

**Department of State Health Services
Council Agenda Memo for State Health Services Council
January 22, 2010**

Agenda Item Title: Amendments to rules concerning the collection and release of hospital discharge data

Agenda Number: 5g

Recommended Council Action:

For Discussion Only

For Discussion and Action by the Council

Background:

The Center for Health Statistics is located in the Chief Operating Officer's Division and is responsible for the data collection and hospital discharge data.

The Center provides data that enables Texas consumers and health plan purchasers to make informed health care decisions. The Center collects data and reports on the quality performance of hospitals and health maintenance organizations operating in Texas. The goal is to provide information that enables consumers to have an impact on the cost and quality of health care in Texas.

The budget for Center for Health Statistics is \$4.52 million. Funding for changes to existing systems to implement the proposed amendments would come from general revenue.

Summary:

The purpose of the amendments is to implement the data submission requirements for hospitals to submit inpatient discharge data to DSHS. The amendments add "diagnosis present on admission" (POA) to the list of data elements. The data element will be collected and used by DSHS for public reporting on the quality of care in the hospitals.

The data elements will provide valuable information regarding the quality of care being provided at hospitals and is necessary for DSHS to produce Patient Safety Indicator and Pediatric Quality Indicator reports for public review.

Some hospitals are exempt from the requirements for submission of POA indicators. The exempted hospitals are Critical Access Hospitals; Inpatient Rehabilitation Hospitals; Inpatient Psychiatric Hospitals; Cancer Hospitals; Children's or Pediatric Hospitals; and Long Term Care Hospitals. The rules allow an exempt hospital to submit the POA indicators to DSHS voluntarily.

The public and hospitals will benefit from the production of additional health care provider reports that report on patient safety and provide information about the quality of care being provided in hospitals. The standardized data and the reports and information developed from the data will assist the consumer in making informed decisions on healthcare issues.

Summary of Input from Stakeholder Groups:

DSHS held two meetings with stakeholders (August 18, 2009 and October 27, 2009) that included representatives from the following organizations: Texas Senate Health and Human Services Committee; Texas Health and

Human Services Commission; Texas Hospital Association; Dallas-Fort Worth Hospital Council; Texas Ambulatory Surgery Center Society; Texas Medical Association; Texas Association of Businesses; Memorial Hermann Hospital System; East Texas Medical Center; Austin Radiological Association; Blue Cross Blue Shield of Texas; Governor's Office; Texas Tech Health Science Center School of Nursing; Hospital Corporation of America; Hilco Partners, Inc.; and Quadra Med, Inc.

The stakeholders suggested that DSHS propose rules to add the POA indicator code to the list of data elements. It was indicated that many of the health plans are requiring POA indicator codes for claims adjudication.

DSHS met with the stakeholders on October 27, 2009, to look at a draft of the proposed amendments. The stakeholders suggested that DSHS follow the Centers for Medicare and Medicaid Services (CMS) guidelines regarding the exempting certain hospitals. DS HS modified the draft of the proposed amendments to follow the stakeholder's suggestions.

Proposed Motion: Motion to recommend HHSC approval for publication of rules contained in agenda item #5g

Approved by Assistant Commissioner/Director:	Ramdas Menon, Ph.D.	Date:	1/4/10
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Approved by CPCPI:	Carolyn Bivens	Date:	12/23/09

Title 25. HEALTH SERVICES
Part 1. DEPARTMENT OF STATE HEALTH SERVICES
Chapter 421. HEALTH CARE INFORMATION
Subchapter A. COLLECTION AND RELEASE OF HOSPITAL DISCHARGE DATA
Amendments, §§421.1, 421.8 and 421.9

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission on behalf of the Department of State Health Services (department), proposes amendments to §§421.1, 421.8 and 421.9, concerning the collection and release of hospital discharge data.

BACKGROUND AND PURPOSE

Sections 421.1 – 421.10 establish the rules regarding the collection requirements and release specifications of hospital inpatient discharge data from Texas hospitals. The rules were originally developed and adopted by the Texas Health Care Information Council (council) and were transferred to the department as result of the consolidation of health and human service agencies under House Bill 2292 (HB 2292), 78th Texas Legislature in 2003.

