CHAPTER 59B-9
PATIENT DATA COLLECTION, AMBULATORY SURGERY AND EMERGENCY DEPARTMENT

59B-9.030 Purpose of Ambulatory and Emergency Department Patient Data Reporting.

The reporting of ambulatory patient data will provide a statewide integrated database that includes hospital based and free standing ambulatory surgery centers, and hospital emergency department services for the assessment of variations in utilization, disease surveillance, access to care and cost trends.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 1-1-10, Formerly 59B-9.010, Amended 01-1-18.

59B-9.031 Definitions.

(1) "Ambulatory Center." For the purposes of this rule, an ambulatory center means a freestanding ambulatory surgery center, a short-term acute care hospital and an Emergency Department.

(2) "Ambulatory Surgical Center" means a facility licensed as an ambulatory surgical center under Chapter 395, F.S.

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

(4) "ECMORB" means a Supplementary Classification of External Causes of Morbidity and Poisoning ICD-10-CM, where environmental events, circumstances, and conditions are the cause of injury, poisoning and other adverse effects as specified in the ICD-10-CM manual and the conventions of coding.

(5) "Emergency Department" means any department of any general hospital when a request is made for emergency services and care for any emergency medical condition which is within the service capability of the hospital as specified in Section 395.1041, F.S.

(6) "Executive Officer" means a reporting facility's chief executive officer, chief financial officer, chief operating officer, president, or vice president of the facility in charge of a principal business unit, division or function (administration or finance).

(7) "HCPCS" means Health Care Common Procedure Coding System which is published annually by the United States Department of Health and Human Services and is required by the Federal Government for Medicare reporting purposes.

(8) "Inpatient" means a patient who has an admission order given by a licensed physician or other individual who has been granted admitting privileges by the hospital.

(9) "NPI" means National Provider Identification. An NPI is a unique identification number assigned to a provider by the Centers for Medicare & Medicaid Services.

(10) "Short-Term Acute Care Hospital" means a hospital as defined in Section 395.002(12), F.S.

(11) "Visit" means 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 as described in subsection 59B-9.034(3), F.A.C. Visits which require the patient to appear in an ambulatory setting prior to the actual procedure (even if this occurs one or more days before the procedure) shall be counted as one visit. The admit date in these instances should be the day of the procedure.

(12) ISO 3166 – International Standard for Organization is a standardized list of country names and codes first published in

1974 and updated 2008. ISO 3166 is available at: http://www.iso.org/iso/english_country_names_and_code_elements.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 1-1-10, Amended 12-5-10 Formerly 59B-9.013, Amended 10-1-15, 01-1-18.

59B-9.032 Ambulatory and Emergency Department Data Reporting and Audit Procedures.
(1) The following entities shall submit patient data reports to the Agency for Health Care Administration (AHCA or Agency):
(a) All licensed short-term acute care hospitals licensed under Chapter 395, F.S.;
(b) All licensed ambulatory surgical centers as defined in Section 395.002(3), F.S.;
(c) All Emergency Departments licensed under Chapter 395, F.S.;
(d) All lithotripsy centers defined in Section 408.07, F.S.;
(e) All cardiac catheterization laboratories defined in Section 408.07, F.S.
(2) Each facility in subsection (1) above shall submit a separate report for each location per Section 408.061(3), F.S.
(3) All ambulatory centers performing the services set forth in Rules 59B-9.030 through 59B-9.039, F.A.C., shall submit ambulatory patient data as set forth in Rules 59B-9.037 and 59B-9.038, F.A.C., unless the reporting entity meets the criteria listed in subsection 59B-9.032(5), F.A.C., below.
(4) Any Ambulatory Surgical Center (ASC) receiving 200 or more patient visits during the reporting quarter periods outlined in Rule 59B-9.033, F.A.C., are required to report data as specified in Rules 59B-9.037 and 59B-9.038, F.A.C.
(5) Ambulatory Surgical Centers (ASC) receiving fewer than 200 patient visits during the reporting quarter periods outlined in Rule 59B-9.033, F.A.C may request an exemption from a quarters reporting requirement. To request an exemption, the ASC shall send a letter on facility letterhead stating the number of patient visits for the reporting quarter and signed by the entity's chief executive officer or director. The exemption letter shall be received at the Agency office in Tallahassee on or prior to the deadline for submission of the quarterly report. This is not a onetime letter, but must be submitted for each quarter with fewer than 200 visits.
(6) Upon notification by the Agency staff, all facilities shall provide access to all required information from the medical records and billing documents underlying and documenting the ambulatory patient data submitted, as well as other patient related documentation deemed necessary by the Agency to conduct complete ambulatory patient data audits subject to the limitations as set forth in Section 408.061(1)(d), F.S. No patient records that support patient data are exempt from disclosure to AHCA for audit purposes.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063, 408.07, 408.08, 408.15(11) FS. History–New 1-1-10, Amended 7-1-11, 10-5-11, Formerly 59B-9.011, Amended 01-1-18.

