Florida

Discharge Data
Reporting Specifications Manual

Agency for Health Care Administration
Office of Data Collection & Quality Assurance
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SECTION 1 INTRODUCTION

Inpatient Data Collection Program

AHCA's inpatient data collection program, as directed by Section 408.061, Florida Statutes, and Chapter 59E-7 of the Florida Administrative Code (F.A.C.), collects three types of discharge data from inpatient health care facilities: acute care hospitals, short-term psychiatric facilities, comprehensive rehabilitation, and long-term psychiatric facilities.

Reportable events include discharges from acute care, intensive care, psychiatric, newborn live discharges, and deaths. Comprehensive rehabilitation data in acute care hospital is included in the inpatient data set.

Ambulatory and Emergency Department Data Collection Program

AHCA's ambulatory (AS) patient data collection program collects discharge data from the state's freestanding ambulatory surgical centers, cardiac catheterization laboratories, and short-term acute care hospitals. AS reportable events include those which are ***surgical in nature*** or invasive diagnostic procedures within a specified CPT range.

Emergency Department (ED) Discharge Data is also included in the outpatient data set. Data includes all emergency department visits during which ED registration occurs, but the patient is not admitted for inpatient care at the reporting entity. Data is submitted in accordance with Section 408.061, Florida Statutes, and Chapter 59B-9, F.A.C. Ambulatory data is authorized under the direction of Section 408.061, Florida Statutes, and Chapter 59B-9, F.A.C.

Data Confidentiality

All discharge data furnished to the Agency are considered confidential under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and are exempt from public records under s. 501.171, F.S. Patient identifying information will not be disclosed. It will be used only for the creation and maintenance of anonymous medical case histories for statistical analysis and reports. The Agency is prohibited from identifying, either directly or indirectly, any individual in its reports. The Agency will not disclose individual patient identities in any manner, except as directed by a court of competent jurisdiction after an application showing good cause.

SECTION 2 REPORTING REQUIREMENTS

Reporting Periods and Due Dates

Rules 59E-7 and 59B-9, F.A.C., define reporting periods, which correspond to calendar year quarters. Reports include all patient visits and all inpatients *discharged* within the reporting quarter.

The rule includes an "*Initial Due Date*" and a "*Certification Due Date*" for submission. The Agency does not enforce action for delinquent 'Initial Due' submission. The Agency encourages data submission prior to the Initial Due Date, or as early as possible, to allow maximum time for error correction.

A facility must certify no later than the "*Certification Due Date*" deadline to avoid fines.

Initial Due Date (*Ambulatory// Inpatient)*	**Certification Due Date**
Q1 May 10 // June 1	August 31
Q2 August 10 // September 1	November 30
Q3 November 10//December 1	February 28 (next year)
Q4 February 10 (next year) // March 1 (next year)	May 31 (next year)

Penalties and Fines

Under the provisions of s. 408.08(13), F.S. and chapter 59B-9.036 and 59E-7.026, F.A.C., facilities that fail to certify quarterly data by the *Certification Due Date* are subject to a fine. The facility will receive an "Intent to Fine" notification informing them of the daily fine amount until certification is complete.

Statute imposes a $100 per day of violation for the first violation, $350 per day of violation for the second violation, and $1000 per day of violation for the third and all subsequent violations. The fine rate matrix resets to the 'first violation' rate upon four (4) successful consecutive quarters.

Facility Noncompliance

Delinquent facilities are referred to the Agency General Counsel for commencement of the fine process and the Bureau of Health Facility Regulation for licensure enforcement.

Ambulatory Exemptions

All ambulatory surgery centers (ASC) and cardiac catheterization laboratories providing services set forth in Rules 59B-9.030 through 59B-9.039, F.A.C., are required to submit ambulatory patient data. However, freestanding ambulatory centers (ASCs that are not physically part of a hospital) may elect to file for an exemption from reporting for any quarter if they have **fewer than 200 patient visits.**

To qualify for a quarterly exemption, Rule 59B-9 requires the entity's Executive Officer, administrator or authorized designee must request to be exempt via the FDDC website. The entry should indicate the facility has less than 200 patient visits for the reporting period.

The Agency must receive the exemption request on or before *the certification deadline*. **The facility must submit a separate exemption request letter for each subsequent quarter in which the freestanding ASC has fewer than 200 patients.**

Exemption requests must be submitted on the FDDC website:
https://apps.ahca.myflorida.com/fddc/

Extensions

The Agency will not grant an extension beyond the Certification Due Date.

An extension request is not required for submissions later than the Initial Due Date. The facility must certify within the 5-month reporting period. Early submission allows adequate time for the facility to correct errors.

Resubmission Requests

A facility may request corrections to previously certified data for a period of twelve (12) after the quarter *Initial Due Date*. Inaccuracies identified in a facility's data after this twelve-month period may cause the hospital to be subject to penalties pursuant to Rule 59E-7.026, F.A.C.

Resubmission requests must be submitted on the FDDC website. The Agency will determine if resubmission is warranted and respond to the facility granting or denying the resubmission request.

Resubmission requests submitted on FDDC should include the following:

- The quarter/ year(s) to be resubmitted.
- Reason for the changes and corrections
- Specify the cause contributing to the inaccurate reporting.
- The number of records affected.

Please note, a separate request must be submitted for each data type.
The facility has 30 days to submit and recertify the data upon approval of the resubmission request. Resubmitted data must use the correct XML schema version for the reporting period covered by the resubmission. ***(See Data XML Schemas in Section 3)***

Registering for FDDC

A reporting facility is required to register their own users on the FDDC website.

https://apps.ahca.myflorida.com/fddc/

For instructions on how to register, visit the FDDC website at *AHCA: Florida Center for Health Information and Policy Analysis: FDDC Training Resources (myflorida.com)*

Establishing/Updating a Facility Contact

In addition to the user registration mentioned above, the facility must also establish a designated contact person on the FDDC website.

AHCA will send all correspondence to the designated facility contact person. You can also elect to be cc'd on AHCA emails.

The facility is responsible for keeping their own contact information up to date.

SECTION 3 DATA SUBMISSION

Data File Format

The facility must format the data file according to an AHCA-defined Extensible Markup Language (XML) schema. Discharges for Inpatient/Comprehensive Rehab and Ambulatory/Emergency Department visit is reported in an integrated XML file. A 'Type of Service' element codifies the record types within the data set.

All file submissions use the following web address:

https://apps.ahca.myflorida.com/fddc/

XML Schemas

All data is submitted electronically and formatted using the relevant XML schema.

The AS/ED data XML Schema is available at:

Q4 2022 https://ahca.myflorida.com/SCHS/DataClection/docs/AS10-5.xsd.xml

The Inpatient Data XML Schema available at

Q4 2022) https://ahca.myflorida.com/SCHS/DataCollection/docs/PD10-5.xsd.xml

FDDC Submission Specifications

FDDC is an online web-based portal which is available 24/7. The application uses claim-based authentication with Secure Socket Layer (SSL) and 128-bit encryption to protect data between the browser and the AHCA Server.

Users should be able to login using the latest version of browsers from Chrome and IE Edge. Users should be using high-speed internet to connect to the system and upload files.

Data Assistance

Please contact Susan Slappey or Krischell Harris if you need help resolving 'Upload Unsuccessful' errors. We are more than happy to aid with data upload errors, XML problems or other questions regarding data submission or data requirements.

Susan Slappey at 850-412-3748 or susan.slappey@ahca.myflorida.com
Krischell Harris at 850-412-3787 or krischell.harris@ahca.myflorida.com

Online Submission: Step-By-Step

Go to the following link to submit data: https://apps.ahca.myflorida.com/fddc/

For step-by-step instructions on how to submit data, please visit our resources page on the AHCA website. AHCA: Florida Center for Health Information and Policy Analysis: FDDC Training Resources (myflorida.com)

Unsuccessful Online Submissions

Schema errors will be displayed on the error screen.

The line item will be listed along with the errors that needing correction. The facility must correct all the errors listed before resubmitting the file.

XML format requires opening and closing tags for each data element, for example:
<RPT_YEAR>2022</RPT_YEAR>.

A common error is omission of the closing tag after the data element. When this occurs, everything after the missing closing tag will fail since the XML language is incorrectly read against the schema.

Dashboard Status

Facilities are encouraged to check the status of their quarterly file submission by viewing their dashboard regularly. Frequently checking the status will ensure completion of the reporting requirement prior to the certification deadline.

FDDC Status Definitions

Initial Due: The quarterly file has not been submitted.

File Accepted: The file has been uploaded successfully to FDDC.

Facility Review: Facility reviews their submission reports for corrections and verifications.

Analyst Review: Request submitted to analyst for review and approval of clean data.

Ready To Certify: The facility has an electronic certification pending signature.

Certified: Quarterly submission has been submitted and certified.

Exempted: Quarterly submission has been exempted from reporting due to having less than 200 visits.

SECTION 4 HEADER RECORD

What Is the Declaration line

The first line in a data file preceding the header is termed the declaration line. The declaration line identifies the schema format location.

Below are the declaration lines for PD10-5 and AS10-5:

PD10-5 (new schema) header line should read:

<?xml version="1.0" encoding="UTF-8" standalone="yes"?>
<HC_DATA xmlns: xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:noNamespaceSchemaLocation="http://ahca.myflorida.com/xmlschemas/PD10-5.xsd">
<HEADER>

AS10-5 (new schema) header line should read:

<?xml version="1.0" encoding="UTF-8"?>
<HC_DATA xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:noNamespaceSchemaLocation="http://ahca.myflorida.com/xmlschemas/AS10-5.xsd">
<HEADER>

What Is a Header Record?

The Header Record is the first record section in the data file that contains the specific data element information described in this section. This information enables AHCA's system to identify the submitting facility, quarters, and other specific system information required for processing. The Data elements and code is described by name, a parameter description, and data standard.

Alpha codes must be in upper case unless otherwise designated.

Header
Data Element Dictionary

Data Element	Edit Checks Performed	Error Type
Report Year	Missing	XSD
	Reporting year in the file header does not match with the Quarterly Submission	XSD
Report Quarter	Missing	XSD
	Reporting quarter in the file header does not match with the Quarterly Submission	XSD
Data Type	Missing	XSD
	Schema Type in the xml file is not valid	XSD
Submission Type	Missing	XSD
	Invalid Code	XSD
Process Date	Missing	SCHEMA
	Invalid date format	XSD
AHCA Number	Missing	XSD
	Invalid AHCA number	XSD
	Facility Number in the file header does not match with the Quarterly Submission	XSD
Medicare Number	Missing	SCHEMA
	Invalid format	SCHEMA
Organization Name	Missing	SCHEMA
	Invalid format	SCHEMA

Common XSD Errors:

Schema Type in XML file is not valid

Data Type in header not updated

User selected the wrong facility type (AS/PD) for upload

Facility Number in the file header does not match with Quarterly Submission

AHCA number has leading zero's

Header has invalid child element "TRANS_CODE'

Delete the Trans_Code line in the header

Common Schema Errors:

The "element" is invalid. The value " is invalid according to its datatype

The value " indicates the element field is empty

The 'CHARGES' element is invalid - The value '' is invalid according to its datatype

The value " indicates the element field is empty. All charge fields must be '0' or charge number

Report Year

Element Name: Report Year

Definition: The year of the data

Parameters: 4 numeric characters

Codes/Values: Format is YYYY

Conditions: Required

Notes:

Edits: Must be present and a valid year

Report Quarter

Element Name: Report Quarter

Definition: The report quarter of the data

Parameters: 1 numeric character

Codes/Values:

1	first quarter of the calendar year (January 1 – March 31)
2	second quarter of the calendar year (April 1 – June 30)
3	third quarter of the calendar year (July 1 – September 30)
4	fourth quarter of the calendar year (October 1 – December 31)

Conditions: Required

Notes: The report quarters are based on the calendar year

Edits: Must be present and a valid code

Data Type

Element Name: Data Type

Definition: The type of data submitted

Parameters: 6 alpha-numeric characters

Codes/Values: Enter **PD10-5** for Inpatient Data beginning Q4 2022 data reporting
Enter **AS10-5** for AS/ED data beginning Q4 2022 data reporting

Conditions: Required

Notes: ICD-10 codes started Q4 2015

Edits: Must be a valid data type for the reporting period

Submission Type

Element Name: Submission Type

Definition: The type of submission

Parameters: 1 alpha character

Codes/Values: **I -** an ***initial*** submission of data or resubmission of previously rejected data

R - *replacement* of previously certified patient data

Conditions: Required

Notes: *Initial submissions* are made until the report has been certified

Replacement (or "resubmissions") is required when the facility or the Agency finds an error or an omission of data in the previously certified data and requests that the facility resubmit their data. *Requires written AHCA permission.*

Edits: Must be present and a valid code

Processing Date

Element Name: Processing Date

Definition: The creation date that the data file

Parameters: 10 numeric characters

Codes/Values: YYYY-MM-DD format

Conditions: Required

Notes: MM represents numbered months of the year from 01-12
DD represents numbered days of the month from 01-31
YYYY represents the year in four digits

Edits:

AHCA Facility Number

Element Name: AHCA Facility Number

Definition: The identification number of the hospital or Ambulatory Center as assigned by AHCA for reporting purposes

Parameters: 1 to 8 numeric characters

Codes/Values: N/A

Conditions: Required

Notes: The AHCA number reported in the Header Record must match the AHCA number reported in the Individual Data Record.

Edits: Must be present and a valid code
Do not use leading zero's

Medicare Number

Element Name: Medicare Number

Definition: The Medicare number of the facility as assigned by Centers for Medicare & Medicaid Services

Parameters: Must contain 7 numeric characters

Codes/Values: N/A

Conditions: Required
Zero pad a leading '0' for 6-digit numbers.

Notes: The schema does not accept alpha characters in a Medicare number. Freestanding ambulatory surgical centers may have a Medicare number containing an alpha followed by 4 numeric numbers. (i.e. F1234) The Medicare prefix code for Florida is 10. You may report your Medicare number by replacing the alpha character with 10. Padding a leading zero, enumeration of the Medicare number is 0101234.

Organization Name

Element Name: Organization Name**

Definition: The name of the facility that performed the services represented by the data, and is responsible for reporting the data

Parameters: Up to 40 characters

Codes/Values: N/A

Conditions: Required

Notes: All questions regarding data accuracy and integrity will be referred to this entity

SECTION 5 INPATIENT/COMP REHAB DATA ELEMENTS

General Specifications

- ✓ Each Data element and code is included with a description of the reportable data and the data standards.
- ✓ Alpha codes **MUST** be in upper case unless otherwise designated.
- ✓ *Do **NOT** zero pad AHCA number or any revenue charges*.
- ✓ The XML format structure does not require zero filling for Other Diagnosis Code, Other Procedure Codes, and Other Procedure Code Date data element fields. Remove unused element tags for these fields in each individual record.
- ✓ Format the ICD-10 Diagnosis code with a decimal.
- ✓ Do not format ICD-10 Procedure code with a decimal.
- ✓ Do not report Revenue codes with decimals or cents. Report as whole numbers only.
- ✓ Unused revenue codes ***must be zero filled***. Do ***not*** remove tags for unused revenue element.
- ✓ Follow official coding guidelines for ICD and POA reporting.
- ✓ Infant Linkage fields must be zero filled if patient is over the age of two. Do not remove the Infant linkage tag or leave blank.
- ✓ **The 'Record id' in the data file for each discrete record is the Patient Control Number. Refer to schema instruction.**

AHCA Facility Number

Element Name: AHCA Facility Number

Definition: The identification number of the facility assigned by AHCA for reporting purposes

Parameters: 1 to 8 numeric characters

Codes/Values: Must be a valid AHCA number

Conditions: Required for IP/CR reporting

Notes: AHCA Number should **NOT** be zero padded in the header or the body of the file. The AHCA number in the individual data record must match the AHCA number in the header record.

Patient Control Number

Element Name: Patient Control Number (Record_Id)

Definition: Patient's unique number assigned by the facility to facilitate retrieval of an individual's account of services (accounts receivable) containing the financial billing records and any postings of payment

Parameters: Up to 24 characters
Alphanumeric
Crosswalk to UB-04 FL 03

Codes/Values: N/A

Conditions: Required

Notes: The Patient Control Number is reported as 'Record id' in the data file for each discrete record. Refer to schema instruction.