The department proposed amendments (32 TexReg 6030 September 7, 2007 *Texas Register*) to collect and report “diagnosis present on admission” (POA) indicators from all hospitals required to report under Health and Safety Code, Chapter 108, and to report the data collected. The amendments concerning the POA indicators were withdrawn from the adopted rules published in the *Texas Register* December 21, 2007 (32 TexReg 9683), in response to comments received.

The proposed amendments are necessary to comply with Health and Safety Code, Chapter 108, which requires the Executive Commissioner to adopt rules to implement the data submission requirements for hospitals to submit inpatient discharge data to the department.

The department held two meetings with stakeholders (August 18, 2009 and October 27, 2009) including representatives from the following organizations: Texas Senate Health and Human Services Committee, Texas Health and Human Services Commission, Texas Hospital Association, Dallas-Fort Worth Hospital Council, Texas Ambulatory Surgery Center Society, Texas Medical Association, Texas Association of Businesses, Memorial Hermann Hospital System, East Texas Medical Center, Austin Radiological Association, Blue Cross Blue Shield of Texas, Governor’s Office, Texas Tech Health Science Center School of Nursing, Hospital Corporation of America, Hillco Partners, Inc. and QuadraMed, Inc.

At the August 18, 2009, meeting the stakeholders recommended that the department collect POA indicators to provide better data for determining the quality of care provided by hospitals and to utilize the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality, Patient Safety and Pediatric Quality indicators that utilize the POA indicators in their methodologies. The department has not produced the Patient Safety Report or several of the Pediatric Quality Indicators because POA indicators are required for reporting these AHRQ reports. The stakeholders suggested that the department propose the POA rules as previously written in 2007.

It was indicated that many of the health plans are requiring POA indicators for claims adjudication.

On October 27, 2009, the department met with the stakeholders to look at a draft of the proposed amendments. A Texas Hospital Association representative suggested that the department follow the Centers for Medicare and Medicaid Services (CMS) guidelines regarding the “Inpatient Prospective Payment System” which exempts: Critical Access Hospitals (CAH), Long-Term Care Hospitals (LTCH), Maryland Waiver Hospitals, Cancer Hospitals, Children’s Inpatient Facilities, Inpatient Rehabilitation Facilities (IRF) and Psychiatric Hospitals. Children’s hospitals have indicated to the department that they would like to include POA indicators in their data, because it would provide a better understanding of the patient care being provided in their facilities. The department researched the hospitals that would be exempt from reporting using the CMS guidelines and determined that 220 hospitals out of 563 would be exempt from reporting. The exempt hospitals’ patients would account for approximately 10% of the total patients in the Public Use Data file. The proposed amendments will require that acute care hospitals submit POA indicators and establish a list of hospital types that are exempt from reporting POA indicators. The exempt hospitals under the proposed amendments may submit POA indicators on a voluntary basis. The additional data collected regarding the quality of care provided in hospitals could potentially identify Hospital Acquired Conditions (HAC). The POA indicators will be new data elements. Therefore, in accordance with Health and Safety Code, Chapter 108, the new data element cannot be required to be submitted to the department before the 90th day after the date the rule is adopted and must take effect no later than the first anniversary after the date the rule is adopted. The department anticipates beginning collecting POA indicators data January 1, 2011. This indicator code will be collected and used by the department for public reporting on the quality of care in the hospitals. The POA indicator code is critical for Patient Safety, Inpatient Quality and Pediatric Quality indicator reporting methodologies developed by the United States Department of Health and Human Services, AHRQ. The AHRQ indicators will be used by the department for public reporting.

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 421.1, 421.8 and 421.9 have been reviewed and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed.

SECTION-BY-SECTION SUMMARY

The amendment to §421.1(32) adds the term “Present on admission (POA) -- Diagnosis present on admission” and renumber the definitions following the added term in the section.