59B-9.033 Schedule for Submission of Ambulatory and Emergency Department Patient Data.
(1) Ambulatory Centers and Emergency Departments shall report patient data according to the provisions in Rules 59B-9.030 through 59B-9.039, F.A.C.
(a) Each report covering patient visits ending between January 1 and March 31, inclusive of each year, shall be submitted no later than June 10 of the calendar year during which the visit occurred. This is considered to be the first quarter, regardless of the facility fiscal year. First quarter reports must be certified by August 31 of the same calendar year.
(b) Each report covering patient visits ending between April 1 and June 30, inclusive of each year, shall be submitted no later than September 10 of the calendar year during which the visit occurred. This is considered to be the second quarter, regardless of the facility fiscal year. Second quarter reports must be certified by November 30 of the same calendar year.
(c) Each report covering patient visits ending between July 1 and September 30, inclusive of each year, shall be submitted no later than December 10 of the calendar year during which the visit occurred. This is considered to be the third quarter, regardless of the facility fiscal year. Third quarter reports must be certified by February 28 of the following calendar year.
(d) Each report covering patient visits ending between October 1 and December 31, inclusive of each year, shall be submitted no later than March 10 of the calendar year following the year in which the visit occurred. This is considered to be the fourth quarter, regardless of the facility fiscal year. Fourth quarter reports must be certified by May 31 of the next calendar year.
(2) Failure to file the report on or before the certification due date as specified in paragraphs 59B-9.033(1)(a)-(d), F.A.C., and failure to correct a report which has been filed but contains errors or deficiencies by the certification deadline is punishable by fine pursuant to Rule 59B-9.036, F.A.C. The agency shall send a notification of errors or deficiencies electronic mail, or fax. Rejected reports must be corrected, resubmitted and certified by the certification due date.

59B-9.034 Reporting Instructions.

(1) Ambulatory Surgical centers shall report data for all non-emergency visits for surgical procedures or services performed in the operating room, ambulatory surgical care, cardiology (cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA)), gastro intestinal, extra-corporeal shock wave treatment (lithotripsy) surgery, and endoscopy corresponding to the following Current Procedural Terminology (CPT) and corresponding HCPCS Codes. For hospitals reporting type of service "1", ambulatory surgical procedures, report CPT codes in the reportable range defined in paragraphs 59B-9.034(1)(a), (b), F.A.C., having revenue charges for 36XX, 48XX, 49XX, 75XX or 79XX as used in the UB-04. Visits without these revenue charges should not be reported even if the CPT codes are in the reportable range. Type of service "2", Emergency Room, visits are not restricted to a CPT-HCPCS reportable range and should report all procedure codes.

(a) 10021 through 69999. Including surgery, cardiac catheterization, endoscopy procedures, and lithotripsy revenue associated procedure codes.

(b) 92920 through 92998 and 93451 through 93533. Includes percutaneous transluminal coronary angioplasty (PTCA) and Cardiac Catheterization.

(c) Exclude visits where the primary reason for the visit is venipuncture for laboratory services.

(d) Report one record for each visit, except pre-operation visits may be combined with the record of the associated ambulatory surgery visit. See subsection 59B-9.031(11), F.A.C.

(2) Emergency Departments (ED) shall report data for:

(a) Emergency department visits in which emergency department registration occurs for the purpose of seeking emergency care services, including observation, and the patient is not admitted for inpatient care at the reporting entity.

(b) The CPT-HCPCS codes representing the services provided as part of the emergency department visit. CPT-HCPCS codes are reported in the 'OTHER CPT-HCPCS' fields (1-30) and are not restricted to the CPT-HCPCS reportable range defined in paragraph 59B-9.034(1)(a), F.A.C., for an ambulatory surgical center.

(c) An Emergency Department Evaluation and Management Procedure code representing the patient's acuity as part of the emergency department visit.

(d) An ED visit occurs even if the only service provided to a registered patient is triage or screening. If a registered patient leaves prior to being seen by a physician, report the discharge status as "07" "AMA/discontinued care" and charges if incurred. Report zero if charges are not incurred.

(e) Do not include visits for registrations that occur in the Emergency Department when the hospital central registration department is closed unless emergency services are provided.

(3) Hospitals shall exclude records of any patient visit in which the outpatient and inpatient billing record is combined because the patient was admitted to inpatient care within a facility at the same location per Section 408.061(3), F.S.

(4) For each patient visit, ambulatory centers shall report all services provided using procedural codes specified in Rules 59B-9.037 and 59B-9.038, F.A.C.

(5) An individual approved by the Agency must submit a zipped XML file by Internet according to the specifications in through (c) below.

(a) Internet Transmission. The Internet address for receipt of ambulatory patient data is https://apps.ahca.myflorida.com/patientdata/.

(b) **Data reported for visits occurring before first quarter 2018 to the Internet address shall be electronically transmitted with the zipped ambulatory data in a XML file using the Ambulatory Patient Data XML Schema AS10-2** available at http://ahca.myflorida.com/xmlschemas/AS10-2.xsd. The Ambulatory Patient Data XML AS10-2 Schema (effective 10/01/2015) is incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-08832.

(c) **Beginning with first quarter 2018 data reporting period as defined in 59B-9.033(1)(c), Ambulatory patient data must be submitted using Ambulatory Ppatient Data XML Schema AS10-3, available at: http://ahca.myflorida.com/xmlschemas/AS10-3.xsd, The Ambulatory Patient Data XML AS10-3 Schema (effective 01/01/2018) is incorporated by reference at http://www.flrules.org/Gateway/reference.asp?No=Ref-08833. The data in the XML file shall contain the data elements, codes and standards required in Rules 59B-9.037 and 59B-9.038, F.A.C.**

59B-9.035 Certification, Audits, and Resubmission Procedures.