Duplicate patient control numbers (Record ids) are not allowed

The PCN identifies a single facility visit for a patient and may be called or defined as an account number.

The PCN is different from the medical record number, which identifies an individual patient and remains the same through multiple facility visits

Edits: Must be a present and in a valid format
PCN code must be present and should be unique within a facility
Duplicate Record ID (Patient Control) numbers exist

Medical or Health Record Number

Element Name: Medical or Health Record Number

Definition: The unique number assigned to the patient's medical/health record by the facility.

Parameters: Up to 24 characters
Alphanumeric
Crosswalk to UB-04 FL 3

Codes/Values: N/A

Conditions: Required

Notes:

Edits: MRN code must be present and in a valid format
MRN code must represent a unique patient

Patient Social Security Number

Element Name: Patient Social Security Number

Definition: The Social Security number (SSN) of the patient receiving treatment

Parameters: 9 numeric characters

Codes/Values: See Unknown SSN Default Codes

Conditions: Required

Notes: One SSN per patient

The last four-digit SSN format must only be used when the full SSN is unknown and not as a substitute for all nine-digit SSN's.

Hospital discharge data is useful to identify cases of traumatic brain injuries and/or birth defects by the Department of Health

Unknown SSN Default Codes	
Where the last 4 digits of the SSN are known	77777XXXX
Patients where efforts to obtain the SSN have been unsuccessful. Patient is a non-US citizen who has not been issued an SSN. Patient is under 2 years of age and does not have an SSN	777777777

Edits:

- Must be a valid SSN or default.
- SSN cannot equal 000000000, 000XXXXXX, XXX00XXXX, XXXXXX000
- SSN cannot begin with 666; any value in the range 900-999; same 9 digits except for default SSN-777777777
- Cannot equal 078051120 or 219099999 as defined by SSA.
- One-number SSNs are prohibited.
- Duplicate SSN's and same DOS
- Identical Patient Social Security Number on one or more other records must have the same Patient Race, Patient Sex, and Patient Date of Birth.

Patient Ethnicity

Element Name: Patient Ethnicity

Definition: Self-designated by the patient, patient's parent, or guardian.
This item gives the **Patient's answer to the question "Are you Hispanic?".** The information is based on self-identification and is to be obtained from the patient, a relative or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Parameters: 2-digit alpha-numeric code

Codes/Values:

E1	Hispanic or Latino
E2	Non-Hispanic or Latino
E7	Unknown

Conditions: Required

Notes: **Hispanic or Latino** - A person of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish culture or origin regardless of race

Non-Hispanic or Latino - A person not of any Spanish culture or origin

Unknown - Use if the patient refuses or fails to disclose.

The Patient's Race/Ethnicity field is useful for statistical and epidemiological purposes.

Edits: Code must be present and a valid code
Facility must verify unknown Ethnicity exceeding 50%

Patient Race

Element Name: Patient Race

Definition: Self-designated by the patient, patient's parent, or guardian. The information is based on self-identification and is to be obtained from the patient, a relative, or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Comments: If the patient chooses not to answer, the facility should enter the code for unknown. If the facility fails

Parameters: 1 numeric code

Codes/Values:

1	American Indian or Alaska Native
2	Asian
3	Black or African American
4	Native Hawaiian or Other Pacific Islander
5	White
6	Other
7	Unknown *(for use if the patient refuses or fails to disclose)*

Conditions: Required

Notes:

American Indian or Alaskan Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains cultural identification through tribal affiliation or community recognition

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, China, Cambodia, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam

Black - A person having origins in any of the black racial groups of Africa.

Native Hawaiian or other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

White - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Other - Use if not described in above categories, including a patient who has more than one race.

Edits: Must be present and a valid code
Facility must verify unknown Race exceeding 50%

Patient Birth Date

Element Name: Patient Birth Date

Definition: Date of birth of the patient

Parameters: 10 characters
Crosswalk to UB-04 FL 10

Codes/Values: Format: YYYY-MM-DD
MM represents months of the year from 01-12
DD represents days of the month from 01-31
YYYY represents the year in four digits.

Conditions: Required

Notes: **Use the default of 1880-01-01 if DOB is unknown**.
The reporting entity must verify an age greater than 115 years.
The date of birth is used to calculate patient age.

Edit*s:* Date of birth must be present and valid:
A valid date- not occurring after admitting or discharge date.
Consistent with diagnosis
Age calculated from date of birth and discharge.
Must verify age greater than 115 years.

Patient Sex

Element Name: Patient Sex

Definition: The sex of the patient ***at admission***

Parameters: 1 alpha character
Crosswalk to UB-04 FL 11

Codes/Values:
M Male
F Female
U Unknown

(Use "unknown" where efforts to obtain the information have been unsuccessful or where the patient's sex cannot be determined due to a medical condition.)

Conditions: Required

Notes: In instances where the patient has a sex change, the patient sex reported should be the ***sex at admission***; the procedure performed will indicate a change in sex

Report a child born with evidence of both sexes as "unknown" sex code U

The patient sex and age are used to determine validity of dependent ICD codes, Diagnostic Related Group (DRG) classification process and in data analysis.

Edits: Must be present and a valid code
Code must be valid and consistent with diagnosis and procedure codes.
Must verify Patient sex =U (unknown)

Patient Zip Code

Element Name: Patient Zip Code

Definition: The five (5) digit US Postal Service zip code of the patient's Address (see note)

Parameters: 5 numeric characters
Crosswalk to UB-04 Fl 9d or HCFA-1500 FL 5

Codes/Values:

ZIP Default	Description
00009	Foreign Residences
00007	Homeless Patients
00000	Unavailable/Unknown

Conditions: Required
Do not include hyphens.

Notes: To verify U.S. Postal Zip Codes, visit the USPS Zip code lookup search at: https://tools.usps.com/go/ZipLookupAction!input.action

The permanent residence is the address ***as declared by the patient***. For individuals that reside seasonally in Florida, but do not declare permanent residency, report the zip code of their resident state or 00009 for foreign residency.

Edits: Postal zip code must be present and be a valid USPS zip code or default

Patient Country Code

Element Name: Patient Country Code

Definition: The country code of residence

Parameters: 2-digit upper case alpha character
Crosswalk to UB-04 Fl 9d or HCFA-1500 FL 5

Codes/Values: Defined from the International Standard for Organizations country code list, ISO 3166 or latest release.

Conditions: Required

Notes: Use 99 where the country of residence is unknown, or where efforts to obtain the information have been unsuccessful.

To look up country codes, go to the Reporting Resource page available at the Florida Center/Data Collection Website address:

http://ahca.myflorida.com/SCHS/DataCollection/help.shtml

If the country is not included on the Data Guide Country Code List, go to the ISO 3166 website below and look up the 2-character country code :

https://www.iso.org/obp/ui/#search

Report the permanent residence ***as declared by the patient***. For individuals that reside seasonally in Florida, but do not declare permanent residency, report the zip code of their resident state or 00009 for foreign residency.

Edits: Must be present and a valid code

Type of Service Code

Element Name: Type of Service Code

Definition: The type of discharges as either acute inpatient OR comprehensive rehabilitation

Parameters: 1-digit numeric code

Codes/Values:

1 Includes acute inpatient, long term care, short- and long-term psychiatric services.

2 Comprehensive Rehabilitation hospitals and inpatient comprehensive rehab distinct part units

Conditions: Required

Notes: **Comprehensive rehabilitation:** defined as a program of integrated intensive care services provided by a multidisciplinary team to patients with severe physical disabilities, such as stroke; spinal cord Morbidity; congenital deformity or other disabilities

Rehab units such as Psychiatric Rehab, ventilator rehab and behavioral are not classified as comprehensive rehab.

An Acute Care hospital license must have comprehensive beds in order to report Type of Service 2.

Edits: Must be present and a valid code
Acute care hospital with TOS=2 and facility unlicensed for comp beds
CR hospital with Type of Service =1
Type of Service =2 and no Comp Rehab Charges
Comp rehab Charges and Type of Service = 1

Priority of Admission

Element Name: Priority of Admission

Definition: A code indicating the scheduling of this admission

Parameters: 1- digit numeric code
Crosswalk to UB04 FL14

Codes/Values:

1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma

Conditions: Required

Notes: **Emergency -** The patient requires immediate medical intervention for a severe, life threatening or disabling condition

Urgent - The patient requires attention for the care and treatment of a physical or mental disorder. Mothers admitted for normal delivery is codified in this category.

Elective - The patient's condition permits adequate time to schedule the services.

Newborn - Newborn indicates the baby was born in your hospital, or the initial hospital to attend the infant following an extramural birth within the first 24 hours of birth.

Excludes babies born in a different hospital and transferred to the reporting hospital

Trauma - Visit to a State of Florida licensed trauma center. The use of Code 5 does not require revenue code 068X.

Edits:

- Must be present and a valid code.
- Trauma Priority of Admission at a Non-Trauma Facility
- Trauma Charge at a Non-Trauma facility
- Admit Date=DOB, Priority of Admission Type not 4, Admit Source must be 04
- Threshold: More Deliveries than Newborns

Source of Admission/Point of Origin

Element Name: Source of Admission/Point of Origin

Definition: A code indicating the source of the referral for this admission or the point of patient origin for this admission or visit

Parameters: 2- digit Numeric code OR 1-digit alpha code
Crosswalk to UB04 FL15

Codes/Values:

01	Non-health care facility
02	Clinic
04	Transfer from a Hospital (different facility)
05	Transfer from a Skilled Nursing Home (SNF)
06	Transfer from another health care facility

Emergency room option discontinued 7/1/2010. To report use Condition Code P7.

08	Court/Law Enforcement
09	Information not available
10	Born inside this hospital
13	Born outside this hospital
D	Transfer from one distinct unit of the hospital to another distinct unit in the same hospital
E	Transfer from an Ambulatory Surgery Center
F	Transfer from a hospice facility and under a hospice plan of care or enrolled in a hospice program

Conditions: Required

Notes: The point of origin is the direct source for the facility.

Emergency Room: Use Source code 04 for patients who come to the emergency room from another health care facility or Source code 05 for patients who come to the emergency room from a SNF.

Example: An accident patient is taken to the emergency department of hospital A, stabilized, then transferred to hospital B (a trauma center) where they receive additional treatment in the ED, and then admitted as an inpatient to hospital B. Emergency Department. The Point of Origin for hospital B is 04-Transfer from another hospital.

Court/Law Enforcement: Includes transfers from incarceration facilities, admissions upon direction of the court, accompanied or under supervision of police/law enforcement.

Newborns: For newborns born at one facility (Hosp A) and transferred to another facility NICU (Hosp B), Hospital B would use Source code 04 Hospital Transfer and Priority of Admission 1-Emergency.

D: For purposes of this code, a "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, and a unit swing bed located in an acute hospital.

E*dits*:

Must be present and a valid code
Newborn source or priority, Age >1 day
Newborn Source of Admission without Newborn Priority
Newborn priority of admission without newborn source

Admission Date

Element Name: Admission Date

Definition: The date of admission for the inpatient episode of care

Parameters: 10 Characters
Crosswalk to UB04 FL12

Codes/Values: Format is YYYY-MM-DD
MM represents months of the year from 01-12
DD represents days of the month from 01-31
YYYY represents the year in four digits.

Conditions: Required

Notes: Admission Date must equal or precede the discharge date

Edits: Must be present and a valid date
Admission Date must equal or precede the discharge date.
Admit Date more than 6 days after ED Date of Arrival
Admit date equal Discharge Date

Inpatient Admission Time

Element Name: Inpatient Admission Time

Definition: The code referring to the hour the patient was admitted for inpatient care

Parameters: 2- digit numeric code
Crosswalk to UB04 FL13

Codes/Values:

AM	**PM**
00-12:00 midnight to 12:59 A.M.	**12**- 12:00 noon to 12:59 P.M.
01- 01:00 to 01:59	**13**- 01:00 to 01:59
02- 02:00 to 02:59	**14**- 02:00 to 02:59
03- 03:00 to 03:59	**15**- 03:00 to 03:59
04- 04:00 to 04:59	**16**- 04:00 to 04:59
05- 05:00 to 05:59	**17**- 05:00 to 05:59
06- 06:00 to 06:59	**18**- 06:00 to 06:59
07- 07:00 to 07:59	**19**- 07:00 to 07:59
08- 08:00 to 08:59	**20**- 08:00 to 08:59
09- 09:00 to 09:59	**21**- 09:00 to 09:59
10- 10:00 to 10:59	**22**- 10:00 to 10:59
11- 11:00 to 11:59	**23**- 11:00 to 11:59
99- Unknown – Use 99 **only** where efforts to obtain the information is unsuccessful.	

Conditions: Required

Notes: Use 99 where efforts to obtain the information have been unsuccessful

Edits: Must be present and a valid code

Discharge Date

Element Name: Discharge Date

Definition: The date of the patient discharge from the care of the reporting facility

Parameters: 10 Characters
Crosswalk to UB04 FL06

Codes/Values: Format is YYYY-MM-DD
MM represents months of the year from 01-12
DD represents days of the month from 01-31
YYYY represents the year in four digits.

Conditions: Required

Notes: ***Discharge date must occur within the quarterly period as shown on the header record***

A *"Discharge*" is defined when a patient is formally released from the facility; transferred to a different facility; transferred to a non-acute care distinct part unit within a facility; or dies.

Organ Harvesting procedures are not reportable to AHCA. *Acute care reporting ends when a patient dies.* A patient 'readmitted' for donor procedures is not reportable. See Glossary/Organ Donor in Section 7

Hospice Patient discharged from distinct "Hospice Units" is **NOT** reportable. Only patients discharged from *Acute Care* are reportable in the inpatient data. If a hospice patient is admitted for acute inpatient care, the acute care stay is reported.

Edits: Must be present and a valid date
Discharge Date must equal or follow the admission date.
Verify Length of Stay >365
Discharge date is not within the Reporting Quarter

Discharge Time

Element Name: Discharge Time

Definition: Code indicating the discharge hour of the patient from inpatient care

Parameters: 2-digit numeric code
Crosswalk to UB04 FL16

Codes/Values:

AM	PM
00-12:00 midnight to 12:59 A.M.	**12**- 12:00 noon to 12:59 P.M.
01- 01:00 to 01:59	**13**- 01:00 to 01:59
02- 02:00 to 02:59	**14**- 02:00 to 02:59
03- 03:00 to 03:59	**15**- 03:00 to 03:59
04- 04:00 to 04:59	**16**- 04:00 to 04:59
05- 05:00 to 05:59	**17**- 05:00 to 05:59
06- 06:00 to 06:59	**18**- 06:00 to 06:59
07- 07:00 to 07:59	**19**- 07:00 to 07:59
08- 08:00 to 08:59	**20**- 08:00 to 08:59
09- 09:00 to 09:59	**21**- 09:00 to 09:59
10- 10:00 to 10:59	**22**- 10:00 to 10:59
11- 11:00 to 11:59	**23**- 11:00 to 11:59
	99- Unknown - Use 99 **only** where efforts to obtain the information have been unsuccessful.

Conditions: Required

Notes: Use 99 where efforts to obtain the information have been unsuccessful

Edits: Must be present and a valid code
Discharge Time equal Admit Time

Patient Discharge Status

Element Name: Patient Discharge Status

Definition: A code indicating the disposition or discharge status of the patient upon release from the facility inpatient status

Parameters: 2- digit Numeric code
Crosswalk to UB04 FL17

Codes/Values:

01	Discharged to home or self-care
02	Discharged or transferred to a short-term general hospital
03	Discharged or transferred to a skilled nursing facility
04	Discharged or transferred to an intermediate care facility
05	Discharged or transferred to a designated cancer center or Children's Hospital
06	Discharged or transferred to home under care of home health care organization
07	Left this hospital against medical advice (AMA) or discontinued care
20	Expired
21	Discharged or transferred to Court/Law Enforcement ***Added Effective 1/1/2011***
50	Hospice – home
51	Hospice medical facility (certified) providing hospice level care
62	Discharged or transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged or transferred to a Medicare certified long term care Hospital
64	Discharged or transferred to a Nursing Facility certified under Medicaid but not Medicare certified
65	Discharged or transferred to a psychiatric hospital including psychiatric distinct part units of a hospital
66	Discharged or transferred to a Critical Access hospital
70	Discharged or transferred to another type of health care institution not defined elsewhere in this code list

Conditions: Required for IP/CR reporting

Notes: **Home - 01** - Includes discharge to home; group home, foster care, and other residential care arrangements; incarceration facilities such as jail, prison, or other detention centers; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state- designated

Skilled Nursing Home (SNF) - 03 - Medicare – Indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For reporting other discharges/transfers to nursing facilities see code 04

Intermediate Care Facility (ICF) -04 - used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities

Designated Cancer Center/Children's Hospital - 05 - Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions. Transfers to non-designated cancer hospitals should use Code 02
A list of (National Cancer Institute) Designated Cancer Centers can be found at: http://cancercenters.cancer.gov/cancer_centers/index.html

Discharged to home under care of home health care organization- 06 - Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home IV provider for home IV services.