The amendment to §421.8(c)(11)(III) adds the data element “POA Indicator (if applicable).” This proposed amendment requires the department to include this new data element in the public use data file. The public use data file is an electronic file with patient level data that identifies facilities and provides consumers, healthcare facilities and independent researchers with additional data regarding quality of care provided in hospitals.

The amendment to §421.9 adds a new subsection (e) for the submission of a new required data element and establishes a list of hospital types that are exempt from the reporting of this new data element and renumbers the following subsection. The data element “POA indicator” is listed to be submitted by all acute care hospitals required to submit data under Health and Safety Code, Chapter 108. Some hospitals are exempted from the requirements for submission of POA indicators. The exempted hospitals are: (1) Critical Access Hospitals; (2) Inpatient Rehabilitation Hospitals; (3) Inpatient Psychiatric Hospitals; (4) Cancer Hospitals; (5) Children’s or Pediatric Hospitals; and (6) Long Term Care Hospitals. The amendment allows for the exempted hospital to submit the POA indicators to the department voluntarily. The Code of Federal Regulations citation is corrected in §421.9(f).

FISCAL NOTE

Ramdas Menon, Ph.D., Director, Center for Health Statistics, has determined that for each calendar year of the first five years that the amended sections are in effect, there will be fiscal implications to the state as a result of enforcing or administering the sections as proposed. The effect on state government will be a one time cost for the department of \$47,500 for development and modification to the current health care data collection system (data file format, file structures, logs, reports and associated data software tools). Cost estimates were requested from all state facilities for collection of diagnosis present on admission for all patients. The proposed rules exempt the department’s mental hospitals and Harris County Psychiatric Center (Psychiatric hospital), the University of Texas M.D. Anderson hospital (Cancer hospital) and the Texas Center for Infectious Disease (Long-Term Care Hospital). The University of Texas Medical Branch at Galveston stated they already collect the data and there would be less than \$20,000 for programming to submit the data as required by the proposed rule. The University of Texas Southwestern University Hospitals – Saint Paul and Zale Lipshy provided an estimate of an initial cost of \$2,500 and an annual recurring cost of \$2,500. The University of Texas Health Center at Tyler system responded to an inquiry on the cost to implement the proposed amendments that there would be no additional costs, that they were already collecting and submitting the data. The fiscal implications of submitting the POA indicator codes as proposed for local governments that own or operate hospitals of systems will vary depending on the complexity of the hospitals’ information technology and contract requirements with any vendors involved. The costs could range from \$0 to \$4,174 per year to thousands of dollars for a new information system. If the facility is already collecting and reporting data for CMS, the department anticipates no new costs. Local government hospitals could manually enter the data in the secured web based data entry tool provided by the department at no cost to the facility. The facility may incur costs for adding resource staff to perform this function and their time would be dependent on the number of discharges occurring in the facility. Based on the time estimates (provided by the department’s state mental hospitals) of 20 records per hour for data entry, the average hourly salary of healthcare support workers in Texas of \$14.22 (2008 Texas Workforce Commission), the average number of claims for a hospital in Texas in 2007 of 5,184 (THCIC Public Use Data File), an annual cost of approximately \$3,686 per year is estimated for data submission. The cost for review and certification of the data is estimated at \$461 per year (1/8 of the time required for data entry based on the estimate from Texas Center for Infectious Disease). Thus the sum total of data submission, review and certification is estimated at approximately \$4,147 per year. Estimating a 4% increase per year, the total costs for the first

through six years is approximately \$27,504. If the facility chose to modify their current billing system, the costs would be dependent upon the complexity of their information system or the contractual agreement with their vendor or they may be required to purchase a new information system and cannot be estimated.