(1) Data submissions for all ambulatory centers must be in compliance with Rules 59B-9.030 through 59B-9.039, F.A.C. The executive officer, administrator, or authorized designee shall certify the data quarterly as accurate, complete and verifiable by completing and signing Ambulatory Certification Form for Ambulatory Patient Data AHCA Form 4200-0007, July 2017, incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-08834. The completed certification form attests the ambulatory patient data report has been examined and, to the best of their knowledge and belief, the information contained in this report is true, accurate, and complete, and has been prepared from the books and records of this ambulatory center, except as noted. The completed certification form must be either mailed to the Agency for Health Care Administration, 2727 Mahan Drive, MS #16, Tallahassee, Florida 32308. Attention: Florida Center for Health Information and Transparency; submitted by facsimile to the Agency's office; or a scanned certification submitted by electronic mail by the certification due date. The Agency will send a certification package to the reporting entity once their data file is complete for certification. Upon receipt of a facility's signed certification form, the facility is considered "certified" for the reporting quarter.

(2) Facilities not certified within five (5) calendar months following the last day of the reporting quarter shall be subject to penalties pursuant to Rule 59B-9.036, F.A.C. A facility will not be penalized for delays caused by the Agency which is documented by the reporting facility to include on-line reporting system downtime or delays in receipt of reports from the Agency.

(3) Changes or corrections to certified data may be accepted from facilities for a period of twelve (12) months following the initial submission due date. The Agency may grant approval if it determines that resubmission will significantly impact data quality. The executive officer, administrator or authorized designee must provide a signed written request to the Agency to request resubmission. The request must specify the reason for the corrections or changes, explain the cause contributing to the inaccurate reporting, describe a corrective action plan to prevent future errors, the total number of records affected by quarters and years, the data type and the date that the replacement file will be submitted to the Agency. Any changes to a facility's data after this twelve-month period shall be subject to penalties pursuant to Rule 59B-9.036, F.A.C. Resubmission of previously certified data must be certified within thirty (30) days following receipt of the data file from the facility.

(4) **The Agency must be notified when a change of the facility contact responsible for handling the data submission or the facility CEO or Administrator occur. Information must include full names, title, applicable phone and fax numbers, and email address.**

59B-9.036 Penalties for Ambulatory Patient Data Reporting and Deficiencies.

(1) For purposes of this rule chapter, a report or other information is "incomplete" when it does not contain all data required by the Agency in this rule, and in forms incorporated by reference, or when it contains inaccurate data. The Agency shall to the extent practical, apply the same audit standards and use the same audit procedures for all facilities or audit a random sample of facilities. The Agency will notify each facility of any possible errors discovered by audit and request that the facility either correct the data or verify that the data is complete and correct. A report or other information is "false" if done or made with the knowledge of the preparer or an administrator that it contains information or data which is not true or accurate.

(2) An ambulatory center which refuses to file, fails to timely file or files false or incomplete reports or other information required to be filed under the provisions of Section 408.08(2), F.S. other Florida Law, or a rule adopted there under, shall be subject to administrative fines pursuant to Section 408.813, F.S. Failure to comply with reporting requirements will also result in the referral of a facility to the Agency's Bureau of Health Facility Regulation.

(3) Notifications will be sent to reporting facilities who do not submit their data file by the initial due date as specified in Rule 59B-9.033, F.A.C.

(4) The penalty period will begin on the first calendar day following the certification due date for purposes of penalty assessments.

(5) Any ambulatory center which is delinquent for a reporting deficiency other than submission of a false report shall be subject to a fine of $100 per day of violation for the first violation, $350 per day of violation for the second violation, and $1,000 per day of violation for the third or subsequent violations. **Following four consecutive non-delinquent quarters, the fine violation matrix**

==will reset to the first violation rate==. Violations will be considered those activities which necessitate the issuance of an administrative complaint by the Agency unless the administrative complaint is withdrawn or final order dismissing the administrative complaint is entered. All fines are to be fixed, imposed and collected by the Agency. Any ambulatory center which files a false report with the Agency or provides false information to the Agency shall be subject to a fine not exceeding $1000 per day per violation, in addition to any other fine imposed hereunder, pursuant to Section 408.813, F.S.

Rulemaking Authority 408.15(8), 408.813 FS. Law Implemented 408.08, 408.061,408.813 FS. History–New 1-1-10, Formerly 59B-9.022, 59B-9.016, Amended.01-1-18.

59B-9.037 Header Record.

The first record in the data file shall be a header record containing the information described below.

(1) Transaction Code. Enter Q for a calendar quarter report. A required field.

(2) Report Year. Enter the year of the data in the format YYYY.

(3) Report Quarter. Enter the quarter of the data, 1, 2, 3 or 4, where 1 corresponds to the first quarter of the calendar year, 2 corresponds to the second quarter of the calendar year, 3 corresponds to the third quarter of the calendar year, and 4 corresponds to the fourth quarter of the calendar year.

(4) Data Type. Enter ==AS10-3== for Ambulatory Data and Emergency Department Data. A required entry.

