or production file.
    a. "Test" should ***only*** be used while a facility is testing their data and submissions and that data file will not be used for production. After the testing is complete, 'Prod' must be used in the file name.

Example: 000_ExampleFacility_201904_20190515_1_PROD.txt

Example: 000_ExampleFacility_201904-201905_20190615_1_PROD.txt

Data quality assurance

Edit checks

HCS will perform a series of validations, or edit checks, for each record. Data quality assurance generally consists of checking for compliance with requirements, completeness, validity, consistency, and uniqueness. HCS may also use clinical code editing software to identify records with a high probability of error. The validations may identify erroneous or questionable items and the results will be provided to the data supplier. OHCS may reject files if data elements or files do not meet requirements. A submission that is not in compliance with these specifications will be rejected and must be resubmitted in its entirety by the due date.

Unified record layout

The following record layout shall be used to submit all inpatient, emergency department, and ambulatory surgery data. All encounter types accommodate multiple line items and all line items for each encounter type shall be submitted.

- It is assumed that a complete snapshot of the encounter is submitted at the time of discharge.
- All encounters are processed as a single unit. Replacement files shall not contain partial encounter history for a given data submission period, and encounters shall not contain partial revenue line detail.
- Header and revenue line are both captured on a single row.
    - Revenue line data elements (HFD029-HFD040; shaded light gray in table below) shall be complete for each revenue line for a given encounter (header) and vary by line for a given encounter.
    - All other header data elements will repeat for each associated revenue line.
    - If available, unbilled procedures added by a medical coder after the encounter occurred should be included on submissions. These may appear with a HCPCS/CPT Procedure Code (HFD031), but without a Revenue Code (HFD030).
- Financial amounts:
    - All financial amounts (charge amounts and estimated amounts due) shall include decimals to reduce risk of truncation.
    - Charge amount (HFD040) shall include the amount charged for a given revenue line.
    - Total charge amounts (HFD041) shall include the total amount charged for the encounter which is typically captured on a claim header.
- Fields shall be left blank if the data are not available or not applicable unless otherwise noted. ‘Blank’ means do not supply any value or character at all between pipes including quotes or other characters.

Table 3 – Record layout for all encounter types

Data element #	Data element name	Description/codes/sources
HFD001	Data supplier name	Name of the healthcare facility submitting the file.
HFD002	Data supplier ID	HCS assigned identifier of healthcare facility.
HFD003	Encounter type	A = ambulatory surgery; E = emergency department; I = inpatient
HFD004	Patient control number	Patient's unique alpha-numeric identification number for this claim assigned by the provider to facilitate retrieval of individual case records and posting of payment.
HFD005	Medical record number	A unique number assigned to a patient by the provider to assist in retrieval of medical records.
HFD006	Patient last name	The last name of the individual to whom services were provided.
HFD007	Patient first name	The first name of the individual to whom services were provided.
HFD008	Patient middle name	The middle name of the individual to whom services were provided.
HFD009	Patient address	Street address of patient residence. Concatenate into a single line if an address contains more than one line.
HFD010	Patient city	City of patient residence.
HFD011	Patient country	If US, leave blank. Insert country code if outside the US. Country codes are maintained by International Standard for Organization (ISO) 3166 Maintenance Agency.
HFD012	Patient state	Two letter state code of patient residence. US state or Canadian province codes are maintained by the US Postal Service and Canada Post.
HFD013	Patient ZIP code	5 or 9-digit ZIP code of patient residence. When submitting the 9-digit ZIP code, do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP codes are maintained by the US Postal Service.
HFD014	Patient Social Security number	Social Security number of the patient receiving care. Should be 9 digits with no hyphens.

Data element #	Data element name	Description/codes/sources
HFD015	Patient date of birth	YYYYMMDD
HFD016	Patient gender	M = male; F = female; U = unknown
HFD017	Patient race	See Appendix A. HL7 FHIR defined value set.
HFD018	Patient ethnicity	See Appendix B. HL7 FHIR defined value set.
HFD019	Patient marital status	See Appendix C. HL7 FHIR defined value set.
HFD020	Type of bill	Do not include the leading zero. Type of bill codes are maintained by the National Uniform Billing Committee (NUBC).
HFD021	Admission date	YYYYMMDD
HFD022	Admission hour	HHMM in military time.
HFD023	Type of admission	Valid codes are: 1 = emergency; 2 = urgent; 3 = elective; 4 = newborn; 5 = trauma center; 9 = information not available. Type of admission codes are maintained by NUBC.
HFD024	Point of origin	A code indicating the point of patient origin for this admission or visit. Admission type codes are maintained by NUBC.
HFD025	Statement covers period–from date	Begin service date. YYYYMMDD
HFD026	Statement covers period–through date	End service date. YYYYMMDD
HFD027	Discharge hour	HHMM in military time.
HFD028	Discharge status	Discharge status codes are maintained by NUBC. Please include a leading zero.
HFD029	Service line	Service line must be present on each row. The first service line of an encounter must be 1 and increase incrementally for each revenue service. All revenue services shall be included as separate service lines.
HFD030	Revenue code	Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC code using leading zeroes, left justified, and four digits. Revenue codes are maintained by NUBC.