Discharged or transferred to Court/law Enforcement-21- Includes transfers to incarceration facilities such as jail, prison, or other detention centers

Discharged to a psychiatric hospital - 63 – For hospitals that meet the Medicare criteria for long term care hospital (LTCH) certification.

Edits: Must be present and a valid code

Principal Payer Code

Element Name: Principal Payer Code

Definition: Describes the expected primary source of reimbursement for services rendered based on the patient's status at discharge or the time of reporting

Parameters: 1 upper case alpha character

Codes/Values:

A	Medicare
B	Medicare Managed Care
C	Medicaid
D	Medicaid Managed Care
E	Commercial Health Insurance
H	Workers' Compensation
I	TriCare or Other Federal Government
J	VA
K	Other State/Local Government
L	Self Pay
M	Other
N	Non-payment
O	KidCare
Q	Commercial Liability Coverage

Conditions: Required

Notes: Report payer codes based on AHCA specifications

Payer A – Medicare

Payer B – Medicare Managed Care

Patients covered by Medicare Advantage plans, Medicare HMO, Medicare PPO, Medicare Private Fee for Service, or any other type of Medicare plan where CMS is not the direct payer.

Payer C – Medicaid

Payer D –Medicaid Managed Care

Patients covered by Medicaid funded capitated plans. This would include any program where the patient is enrolled in the Medicaid program, but the payment is not directly from the state of Florida Medicaid program.

Payer E – Commercial Health Insurance

Patients are covered by any type of private coverage, including HMO, PPO, or self-insured plans.

Payer H – Workers' Compensation

Payer I – Tricare or Other Federal Government, CHAMPUS

Payer J – VA

Payer K – Other State/Local Government
Prison system and court orders is classified in this payer category

Payer L – Self-Pay
Patients with no insurance coverage. Uninsured or self-pay patients. It is unusual to not report any patients in this category. No third-party coverage or less than 30% estimated insurance coverage.

Payer M – Other
Includes Letter of Protection and other categories undesignated

Payer N – Non-Payment
Includes charity, professional courtesy, no charge, research/clinical trial, refusal to pay/bad debt, Hill Burton free care, research/donor that is known at the time of reporting.

Payer O – Kidcare
Includes Healthy Kids, MediKids and Children's Medical Services (CMS)

Payer Q – Commercial Liability Coverage
Includes Auto insurance claims, homeowners, or general business liability coverage, and/or commercial liability claims.

Edits:

Must be present and a valid code
Patient Age Over 19 and Payer=O (Kid-Care)
Invalid use of Payer P
Payer M records greater than 10%

Principal Diagnosis Code

Element Name: Principal Diagnosis Code

Definition: The code representing the diagnosis established, after study, to be chiefly responsible for occasioning the admission. Principal diagnosis code must contain a valid ICD-10-CM code for the reporting period.

Parameters: Alphanumeric
Crosswalk UB04 FL67

Codes/Values: ICD-10-CM. Must be a valid ICD-10-CM based on the quarter reported.

The ICD code must contain a decimal point that is included in the valid code. All alpha characters MUST be in upper case.

Conditions: Required

Notes: ICD-10 code **MUST** include the decimal
Include POA- Present on Admission Indicator

Edits: Must be a valid code
Principal diagnosis is missing.
Consistent with sex and age
Consistent with a valid MS-DRG- ungroupable
ECMORB code cannot be used for principal diagnosis.
Principal diagnosis repeated in secondary codes.
PDX Invalid as a discharge diagnosis (DRG 998)

Other Diagnosis Code 1-30

Element Name: Other Diagnosis Code (1-30)

Definition: A code representing a condition related to the services provided during the hospitalization excluding external cause of Morbidity codes.

Parameters: Alphanumeric
Crosswalk UB04 FL67

Codes/Values: ICD-10-CM code
Other Diagnosis Codes (1) thru Other Diagnosis Code (30)

Must be a valid ICD-10-CM based on the quarter reported.

Enter the code with a decimal point that is included in the valid code and **UPPER-CASE** alpha characters.

Conditions: No entry is permitted

Notes: **I**nclude POA- Present on Admission Indicator

Remove unused XML tags if not reported.

No more than thirty (30) other diagnosis codes may be reported. Less than thirty (30) entries or no entry is permitted.

Report external cause of morbidity codes in the designated ECMORB fields.

Edits: Must be a valid code
Consistent with sex and age
Consistent with a valid MS-DRG- ungroupable
An ECMORB code cannot be used as a secondary diagnosis.
Other diagnosis repeated in secondary codes.

Present on Admission Indicator (POA)

Element Name: Present on Admission Indicator (POA) for Principal Diagnosis Code
Present on Admission Indicator for Other Diagnosis Code
Present on Admission Indicator for External Cause of Morbidity Code

Definition: A code differentiating whether the condition represented by the corresponding Principal Diagnosis Code, Other Diagnosis Code and External Cause of Morbidity Code was present on admission or whether the condition developed after admission as determined by the physician, medical record, or nature of the condition

Parameters: 1 Alpha and/or 1 numeric code
Crosswalk to UB04 FL67

Codes/Values: Present on Admission Indicator must be a one-character alpha code, or one numeric code as follows:

Y	Yes — Present at the time that the order for inpatient admission occurs
N	No — Not present at the time that the order for inpatient admission occurs
U	Unknown — Documentation is insufficient to determine if condition is present on admission
W	Clinically Undetermined — Provider is unable to clinically determine whether condition was present on admission or not
1	Excluded from reporting POA. ICD is on the CMS excluded list.

Conditions: Required for principal diagnosis and all secondary diagnoses reported.

Notes: Coding professionals should follow the comprehensive guidelines on POA as published in the ICD-10-CM Official Guidelines or Coding and Reporting. National guidelines for POA are located at the following link: http://www.cdc.gov/nchs/icd/icd10cm.htm

Edits: Must be a valid code
POA for Principal DX is not valid.
POA for SDX is not valid.
POA for ECMORB 1, 2, OR 3 is not a valid Code.

Principal Procedure Code

Element Name: Principal Procedure Code

Definition: The ICD-10-PCS code that identifies the principal procedure performed.

Parameters: Alphanumeric
Crosswalk to UB04 FL74

Codes/Values: Must be valid ICD-10- PCS code based on the reporting period.

Enter the Procedure code without a decimal point. Alpha characters must use UPPER case.

Conditions: No entry is permitted

Notes: Remove unused XML tag if not reported

If a principal procedure date is reported, a valid principal procedure code must be reported

Edits: Must be a valid code
Consistent with sex and age
Principal Procedure without valid procedure date
Principal Procedure date without Principal Procedure
Principal Procedure code after discharge date
Principal Procedure w/o Performing ID OR Performing ID w/o Principal Procedure

Principal Procedure Date

Element Name: Principal Procedure Date

Definition: The date when the principal procedure was performed

Parameters: A ten (10) character field
Numeric
Crosswalk to UB04 FL74

Codes/Values: Format YYYY-MM-DD
MM represents the numbered months of the year from 1-12
DD represents the days of the month from 1-31
YYYY represents the year in four digits.

Conditions: A required entry if a corresponding procedure code is present

Notes: The procedure date must be less than six (6) days prior to admission date and not later than the discharge date

Remove unused XML tags if not reported.

Edits: Principal Procedure date is invalid
Principal Procedure without valid procedure date
Principal Procedure date without Principal Procedure
Principal Procedure without Operating Practitioner
Operating Practitioner without Principal Procedure
Principal Procedure date after discharge date
Principal Procedure date more than 6 days before admission

Other Procedure Code (1-30)

Element Name: Other Procedure Code 1-30

Definition: The ICD-10-PCS code identifies all significant procedures other than the principal procedure. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Parameters: Alphanumeric
Crosswalk to UB04 FL74a-e

Codes/Values: Must be valid ICD-10- PCS code based on the reporting period,

The code must NOT be entered with use of a decimal point. Alpha characters MUST be in upper case.

Conditions: No entry is permitted
If a principal procedure is not reported, an Other Procedure Code must not be reported.

Notes: Remove unused XML tags if not reported

Up to thirty (30) other ICD-10-PCS codes may be reported in this field. Less than thirty (30) or no entry is permitted consistent with the records of the reporting entity.

Edits: Must be a valid code
Consistent with sex and age
Other Procedure without valid procedure date
Other Procedure code without Other Procedure date

Other Procedure Code Date (1-30)

Element Name: Other Procedure Code Date (1-30)

Definition: The date the procedure is performed

Parameters: A 10-character numeric field
Crosswalk to UB04 FL74a-e

Codes/Values: Format: YYYY-MM-DD
MM represents the numbered months of the year from 1-12
DD represents the days of the month from 1-31
YYYY represents the year in four digits.

Conditions: A required entry if a corresponding procedure code is reported

Notes: Remove unused XML tags if not reported

Edits: Other Procedure date is invalid
Other Procedure without valid procedure date
Other Procedure date without Other Procedure
Other Procedure date after discharge date
Other Procedure date more than 6 days before admission

Attending Practitioner Identification Number

Element Name: Attending Practitioner Identification Number

Definition: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the patient's medical care and treatment

Parameters: Alphanumeric. Alpha prefix must be in upper case.
Crosswalk to UB04 FL76

Codes/Values: Report the alpha prefix and number without leading zeros.
See Florida License Prefix Table in Section 6

Conditions: Required

Notes: To verify practitioner license numbers, visit the DOH Florida Medical License Search: *FL DOH MQA Search Portal | Home Page (state.fl.us)*

For military physicians not licensed in Florida, use US999999999 in upper case.

Edits: Must be present
Must be a valid Florida license ID or default.

Attending Practitioner National Provider Identification Number (NPI)

Element Name: Attending Practitioner Provider Identification Number (NPI)

Definition: The NPI number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced practice registered nurse who had primary responsibility for the patient's medical care and treatment

Parameters: 10-character number
Crosswalk to UB04 FL76

Codes/Values: Use 9999999999 as default (see notes)

Conditions: Required

Notes: For military physicians, medical residents, or practitioners not required to obtain a NPI number, or where efforts to obtain a NPI are unsuccessful, use 9999999999.

Required for US practitioners or its territories.

Edits: Must be present
Attending practitioner NPI is invalid.

Operating or Performing Practitioner Identification Number

Element Name: Operating or Performing Practitioner Identification Number

Definition: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the procedure performed

Parameters: Alphanumeric. Alpha prefix must be in upper case.
Crosswalk to UB04 FL77

Codes/Values: Report the alpha prefix and number without leading zeros.
See Florida License Prefix Table in Section 6

Conditions: No entry is permitted

Notes: To verify practitioner license numbers, visit the DOH Florida Medical License Search:
FL DOH MQA Search Portal | Home Page (state.fl.us)

The operating medical doctor is the practitioner performing the principal procedure.

For military physicians not licensed in Florida, use US999999999 in upper case.

Edits: Must be a valid Florida license ID or default
Performing practitioner ID without Principal Procedure
Principal Procedure without Performing practitioner.
Operating Practitioner and Other Practitioner are the same

Operating or Performing Practitioner National Provider Identification Number

Element Name: Operating or Performing Practitioner National Provider Identification Number (NPI)

Definition: The NPI number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the patient's medical care and treatment or who had primary responsibility for the procedure performed

Parameters: 10-character number
Crosswalk to UB04 FL77

Codes/Values: Use 9999999999 as default (see notes)

Conditions: Required if Operating Practitioner reported

Notes: **The operating medical doctor is the practitioner performing the principal procedure**

For military physicians, medical residents, or practitioners not required to obtain a NPI number, or where efforts to obtain a NPI are unsuccessful, use 9999999999.

Required for US practitioners or its territories.

The Operating or Performing Practitioner may be the same as the attending practitioner.

Edits: Operating practitioner NPI is invalid
Operating practitioner ID without NPI number or NPI w/o Operating practitioner license ID

Other Operating or Performing Practitioner Identification Number

Element Name: Other Operating or Performing Practitioner Identification Number

Definition: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had assisted the operating or performing physician or performed a secondary procedure

Parameters: Alphanumeric. Alpha prefix must be in upper case.
Crosswalk to UB04 FL77

Codes/Values: Report the alpha prefix and number without leading zeros.
See Florida License Prefix Table in Section 6

Conditions: No entry is permitted

Notes: To verify practitioner license numbers, visit the DOH Florida Medical License Search: *FL DOH MQA Search Portal | Home Page (state.fl.us)*

For military physicians not licensed in Florida, use US999999999 in upper case.

All Other Operating or Performing Practitioners must be licensed in the State of Florida

Edits: Other practitioner State license ID is invalid
Other practitioner ID is the same as Performing practitioner.

Other Operating or Performing Practitioner National Provider Identification Number (NPI)

Element Name: Other Operating or Performing Practitioner National Identification Number (NPI)

Definition: The NPI number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who assisted the operating or performing physician or performed a secondary procedure

Parameters: 10-character number
Crosswalk to UB04 FL77

Codes/Values: Use 9999999999 as default (see notes)

Conditions: Required if Other Practitioner reported

Notes: For military physicians, medical residents, or practitioners not required to obtain a NPI number, or where efforts to obtain a NPI are unsuccessful, use 9999999999

Required for US practitioners or its territories.

Edits: Other practitioner NPI is invalid
Other practitioner ID without NPI number or NPI w/o Other practitioner license ID

Revenue Code Category Charges

Element Name: Revenue Code Category Charges (Excludes Nursery Charges)
Definition: Total charges for the related revenue code category
Parameters: Numeric
Crosswalk to UB04 FL42 and FL47

Codes/Values: Whole dollars only, rounded to the nearest dollar.
Reportable categories:

Room/Board	11x – 016x
Intensive Care	020x
Coronary Care	021x
Pharmacy	25x and 63x
Medical/Surgical Supply	27x and 62x
Laboratory	30x-31x
Radiology	32x-35x; 40x; and 61x
Cardiology	48x
Respiratory/Pulmonary	41x and 46x
Operating Room	36x
Anesthesia	37x
Recovery Room	71x
Labor Room	72x
Emergency Room	45x
Trauma Response	68x
Treatment/Observation	76x
Behavioral Health	91x and 100x
Oncology	28x
Physical Therapy	42x
Occupational Therapy	43x
Speech/Language Therapy	44X
Comp Rehab	0118, 0128, 0138, 0148, 0158
Other Charges	DO NOT Include 96x-99x

Conditions: Required

Notes: Do not use negative numbers, alpha characters, cents, decimals, dollar signs or commas

Report zero (0) if there are no charges. Populate all revenue codes with either a charge amount or zero.

Do not remove unused revenue tags.
Include charges for services rendered by the hospital excluding professional fees.

Intensive Care charge (Rev code 020X) **excludes** neonatal intensive care charges reported as a Level III

Radiology includes charges for the performance of diagnostic and therapeutic radiology services including computed tomography, mammography, magnetic resonance imaging, nuclear medicine and chemotherapy administration of radioactive substances

Cardiology includes charges for cardiac procedures rendered such as, but not limited to, heart catheterization or coronary angiography

Oncology charges **exclude** therapeutic radiology services reported in radiology and other imaging services

DO NOT include charges from revenue codes 96X, 97X, 98X or 99X for professional fees and personal convenience items

Report combined charges for every revenue line item in a specific reportable category.