(5) Submission Type. Enter I or R where I indicates an initial submission of a data file or resubmission of a data file prior to certification and R indicates a replacement submission of previously certified patient data where resubmission has been requested or authorized by the Agency. A required entry.

(6) Processing Date. Enter the date that the data file was created in the format YYYY-MM-DD where MM represents numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits.

(7) AHCA Facility Number. Enter the identification number of the ambulatory center as assigned by the Agency for reporting purposes. A valid identification number must contain at least eight digits and no more than 10 digits.

(8) Medicare Number. Enter the Medicare number of the facility as assigned by Centers for Medicare & Medicaid Services (CMS). A valid identification number must contain seven (7) numeric digits. A required field.

(9) Organization Name. Enter the name of the ambulatory center that performed the ambulatory services represented by the data, and which is responsible for reporting the data. All questions regarding data accuracy and integrity will be referred to this entity. Up to a forty character field.

(10) Contact Person Name. Enter the name of the contact person at the ambulatory center. Submit name in the Last, First format. Up to a twenty-five character field.

(11) Contact Person Telephone Number. The area code, business telephone number, and if applicable, extension for the contact person. Enter the contact person telephone number in the numeric format (AAA)XXX-XXXX-EEEEE where AAA is the area code, and EEEEE is the extension. Blank fill if no extension.

(12) Contact Person E-Mail Address. The e-mail address of the contact person.

(13) Contact Person Street or P. O. Box Address. Enter the Street or Post Office Box address of the contact person. Up to a forty character field.

(14) Mailing Address City. Enter the city of the address of the contact person. Up to a twenty-five character field.

(15) Mailing Address State. Enter the state of the address of the contact person using the U.S. Postal Service state abbreviation in the format XX. Use the abbreviation FL for Florida.

(16) Mailing Address Zip Code. Enter the numeric zip code of the address of the contact person in the format XXXXX-XXXX. Blank fill if no extension.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 1-1-10, Formerly 59B-9.018, Amended 10-1-15, 01-1-18.

59B-9.038 Ambulatory Data Elements, Codes and Standards.

All data elements and data element codes listed below shall be reported. All facilities submitting data in compliance with Rules 59B-9.030 through 59B-9.039, F.A.C., shall report the following required data elements as stipulated by the Agency.

(1) AHCA Facility Number. An identification number assigned by the Agency or reporting purposes. The number must match the facility number recorded on the header record. A valid identification number must contain at least eight digits and no more than 10 digits. A required entry.

(2) Patient Control Number. An alpha-numeric code containing standard letters or numbers assigned by the facility as a unique identifier for each record submitted in the reporting period to facilitate retrieval of individual's account of services (accounts receivable) containing the financial billing records and any postings of payment. The 'Patient Control Number' is defined as 'Record id' in the schema. Up to twenty four (24) characters. Duplicate patient control numbers are not permitted. The facility must maintain a key list to locate actual records upon request by the Agency. A required field.

(3) Medical or Health Record Number. An alpha-numeric code assigned to the patient's medical or health record by the facility. The medical/health record number references a file that contains the history of treatment. It should not be substituted for the Patient Control Number which is the financial record associated with a visit. Up to twenty four (24) characters. A required field.

(4) Patient Social Security Number. The social security number (SSN) of the patient. A nine digit field to facilitate retrieval of individual case records, to be used to track multiple patient visits, and for medical research. Reporting 777777777 is acceptable for those patients where efforts to obtain the SSN have been unsuccessful or the patient is under two (2) years of age and does not have a SSN or for patients who are non-U.S. citizens who have not been issued SSNs. If only the last four digits of a patients SSN are known, report 77777XXXX where XXXX represent the last known four digits of the patient SSN. **The last four digit SSN format must be used only when the full SSN is unknown and not as a substitute for all nine digit SSN's**. A required entry.

(5) Patient Ethnicity. Self-designated by the patient, patient's parent or guardian. Use "Unknown" where efforts to obtain the information from the patient or from the patient's parent or guardian have been unsuccessful. The patient's ethnic background shall be reported as one choice from the following list of alternatives. A required entry. Must be a two (2) digit code as follows:

(a) E1 = Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

(b) E2 = Non-Hispanic or Latino. A person not of any Spanish culture or origin.

(c) E7 = Unknown.

(6) Patient Race. Self-designated by the patient, patient's parent or guardian. Use "Unknown" where efforts to obtain the information from the patient or from the patient's parent or guardian have been unsuccessful. The patient's racial background shall be reported as one choice from the following list of alternatives. A required entry. Must be a one (1) digit code as follows:

(a) 1 – American Indian or Alaskan Native. A person having origins in any of the original peoples of North and South America (including Central America) America, and who maintains cultural identification through tribal affiliation or community recognition.

(b) 2 – 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, Cambodia, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

(c) 3 – Black or African American. A person having origins in any of the black racial groups of Africa.

(d) 4 – Native Hawaiian or other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

(e) 5 – White. A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

(f) 6 – Other. Any other possible options not covered in the above categories, including a patient who has more than one race.

(g) 7 – Unknown. Use if the patient refuses or fails to disclose.

(7) Patient Birth Date. The date of birth of the patient. A ten character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Unknown birthdates should use the default of 1880-01-01 where efforts to obtain the patient's birth date have been unsuccessful. A birth date after the patient visit ending date is not permitted. A required entry.