The following state facilities that are exempted from reporting POA indicators under the proposed amendments provided cost estimates if they were to voluntarily submit the additional data to the department. The department's mental hospitals (exempted under the proposed rules as "psychiatric hospitals") provided a monthly cost estimate of \$2,384 (annual cost - \$28,608) for their 10 facilities to comply with the rules if all facilities elected to submit POA indicators. Texas Center for Infectious Disease, exempted under the proposed rules as a "long term acute care hospital", reported an annual additional, recurring cost of \$2600 if they elected to comply with the amendment to the rules. The University of Texas M.D. Anderson Cancer Center (exempt under the proposed rules as "cancer hospital") reported that they would have a one-time cost of \$900 to comply with the amendments to the rules. Harris County Psychiatric Center (exempted under the proposed rules as a "Psychiatric Hospital") estimated a one-time cost for development of \$900 - \$1,000 to submit POA indicators.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Dr. Menon anticipates that only 2 acute care hospitals out of 42 hospitals with less than 100 in staffing (2007 Annual Hospital Survey) and with potential gross receipts of less than \$6,000,000 would possibly have to comply with the proposed amendments. These two hospitals were not exempted by Health and Safety Code, Chapter 108, as "Rural Providers" nor exempted as critical access hospitals, rehabilitation hospitals or long term care hospitals under the proposed rules. The department, therefore, does anticipate there may be an economic impact on these small or micro-business hospitals regarding the requirements for collection and reporting of POA. The costs could range from \$0 to \$294 per year to thousands of dollars for a new information system. If the facility is already collecting and reporting data for CMS, no new costs are anticipated. These hospitals could manually enter the data in the secured web based data entry tool provided by the department at no cost to the facility. The facility may incur costs for adding resource staff to perform this function and their time would be dependent on the number of discharges occurring in their facility. Based on the time estimates (provided by the department's state mental hospitals) of 20 records per hour for data entry, the average hourly salary of healthcare support workers in Texas of \$14.22 per hour (2008 Texas Workforce Commission), the average number of claims for a hospital in Texas in 2007 of 367 (THCIC Public Use Data File), an annual cost of approximately \$261 per year is estimated for data submission. The cost of the review of records and certification of the data is estimated at \$33 per year (1/8 of the time required for data entry based on the estimate from Texas Center for Infectious Disease). The total cost for data submission, review and certification is estimated to be approximately \$294 per year. Estimating a 4% increase per year, the total cost for the first through six years is approximately \$1,947. If the facility chooses to modify their current billing system, the costs would be dependent upon the complexity of their information system or the contractual agreement with their vendor or they may be required to purchase a new information system and cannot be estimated.

The anticipated economic costs to persons (hospitals that are required to report under Health and Safety Code, Chapter 108) who are required to comply with the sections as proposed will be dependent upon the complexity and status of their information systems and will range from no additional costs to an estimated \$20,000 for the first year. The annual costs thereafter would range from zero to \$4,147.

Department staff looked at alternative and solutions for reducing the adverse economic impact on these hospitals and found the following: First alternative solution was to collect the POA indicator code voluntarily from all hospitals. Making the POA data elements an option rarely gets hospital to comply, because hospitals are not reimbursed for the submission of the data and the POA may identify potential errors in the care of the patient. A second alternative solution was to collect the data from the CMS. This would provide data on only a select set of patients, the elderly or very young. The data is difficult to obtain and does not contain patient identifiers. A third alternative solution was to have these facilities submit the data in an alternate manner such as Microsoft Excel spreadsheet, but this would have issues regarding: data confidentiality, data matching to the correct records, data validity and certification. Currently, the Health Care Information Collection, Health Care Data Collection System is the only program in the state that collects patient level data for all patients, including the homeless and self-pay patients. The system does provides a method of manual entry and online correction of the data. Health and Safety Code, §108.006(a)(9)(D), requires the department to collect and report data regarding the quality and effectiveness of health care for all citizens of Texas.

There will be little effect on local employment. The department assumes any hires to occur in the first year that the rules are in effect. No additional local employment is anticipated in the subsequent years. Several facilities stated they would need to hire one full time person to collect and submit the data.