Edits:

- Record has no room charges.
- Per Diem not between $200 and $200,000
- Sum of sub charges <> total or charge data invalid
- Total Charges = 0 and priority type not 4
- Comp Rehab Charges but Type of Service not 2
- Type of Service =2, comp rehab charges not reported
- Inpatient Emergency Room Charges must be greater than $0.00 when the Inpatient Condition Code is P7 and the Inpatient Principal Payer is not A, B, or I.
- Trauma Charge>0 and Priority of Admission not "5"

Nursery Level I, II, III Charges

Element Name: Nursery Level I Charges
Nursery Level II Charges
Nursery Level III Charges

Definition: Accommodation charges for nursing care to newborn and premature infants in nursery

Parameters: Numeric
Crosswalk to UB04 FL42, Revenue Code 17X

Codes/Values: Whole dollars only, rounded to the nearest dollar without decimals, dollar signs, or commas

Reportable categories:
0170; 0171; 0172; 0173; 0174; 0179

Conditions: Required

Notes: The levels of care correlate to the intensity of medical care provided to the infant

Report zero (0) if there are no charges. Populate all revenue codes with either a charge or zero**. Do NOT remove unused revenue tags .**

Level I: Accommodation charges for well-baby care services which include sub-ventilation care, intravenous feedings and gavage to neonates. Includes revenue codes 0170, 0171 and 0179.

Level II: Accommodation charges for services which include provision of ventilator services and at least 6 hours of nursing care per day. Restricted to neonates of 1000 grams birth weight and over with the exception of those neonates awaiting transfer to Level III. Includes revenue codes 0172 and 0179.

Level III: Accommodation charges for services which include the provision of continous cardiopulmonary support services 12 or more hours of nursing care per day, complex pediatric surgery, neonatal cardiovascular surgery, pediatric neurology and neurosurgery and pediatric cardiac catheterization. Includes revenue codes 0173, 0174 and 0179.

Level IV: Florida does not have Level IV licensure.

Edits: Nursery Charges are not reported or invalid

Total Gross Charges

Element Name: Total Gross Charges

Definition: The total of undiscounted charges for services rendered by the Hospital

Parameters: Numeric
Crosswalk to UB04 FL47

Codes/Values: Whole dollars only, rounded to the nearest dollar.

Conditions: Required

Notes: Do not use negative numbers, alpha characters, cents, decimals, dollar signs or commas

Report zero (0) if there are no charges. Populate all revenue codes with either a charge or zero.

Do not remove unused revenue tags

Include charges for services rendered by the hospital excluding professional fees

Edits: Must be present
Sum of sub charges <> total or charge data invalid
Total charges > 3 million
Total Charges = $0 and Admit Priority not 4

Infant Linkage Identifier

Element Name: Infant Linkage Identifier

Definition: The social security number of the patient's birth mother where the patient is less than two (2) years of age

Parameters: A nine (9) digit field to facilitate retrieval of individual case records, to be used to link infant and mother records and for medical research

Codes/Values: 9 Numeric characters
See Unknown SSN Default Codes

Conditions: Required

- Patient age is less than two (2) years of age at admission enter the mother's SSN or unknown default below.
- Patient is two (2) years of age or older, use 000000000

Notes: This data allows for linking of multiple records for the same patient. Hospital discharge data is used by the Department of Health to identify cases of traumatic brain injuries and/or birth defects.

Unknown SSN Default Codes	
Infants in the custody of the state of Florida or adoptions and if the birth mother's SSN is not available	333333333
Where the last 4 digits of the SSN are known	77777XXXX
Patients where efforts to obtain the SSN have been unsuccessful. Patient is a non-US citizen who has not been issued an SSN. Patient is under 2 years of age and does not have an SSN	777777777

Edits: Must be present
Infant Linkage Identifier is not valid.
Infant Linkage Identifier ≠ Patient's SSN

Admitting Diagnosis

Element Name: Admitting Diagnosis

Definition: The diagnosis provided by the admitting physician at the time of admission which describes the patient's condition upon admission or purpose of admission.

Parameters: Alphanumeric
Crosswalk to UB04 FL69

Codes/Values: Must contain a valid ICD-10-CM code for the reporting period.

Enter the code with a decimal point that is included in the valid code and **UPPER-CASE** alpha characters.

Conditions: Required

Notes: This data element **does not require** a Present on Admission (POA) indicator

Edits: Must be present
Must be a valid code.
Consistent with sex and age
Admitting diagnosis is an ECMORB code.

External Cause of Morbidity Code (1), External Cause of Morbidity Code (2) and External Cause of Morbidity Code (3)

Element Name: External Cause of Morbidity Code (1), External Cause of Morbidity Code (2) and External Cause of Morbidity Code (3)

Definition: A code representing circumstances or conditions as the cause of the Morbidity, poisoning, or other adverse effects recorded as a diagnosis

Parameters: Alphanumeric
Crosswalk to UB04 FL72a-c

Codes/Values: Entry must be a valid ICD-10-CM cause of Morbidity code (ECMORB code) for the reporting period.

Enter the code with a decimal point that is included in the valid code and **UPPER CASE** alpha characters.

Conditions: No entry is permitted

Notes: **ECOMB code reportable range is V00-Y99**

Less than three (3) or no entry is permitted consistent with the records of the reporting entity.

Report External cause of Morbidity codes only in the ECMORB designated fields. Do not use ECMORB codes as a principal or other diagnosis.

An external cause of Morbidity code cannot repeat in a record.

Do not assign ECMORB codes on transfers from other hospitals.
Assign place of occurrence on injuries and poisonings if documented in the patient medical record.

Refer to national coding guidelines for assistance with proper code assignment and coding guidelines.

Edits: Must be a valid code
Consistent with sex and age
ECMORB code is Repeated.
ECMORB cannot be used in Principle, Other, or Admit diagnosis fields

Emergency Department (ED) Date of Arrival

Element Name: Emergency Department (ED) Date of Arrival

Definition: The date the patient registered in the Emergency Department
Parameters: 10 Characters

Codes/Values: Format is YYYY-MM-DD
MM represents months of the year from 01-12
DD represents days of the month from 01-31
YYYY represents the year in four digits.

Conditions: Required
Use default 0000-00-00 for patients not admitted through the ED.

Notes: Emergency Date of Arrival must equal or precede the admission date.

ED data elements must agree.

Patient admitted thru ED:

- Condition Code=P7
- ED Charge >$0
- ED Date
- ED Time

Patient not admitted thru ED:

- Condition Code= 00
- ED Charge = 0
- ED Date = 0000-00-00
- ED Time= 99

Edits: Must be present
ED Date of Arrival without ED charges
ED Date of Arrival is after hospital Admit Date
ED Date of Arrival without Hour or Hour without Date
Admit Date more than 6 days after ED Date of Arrival

Emergency Department (ED) Hour of Arrival

Element Name: Emergency Department (ED) Hour of Arrival

Definition: The code referring to the hour during which the patient registered in the ED

Parameters: 2-digit numeric code
Crosswalk to UB04 FL13

Codes/Values:

AM	PM
00-12:00 midnight to 12:59 A.M.	**12**- 12:00 noon to 12:59 P.M.
01- 01:00 to 01:59	**13**- 01:00 to 01:59
02- 02:00 to 02:59	**14**- 02:00 to 02:59
03- 03:00 to 03:59	**15**- 03:00 to 03:59
04- 04:00 to 04:59	**16**- 04:00 to 04:59
05- 05:00 to 05:59	**17**- 05:00 to 05:59
06- 06:00 to 06:59	**18**- 06:00 to 06:59
07- 07:00 to 07:59	**19**- 07:00 to 07:59
08- 08:00 to 08:59	**20**- 08:00 to 08:59
09- 09:00 to 09:59	**21**- 09:00 to 09:59
10- 10:00 to 10:59	**22**- 10:00 to 10:59
11- 11:00 to 11:59	**23**- 11:00 to 11:59
	99- Unknown – Use 99 **only** where efforts to obtain the information have been unsuccessful.

Conditions: Required

Notes: Use default 99 if the patient is not admitted through the ED OR if efforts to obtain the information is unsuccessful.

Report the time a patient registered in the ER for *emergency department services*. ***Do not report an ED hour of Arrival time for routine inpatient admissions.***

Edits: Must be present
Must be a valid code.
ED Hour of Arrival without ED charges
ED Date of Arrival without Hour or Hour without Date
ED Hour of Arrival equal Inpatient Discharge Time

Condition Code

Element Name: Condition Code

Definition: A two-character code that describes patients admitted to the inpatient facility after receiving treatment in the facility's emergency department.

Parameters: Two-character code
Alpha-numeric

Codes/Values:

P7	Admitted from the ED after receiving services
0	Not admitted from the ED

Conditions: Required

Notes: Do not use P7 for hospital admissions where patients are processed through the ED because the registration department is closed.

ED data elements must agree.

Patient admitted thru ED:

- Condition Code=P7
- ED Charge >$0
- ED Date
- ED Time

Patient not admitted thru ED:

- Condition Code= 00
- ED Charge = 0
- ED Date = 0000-00-00
- ED Time= 99

Edits: Must be present
Must be a valid code.
Condition Code is P7 and ED Date of Arrival or ED Hour is missing
Condition Code is 00 and ED Data elements are present.

Trailer Record

Element Name: Trailer Record

Definition: The last record in the data file shall be a trailer record and must accompany each data set. The trailer record must be placed as the last record in the data set

Parameters: 1 data element
Numeric

Codes/Values: N/A

Conditions: Required

Notes: Report the total number of patient data records contained in the file excluding the header and trailer records. **Do NOT include leading zeros.**

The number entered must equal the number of patient records processed.

Update the record count in the Trailer Record if records are added or deleted with editing.

Edits: Must be present
Records reported does not match number of records submitted.

SECTION 6 AMBULATORY/EMERGENCY DEPARTMENT DATA ELEMENTS

General Specifications

- ✓ Data elements and codes are included with a description of the data and standards.
- ✓ ***Alpha codes should be in upper case unless otherwise designated.***
- ✓ **Do NOT zero pad AHCA number or revenue charges**.
- ✓ The XML format structure does not require zero-filling for Other Diagnosis Code, Other Procedure Codes, Other Procedure Code Date, Service Location, or ECMORB data element fields. Remove element tags for these fields when not reported.
- ✓ Use the decimal point included in the valid ICD-10 diagnosis code and upper-case alpha characters.
- ✓ Do not used a decimal point with ICD-10 Procedures code format does not include a decimal. Use upper case alpha characters.
- ✓ Zero-fill unused revenue code charges. Do not remove unused revenue codes.
- ✓ Do not use negative numbers, alpha characters, cents, decimals, dollar signs or commas when reporting revenue codes.
- ✓ Follow official coding guidelines for ICD-10 reporting.
- ✓ **Report the Patient Control Number element as 'Record id' in the data file for each discrete record. Refer to schema instruction.**
- ✓ Remove the *Service Location* element tag if type of service is '1' or the facility is not licensed for an off-site emergency department.
- ✓ Remove Evaluation and Management element tags if type of service is '1'

A reportable "ambulatory surgical" visit is not the same as a hospital "outpatient" visit. Ambulatory surgical visits must meet the criteria below. If charges are not present for the following revenue categories, do NOT report the visit.

- Charges are present for any of the following revenue buckets:
  - CARDIOLOGY_CHARGES – Rev 48X
  - OPER_ROOM_CHARGES - Rev 36X and 49X
  - GI_SERVICES_CHARGES – Rev 75X
  - EXTRA_CORP_SHOCK_WAVE_CHARGES – Rev 79X

AND

- The primary procedure performed corresponds to a CPT code between 10001-36399; 36426 through 69999; 92920 through 92998; 93451 through 93533; 93580-93583; 93590 through 93597; and 93650 through 93657. AND must contain charges greater than $0 in required revenue code categories. (Cardiology, Operating Room, GI Services or Lithotripsy)

- The procedure is performed in one of these areas: general operating rooms, ambulatory surgery rooms, endoscopy units, lithotripsy or cardiac catheterization laboratories of a hospital or freestanding ambulatory surgery clinic.

DO NOT REPORT type of service 1 visits for wound care, radiology therapy, blood transfusion, chemotherapy, labor checks, dialysis, venipuncture, or laboratory services, etc. These are outpatient procedures, not surgical, and do not meet the revenue charge criteria.

NOTES:

- ***Report a single record for patients having multiple procedures performed on the same date of service containing all procedures performed and charges*****,** regardless of the payer, procedure, or practitioner.

- Report the payer and the operating practitioner for the primary procedure. Report the secondary procedure practitioner in Other Practitioner field.

- CPT code fields allow reporting for up to 30 procedures.

- The procedure is a *non-emergency* surgical procedure performed on an outpatient basis.

Criteria for Reporting Emergency Department Visits

An Emergency Department visit is reported if the following criteria are met. If the patient does not meet the criteria, do NOT report the visit.

- Visits in which ED registration occurs for the *purposes of seeking emergency care* services, *including observation*, and the patient is not admitted for inpatient care.

- The patient is registered in the ED ***AND*** is triaged and/or screened.

NOTES:

Patients that register, triaged, but leave before seeing the physician are reported with Discharge Status AMA status "07", zero ED Charges, and Evaluation and Management code 99999.

Registrations that occur in the emergency department after hours when the central registration department is closed are NOT included unless services are received in the emergency department.

Emergency Departments shall report an Emergency Department Evaluation and Management Procedure code representing the patient's acuity level.

Report all CPT/HCPCS codes for Emergency Department services rendered during the emergency room visit. ED CPT code sare not limited to a reporting range.

CPT/HCPCS codes must be valid for the reporting period.

Report the Evaluation and Management CPT code only in the designated EM fields.

Do not use EM codes in the CPT code fields.

AHCA Facility Number

Element Name: AHCA Facility Number

Definition: The identification number of the facility as assigned by AHCA for reporting purposes

Parameters: 1 to 8 numeric characters

Codes/Values: Must be a valid AHCA number.

Conditions: Required

Notes: The AHCA number in the individual data record must match the AHCA number in the header record

Edits: Must be present and a valid code
Do not use leading zero's.

Patient Control Number

Element Name: Patient Control Number (Record_id)

Definition: Patient's unique number assigned by the facility to facilitate retrieval of an individual's account of services (accounts receivable) containing the financial billing records and any postings of payment

Parameters: Up to 24 characters
Alpha-numeric
Crosswalk to UB-04 FL 3a or HCFA-1500 FL 26

Codes/Values: N/A

Conditions: Required

Notes: Duplicate record identification numbers are not permitted

The Patient Control Number is reported as 'Record id' in the data file for each discrete record. Refer to schema instruction.

The PCN identifies a single facility visit for a patient and may be called or defined as an account number.

The PCN is different from the medical record number, which identifies an individual patient and remains the same through multiple facility visits.

Edits: Must be a present and in a valid format
Duplicate Record ID (Patient Control) numbers exist.

Medical or Health Record Number

Element Name: Medical or Health Record Number

Definition: The unique number assigned to the patient's medical/ health record by the facility

Parameters: Up to 24 characters
Alpha-numeric

Codes/Values: N/A

Conditions: Required

Notes: The hospital must maintain a key list to locate actual records upon request by AHCA

Edits: MRN code must be present and in a valid format
MRN code must represent a unique patient.

Patient Social Security Number

Element Name: Patient Social Security Number

Definition: The Social Security number (SSN) of the patient receiving treatment

Parameters: 9 numeric characters

Codes/Values: See Unknown SSN Default Codes

Conditions: Required

Notes: One SSN per patient

The last four-digit SSN format must only be used when the full SSN is unknown and not as a substitute for all nine digit SSN's.

Hospital discharge records are used to identify cases of traumatic brain injuries and/or birth defects by the Department of Health

Unknown SSN Default Codes	
Where the last 4 digits of the SSN are known	77777XXXX
Patients where efforts to obtain the SSN have been unsuccessful. Patient is a non-US citizen who has not been issued a SSN. Patient is under 2 years of age and does not have an SSN	777777777

Edits:

- Must be a valid SSN or default.
- SSN cannot equal 000000000, 000XXXXXX, XXX00XXXX, XXXXXX000
- SSN cannot begin with 666 , any value in the range 900-999, same 9 digits except for default SSN-777777777
- Cannot equal 078051120 or 219099999 as defined by SSA.
- One Number Prohibition except default
- Identical Patient Social Security Number on one or more other records must have the same Patient Race, Patient Sex, and Patient Date of Birth.
- Duplicate Social Security Numbers found with the same dates of service and type of Service=1

Patient Ethnicity

Element Name: Patient Ethnicity

Definition: Self-designated by the patient, patient's parent, or guardian
This item gives the **Patient's answer to the question "Are you Hispanic?".** The information is based on self-identification and is to be obtained from the patient, a relative or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Parameters: 2-digit alpha-numeric code

Codes/Values:

E1	Hispanic or Latino
E2	Non-Hispanic or Latino
E7	Unknown

Conditions: Required

Notes: **Hispanic or Latino -** A person of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish culture or origin regardless of race

Non-Hispanic or Latino - A person not of any Spanish culture or origin

Unknown - Use if the patient refuses or fails to disclose.