(8) Patient Sex – The patient sex at the time of admission. A required entry. Alpha characters must be in upper case. Must be a one (1) digit code as follows:

(a) M – Male.

(b) F – Female.

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

(9) Patient Zip Code. The five digit United States Postal Service ZIP Code of the patient's address. Use 00009 for foreign residences. Use 00007 for homeless patients. Use 00000 where efforts to obtain the information have been unsuccessful. A required entry.

(10) Patient Country Code. The country code of residence. A two (2) digit upper case alpha code from the Code for Representation of Names of Countries, ISO 3166 or latest release. Use 99 where the country of residence is unknown, or where efforts to obtain the information have been unsuccessful. A required entry for type of service "2".

(11) Type of Service Code. A code designating the type of service, either ambulatory surgery or emergency department visit. A required entry. Must be a one (1) digit code as follows:

(a) 1 – Ambulatory surgery, as described in subsection 59B-9.034(1) , F.A.C.

(b) 2 – Emergency department visit, as described in subsection 59B-9.034(2), F.A.C.

(12) Source or Point of Origin of Admission. Must be a one (1) character alpha code or two (2) digit numeric code indicating the direct source or point of patient origin for this visit. A required entry if type of service is "2". Zero fill if type of service is "1". Alpha characters must use upper case.

(a) 01 – Non-health care facility point of origin – The patient presented to this facility for outpatient services. Includes patients coming from home or workplace.

(b) 02 – Clinic or Physician's Office. The patient presented to this facility for outpatient services from a clinic or physician's office.

(c) 04 – Transfer from a hospital. The patient was transferred to this facility as an outpatient from an acute care facility. Transfer must be from a different hospital.

(d) 05 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). The patient was referred to this facility as a transfer from a SNF or ICF where the patient was a resident.

(e) 06 – Transfer from another health care facility. The patient was referred to this facility for services by another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.

(f) 08 – Court/Law Enforcement. The patient was referenced to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services. Includes transfers from incarceration facilities.

(g) 09 – Information Not Available. The means by which the patient was referred to this hospital's outpatient department is not known.

(h) D – Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim. The patient received outpatient services in this facility as a transfer from within this hospital resulting in a separate claim to the payer.

(i) E – Transfer from Ambulatory Surgery Center. The patient was referred to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.

(j) F – Transfer from hospice and under a hospice plan of care or enrolled in a hospice program. The patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.

(13) Principal Payer Code. Describes the primary source of expected reimbursement for services rendered based on the patient's status at the time of reporting. A required entry. Must be a one (1) character alpha field using upper case as follows:

(a) A – Medicare. Patients covered by Medicare where Centers for Medicare & Medicaid Services is the direct payer.

(b) 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 Centers for Medicare & Medicaid Services is not the direct payer.

(c) C – Medicaid. Patients covered by state administered, non-managed Florida Medicaid. This would include those Medicaid recipients enrolled in MediPass.

(d) D – Medicaid Managed Care. Patients covered by Medicaid HMOs, Medicaid provider sponsored networks (PSNs) or other Medicaid funded plans that are licensed in the state of Florida. This would include any type of program where the patient qualifies for Medicaid but payment is not directly from the State of Florida Medicaid program regardless of whether the hospital has a contract with that plan.

(e) E – Commercial Health Insurance. Patients covered by any type of private coverage, including HMO, PPO or self-insured plans.

(f) H – Workers Compensation. Patients covered by any type of workers compensation plan, including self insured plans, managed care plans or the State of Florida sponsored workers compensation plan.

(g) I – TriCare or Other Federal Government. Patients covered by any federal government program for active and retired military and their families; Black Lung, Section 1011; the Federal Prison System; or any other federal program.

(h) J – VA. Patients covered by the Veteran's Administration (VA).

(i) K – Other State/Local Government. Patients covered by a state program or local government that does not fall into any of the payer categories listed. This would include those covered by the Florida Department of Corrections or any county or local corrections department, patients covered by county or local government indigent care programs if the reimbursement is at the patient level; any out-of-state Medicaid programs and county health departments or clinics.

(j) L – Self Pay. Patients with no insurance coverage.

(k) M – Other. This would include patients covered by any other type of payer not meeting the descriptions in paragraphs (a)-(j) above or paragraphs (l)-(o) below.

(l) 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.

(m) O – KidCare. Includes Healthy Kids, MediKids and Children's Medical Services.

(n) P – Unknown. Unknown shall be reported if principal payer information is not available and type of service is "2" and patient status is "07".

(o) Q – Commercial Liability Coverage. Patients whose health care is covered under a liability policy, such as automobile, homeowners or general business.

(14) Principal Diagnosis Code. The code representing the diagnosis chiefly responsible for the services performed during the visit. Must contain a valid ICD-10-CM diagnosis code if type of service is "1" indicating ambulatory surgery. Must contain a valid ICD-10-CM diagnosis code if type of service is "2" indicating an emergency department visit unless patient status is "07" indicating that the patient left against medical advice or discontinued care. A blank field is permitted if type of service is "2" and patient status is "07." If not space filled, must contain a valid ICD-10-CM diagnosis code for the reporting period. A diagnosis code cannot be used more than once as a principal or other diagnosis for each visit reported. The code must be entered with a decimal point that is included in the valid code. Alpha characters must be in upper case.