PUBLIC BENEFIT

Dr. Menon has also determined that for each year of the first five years the amendments are in effect, the public will benefit from the adoption of the amended sections. The public benefit anticipated as a result of collecting and reporting of this data element is the ability to provide the public with additional data regarding whether a diagnosis was present at the time the patient was admitted to the hospital or after the patient had been admitted to the hospital. The public will benefit from the production of additional health care provider reports that report on patient safety and provide information about the quality of care being provided in hospitals. The standardized data and the reports and information developed from the data will assist the consumer in making informed decisions on healthcare issues. The department is encouraging hospitals that are exempted under the proposed rules to voluntarily submit the POA indicators codes, because of the potential benefits to the public regarding reports on patient safety.

REGULATORY ANALYSIS

The department has determined that the proposed amendments are not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human

health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. The proposed amendments are not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed amendments do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Bruce M. Burns, D.C., Center for Health Statistics, Mail Code 1898, Department of State Health Services, P.O. Box 149347, Austin, TX 78714-9909, (512) 458-7740 or by E-mail to Bruce.Burns@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The amendments are authorized by Health and Safety Code, §§108.006, 108.009, 108.010 and 108.011, which require the Executive Commissioner to adopt rules regarding which data elements are to be required for submission to the department and which data elements are to be released in a public use data file; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The amendments affect the Health and Safety Code, Chapters 108 and 1001; and Government Code, Chapter 531.

Legend: (Proposed amendments)

Single Underline = Proposed new language

[Bold Print, and Brackets] = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

§421.1. Definitions. The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (31) (No change.)

(32) Present on admission (POA)--Diagnosis present on admission.

(33) [(32)] Provider--A physician or health care facility.

(34) [(33)] Provider quality data--A report or reports authored by the department on provider quality or outcomes of care, as defined in Chapter 108 of Health and Safety Code, created from data collected by the department or obtained from other sources.

(35) [(34)] Public use data file--A data file composed of discharge claims with risk and severity adjustment scores which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of hospital discharge data imposed by statute.

(36) [(35)] Race--A division of patients according to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Hospitals shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other.

(37) [(36)] Required minimum data set--The list of data elements which hospitals are required to submit in a discharge claim for each inpatient stay in the hospital. The required minimum data set is specified in §421.9(d) of this title. This list does not include the data elements that are required by the ANSI 837 Institutional Guide to submit an acceptable discharge report. For example: Interchange Control Headers and Trailers, Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify which qualify as subsequent data elements).

(38) [(37)] Research data file--A customized data file, which includes the data elements in the public use file and may include data elements other than the required minimum data set submitted to the department, except those data elements that could reasonably identify a patient or physician. The data elements may be released to a requestor when the requirements specified in §421.8 of this title (relating to Hospital Discharge Data Release) are completed.

(39) [(38)] Risk adjustment--A statistical method to account for a patient's severity of illness at the time of admission and the likelihood of development of a disease or outcome, prior to any medical intervention.

(40) [(39)] Rural provider--A health care facility located in a county with a population of not more than 35,000 as of July 1 of the most recent year according to the most recent United States Bureau of the Census estimate; or located in a county with a population of more than 35,000 but with 100 or fewer licensed hospital beds and not located in an area that is delineated as an urbanized area by the United States Bureau of the Census; and is not state owned, or not managed or directly or indirectly owned by an individual, association, partnership, corporation, or other legal entity that owns or manages one or more other hospitals. A health care facility is not a rural provider if an individual or legal entity that manages or owns one or more other hospitals owns or controls more than 50% of the voting rights with respect to the governance of the facility.

(41) [(40)] Service Unit Indicator--An indicator derived from submitted data (based on Bill type or Revenue Codes) and represents the type of service unit or units (e.g., Coronary Care Unit, Detoxification Unit, Intensive Care Unit, Hospice Unit, Nursery, Obstetric Unit, Oncology Unit, Pediatric Unit, Psychiatric Unit, Rehabilitation Unit, Sub acute Care Unit or Skilled Nursing Unit) where the patient received treatment.

(42) [(41)] Severity adjustment--A method to stratify patient groups by degrees of illness and mortality.