The Race/Ethnicity field is used for statistical/epidemiological purposes.

Edits: Code must be present and a valid code
Facility must verify unknown Ethnicity exceeding 50%

Patient Race

Element Name: Patient Race

Definition: *Self-designated by the patient, patient's parent, or guardian.* The information is based on self-identification and is to be obtained from the patient, a relative, or a friend. The facility is **not** to categorize the patient based on observation or personal judgment.

Parameters: 1 numeric code

Codes/Values:

1	American Indian or Alaska Native
2	Asian
3	Black or African American
4	Native Hawaiian or Other Pacific Islander
5	White
6	Other
7	Unknown *(for use if the patient refuses or fails to disclose)*

Conditions: Required

Notes: **American Indian or Alaskan Native** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains cultural identification through tribal affiliation or community recognition

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, China, Cambodia, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

Black - A person having origins in any of the black racial groups of Africa.

Native Hawaiian or other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

White - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Other - Use if not described in above categories, including a patient who has more than one race.

Edits: Must be present and a valid code
Facility must verify unknown Races exceeding 50%

Patient Birth Date

Element Name: Patient Birth Date

Definition: Date of birth of the patient

Parameters: 10 characters
Crosswalk to UB-04 FL 10 or HCFA-1500 FL 3

Codes/Values: Format: YYYY-MM-DD
MM represents months of the year from 01-12
DD represents days of the month from 01-31
YYYY represents the year in four digits.

Conditions: Required

Notes: **Use the default of 1880-01-01 if DOB is unknown.**
The reporting entity must verify an age greater than 115 years.
The date of birth is used to calculate patient age.

Edits*:* Date of birth must be present
A valid date- not occurring after admitting or discharge date.
Consistent with diagnosis
Age calculated from date of birth and discharge.
Verify age greater than 115 years.

Patient Sex

Element Name: Patient Sex

Definition: The sex of the patient ***at admission***

Parameters: 1 alpha character
Crosswalk to UB-04 FL 11 or HCFA-1500 FL 3

Codes/Values:

M Male
F Female
U Unknown

Use "unknown" where efforts to obtain the information have been unsuccessful or where the patient's sex cannot be determined.

Conditions: Required

Notes: The reporting entity must verify records with Unknown Patient sex.

In instances where the patient has a change sex, the patient sex reported should be the sex at admission; the procedure performed will indicate a change in sex.

Edits: Must be present and a valid code
Code must be valid and consistent with diagnosis and procedure codes.
Verify Unknown Sex =U

Patient Zip Code

Element Name: Patient Zip Code

Definition: The five (5) digit US Postal Service zip code of the patient's address (see note)

Parameters: 5 numeric characters
Crosswalk to UB-04 Fl 9d or HCFA-1500 FL 5

Codes/Values:

ZIP Default	Description
00009	Foreign Residences
00007	Homeless Patients
00000	Unavailable/Unknown

Conditions: Required
Do not include hyphens

Notes: To verify U.S. Postal Zip Codes, visit the USPS Zip code lookup search at: https://tools.usps.com/go/ZipLookupAction!input.action

The address is a patient's permanent residence ***as declared by the patient***. For individuals that reside seasonally in Florida, but do not declare permanent residency, report the zip code of their resident state or 00009 for foreign residency.

Edits: Postal zip code must be present and be a valid USPS zip code or default

Patient Country Code

Element Name: Patient Country Code

Definition: The country code of residence

Parameters: 2-digit upper case alpha character
Crosswalk to UB-04 Fl 9d or HCFA-1500 FL 5

Codes/Values: Defined from the International Standard for Organizations country code list, ISO 3166 or latest release.

Conditions: Required

Notes: **Type of Service 1-(Ambulatory) use default 99.**

Use default code 99 where the country of residence is unknown, or where efforts to obtain the information have been unsuccessful.

To look up country codes, go to the Reporting Resource page at Florida Center/Data Collection Website address:

http://ahca.myflorida.com/SCHS/DataCollection/help.shtml

If the country is not included on the Data Guide Country Code List, go to the ISO 3166 website below and look up the 2-character country code :

https://www.iso.org/obp/ui/#search

Report the permanent residence ***as declared by the patient***. For individuals that reside seasonally in Florida, but do not declare permanent residency, report the zip code of their resident state or 00009 for foreign residency.

Edits: Must be present and a valid code
Type of Service 1 must use 99.

Type of Service Code

Element Name: Type of Service Code

Definition: The code designating the type of service, either ambulatory surgery or emergency department visits

Parameters: 1-digit numeric code

Codes/Values:

1 Ambulatory Surgery

2 Emergency Department

Conditions: Required

Notes: Report observation patients as TOS=2

Edits: Must be present and a valid code

Source of Admission/Point of Origin

Element Name: Source of Admission/Point of Origin

Definition: A code indicating the source of the referral for this admission or the point of patient origin for this admission or visit

Parameters: 2-digit Numeric code OR 1 digit alpha code
Crosswalk to UB04 FL15

Codes/Values:

01	Non-health care facility
02	Clinic
04	Transfer from a Hospital (different facility)
05	Transfer from a Skilled Nursing Home (SNF)
06	Transfer from another health care facility
08	Court/Law Enforcement
09	Information not available
D	Transfer from one distinct unit of the hospital to another distinct unit in the same hospital
E	Transfer from an Ambulatory Surgery Center
F	Transfer from a hospice facility and under a hospice plan of care or enrolled in a hospice program

Conditions: Required
Type of service 1 – use default code '00.'

Notes: The point of origin is the direct source for the facility.

Emergency Room: Use Source code 04 for patients who come to the emergency room from another health care facility or Source code 05 for patients who come to the emergency room from a SNF.

Example: An accident patient is taken to the emergency department of hospital A, stabilized, then transferred to hospital B (a trauma center) where they receive additional treatment in the ED, and then are admitted as an inpatient to hospital B. The Point of Origin for hospital B is 04-Transfer from another hospital.

Court/Law Enforcement: Includes transfers from incarceration facilities, admissions upon direction of the court, accompanied or under supervision of police/law enforcement.

Newborns: For newborns born at one facility (Hosp A) and transferred to another facility NICU (Hosp B), Hospital B would use Source code 04 Hospital Transfer and Priority of Admission 1 - Emergency.

D: For purposes of this code, the "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, and a unit swing bed located in an acute hospital.

Edits:

Must be present and a valid code
Type of Service =1 and Source Code not 00
Type of Service =2 and Source Code = 00

Principal Payer Code

Element Name: Principal Payer Code

Definition: Describes the expected primary source of reimbursement for services rendered based on the patient's status at discharge or the time of reporting

Parameters: 1 upper case alpha character

Codes/Values:

A	Medicare
B	Medicare Managed Care
C	Medicaid
D	Medicaid Managed Care
E	Commercial Health Insurance
H	Workers' Compensation
I	TriCare or Other Federal Government
J	VA
K	Other State/Local Government
L	Self Pay
M	Other
N	Non-payment
O	KidCare
P	Unknown *(**ONLY** ED-Type 2)*
Q	Commercial Liability Coverage

Conditions: Required

Notes: Report payer codes based on AHCA specifications

Payer A – Medicare

Payer B – Medicare Managed Care

Patients covered by Medicare Advantage plans, Medicare HMO, Medicare PPO, Medicare Private Fee for Service, or any other type of Medicare plan where CMS is not the direct payer.

Payer C – Medicaid

Payer D –Medicaid Managed Care

Patients covered by Medicaid funded capitated plans. This would include any program where the patient is enrolled in the Medicaid program, but the payment is not directly from the state of Florida Medicaid program.

Payer E – Commercial Health Insurance

Patients are covered by any type of private coverage, including HMO, PPO, or self-insured plans.

Payer H – Workers' Compensation
Payer I – Tricare or Other Federal Government, CHAMPUS
Payer J – VA

Payer K – Other State/Local Government
Prison system and court orders is classified in this payer category
Payer L – Self-Pay
Patients with no insurance coverage. Uninsured or self-pay patients. It is unusual to not report any patients in this category. No third-party coverage or less than 30% estimated insurance coverage.
Payer M – Other
Includes Letter of Protection and other categories undesignated
Payer N – Non-Payment
Includes charity, professional courtesy, no charge, research/clinical trial, refusal to pay/bad debt, Hill Burton free care, research/donor that is known at the time of reporting.
Payer O – Kidcare
Includes Healthy Kids, MediKids and Children's Medical Services (CMS)
Payer Q – Commercial Liability Coverage
Includes Auto insurance claims, homeowners, or general business liability coverage, and/or commercial liability claims.

Payer P – Unknown
Report the principal payer code P, if payer information is not available, and type of service is "2" and patient status is "07"

Payer Q – Commercial Liability Coverage
Includes Auto insurance claims, homeowners, or general business liability coverage, and/or commercial liability claims.

Edits:
Must be present and a valid code
Patient Age Over 19 and Payer=O (Kid-Care)
Invalid use of Payer P in ED data
Invalid use of Payer P in ASC
Payer M records greater than 10%

Principal Diagnosis Code

Element Name: Principal Diagnosis Code

Definition: The code representing the diagnosis established, after study, to be chiefly responsible for occasioning the admission. Principal diagnosis code must contain a valid ICD-10-CM code for the reporting period.

Parameters: Alphanumeric
Crosswalk to UB-04 FL 67 or HCFA-1500 21(1)

Codes/Values: ICD-10-CM

Must be a valid ICD-10-CM based on the time period reported.

The ICD code must contain a decimal point and upper-case alpha characters.

Conditions: Required for AS

Notes: A blank field is permitted if type of service is “2” and patient status is “07”

Edits: Principal Diagnosis is invalid
Principal Diagnosis conflicts with Patient Age or Sex
Principal Diagnosis is repeated in Secondary Diagnosis Codes
Principal Diagnosis is empty and Not ED Discharged AMA
Principal Diagnosis cannot be an ECMORB code.

Other Diagnosis Code 1-9

Element Name: Other Diagnosis Code 1-9

Definition: A code representing a condition that is related to the services provided during the hospitalization excluding external cause of Morbidity codes.

Parameters: Alphanumeric
Crosswalk UB04 FL67 a-I or HCFA-1500 21 (2-9)

Codes/Values: ICD-10-CM code
Other Diagnosis Codes (1) thru Other Diagnosis Code (09)

Must be a valid ICD-10-CM based on the time period reported.

The ICD code must contain a decimal point and upper-case alpha characters.

Conditions: No entry is permitted

Notes: No more than nine (9) other diagnosis codes may be reported. Less than nine (9) entries or no entry is permitted.

Remove unused Other Diagnosis element tags.

Edits: Other Diagnosis is invalid
Other Diagnosis conflicts with Patient Age or Sex
Other Diagnosis is repeated in Secondary Diagnosis Codes
Other Principal Diagnosis cannot be an ECMORB code.

Evaluation and Management Code (1) to (5)

Element Name: Evaluation and Management Code (1) to (5)

Definition: A code representative of the patient acuity for the services provided

Parameters: Alphanumeric

Codes/Values: CPT or HCPCS code
Must be a valid CPT or HCPCS based on the quarter reported.

Conditions: Required for ED - type of service '2'
Not a required field for AS – type of service '1'. Remove XML tag.

Must contain a valid CPT code in the range: 99281-99285; 99288; 99291-99292; and G0380-G0384

Notes: Remove unused 'Evaluation/Management XML tags.

Remove the tag if type of service is '1'

If patient discharge status is '07', enter default code 99999 to indicate patient *was not evaluated* by a physician. A Patient Status '07' after evaluation by a physician should the lowest acuity E&M code.

Edits: Type of Service =2 and E&M code blank
Type of Service = 1 and E&M Code is present
At Least 1 E&M Code is not in the reportable range.
E&M Code is 99999, not '07' discharge status or $0 charges.
EM codes can only be used in ED code fields.

Other CPT or HCPCS Procedure Code (1) thru (30)

Element Name: Other CPT or HCPCS Procedure Code (1) thru (30)

Definition: A code representing a surgical procedure or service provided during the visit. Do not report visits within the reportable range that are non-surgical in nature. Examples of non-surgical visits that are non-reportable are chemotherapy administration, blood transfusion and wound care visits.

Parameters: Alphanumeric
Crosswalk to UB04 FL72a-e or HCFA-1500 24

Codes/Values: CPT or HCPCS code
Must be a valid CPT or HCPCS based on the quarter reported.

Conditions: Required for AS
Type of Service 1- MUST be within the reportable range.

Type of service 2- Reportable range is not applicable.

CPT codes 36400-36425 are not included in the AS reportable range.

Notes: Remove unused XML tags if not reported

Report the procedures performed in the Other CPT's 1-30 fields. At least one procedure must be surgical in nature and within the reportable range for type of service 1. The reportable range for the edit is 10001-36399; 36426 through 69999; 92920 through 92998; 93451 through 93533; 93580-93583; 93590 through 93597; and 93650 through 93657. **AND** must contain charges greater than $0 in required revenue code categories.

No more than 30 other CPT or HCPCS procedure codes may be reported.

Do not report Evaluation & Management codes in the Other CPT fields.

Edits:

- Other CPT/HCPCS invalid
- Other CPT/HCPCS code conflicts with Patient Age or Sex
- Other CPT/HCPCS codes are not in the reportable range for freestanding ASC
- Other CPT/HCPCS codes and/or revenue codes are not in the reportable range for hospital.
- At least 1 Other CPT/HCPCS code is an E&M code.

Attending Practitioner Identification Number

Element Name: Attending Practitioner Identification Number

Definition: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the patient's medical care and treatment or who certified as to the medical necessity of the services rendered

Parameters: Alphanumeric. Alpha prefix must be in upper case.

Codes/Values: Report the alpha prefix and number without leading zeros.
See Florida License Prefix Table in Section 6

Conditions: Required

Notes: To verify practitioner license numbers, visit the DOH Florida Medical License Search: *FL DOH MQA Search Portal | Home Page (state.fl.us)*

For military physicians not licensed in Florida, use US999999999 in upper case for TOS-1

Use "**NA" in upper case for service type 2 only**, if the patient was not treated by a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse.

Edits: Must be a valid Florida license ID
Attending Practitioner ID w/out NPI number or NPI w/out a Florida license

Attending Practitioner National Provider Identification Number (NPI)

Element Name:	Attending Practitioner NPI Identification Number
Definition:	The NPI number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the patient's medical care and treatment or who certified as to the medical necessity of the services rendered
Parameters:	10-character number
Codes/Values:	Use 9999999999 as default (see notes)
Conditions:	Required
Notes:	For military physicians, medical residents, practitioners not required to obtain a NPI number, or where efforts to obtain a NPI are unsuccessful, use 9999999999 Required for US practitioners or its territories.
Edits:	Must be a present Attending Practitioner ID w/out NPI number or NPI w/out a Florida license

Operating or Performing Practitioner Identification Number

Element Name: Operating or Performing Practitioner Identification Number

Definition: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the procedure performed

Parameters: Alphanumeric. Alpha prefix must be in upper case.

Codes/Values: Report the alpha prefix and number without leading zeros.
See Florida License Prefix Table in Section 6

Conditions: Required for AS TOS-1

Notes: Remove unused XML tags if not reported

The operating medical doctor should be the practitioner performing the principal SURGICAL procedure

The operating or performing practitioner may be the attending physician.

For military physicians not licensed in Florida, use US999999999 in upper case.