Data element #	Data element name	Description/codes/sources
HFD031	HCPCS/CPT procedure code	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association.
HFD032	CPT modifier 1	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association.
HFD033	CPT modifier 2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association.
HFD034	CPT modifier 3	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association.
HFD035	CPT modifier 4	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association.
HFD036	National drug code	Report NDC only when a medication is billed as part of a medical claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration (FDA).
HFD037	Service date	YYYYMMDD
HFD038	Units of service	The quantity of units, times, days, visits, services, or treatments for the service described by the HCPCS/CPT procedure code or revenue code

Data element #	Data element name	Description/codes/sources
HFD039	Unit of measure	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Type of units reported in units of service. Example codes: DA=Days; MJ= Minutes; UN=Units. Unit of measure codes are maintained by the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12.
HFD040	Charge amount	Charge amount for a service line.
HFD041	Total charge amount	Total charge amount for the whole encounter.
HFD042	Primary payer name	Name of the payer.
HFD043	Primary payer ID	Unique payer identifier issued by clearinghouse for EDI transactions. Leave blank for self-pay.
HFD044	Primary payer typology	Source of payment typology for the payer. See Appendix D.
HFD045	Estimated amount due–primary payer	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).
HFD046	Prior payment–primary payer	The amount the hospital has received toward the payment prior to the billing date from the indicated payer.
HFD047	Insured unique ID–primary payer	Policy or contract number assigned by the insurer.
HFD048	Secondary payer name	Name of the payer.
HFD049	Secondary payer ID	Unique payer identifier issued by clearinghouse for EDI transactions. Leave blank for self-pay.
HFD050	Secondary payer typology	Source of payment typology for the payer. See Appendix D
HFD051	Estimated amount due–secondary payer	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).
HFD052	Prior payment–secondary payer	The amount the hospital has received toward the payment prior to the billing date from the indicated payer.
HFD053	Insured unique ID–secondary payer	Policy or contract number assigned by the insurer.

Data element #	Data element name	Description/codes/sources
HFD054	Tertiary payer name	Name of the payer.
HFD055	Tertiary payer ID	Unique payer identifier issued by clearinghouse for EDI transactions. Leave blank for self-pay.
HFD056	Tertiary payer typology	Source of payment typology for the payer. See Appendix D.
HFD057	Estimated amount due–tertiary payer	The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).
HFD058	Prior payment–tertiary payer	The amount the hospital has received toward the payment prior to the billing date from the indicated payer.
HFD059	Insured unique ID–tertiary payer	Policy or contract number assigned by the insurer.
HFD060	Principal diagnosis	International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code. Do not include decimal. Do not include external cause codes.
HFD061	Principal diagnosis–present on admission (POA)	POA code for principal diagnosis. Present on admission is defined as present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. POA is maintained by NUBC. If not recorded at time of admission, please fill with "1."
HFD062	Other diagnosis 1	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD063	Other diagnosis 1–POA	POA code for other diagnosis 1.
HFD064	Other diagnosis 2	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD065	Other diagnosis 2–POA	POA code for other diagnosis 2.
HFD066	Other diagnosis 3	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD067	Other diagnosis 3–POA	POA code for other diagnosis 3.