(15) Other Diagnosis Code (1), Other Diagnosis (2), Other Diagnosis (3), Other Diagnosis (4), Other Diagnosis (5), Other Diagnosis (6), Other Diagnosis (7), Other Diagnosis (8), Other Diagnosis (9). A code representing a diagnosis related to the services provided during the visit. If no principal diagnosis code is reported, another diagnosis code must not be reported unless the patient discharge status is "07" indicating that the patient left against medical advice or discontinued care. No more than nine other diagnosis codes may be reported. Less than nine entries is permitted. If not space filled, must contain a valid ICD-10-CM code for the reporting period. A diagnosis code cannot be used more than once as a principal or other diagnosis for each visit reported. The code must be entered with use of a decimal point that is included in the valid code. Alpha characters must be in upper case.

(16) Evaluation and Management Code (1), Evaluation and Management Code (2), Evaluation and Management Code (3), Evaluation and Management Code (4), Evaluation and Management Code (5). A code representative of the patient acuity level for the services provided. If type of service is "2", must contain a valid Evaluation and Management (EM) Code range 99281-99285; 99288; 99291-99292; and G0380-G0384, even if the only service provided to a registered patient is triage or screening. If patient discharge status is "07" meaning the patient left against medical advice or discontinued care, or where a visit occurs resulting in zero charges, enter default code 99999 to indicate that the patient was not evaluated by a physician. No more than five EM codes may be reported. Less than five entries is permitted. Ambulatory surgical centers, type of service "1", should not report Evaluation and Management codes. A required field.

(17) Other CPT or HCPCS Procedure Code (1), Other CPT or HCPCS Procedure Code (2), Other CPT or HCPCS Procedure Code (3), Other CPT or HCPCS Procedure Code (4), Other CPT or HCPCS Procedure Code (5), Other CPT or HCPCS Procedure Code (6), Other CPT or HCPCS Procedure Code (7), Other CPT or HCPCS Procedure Code (8), Other CPT or HCPCS Procedure Code (9), Other CPT or HCPCS Procedure Code (10), Other CPT or HCPCS Procedure Code (11), Other CPT or HCPCS Procedure Code (12), Other CPT or HCPCS Procedure Code (13), Other CPT or HCPCS Procedure Code (14), Other CPT or HCPCS Procedure Code (15), Other CPT or HCPCS Procedure Code (16), Other CPT or HCPCS Procedure Code (17), Other CPT or HCPCS Procedure Code (18), Other CPT or HCPCS Procedure Code (19), Other CPT or HCPCS Procedure Code (20), Other CPT or HCPCS Procedure Code (21), Other CPT or HCPCS Procedure Code (22), Other CPT or HCPCS Procedure Code (23), Other

CPT or HCPCS Procedure Code (24), Other CPT or HCPCS Procedure Code (25), Other CPT or HCPCS Procedure Code (26), Other CPT or HCPCS Procedure Code (27), Other CPT or HCPCS Procedure Code (28), Other CPT or HCPCS Procedure Code (29), Other CPT or HCPCS Procedure Code (30). A code representing a procedure or service provided during the patient visit. If not space filled, must be a valid CPT or HCPCS code for the reporting period. Alpha characters must be in upper case. No more than thirty (30) other CPT or HCPCS procedure codes may be reported. Less than thirty (30) entries or no entry is permitted.

(18) Attending Practitioner Identification Number. The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced registered nurse practitioner who had primary responsibility for the patient's care during the visit. An alpha-numeric field of up to eleven characters, alpha characters must be in upper case. For military physicians not licensed in Florida, use US999999999. Use NA if the patient was not treated by a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner. A required entry.

(19) Attending Practitioner National Provider Identification (NPI). A unique ten (10) character identification number assigned to a provider. A required entry for providers in the US or its territories and providers not in the U.S. or its territories upon mandated HIPAA NPI implementation date. For military physicians, medical residents, or individuals not required to obtain a NPI number, use 9999999999.

(20) Operating or Performing Practitioner Identification Number. The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced registered nurse practitioner who had primary responsibility for the principal procedure performed. The operating or performing practitioner may be the attending practitioner. An alpha-numeric field of up to eleven characters, alpha characters must be in upper case. For military physicians not licensed in Florida, use US999999999. A required entry. A blank or no entry is permitted if a principal procedure is not reported.

(21) Operating or Performing Practitioner National Provider Identification (NPI). A unique ten (10) character identification number assigned to a provider. A required entry for providers in the U.S. or its territories and providers not in US or its territories upon mandated HIPAA NPI implementation date. For military physicians, medical residents, or individuals not required to obtain a NPI number, use 9999999999.

(22) Other Operating or Performing Practitioner Identification Number. The Florida license number of a different operating or performing practitioner. Report a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced registered nurse practitioner who rendered care to the patient other than the person reported in paragraphs (19) or (21) above. An alpha-numeric field of up to eleven characters, alpha characters must be in upper case. For military physicians not licensed in Florida, use US999999999. A blank or no entry is permitted.

(23) Other Operating or Performing Practitioner National Provider Identification (NPI). A unique ten (10) character identification number assigned to a provider. A required entry for providers in the US or its territories and providers not in US or its territories upon mandated HIPAA NPI implementation date. For military physicians, medical residents, or individuals not required to obtain a NPI number, use 9999999999.