All operating or performing practitioners must be licensed in Florida
To verify practitioner license numbers, visit the DOH Florida Medical License Search: *FL DOH MQA Search Portal | Home Page (state.fl.us)*

Edits: Must be a valid Florida license ID
Operating or Performing Practitioner ID w/out NPI number or NPI w/out a Florida license
Operating or Performing Practitioner cannot be same as Other Practitioner
Performing Practitioner without CPT Procedure code

Operating or Performing Practitioner National Identification Number

Element Name: Operating or Performing Practitioner National Identification Number

Definition: The NPI number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the patient's medical care and treatment or who had primary responsibility for the procedure performed

Parameters: 10-character number

Codes/Values: Use 9999999999 as default (see notes)

Conditions: Required for AS TOS=1

Notes: Remove unused XML tags if not reported

The operating medical doctor should be the practitioner performing the principal **SURGICAL procedure.**

For military physicians, medical residents, or practitioners not required to obtain a NPI number, or where efforts to obtain a NPI are unsuccessful, use 9999999999.

Required for US practitioners or its territories.

The operating or performing practitioner may be the attending physician.

Edits: Must be a valid Florida license ID
Performing practitioner ID without Principal Procedure
Principal Procedure without Performing practitioner.

Other Operating or Performing Practitioner Identification Number

Element Name: Other Operating or Performing Practitioner Identification Number

Definition: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had assisted the operating or performing physician or performed a secondary procedure

Parameters: Alphanumeric. Alpha prefix must be in upper case.

Codes/Values: Report the alpha prefix and number without leading zeros.
See Florida License Prefix Table in Section 6

Conditions: No entry is permitted

Notes: Remove unused XML tags if not reported

The other operating or performing practitioner can *NOT* be the same as the operating or performing practitioner.

For military physicians not licensed in Florida, use US999999999 in upper case.

All other operating or performing practitioners must be licensed in the State of Florida

To verify practitioner license numbers, visit the DOH Florida Medical license Search: http://ww2.doh.state.fl.us/irm00praes/praslist.asp

Edits: Must be a valid license ID
Other Performing Practitioner ID w/out NPI number or NPI w/out a Florida license
Other Performing Practitioner cannot be same as Performing Practitioner

Other Operating or Performing Practitioner National Identification Number

Element Name: Other Operating or Performing Practitioner National Identification Number

Definition: The NPI number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who assisted the operating or performing practitioner or performed a secondary procedure

Parameters: 10-character number

Codes/Values: Use 9999999999 as default.

Conditions: No entry is permitted

Notes: For military physicians, medical residents, or practitioners not required to obtain a NPI number, or where efforts to obtain a NPI are unsuccessful, use 9999999999

Required for US practitioners or its territories.

Edits: Must be present
Other Performing Practitioner ID w/out NPI number or NPI w/out a state Florida license

Revenue Code Category Charges

Element Name: Revenue Code Category Charges

Definition: Total charges for the related revenue code category

Parameters: 7 Positions
Numeric
Crosswalk to UB04 FL42 and FL47 or HCFA-1500 24F

Codes/Values: Whole dollars only, rounded to the nearest dollar.

Reportable categories:

Pharmacy	25x and 63x
Medical/Surgical Supply	27x and 62x
Laboratory	30x-31x
Radiology	32x-35x; 40x; and 61x
Cardiology	48x
Operating Room	36x
Anesthesia	37x
Recovery Room	71x
Emergency Room	45x
Trauma Response	068x
Treatment/Observation	76x
Gastro-Intestinal (GI)	075x
Extra-Corporeal Shock Wave (Lithotripsy)	079x
Other Charges	

Conditions: Required

Notes: **Report zero (0) if there are no charges.**
Round off to whole number
Do not use alpha characters, cents, decimals, dollar signs or commas.
Do not 'zero' pad.
Revenue tags can **NOT** be removed.

Edits: Must be a whole number
Report zero (0) if there are no charges.
Trauma Charge at a Non-Trauma Facility (ED)

Total Gross Charges

Element Name: Total Gross Charges

Definition: The total of undiscounted charges for services rendered by the reporting entity. The sum of pharmacy charges, medical and surgical supply charges, laboratory charges, radiology and other imaging charges, cardiology charges, operating room charges, anesthesia charges, recovery room charges, emergency room charges, treatment or observation room charge, and other charges must equal total charges, plus or minus thirteen (13) dollars.

Parameters: Numeric

Codes/Values: Whole dollars only, round to the nearest dollar
Crosswalk to UB04 FL 47 or HCFA-1500 28

Conditions: Required

Notes: **Report zero (0) if there are no charges.**
Round off to whole number.
Do not use alpha characters, cents, decimals, dollar signs or commas
Do not 'zero' pad.
Revenue tags can **NOT** be removed.

Edits: Must be a whole number
Total Charge not within $13 of Sum of Sub-Charges
E.D. Bill with Total Charge>$300,000
Hospital Outpatient Bill with Total Charge>$300,000
ASC with Total Charge>$300,000
Total charges exceed $1,000,000.
Total Charge=0 for TOS=2 and Not ED Discharged AMA

Patient Visit Beginning Date

Element Name: Patient Visit Beginning Date

Definition: The date at the beginning of the patient's visit for ambulatory surgery or the date at the time of registration in the emergency department

Parameters: 10 characters
Crosswalk to UB04 FL06 or HCFA-1500 24A

Codes/Values: Format is YYYY-MM-DD
MM represents months of the year from 01-12
DD represents days of the month from 01-31
YYYY represents the year in four digits.

Conditions: Required

Notes: Patient visit beginning date or beginning service date must equal or precede the patient visit ending date or ending service date

If a patient is admitted following an ambulatory procedure, the visit should be rolled into the inpatient discharge data and not reported as a separate Ambulatory visit.

If a patient has services provided prior to the actual procedure, (even if this occurs one or more days before the procedure) report as one visit.

Edits: Patient Visit Beginning Date must be present and a valid date:
Patient Visit Beginning Date must be equal to or before Patient Visit End Date
Patient Visit Beginning Date is not in the reporting period.
Type of service =1 and LOS>2 days
Sunday Visits (Freestanding ASC Pro Code 14)

Patient Visit Ending Date

Element Name: Patient Visit Ending Date

Definition: The date at the end of the patient's visit

Parameters: 10 characters
Crosswalk to UB04 FL06

Codes/Values: Format is YYYY-MM-DD
MM represents months of the year from 01-12
DD represents days of the month from 01-31
YYYY represents the year in four digits.

Conditions: Required

Notes: Facility must verify records where the end date of the patient's visit is more than 8 days after the beginning date for TOS=2.

Edits*:* Patient Visit End Date must be present and a valid date:
Patient Visit End Date must be equal to or before Patient Visit Begin Date

Patient Visit End Date is not in the reporting period.
Patient Visit End Date > 8 days for TOS=2
Type of service =1 and LOS>2 days

Hour of Arrival

Element Name: Hour of Arrival Time

Definition: The hour on a 24-hour clock during which the patient's visit for ambulatory surgery began or during which registration in the emergency department occurred

Parameters: 2 Numeric characters
Crosswalk to UB04 FL16

Codes/Values:

AM	PM
00-12:00 midnight to 12:59 A.M.	**12**- 12:00 noon to 12:59 P.M.
01- 01:00 to 01:59	**13**- 01:00 to 01:59
02- 02:00 to 02:59	**14**- 02:00 to 02:59
03- 03:00 to 03:59	**15**- 03:00 to 03:59
04- 04:00 to 04:59	**16**- 04:00 to 04:59
05- 05:00 to 05:59	**17**- 05:00 to 05:59
06- 06:00 to 06:59	**18**- 06:00 to 06:59
07- 07:00 to 07:59	**19**- 07:00 to 07:59
08- 08:00 to 08:59	**20**- 08:00 to 08:59
09- 09:00 to 09:59	**21**- 09:00 to 09:59
10- 10:00 to 10:59	**22**- 10:00 to 10:59
11- 11:00 to 11:59	**23**- 11:00 to 11:59
	99- Unknown - Use 99 **only** where efforts to obtain the information have been unsuccessful.

Conditions: Required

Notes: Use 99 where efforts to obtain the information have been unsuccessful

Edits: Must be present and a valid code
Hour of Arrival and ED Discharge Hour = 99

Emergency Department (ED) Hour of Discharge

Element Name: ED Hour of Discharge

Definition: The hour on a 24-hour clock during which the patient's left the emergency department

Parameters: 2 Numeric characters

Codes/Values:

AM	PM
00-12:00 midnight to 12:59 A.M.	**12**- 12:00 noon to 12:59 P.M.
01- 01:00 to 01:59	**13**- 01:00 to 01:59
02- 02:00 to 02:59	**14**- 02:00 to 02:59
03- 03:00 to 03:59	**15**- 03:00 to 03:59
04- 04:00 to 04:59	**16**- 04:00 to 04:59
05- 05:00 to 05:59	**17**- 05:00 to 05:59
06- 06:00 to 06:59	**18**- 06:00 to 06:59
07- 07:00 to 07:59	**19**- 07:00 to 07:59
08- 08:00 to 08:59	**20**- 08:00 to 08:59
09- 09:00 to 09:59	**21**- 09:00 to 09:59
10- 10:00 to 10:59	**22**- 10:00 to 10:59
11- 11:00 to 11:59	**23**- 11:00 to 11:59
	99- Unknown - Use 99 **only** where efforts to obtain the information have been unsuccessful.

Conditions: Required

Notes: **AS (TOS 1**) –use default code '99'
ED (TOS 2) report hour of discharge

Edits: Must be present and a valid code
Hour of Arrival and ED Discharge Hour = 99
ED Hour of Discharge Time is not 99 for ASC.

Patient's Reason for Visit (Admitting Diagnosis)

Element Name: Patient's Reason for Visit (Admitting Diagnosis)

Definition: The ICD-CM diagnosis codes describing the patient's chief complaint or stated reason for seeking care

Parameters: Alphanumeric
Crosswalk UB-04 FL 70a-c

Codes/Values: Must be a valid ICD-10-CM based on the quarter reported.

The ICD code must contain a **decimal point and upper-case alpha characters.**

Conditions: Required reporting for ED type of service 2
Not required for AS type of service 1.

Notes: Remove unused XML tags if not reported
ICD-10 diagnosis codes require use of decimals.

Edits: Must be a valid code ICD-10 code for the reporting period
Patient Reason code invalid
Patient reason and type of service = 1

External Cause of Morbidity Code (1), External Cause of Morbidity Code (2) and External Cause of Morbidity Code (3)

Element Name: External Cause of Morbidity Code (1), External Cause of Morbidity Code (2) and External Cause of Morbidity Code (3)

Definition: A code representing circumstances or conditions as the cause of the Morbidity, poisoning, or other adverse effects recorded as a diagnosis

Parameters: Alphanumeric
Crosswalk to UB04 FL 72a-c or HCFA-1500 FL 21(2-4)

Codes/Values: Must be a valid ICD-10-CM cause of Morbidity code (ECMORB code) for the reporting period.

The ICD code must contain a decimal point and upper-case alpha characters.

Conditions: No entry is permitted
Report for ED type of service '2'
Do not report for Type of service 1 at freestanding ASC.

Notes: **ECOMB code reportable range is V00-Y99**

Remove unused XML tags for External Cause of Morbidity Code

Less than three (3) or no entry is permitted consistent with the records of the reporting entity. An external cause of Morbidity code cannot be used more than once for each hospitalization reported.

Edits: Must be a valid code ICD-10 code for the reporting period
ECMORB code invalid
ECMORB code is repeated.
ECMORB code in Diagnosis or Reason for Visit Codes
ECMORB code reported for ASC.

Service Location

Element Name: Service Location

Definition: The code designating services performed at an off-site emergency department location licensed under Chapter 395, Part 1, F.S. and 59A-3, F.A.C. ***Urgent Care Centers are not classified as an off-site ED location. Do not include Urgent Care records in the ED data reporting.***

Parameters: 1-digit upper case alpha code

Codes/Values: **'A -Z'** Off-site ED location

Conditions: Required for ED TOS=2 reporting *if the facility license includes an "offsite" Emergency department.*

Facilities having more than one off-site location will use sequential alpha designations assigned by AHCA.

Notes: Remove XML tag if type if service is 1
Remove XML tag for hospitals without an offsite ED location.

Including blank elements will result in the file being rejected at upload.

Edits Must be a valid code.
Facility unlicensed for Service Location code
Type of service = 1, Service Location reported

Patient Discharge Status

Element Name: Patient Status

Definition: Patient disposition at end of visit

Parameters: 2 Numeric characters
Crosswalk UB04 FL17

Codes/Values:

01	Discharged to home or self-care
02	Discharged or transferred to a short-term general hospital
03	Discharged or transferred to a skilled nursing facility
04	Discharged or transferred to an intermediate care facility
05	Discharged or transferred to a designated cancer center or Children's Hospital
06	Discharged or transferred to home under care of home health care organization
07	Left facility against medical advice (AMA), discontinued care, or elopement
20	Expired
21	Discharged or transferred to Court/Law Enforcement ***Added Effective 1/1/2011***
50	Hospice – home
51	Hospice medical facility (certified) providing hospice level care
62	Discharged or transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged or transferred to a Medicare certified long term care Hospital
64	Discharged or transferred to a Nursing Facility certified under Medicaid but not Medicare certified
65	Discharged or transferred to a psychiatric hospital including psychiatric distinct part units of a hospital
66	Discharged or transferred to a Critical Access hospital
70	Discharged or transferred to another type of health care institution not degined elsewhere in this code list.

Conditions: Required

Notes: **Home - 01** - Includes discharge to home; group home, foster care, and other residential care arrangements; incarceration facilities such as jail, prison, or other detention centers; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state- designated

Skilled Nursing Home (SNF) - 03 - Medicare – Indicates that the patient is discharged/transferred to Medicare certified nursing facility. For reporting other discharges/transfers to nursing facilities see code 04

Intermediate Care Facility (ICF) - 04 - used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities

Designated Cancer Center/Children's Hospital - 05 - Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions. Transfers to non-designated cancer hospitals should use Code 02
A list of (National Cancer Institute) Designated Cancer Centers can be found at
http://cancercenters.cancer.gov/cancer_centers/index.html

Discharged to home under care of home health care organization - 06 - Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home IV provider for home IV services.

Discharged or transferred to Court/law Enforcement-21- Includes transfers to incarceration facilities such as jail, prison, or other detention centers

Discharged to a psychiatric hospital - 63 – For hospitals that meet the Medicare criteria for long term care hospital (LTCH) certification.

Edits:

Must be present and a valid code
Verify Ambulatory Surgery Death (discharge status=20)

Trailer Record

Element Name: Trailer Record

Definition: The last record in the data file shall be a trailer record and must accompany each data set. The trailer record must be placed as the last record in the data set.

Parameters: 1 data element
Numeric

Codes/Values: N/A

Conditions: Required

Notes: Report the total number of patient data records contained in the file excluding the header and trailer records.

The number entered must equal the number of patient records.

If a record is being deleted from the file, update the record count in the Trailer Record

Edits: The total number of records does not match number in trailer

SECTION 7 APPENDICES

Glossary of Terms

AS/ED: Ambulatory/Emergency Department

Acute Care: General routine inpatient care provided to patients who are in an acute phase of illness, which includes the concentrated and continuous observation and care provided in the intensive care units of an institution.

AHCA Identification Number: A unique number assigned by AHCA to each facility and must be used to identify the facility.

Ambulatory Surgical Center: A licensed ambulatory surgical center as defined in Section 395.002(3), F.S. Ambulatory center includes freestanding ambulatory surgery centers, short-term acute care hospitals, and cardiac catheterization laboratories.

Anesthetic Risk: Any procedure that either requires or is regularly performed under general anesthesia which carries anesthetic risk, as do procedures under local, regional, or other forms of anesthesia that induce sufficient functional impairment necessitating special precautions to protect the patient from harm.

Attending Physician: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the patient's medical care and treatment or who certified as to the medical necessity of the services rendered.

Audit: Methods used by the AHCA to evaluate submitted data for completeness and accuracy. Audits involve both computerized and manual evaluation of the data.

CMS: Centers for Medicare & Medicaid Services

Civil Penalty: Monetary penalty imposed on a hospital by AHCA for failure to comply with the reporting requirements.

Comprehensive Rehabilitation: Means services provided in a Speciality Rehabilitative Hospital licensed under Chapter 395.002, F.S.

Courtesy Reminder: Email reminder sent to a facility contact when a facility has not submitted their initial due file, fails to return a corrected data report or certification.