Data element #	Data element name	Description/codes/sources
HFD068	Other diagnosis 4	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD069	Other diagnosis 4–POA	POA code for other diagnosis 4.
HFD070	Other diagnosis 5	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD071	Other diagnosis 5–POA	POA code for other diagnosis 5.
HFD072	Other diagnosis 6	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD073	Other diagnosis 6–POA	POA code for other diagnosis 6.
HFD074	Other diagnosis 7	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD075	Other diagnosis 7–POA	POA code for other diagnosis 7.
HFD076	Other diagnosis 8	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD077	Other diagnosis 8–POA	POA code for other diagnosis 8.
HFD078	Other diagnosis 9	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD079	Other diagnosis 9–POA	POA code for other diagnosis 9.
HFD080	Other diagnosis 10	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD081	Other diagnosis 10–POA	POA code for other diagnosis 10.
HFD082	Other diagnosis 11	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD083	Other diagnosis 11–POA	POA code for other diagnosis 11.
HFD084	Other diagnosis 12	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD085	Other diagnosis 12–POA	POA code for other diagnosis 12.
HFD086	Other diagnosis 13	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD087	Other diagnosis 13–POA	POA code for other diagnosis 13.
HFD088	Other diagnosis 14	ICD-10-CM code. Do not include decimal. Do not include external cause codes.

Data element #	Data element name	Description/codes/sources
HFD089	Other diagnosis 14–POA	POA code for other diagnosis 14.
HFD090	Other diagnosis 15	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD091	Other diagnosis 15–POA	POA code for other diagnosis 15.
HFD092	Other diagnosis 16	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD093	Other diagnosis 16–POA	POA code for other diagnosis 16.
HFD094	Admitting diagnosis	ICD-10-CM code. Do not include decimal. Do not include external cause codes.
HFD095	Reason for visit 1	The diagnosis code describing the patient's reason for visit at the time of outpatient registration. ICD-10-CM code. Do not include decimal.
HFD096	Reason for visit 2	The diagnosis code describing the patient's reason for visit at the time of outpatient registration. ICD-10-CM code. Do not include decimal.
HFD097	Reason for visit 3	The diagnosis code describing the patient's reason for visit at the time of outpatient registration. ICD-10-CM code. Do not include decimal.
HFD098	Diagnosis related group	CMS diagnosis related group (DRG) for this claim, as available.
HFD099	External cause code 1	ICD-10-CM code identifying the cause of injury, poisoning, morbidity, and other consequences of external cause. Do not include decimal.
HFD100	External cause code 1–POA	POA code for external cause code 1.
HFD101	External cause code 2	ICD-10-CM code identifying the cause of injury, poisoning, morbidity, and other consequences of external cause. Do not include decimal.
HFD102	External cause code 2–POA	POA code for external cause code 2.
HFD103	External cause code 3	ICD-10-CM code identifying the cause of injury, poisoning, morbidity, and other consequences of external cause. Do not include decimal.
HFD104	External cause code 3–POA	POA code for external cause code 3.

Data element #	Data element name	Description/codes/sources
HFD105	Principal ICD procedure	ICD-10 Procedure Coding System (ICD-10-PCS) code. Do not include decimal. Required for inpatient only.
HFD106	Principal ICD procedure date	YYYYMMDD
HFD107	Other ICD procedure 1	ICD-10 Procedure Coding System (ICD-10-PCS) code. Do not include decimal. Required for inpatient only.
HFD108	Other ICD procedure 1 date	YYYYMMDD
HFD109	Other ICD procedure 2	ICD-10 Procedure Coding System (ICD-10-PCS) code. Do not include decimal. Required for inpatient only.
HFD110	Other ICD procedure 2 date	YYYYMMDD
HFD111	Other ICD procedure 3	ICD-10 Procedure Coding System (ICD-10-PCS) code. Do not include decimal. Required for inpatient only.
HFD112	Other ICD procedure 3 date	YYYYMMDD
HFD113	Other ICD procedure 4	ICD-10 Procedure Coding System (ICD-10-PCS) code. Do not include decimal. Required for inpatient only.
HFD114	Other ICD procedure 4 date	YYYYMMDD
HFD115	Other ICD procedure 5	ICD-10 Procedure Coding System (ICD-10-PCS) code. Do not include decimal. Required for inpatient only.
HFD116	Other ICD procedure 5 date	YYYYMMDD
HFD117	Attending provider NPI	National Provider Identifier (NPI) for attending provider as enumerated in National Plan and Provider Enumeration System. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter.
HFD118	Attending provider secondary ID qualifier	Secondary identifier qualifiers: 0B - state license number 1G - provider UPIN number G2 - provider commercial number
HFD119	Attending provider secondary ID	Attending provider secondary identifier indicated by HFD118.