(43) [(42)] Submission--The transfer of a set of computer records as specified in §421.9 of this title that constitutes the discharge report for one or more hospitals.

(44) [(43)] Submitter--The person or organization, which physically prepares discharge reports for one or more hospitals and submits them to the department. A submitter may be a hospital or an agent designated by a hospital or its owner.

(45) [(44)] THCIC Identification Number--A string of six characters assigned by the department to identify health care facilities for reporting and tracking purposes.

(46) [(45)] Uniform facility identifier--A unique number assigned by the department to each health care facility licensed in the state. For hospitals, this will include the hospital's state license number. For hospitals operating multiple facilities under one license number and duplicating services, the department will assign a distinguishable uniform facility identifier for each separate facility. The relationship between facility identifier and the name and license number of the facility is public information.

(47) [(46)] Uniform patient identifier--A unique identifier assigned by the department to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across hospitals and inpatient admissions. The relationship of the identifier to the patient-specific data elements used to assign it is confidential.

(48) [(47)] Uniform physician identifier--A unique identifier assigned by the department to a physician or other health professional who is reported as attending or treating a hospital inpatient and which remains constant across hospitals. The relationship of the identifier to the

physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters.

(49) [(48)] Validation--The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification.

§421.8. Hospital Discharge Data Release.

(a) – (b) (No change.)

(c) Creation of public use data file. The department will create a public use data file by creating a single record for each inpatient discharge and adding, modifying or deleting data elements in the following manner as listed in paragraphs (1) - (11) of this subsection:

(1) – (10) (No change.)

(11) data elements to be included in the public use data file:

(A) – (HHHH) (No change.)

(III) POA indicator (if applicable).

(d) – (l) (No change.)

§421.9. Discharge Reports--Records, Data Fields and Codes.

(a) – (d) (No change.)

(e) A hospital shall submit the “POA indicator” for all diagnosis codes on inpatient claims filed, unless exempted by this subsection. Exempted hospitals may, but is not required to submit POA indicators to the department. The following hospital types are exempted from reporting POA indicators to the department for the purposes of this subsection:

(1) Critical Access Hospitals (certified by the Secretary of the United States Department of Health and Human Services as a critical access hospital under Title 42 United States Code §1395i-4).

(2) Inpatient Rehabilitation Hospitals (a majority of the patients are inpatients being rehabilitated).

(3) Inpatient Psychiatric Hospitals (a majority of the patients are inpatients being treated for psychiatric diseases or associated conditions).

(4) Cancer Hospitals (a majority of the patients are inpatients being treated for cancer or associated cancerous conditions).

(5) Children's or Pediatric Hospitals (a majority of the patients are under the age of 18 and admitted as inpatients).

(6) Long Term Care Hospitals (a majority of the patients are inpatients being treated for chronic conditions or associated diseases that require extended stays in a hospital).

(f) [(e)] For patients which are covered by 42 USC 290dd-2 and 42 CFR Part 2 [2.1], the hospital shall submit the following patient identifying information or default values in the specified Record and Field locations as required by subsection (a) of this section:

(1) Patient Account Number - This alphanumeric patient control number shall be reported. This number is unique to the institution and episode of care and will be used by the hospital to review and certify data.

(2) Last Name - The patient's last name shall be removed and replaced with "Doe_".[.]

(3) First Name - The patient's first name shall be removed and replaced with "Jane" if female, or "John" if male, and can include a sequential number (e.g., John1, John2, John3... etc.).

(4) Middle Initial - The patient's middle initial shall be removed and left blank (space filled).

(5) Date of Birth - The patient's date of birth shall be reported.

(6) Address - The patient's residence address shall be removed and replace with the hospital's street address.

(7) City - The patient's city of residence shall be reported.

(8) State - The patient's state of residence shall be reported.

(9) ZIP Code - The patient's ZIP code of residence shall be reported.

(10) Medical Record Number - The patient's medical record number shall be removed and replaced with "99999" and reported.

(11) Social Security Number - The patient's Social Security Number shall be removed and replaced with "999999999_".[.]