CPT: Current Procedural Terminology refers to a coding system established by the American Medical Association to describe physician services which is published annually in the Physicians' Current Procedural Terminology manual which is incorporated by reference.

CR: Comprehensive Rehabilitative services

Data Universe: The number of records sharing common data elements on which an error threshold is determined, and upon which audits specific to those common data elements are conducted.

Discharge: For a discharge to take place, the patient must have been formally admitted as an inpatient. A discharge is defined as an inpatient who:

- is formally released from the care of the hospital and leaves the hospital.
- **is transferred within the hospital from acute care to another type of care, such as a hospice bed, rehabilitation, psychiatric or other type of distinct unit**
- leaves the hospital against medical advice, without a physician's order or is a psychiatric patient who is discharged as away without leave (AWOL)
  has died.

Death: When an inpatient expires, the date of death constitutes a discharge.

Distinct Part Unit: A unique unit or level of care at a hospital requiring the issuance of a separate claim to the payer.

DRG: Diagnosis Related Groups is a classification scheme with which to categorize inpatients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, was established, and is revised annually by the U.S. Department of Health and Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS).

ED: Emergency Department

Error: Any record found to have an invalid entry, or have incomplete data, or has illogical data.

External Cause of Morbidity Code: A code representing circumstances or conditions as the cause of the Morbidity, poisoning, or other adverse effects recorded as a diagnosis.

FDDC Status: The status of file submission thru FDDC

- Initial: File not uploaded for the quarter
- Exempt: ASC facility with fewer than 200 visits per quarter
- File Accepted: File uploaded and waiting in queue for processing.
- Facility Review: Reports ready for facility review.
- Analyst Review: Waiting for Analyst approval.
- Ready to Certify: Facility ready to certify.
- Certified: Facility certified for the quarter

Fine Assesment: A formal fine letter sent to the facility CEO for late reporting. The letter includes the facility total fine amount and hearing rights.

ICD-10-CM and ICD-10-PCS: The International Classification of Diseases, 10th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-10 diagnosis and procedures are made nationally by the "cooperating parties" (the American Hospital Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, and the American Health Information Management Association).

Initial Due Date: The report due date for initial file submissions by the facility.

Inpatient: An inpatient is defined as a baby born alive in this hospital or a person who was formally admitted to the hospital for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer.

Intent to Fine Notification: A notification sent to a facility CEO when a facility fails to certify by the certification deadline.

IP: Inpatient

Lithotripsy Center: A freestanding facility that employs or contracts with licensed health care professionals to provide diagnosis or treatment services using electro-hydraulic shock waves.

Newborn: A newborn baby born within the facility or the initial admission of an infant to any acute care facility **within 24 hours of birth** following an extramural birth. Infants older than 24 hours should **not** be coded as newborn type of admission.

NPI: National Provider Identification. A unique identification number assigned to a provider by the Centers for Medicare & Medicaid Services**.**

NUBC: National Uniform Billing Committee. A national body that defines the data fields that are reported on the Uniform Bill UB-04 which is published annually.

Operating or Performing Physician: The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced practice registered nurse who had primary responsibility for the Principal Procedure.

Organ Procurement: ***The procedures for harvesting the organs should not be reported to AHCA***. AHCA's reporting requirements end when a patient expires.

Outpatient:
If a person expires in the emergency room and an organ is to be donated; only the emergency room visit is reported.

Inpatient:
If an inpatient dies, the date of death is the date of discharge. Any procedure occurring after the patient death is NOT reportable.

Patient Control Number: Patient's unique number assigned by the facility to facilitate retrieval of an individual's account of services (accounts receivable) containing the financial billing records and any postings of payment. The Patient Control Number is displayed as the "Record id" in the data file.

Patient's Reason for Visit ICD-10-CM Code (Admitting Diagnosis): The code representing the patient's chief complaint or stated reason for seeking care.

Physical Rehabilitation Care: Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds included on a hospital's license within the general acute care classification.

Procedural Risk: This term refers to a professionally recognized risk that a given procedure may induce some functional impairment, Morbidity, morbidity, or even death. This risk may arise from direct trauma, physiologic disturbances, interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

Psychiatric Care: Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification of acute psychiatric beds.

Reporting Period: The quarterly time periods for which data is reported each year. Quarterly periods are defined as:

- January 1-March 31 Q1
- April 1-June 30 Q2
- July 1-September 30 Q3
- October 1-December 31 Q4

Recertification: The submission of a corrected data set **after certification** of the original data reported for any given reporting period.

Short-Term Acute Care Hospital: A hospital as defined in Section 395.002(12), F.S.

Space Fill: A programming description used in data collection rules to indicate that reporting is not mandatory for the element. If the element is not reported, the XML element tag is removed from the data file record. Element tags without data will result in an error.

Submission: The official upload of a data file to FDDC.

Submission Type: File designation used to identify a data report where I indicates an initial submission of data or resubmission of previously rejected data and R indicates a replacement submission of previously processed and certified patient data.

Surgery: Includes incision, excision, amputation, introduction, endoscopy repair, destruction, suture, and manipulation.

Test submission: A data set submitted by a facility during a Test Period, to be evaluated for the purpose of assisting the facility in meeting the reporting requirements.

Threshold: An evaluation process conducted on each submitted data set to determine, for specifically selected data elements, if a level of error at which the data becomes suspect is present in the data set.

Visit: A face to face encounter between a health care provider and a patient who is not formally admitted as an inpatient in an acute care hospital setting at the time of the encounter or who is not admitted to the same facility's acute care hospital setting immediately following the encounter.

Rules & Statutes

Laws and regulations are found at the following links:

- Ambulatory/ED Discharges
  - Section 408.061, F.S.
  - Chapter 59B-9, F.A.C.
  -
- Inpatient Discharges and Comprehensive Rehabilitation Inpatient
  - Section 408.061, F.S.
  - Chapter 59E-7, F.A.C.

Florida Local Health Council Districts (Facility Regions)

LOCAL HEALTH COUNCIL	*COUNTIES*
1	*Escambia, Okaloosa, Santa Rosa And Walton*
2	*Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington*
3	*Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union*
4	*Baker, Clay, Duval, Flagler, Nassau, St. Johns And Volusia*
5	*Pasco And Pinellas*
6	*Hardee, Highlands, Hillsborough, Manatee And Polk*
7	*Brevard, Orange, Osceola and Seminole*
8	*Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota*
9	*Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie*
10	*Broward*
11	*Miami-Dade and Monroe*

Florida County Code Table

NUMBER	COUNTY	NUMBER	COUNTY
1	*Alachua*	**35**	*Lake*
2	*Baker*	**36**	*Lee*
3	*Bay*	**37**	*Leon*
4	*Bradford*	**38**	*Levy*
5	*Brevard*	**39**	*Liberty*
6	*Broward*	**40**	*Madison*
7	*Calhoun*	**41**	*Manatee*
8	*Charlotte*	**42**	*Marion*
9	*Citrus*	**43**	*Martin*
10	*Clay*	**44**	*Monroe*
11	*Collier*	**45**	*Nassau*
12	*Columbia*	**46**	*Okaloosa*
13	*Miami-Dade*	**47**	*Okeechobee*
14	*DeSoto*	**48**	*Orange*
15	*Dixie*	**49**	*Osceola*
16	*Duval*	**50**	*Palm Beach*
17	*Escambia*	**51**	*Pasco*
18	*Flagler*	**52**	*Pinellas*
19	*Franklin*	**53**	*Polk*
20	*Gadsden*	**54**	*Putnam*
21	*Gilchrist*	**55**	*St. Johns*
22	*Glades*	**56**	*St. Lucie*
23	*Gulf*	**57**	*Santa Rosa*
24	*Hamilton*	**58**	*Sarasota*
25	*Hardee*	**59**	*Seminole*
26	*Hendry*	**60**	*Sumter*
27	*Hernando*	**61**	*Suwannee*
28	*Highlands*	**62**	*Taylor*
29	*Hillsborough*	**63**	*Union*
30	*Holmes*	**64**	*Volusia*
31	*Indian River*	**65**	*Wakulla*
32	*Jackson*	**66**	*Walton*
33	*Jefferson*	**67**	*Washington*
34	*Lafayette*	**99**	*Unknown*

Practitioner License Prefix Table

LICENSE PREFIX	PROFESSION	REPORTING FORMAT
Advanced Practice Registered Nurse		
APRN	Advanced Practice Registered Nurse	APRN1234567
Medical Physician		
ACN	Area of Critical Need	ACN123
ME	Medical Doctor	ME12345
LDC	Medical Doctor Limited to Cleveland Clinic	LDC1234
LD	Medical Doctor Limited to Mayo Clinic	LD1234
LL	Limited License Medical Doctor	LL1234
PPC	Medical Doctor Public Psychiatry Certificate	PPC1234
RS	Medical Doctor Restricted	RS1234
MFC	Medical Faculty Certificate	MFC1234
OSR	Office Surgery Registration	OSR1234
TME	Temporary Military Medical Doctor	TME1234
UM	Registration for Resident/HSE Physician	UM1234
PA	Physician Assistant	PA1234567
TPA	Temporary Military Physician Assistant	TPA1234
Osteopath Physician		
OS	Osteopathic Physician	OS12345
UO	Unlicensed Osteopathic Registration	UO1234
ORP	Osteopathic Residency Programs	ORP1234
OCN	Osteopathic – Area of Critical Need	OCN1234
UO	Osteopathic Resident Registration	UO1234
OFC	Osteopathic Faculty Certificate	OFC1234
TOS	Temporary Military Osteopathic Physician	TOS1234
Dentist		
DN	Dentist	DN1234
DTP	Dental Teaching Permit	DTP1234
DTC	Dental Temporary Certificate	DTC1234
DRP	Dental Residency Permit	DRP1234
Podiatrist		
PO	Podiatric Physician	PO12345
PR	Podiatric Resident Registration	PR123
PRP	Podiatric Resident Program	PRP1234
Chiropractor		
CH	Chiropractic Physician	CH1234

U.S. STANDARD STATE ABBREVIATIONS

ALABAMA	AL	NEW HAMPSHIRE	NH
ALASKA	AK	NEW JERSEY	NJ
ARIZONA	AZ	NEW MEXICO	NM
ARKANSAS	AR	NEW YORK	NY
CALIFORNIA	CA	NORTH CAROLINA	NC
COLORADO	CO	NORTH DAKOTA	ND
CONNECTICUT	CT	OHIO	OH
DELAWARE	DE	OKLAHOMA	OK
DISTRICT OF COLUMBIA	DC	OREGON	OR
FLORIDA	FL	PENNSYLVANIA	PA
GEORGIA	GA	RHODE ISLAND	RI
HAWAII	HI	SOUTH CAROLINA	SC
IDAHO	ID	SOUTH DAKOTA	SD
ILLINOIS	IL	TENNESSEE	TN
INDIANA	IN	TEXAS	TX
IOWA	IA	UTAH	UT
KANSAS	KS	VERMONT	VT
KENTUCKY	KY	VIRGINIA	VA
LOUISIANA	LA	WASHINGTON	WA
MAINE	ME	WEST VIRGINIA	WV
MARYLAND	MD	WISCONSIN	WI
MASSACHUSETTS	MA	WYOMING	WY
MICHIGAN	MI		
MINNESOTA	MN	**AMERICAN TERRITORIES**	
MISSISSIPPI	MS	AMERICAN SAMOA	AS
MISSOURI	MO	CANAL ZONE	CZ
MONTANA	MT	GUAM	GU
NEBRASKA	NE	PUERTO RICO	PR
NEVADA	NV	TRUST TERRITORIES	TT
		VIRGIN ISLANDS	VI

CANADIAN PROVINCES

ALBERTA	AB		
BRITISH COLUMBIA	BC	NOVA SCOTIA	NS
LABRADOR	LB	ONTARIO	ON
MANITOBA	MB	PR. EDWARD ISLAND	PE
NEW BRUNSWICK	NB	QUEBEC	QB
NEWFOUNDLAND	NF	SASKATCHEWAN	SK
NORTHWEST TERRITORY	NT	YUKON	YK

COUNTRY NAME	CODE
AFGHANISTAN	AF
ÅLAND ISLANDS	AX
ALBANIA	AL
ALGERIA	DZ
AMERICAN SAMOA	AS
ANDORRA	AD
ANGOLA	AO
ANGUILLA	AI
ANTARCTICA	AQ
ANTIGUA AND BARBUDA	AG
ARGENTINA	AR
ARMENIA	AM
ARUBA	AW
AUSTRALIA	AU
AUSTRIA	AT
AZERBAIJAN	AZ
BAHAMAS	BS
BAHRAIN	BH
BANGLADESH	BD
BARBADOS	BB
BELARUS	BY
BELGIUM	BE
BELIZE	BZ
BENIN	BJ
BERMUDA	BM
BHUTAN	BT
BOLIVIA, PLURINATIONAL STATE OF	BO
BONAIRE, SINT EUSTATIUS AND SABA	BQ
BOSNIA AND HERZEGOVINA	BA

COUNTRY NAME	CODE
BOTSWANA	BW
BOUVET ISLAND	BV
BRAZIL	BR
BRITISH INDIAN OCEAN TERRITORY	IO
BRUNEI DARUSSALAM	BN
BULGARIA	BG
BURKINA FASO	BF
BURUNDI	BI
BRAZIL	BR
BRITISH INDIAN OCEAN TERRITORY	IO
BRUNEI DARUSSALAM	BN
BULGARIA	BG
BURKINA FASO	BF
BURUNDI	BI
CAMBODIA	KH
CAMEROON	CM
CANADA	CA
CAPE VERDE	CV
CAYMAN ISLANDS	KY
CENTRAL AFRICAN REPUBLIC	CF
CHAD	TD
CHILE	CL
CHINA	CN
CHRISTMAS ISLAND	CX
COCOS (KEELING) ISLANDS	CC
COLOMBIA	CO
COMOROS	KM
CONGO	CG
CONGO, THE DEMOCRATIC REPUBLIC OF THE	CD

COUNTRY NAME	CODE
COOK ISLANDS	CK
COSTA RICA	CR
CÔTE D'IVOIRE	CI
CROATIA	HR
CUBA	CU
CURAÇAO	CW
CYPRUS	CY
CZECH REPUBLIC	CZ
DENMARK	DK
DJIBOUTI	DJ
DOMINICA	DM
DOMINICAN REPUBLIC	DO
ECUADOR	EC
EGYPT	EG
EL SALVADOR	SV
EQUATORIAL GUINEA	GQ
ERITREA	ER
ESTONIA	EE
ETHIOPIA	ET
FALKLAND ISLANDS (MALVINAS)	FK
FAROE ISLANDS	FO
FIJI	FJ
FINLAND	FI
FRANCE	FR
FRENCH GUIANA	GF
FRENCH POLYNESIA	PF
FRENCH SOUTHERN TERRITORIES	TF
GABON	GA

COUNTRY NAME	CODE
GAMBIA	GM
GEORGIA	GE
GERMANY	DE
GHANA	GH
GIBRALTAR	GI
GREECE	GR
GREENLAND	GL
GRENADA	GD
GUADELOUPE	GP
GUAM	GU
GUATEMALA	GT
GUERNSEY	GG
GUINEA	GN
GUINEA-BISSAU	GW
GUYANA	GY
HAITI	HT
HEARD ISLAND AND MCDONALD ISLANDS	HM
HOLY SEE (VATICAN CITY STATE)	VA
HONDURAS	HN
HONG KONG	HK
HUNGARY	HU
ICELAND	IS
INDIA	IN
INDONESIA	ID
IRAN, ISLAMIC REPUBLIC OF	IR
IRAQ	IQ
IRELAND	IE
ISLE OF MAN	IM

COUNTRY NAME	CODE
ISRAEL	IL
ITALY	IT
JAMAICA	JM
JAPAN	JP
JERSEY	JE
JORDAN	JO
KAZAKHSTAN	KZ
KENYA	KE
KIRIBATI	KI
KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF	KP
KOREA, REPUBLIC OF	KR
KUWAIT	KW
KYRGYZSTAN	KG
LAO PEOPLE'S DEMOCRATIC REPUBLIC	LA
LATVIA	LV
LEBANON	LB
LESOTHO	LS
LIBERIA	LR
LIBYA	LY
LIECHTENSTEIN	LI
LITHUANIA	LT
LUXEMBOURG	LU
MACAO	MO
MACEDONIA, THE FORMER YUGOSLAV REPUBLIC OF	MK
MADAGASCAR	MG
MALAWI	MW
MALAYSIA	MY
MALDIVES	MV
MALI	ML