Data element #	Data element name	Description/codes/sources
HFD120	Operating provider NPI	National Provider Identifier (NPI) for attending provider as enumerated in National Plan and Provider Enumeration System. The operating provider is the individual with the primary responsibility for performing the surgical procedure(s).
HFD121	Operating provider secondary ID qualifier	Secondary identifier qualifiers: 0B—state license number 1G—provider UPIN number EI—employer's identification number SY—Social Security number
HFD122	Operating provider secondary ID	Attending provider secondary identifier indicated by HFD121.
HFD123	Other provider 1 provider type qualifier	Provider type qualifier codes/definition/situational usage notes: DN—Referring provider: The provider who sends the patient to another provider for services. Required on an outpatient claim when the referring provider is different than the attending physician. If not required, do not send. ZZ—Other operating physician: An individual who performs a secondary surgical procedure or assists the operating physician. Required when another operating physician is involved. If not required, do not send. 82—Rendering provider: The health care professional who delivers or completes a particular medical service or non-surgical procedure.
HFD124	Other provider 1 NPI	NPI for other provider 1 as enumerated in National Plan and Provider Enumeration System.
HFD125	Other provider 1 secondary ID qualifier	Secondary identifier qualifiers: 0B—state license number 1G—provider UPIN number EI—employer's identification number SY—Social Security number
HFD126	Other provider 1 secondary ID	Other provider 1 secondary identifier indicated by HFD125.

Appendix A: Race

This value set is defined as part of HL7 v3. http://hl7.org/fhir/v3/Race
Values in this set are limited to the Level 1 race codes.

Code	Description
1002-5	American Indian/Alaska Native
2028-9	Asian
2054-5	Black/African American
2076-8	Native Hawaiian or other Pacific Islander
2106-3	White
2131-1	Other race

Appendix B: Ethnicity

This value set is defined as part of HL7 v3. http://hl7.org/fhir/v3/Ethnicity
Values in this set are limited to the Level 1 ethnicity codes.

Code	Description
2135-2	Hispanic or Latino
2186-5	Not Hispanic or Latino

Appendix C: Marital status

This value set is defined by the FHIR project. https://www.hl7.org/fhir/valueset-marital-status.html

Code	Display	Definition
A	Annulled	Marriage contract has been declared null and to not have existed
D	Divorced	Marriage contract has been declared dissolved and inactive
I	Interlocutory	Subject to an interlocutory decree
L	Legally separated	Legally separated
M	Married	A current marriage contract is active
P	Polygamous	More than 1 current spouse
S	Never married	No marriage contract has ever been entered
T	Domestic partner	Person declares that a domestic partner relationship exists
U	Unmarried	Currently not in a marriage contract
W	Widowed	The spouse has died
UNK	Unknown	Description: A proper value is applicable, but not known. Usage notes: This means the actual value is not known. No properties should be included for a datatype with this property unless: Those properties themselves directly translate to a semantic of "unknown."

Appendix D: Source of payment typology

This value set is adapted from the Users Guide for Source of Payment Typology 9.2. The typology was created by the Public Health Data Standards Consortium's (PHDSC) Payer Typology Subcommittee and is now hosted and maintained by the National Association of Health Data Organizations (NAHDO).
https://www.nahdo.org/sites/default/files/2020-12/SourceofPaymentTypologyVersion9_2%20-Dec%2011_2020_Final2.pdf

Code	Description	Definition
1	Medicare	Medicare managed care, Medicare fee for service, Medicare hospice, or dual eligibility Medicare/Medicaid organization
2	Medicaid	Medicaid managed care, Medicaid fee for service, CHIP, Medicaid long term care, or Medicaid dental
3	Other government	Department of Defense (Tricare), Department of Veterans Affairs, Indian Health Service or tribe, HRSA program, black lung, state government, or local government
4	Department of Corrections	Federal, state, or local corrections
5	Private health insurance	Managed care (HMO, PPO, POS), private health insurance (commercial indemnity or self-funded ERISA), organized delivery system, or small employer purchasing group
6	Blue Cross/Blue Shield	BCBS managed care or BCBS indemnity insurance
7	Managed care, unspecified	Only use if cannot distinguish public from private managed care.
8	No payment from an organization/agency/program/private payer listed	Self-pay, no charge, charity, refusal, research/donor, or no payment
9	Miscellaneous/other	Workers compensation, foreign national, disability, long-term care, auto insurance, or legal liability
	Unknown	Leave blank if payer typology is unknown, unavailable, or blank

Appendix E: Example layout

An example layout is available as a spreadsheet, as is the file layout and all other appendix tables.