(24) Pharmacy Charges. Charges for medication. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no pharmacy charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(25) Medical and Surgical Supply Charges. Charges for supply items required for patient care. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no medical and surgical supply charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(26) Laboratory Charges. Charges for the performance of diagnostic and routine clinical laboratory tests. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no laboratory charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(27) Radiology and Other Imaging Charges. 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. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no radiology or computed tomography charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(28) Cardiology Charges (Cardiac Cath). Charges for cardiac procedures rendered such as heart catheterization. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no cardiology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(29) Operating Room Charges. Charges for the use of the operating room. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no operating room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(30) Anesthesia Charges. Charges for anesthesia services by the facility. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no anesthesia charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(31) Recovery Room Charges. Charges for the use of the recovery room. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no recovery room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(32) Emergency Room Charges. Charges for medical examinations and emergency treatment. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no emergency room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(33) Trauma Response Charges. Charges for a trauma team activation at a State of Florida licensed Trauma Center. Report charges for revenue code 68X used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no trauma response charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(34) Treatment or Observation Room Charges. Charges for use of a treatment room or for the room charge associated with observation services. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no treatment or observation room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(35) Gastro-Intestinal (GI) services. Charges for gastro-intestinal procedures rendered such as colonoscopy and endoscopy services. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no GI charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(36) Extra-Corporeal Shock Wave Therapy (Lithotripsy). Charges for Extra-Corporeal Shock Wave Therapy (Lithotripsy) procedures. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no Lithotripsy charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(37) Other Charges. Other facility charges not included in paragraphs (24) to (36) above. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report 0 (zero) if there are no other charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(38) Total Gross Charges. The total of undiscounted charges for services rendered by the reporting entity. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Include charges for services rendered by the ambulatory center excluding professional fees. Negative amounts are not permitted unless verified separately 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 charges, Gastro-Intestinal (GI) services, Extra-Corporeal Shock Wave Therapy (Lithotripsy), and other charges must equal total charges, plus or minus 13. A required entry.

(39) Patient Visit Beginning Date. 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. A ten (10) character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Patient visit beginning date must equal or precede the patient visit ending date. A required entry.

(40) Patient Visit Ending Date. The date at the end of the patient's visit. A ten (10) character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Patient visit ending date must equal or follow the patient visit beginning date. Patient visit ending date must occur within the calendar quarter included in the data report.

(41) Hour of Arrival. 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. A required entry. Use 99 where efforts to obtain the information have been unsuccessful. Must be two digits as follows:
A.M. HOURS

(a) 00 – 12:00 midnight to 12:59:59
(b) 01 – 01:00 to 01:59:59
(c) 02 – 02:00 to 02:59:59
(d) 03 – 03:00 to 03:59:59
(e) 04 – 04:00 to 04:59:59
(f) 05 – 05:00 to 05:59:59
(g) 06 – 06:00 to 06:59:59
(h) 07 – 07:00 to 07:59:59
(i) 08 – 08:00 to 08:59:59
(j) 09 – 09:00 to 09:59:59
(k) 10 – 10:00 to 10:59:59
(l) 11 – 11:00 to 11:59:59

P.M. HOURS

(m) 12 – 12:00 noon to 12:59:59
(n) 13 – 01:00 to 01:59:59
(o) 14 – 02:00 to 02:59:59
(p) 15 – 03:00 to 03:59:59
(q) 16 – 04:00 to 04:59:59
(r) 17 – 05:00 to 05:59:59
(s) 18 – 06:00 to 06:59:59
(t) 19 – 07:00 to 07:59:59
(u) 20 – 08:00 to 08:59:59
(v) 21 – 09:00 to 09:59:59
(w) 22 – 10:00 to 10:59:59
(x) 23 – 11:00 to 11:59:59
(y) 99 – Unknown.

(42) Emergency Department (ED) Hour of Discharge. The hour on a 24-hour clock during which the patient left the emergency department. A required entry. Use 99 where efforts to obtain the information have been unsuccessful or type of service is "1". Must be two digits as follows:

A.M. HOURS

(a) 00 – 12:00 midnight to 12:59:59
(b) 01 – 01:00 to 01:59:59
(c) 02 – 02:00 to 02:59:59
(d) 03 – 03:00 to 03:59:59
(e) 04 – 04:00 to 04:59:59
(f) 05 – 05:00 to 05:59:59
(g) 06 – 06:00 to 06:59:59
(h) 07 – 07:00 to 07:59:59
(i) 08 – 08:00 to 08:59:59
(j) 09 – 09:00 to 09:59:59
(k) 10 – 10:00 to 10:59:59
(l) 11 – 11:00 to 11:59:59

P.M. HOURS

(m) 12 – 12:00 noon to 12:59:59
(n) 13 – 01:00 to 01:59:59
(o) 14 – 02:00 to 02:59:59
(p) 15 – 03:00 to 03:59:59
(q) 16 – 04:00 to 04:59:59
(r) 17 – 05:00 to 05:59:59

(s) 18 – 06:00 to 06:59:59

(t) 19 – 07:00 to 07:59:59

(u) 20 – 08:00 to 08:59:59

(v) 21 – 09:00 to 09:59:59

(w) 22 – 10:00 to 10:59:59

(x) 23 – 11:00 to 11:59:59

(y) 99 – Unknown.