COUNTRY NAME	CODE
MALTA	MT
MARSHALL ISLANDS	MH
MARTINIQUE	MQ
MAURITANIA	MR
MAURITIUS	MU
MAYOTTE	YT
MEXICO	MX
MICRONESIA, FEDERATED STATES OF	FM
MOLDOVA, REPUBLIC OF	MD
MONACO	MC
MONGOLIA	MN
MONTENEGRO	ME
MONTSERRAT	MS
MOROCCO	MA
MOZAMBIQUE	MZ
MYANMAR	MM
NAMIBIA	NA
NAURU	NR
NEPAL	NP
NETHERLANDS	NL
NEW CALEDONIA	NC
NEW ZEALAND	NZ
NICARAGUA	NI
NIGER	NE
NIGERIA	NG
NIUE	NU
NORFOLK ISLAND	NF
NORTHERN MARIANA ISLANDS	MP
NORWAY	NO

COUNTRY NAME	CODE
OMAN	OM
PAKISTAN	PK
PALAU	PW
PALESTINE, STATE OF	PS
PANAMA	PA
PAPUA NEW GUINEA/ PAPOUASIE-NOUVELLEGUINÉE (LA)	PG
PARAGUAY	PY
PERU	PE
PHILIPPINES	PH
PITCAIRN	PN
POLAND	PL
PORTUGAL	PT
PUERTO RICO	PR
QATAR	QA
RÉUNION	RE
ROMANIA	RO
RUSSIAN FEDERATION	RU
RWANDA	RW
SAINT BARTHÉLEMY	BL
SAINT HELENA, ASCENSION AND TRISTAN DA CUNHA	SH
SAINT KITTS AND NEVIS	KN
SAINT LUCIA	LC
SAINT MARTIN (FRENCH PART)	MF
SAINT PIERRE AND MIQUELON	PM
SAINT VINCENT AND THE GRENADINES	VC
SAMOA	WS
SAN MARINO	SM
SAO TOME AND PRINCIPE	ST

COUNTRY NAME	CODE
SERBIA	RS
SEYCHELLES	SC
SIERRA LEONE	SL
SINGAPORE	SG
SINT MAARTEN (DUTCH PART)	SX
SLOVAKIA	SK
SLOVENIA	SI
SOLOMON ISLANDS	SB
SOMALIA/SOMALIE	SO
SOUTH AFRICA	ZA
SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS	GS
SOUTH SUDAN	SS
SPAIN	ES
SRI LANKA	LK
SUDAN	SD
SURINAME	SR
SVALBARD AND JAN MAYEN	SJ
SWAZILAND	SZ
SWEDEN	SE
SWITZERLAND	CH
SYRIAN ARAB REPUBLIC	SY
TAIWAN, PROVINCE OF CHINA	TW
TAJIKISTAN	TJ
TANZANIA, UNITED REPUBLIC OF	TZ
THAILAND	TH
TIMOR-LESTE	TL
TOGO	TG
TOKELAU	TK

COUNTRY NAME	CODE
TOGO	TG
TOKELAU	TK
TONGA	TO
TRINIDAD AND TOBAGO	TT
TUNISIA	TN
TURKEY	TR
TURKMENISTAN	TM
TURKS AND CAICOS ISLANDS	TC
TUVALU	TV
UGANDA	UG
UKRAINE	UA
UNITED ARAB EMIRATES	AE
UNITED KINGDOM	GB
UNITED STATES	**US**

COUNTRY NAME	CODE
UNITED STATES MINOR OUTLYING ISLANDS	UM
URUGUAY	UY
UZBEKISTAN	UZ
VANUATU	VU
VENEZUELA, BOLIVARIAN REPUBLIC OF	VE
VIET NAM	VN
VIRGIN ISLANDS, BRITISH	VG
VIRGIN ISLANDS, U.S.	VI
WALLIS AND FUTUNA	WF
WESTERN SAHARA	EH
YEMEN	YE
ZAMBIA	ZM
ZIMBABWE	ZW

This lists the country names (official short names in English) in alphabetical order as given in ISO 3166-1 and the corresponding ISO 3166-1-alpha-2 code elements.

The ISO 3166 Country Code List link is available at the Reporting Resources page of the Florida Center/Data Collection Web address:

http://ahca.myflorida.com/SCHS/DataCollection/help.shtml

Helpful Links

Links to the following are available at the Reporting Resources page at the Florida Center/Data Collection Web address: *AHCA: Florida Center for Health Information and Policy Analysis: Data Collection FDDC Resources (myflorida.com)*

- Social Security Administration website for verification of assigned Social Security number prefixes.
- To verify physician license numbers on the DOH Florida Medical License Search
- To verify U.S. Postal Zip Codes with the USPS Zip Code lookup search
- To verify Country Codes on the ISO 3166 website:

Data Specifications

Data Specifications for Inpatient, Outpatient, and Emergency Department PD10-5 and AS10-5, may be found at the FDDC General Reporting Resources page at the Florida Center/Data Collection Web address:

AHCA: Florida Center for Health Information and Policy Analysis: Data Collection FDDC Resources (myflorida.com)

Inpatient

Data Specifications: (**PD10-5, Q4 2022**)

- Inpatient/ Comprehensive Rehab XML Schema PD10-5 AND Sample File
- *AHCA: Florida Center for Health Information and Policy Analysis: Data Collection FDDC Resources (myflorida.com)*

AS/ED

Data Specifications: (**AS10-5, Q4 2022)**

- Ambulatory/ED XML Schema and Sample File
- *AHCA: Florida Center for Health Information and Policy Analysis: Data Collection FDDC Resources (myflorida.com)*

Header Data Specifications

ELEMENT	XSD DATA TYPE	REQUIRED IN XSD	ACCEPT NULL VALUES	MINIMUM CONSTRAINT	MAXIMUM CONTRAINT	FORMAT	PATTERN
RPT_YEAR	xs:string	YES	NO	4	4	N	
RPT_QTR	xs:string	YES	NO	1	1	N	
DATA_TYPE	xs:string	YES	NO	6	6	AN	
SUBMISSION_TYPE	xs:string	YES	NO	1	1	A	
PROC_DATE	xs:date	YES	NO	10	10	N	
AHCA_NUM	xs:string	YES	NO	1	10	N	
MEDICARE_NUM	xs:string	YES	NO	7	7	N	
ORG_NAME	xs:string	YES	NO	1	40	AN	

Ambulatory Data Specifications

ELEMENT	XSD DATA TYPE	REQUIRED IN XSD	ACCEPT NULL VALUES	MINIMUM CONSTRAINT	MAXIMUM CONTRAINT	FORMAT	PATTERN
RECORD id	xs:string	YES	NO	1	24	AN	underscore, comma, decimal, hyphen
AHCA_NUM	xs:string	YES	NO	1	10	N	
MED_REC_NUM	xs:string	YES	NO	1	24	AN	underscore, comma, decimal, hyphen
PATIENT_SSN	xs:string	YES	NO	9	9	N	
PATIENT_ETHNICITY	xs:string	YES	NO	2	2	AN	
PATIENT_RACE	xs:string	YES	NO	1	1	N	
PATIENT_BIRTHDATE	xs:date	YES	NO	10	10	N	
PATIENT_SEX	xs:string	YES	NO	1	1	A	
PATIENT_ZIP	xs:string	YES	NO	5	10	N	
PATIENT_COUNTRY	xs:string	YES	NO	2	2	AN	
SERVICE_CODE	xs:string	YES	NO	1	1	N	
ADMIT_SOURCE	xs:string	YES	NO	1	2	AN	
PRINC_PAYER_CODE	xs:string	YES	NO	1	1	A	
PRINC_DIAG_CODE	xs:string	NO	YES	3	8	AN	
OTHER_DIAG_CODE	xs:string	NO	YES	3	8	AN	
EVAL_MGMT_CODE	xs:string	NO	YES	5	5	AN	
OTHER_CPT_HCPCS _CODE	xs:string	NO	YES	5	5	AN	
ATTENDING_PRACT_ID	xs:string	YES	NO	4	15	AN	
ATTENDING_PRACT_NPI	xs:string	YES	NO	10	10	N	
OPERATING_PRACT_ID	xs:string	NO	YES	4	15	AN	
OPERATING_PRACT_NPI	xs:string	NO	YES	10	10	N	
OTHER_PRACT_ID	xs:string	NO	YES	4	15	AN	
OTHER_PRACT_NPI	xs:string	NO	YES	10	10	N	
PHARMACY_CHARGES	xs:string	YES	NO	1	7	N	
MED_SURG_SUPPLY_ CHARGES	xs:string	YES	NO	1	7	N	

LAB_CHARGES	xs:string	YES	NO	1	7	N	
RADIOLOGY_IMAGING_ CHARGES	xs:string	YES	NO	1	7	N	
CARDIOLOGY_CHARGES	xs:string	YES	NO	1	7	N	
OPER_ROOM_CHARGES	xs:string	YES	NO	1	7	N	
ANESTHESIA_CHARGES	xs:string	YES	NO	1	7	N	
RECOVERY_ROOM_ CHARGES	xs:string	YES	NO	1	7	N	
ER_ROOM_CHARGES	xs:string	YES	NO	1	7	N	
TRAUMA_RESP_CHARGES	xs:string	YES	NO	1	7	N	
TREATMENT_OBSERVATION_ ROOM_CHARGES	xs:string	YES	NO	1	7	N	
GI_SERVICES_CHARGES	xs:string	YES	NO	1	7	N	
EXTRA_CORP_SHOCK_ WAVE_ CHARGES	xs:string	YES	NO	1	7	N	
OTHER_CHARGES	xs:string	YES	NO	1	7	N	
TOTAL_CHARGES	xs:string	YES	NO	1	7	N	
VISIT_BEGIN_DATE	xs:date	YES	NO	10	10	N	
VISIT_END_DATE	xs:date	YES	NO	10	10	N	
ARRIVAL_HOUR	xs:string	YES	NO	2	2	N	
ED_DISCHARGE_HOUR	xs:string	YES	NO	2	2	N	
PATIENT_REASON	xs:string	NO	YES	3	8	AN	
ECMORB	xs:string	NO	YES	3	8	AN	
SERVICE_LOCATION	xs:string	NO	NO	1	1	A	
PATIENT_STATUS	xs:string	YES	NO	2	2	N	
TRAILER	xs:string	YES	NO	1		N	

Inpatient Data Specifications

ELEMENT	XSD DATA TYPE	REQUIRED IN XSD	ACCEPT NULL VALUES	MINIMUM CONSTRAINT	MAXIMUM CONTRAINT	FORMAT	PATTERN
RECORD id	xs:string	YES	NO	1	24	AN	underscore, comma, decimal, hyphen
AHCA_NUM	xs:string	YES	NO	1	10	N	
MED_REC_NUM	xs:string	YES	NO	1	24	AN	underscore, comma, decimal, hyphen
PATIENT_SSN	xs:string	YES	NO	9	9	N	
PATIENT_ETHNICITY	xs:string	YES	NO	2	2	AN	
PATIENT_RACE	xs:string	YES	NO	1	1	N	
PATIENT_BIRTHDATE	xs:date	YES	NO	10	10	N	
PATIENT_SEX	xs:string	YES	NO	1	1	A	
PATIENT_ZIP	xs:string	YES	NO	5	10	N	
PATIENT_COUNTRY	xs:string	YES	NO	2	2	AN	
TYPE OF SERVICE_ CODE	xs:string	YES	NO	1	1	N	
ADMIT_PRIORITY	xs:string	YES	NO	1	1	N	
ADMIT_SOURCE	xs:string	YES	NO	1	2	AN	
ADMIT_DATE	xs:date	YES	NO	10	10	N	
INP_ADMIT_TIME	xs:string	YES	NO	2	2	N	
DISCH_DATE	xs:date	YES	NO	10	10	N	
DISCH_TIME	xs:string	YES	NO	2	2	N	
DISCH_STATUS	xs:string	YES	NO	2	2	N	
PRINC_PAYER_CODE	xs:string	YES	NO	1	1	A	
PRINC_DIAG_CODE	xs:string	YES	NO	3	8	AN	
OTHER_DIAG_CODE	xs:string	NO	YES	3	8	AN	
PRESENT_ON_ADMIT	xs:string	YES	NO	1	1	AN	
PRIN_PROC_CODE	xs:string	NO	YES	7	7	AN	
OTHER_PROC_ CODE	xs:string	NO	YES	7	7	AN	
PROC_DATE	xs:date	NO	YES	10	10	n	
ATTENDING_PRACT _ ID	xs:string	YES	NO	4	15	AN	

ATTENDING_PRACT _ NPI	xs:string	YES	NO	10	10	N	
OPERATING_PRACT _ ID	xs:string	NO	YES	4	15	AN	
OPERATING_PRACT _ NPI	xs:string	NO	YES	10	10	N	
OTHER_PRACT_ID	xs:string	NO	YES	4	15	AN	
OTHER_PRACT_NPI	xs:string	NO	YES	10	10	N	
ROOM_BOARD_ CHARGES	xs:string	YES	NO	1	7	N	
NURSERY_LEVEL_1_ CHARGES	xs:string	YES	NO	1	7	N	
NURSERY_LEVEL_2_ CHARGES	xs:string	YES	NO	1	7	N	
NURSERY_LEVEL_3_ CHARGES	xs:string	YES	NO	1	7	N	
INTENSIVE_CARE_ CHARGES	xs:string	YES	NO	1	7	N	
CORONARY_CARE_ CHARGES	xs:string	YES	NO	1	7	N	
PHARMACY_ CHARGES	xs:string	YES	NO	1	7	N	
MED_SURG_ SUPPLY_ CHARGES	xs:string	YES	NO	1	7	N	
LAB_CHARGES	xs:string	YES	NO	1	7	N	
RADIOLOGY_ IMAGING _ CHARGES	xs:string	YES	NO	1	7	N	
CARDIOLOGY_ CHARGES	xs:string	YES	NO	1	7	N	
RESPIRATORY_ PULMONARY_ CHARGES	xs:string	YES	NO	1	7	N	
OPER_ROOM_ CHARGES	xs:string	YES	NO	1	7	N	
ANESTHESIA_ CHARGES	xs:string	YES	NO	1	7	N	
RECOVERY_ROOM_ CHARGES	xs:string	YES	NO	1	7	N	
LABOR_ROOM_ CHARGES	xs:string	YES	NO	1	7	N	
ER_ROOM_CHARGES	xs:string	YES	NO	1	7	N	
TRAUMA_RESPONSE_ CHARGES	xs:string	YES	NO	1	7	N	

TREATMENT_ OBSERVATION_ ROOM_ CHARGES	xs:string	YES	NO	1	7	N	
BEHAVIORAL_HEALTH _ CHARGES	xs:string	YES	NO	1	7	N	
ONCOLOGY_CHARGES	xs:string	YES	NO	1	7	N	
PHYS_THERAPY_ CHARGES	xs:string	YES	NO	1	7	N	
OCCUPATIONAL_ THERAPY_ CHARGES	xs:string	YES	NO	1	7	N	
SPEECH_THERAPY_ CHARGES	xs:string	YES	NO	1	7	N	
COMP_REHAB_ CHARGES	xs:string	YES	NO	1	7	N	
OTHER_CHARGES	xs:string	YES	NO	1	7	N	
TOTAL_CHARGES	xs:string	YES	NO	1	7	N	
INFANT_LINKAGE_ID	xs:string	YES	NO	9	9	N	
ADMIT_DIAGNOSIS	xs:string	YES	NO	3	8	AN	
ECMORB	xs:string	NO	YES	3	8	AN	
PRESENT_ON_ADMIT	xs:string	YES	NO	1	1	AN	
EMERG_DATE_ ARRIVAL	xs:date	YES	NO	10	10	N	
EMERG_HOUR_ ARRIVAL	xs:string	YES	NO	2	2	N	
CONDITION_CODE	xs:string	YES	NO	2	2	AN	
TRAILER	xs:string	YES	NO	1		N	