(43) 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 in the Emergency Department. Must contain a valid ICD-10-CM code for the reporting period if type of service is "2" indicating an emergency department visit. If not space filled, must contain a valid ICD-10-CM diagnosis code. The code must be entered with use of a decimal point that is included in the valid code. Space fill if type of service is "1" indicating ambulatory surgery. Alpha characters must be in upper case.

(44) External Cause of Morbidity Code (1), External Cause of Morbidity Code (2) and External Cause of Morbidity Code (3). A code representing circumstances or conditions as the cause of the injury, poisoning or other adverse effects recorded as a diagnosis. No more than three (3) external cause of morbidity codes may be reported. Less than three (3) or no entry is permitted. If not space filled, must be a valid ICD-10-CM cause of morbidity code for the reporting period. An external cause of morbidity code cannot be used more than once for each encounter reported. The code must be entered with use of a decimal point that is included in the valid code. Alpha characters must be in upper case.

(45) Service Location. A code designating services performed at an offsite emergency department location at facilities whose license includes a "offsite" emergency department. **For type of service "2", enter an upper case "A through Z" for services performed at each offsite emergency department location. Facilities with a single off-site location will use service location code "A".** The Agency will assign an alpha service code to identify each location if a facility has more than one location. The Agency's Data Layout will reference the assigned offsite identifiers for each facility having more than one location. Remove element tag if type of service is "1" or for hospitals without an offsite emergency department location.

(48) Patient Status. Patient disposition at end of visit. A required entry. Must be a two (2) digit code as follows:

(a) 01 – Discharged to home or self care (routine discharge).

(b) 02 – Transferred to a short-term general hospital for inpatient care.

(c) 03 – Transferred to a skilled nursing facility with Medicare certification in anticipation of skilled care.

(d) 04 – Transferred to an intermediate care facility.

(e) 05 – Transferred to a designated cancer center or Children's Hospital.

(f) 06 – Discharged to home under care of home health care organization service in anticipation of covered skilled care.

(g) 07 – Left against medical advice or discontinued care.

(h) 20 – Expired.

(i) 21 – Discharged or transferred to court/law enforcement.

(j) 50 – Discharged to hospice – home.

(k) 51 –. Transferred to hospice. Hospice medical facility (certified) providing hospice level of care.

(l) 62 – Transferred to an Inpatient Rehabilitation Facility (IRF) including rehabilitation distinct part units of a hospital.

(m) 63 – Discharged or transferred to a Medicare certified long term care hospital.

(n) 64 – Discharged or transferred to a Nursing Facility certified under Medicaid but not certified under Medicare.

(o) 65 – Discharged or transferred to a psychiatric hospital including psychiatric distinct part units of a hospital.

(p) 66 – Discharged or transferred to a Critical Access hospital.

(q) 70 – Discharged or transferred to another type of health care institution not defined elsewhere in this code list.

(49) Trailer Record: The last record in the data file shall be a trailer record and must accompany each data set. Report only the total number of patient data records contained in the file, excluding header and trailer records. The number entered must equal the number of records processed. Do not include leading zeros.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 1-1-10, Amended 12-5-10, Formerly 59B-9.018, Amended 10-1-1, 01-1-18.

59B-9.039 Patient Data Release.

(1) Agency records, public records under Chapter 119, F.S., (Florida's Public Records Law), are available for public inspection

during normal business hours. Copies of such records may be obtained upon request and upon payment of the cost of copying.

(2) Patient-specific records collected by the Agency pursuant to Rules 59B-9.030 through 59B-9.039. F.A.C., are exempt from disclosure pursuant to Section 408.061(7), F.S., and shall not be released unless modified to protect patient confidentiality as described in paragraph (2)(a) below and released in the manner described in paragraphs (2)(c) and (2)(d).

(a) The patient-specific record shall be modified to protect patient confidentiality as follows:

1. Patient Control Number	Delete
2. Patient Social Security Number	Delete
3. Patient Birth Date	Substitute Age in years and an indicator of Age <29 Days except for persons 100 and older, substitute Age > 100 years
4. Visit Date	Substitute Quarter Indicator (1-4) (visit month cannot be substituted)
5. Medical or Health Record Number	Delete

(b) A record linkage number shall be assigned which does not identify an individual patient and cannot reasonably be used to identify individual patients through use of data available through the Agency, but which can be used for confidential data output for bonafide research purposes.

(c) The modified data records described in paragraph (2)(a) shall be released as a set of all records occurring in one calendar quarterly period based on date of visit.

(d) The modified data described in paragraph (2)(a) shall be released in accordance with the Limited Data Set requirements of the federal Health Insurance Portability and Accountability Act and shall be made available on or after quarterly data has been certified as accurate by the facility as required by Section 408.061(1)(a), F.S.

(3) Aggregate reports derived from patient-specific records collected pursuant to Rules 59B-9.030 through 59B-9.038, F.A.C., are public records and shall be released as described in subsection (1) of this rule, provided the aggregate reports do not include patient control number, patient birth date, visit date, patient social security number, medical or health record number or provided the aggregate reports contain the combination of five or more records for any data disclosed.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061 FS. History–New 1-1-10, Formerly 59B-9.023, Amended 01-1-18.