AGENCY FOR HEALTH CARE ADMINISTRATION

AHCA Patient Data Submission Guide

Includes All You Need
To Comply With Data Submission
Requirements

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Dear Friend:

Our mission at the Agency for Health Care Administration is Better Health Care for all Floridians, and over the years, your data has demonstrated that health care in Florida does indeed continue to get better, from increasing health screenings to fewer potentially preventable readmissions, from better care upon admission to the ER to lower costs for a variety of procedures. The data you report and that we share has been an incredibly useful tool in driving continuous improvement and in helping providers, payers and especially patients strive for ever-increasing quality.

We value our relationships with providers across the state. You have given us meaningful input on both the process of collecting data and on the data standards themselves. Our team has listened to you, and we developed this guide to share some of those ideas and best practices. This guide, developed by the Data Collection and Quality Assurance Unit in our Florida Center for Health Information and Transparency, was designed to help you with the complex task of filing discharge data.

We hope that this guide will be a valuable tool for you in explaining what data to file, when to file it and how to file it. It is intended to clarify the often complex regulations that have governed this process in the past, and we hope you will continue offering your suggestions on how we can make the process even easier in the future.

In addition, if you have thoughts on how we can make this data more useful to you and the patients and families we all serve, I hope you will let us know that, too. We are eager to partner with leaders across this state to make the data more accessible and more user-friendly, and we welcome your input.

Thank you for your many years of partnering with our Agency and for joining us in our efforts to improve the quality of health care in Florida.

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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 309 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.

The State of Florida has collected inpatient discharge data since 1988. Beginning in 1997, short-term acute care psychiatric hospitals were included as well. Long-term psychiatric hospitals were added in 2006. The 52 data elements that comprise the inpatient data are used by universities, the hospital industry, and government to evaluate the state's health care system.

Comprehensive rehabilitation discharge data collection started in since 1993. The data is detail patient level but based on the HCFA10 primary condition codes. This data set was collected in accordance with Section 408.61, Florida Statutes, and by Chapter 59E-7.201, F.A.C., until January 1, 2010.

Ambulatory and Emergency Department Data Collection Program

AHCA's ambulatory (AS) patient data collection program began in 1997 with the commencement of the collection of discharge data from the state's freestanding ambulatory surgical centers, radiation therapy centers (ended 12/31/02), lithotripsy centers, cardiac catheterization laboratories, and short-term acute care hospitals.

Emergency Department (ED) Discharge Data has been collected since 2005. 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.

Historically, data was collected from approximately 650 freestanding ambulatory surgical centers and about 300 short-term acute care hospitals, including lithotripsy centers and cardiac catheterization laboratories. AS reportable events include those which are ***surgical in nature*** or invasive diagnostic procedures within a specified CPT range. ED reportable events include all emergency department visits in which emergency department registration occurs and the patient is not admitted for inpatient care at the reporting entity.

AHCA's ambulatory dataset consists of 59 data elements, including patient demographic information, hospital identification information, payer information, charges, procedures, and diagnosis information. The data provides information on ambulatory surgery and hospital emergency data services for the assessment of variations in utilization, disease surveillance, access to care and cost trends.

59E-7 and 59B-9 F.A.C.

Beginning January 1, 2010, all facility types will submit data to AHCA according to Rule 59E-7.012; 59E-7.20-7.030; and 59B-9.30-9.039, Florida Administrative Code (F.A.C.).

Comprehensive rehabilitation data is submitted in XML format according to schema via online transmission.

New Rule 59E-7 incorporates the comprehensive rehab data into an integrated inpatient data file. Both freestanding rehabilitation hospitals and rehab services provided in inpatient distinct part units are required to report. Reportable events include all discharges from acute, intensive care, psychiatric, including newborn live discharges and deaths

New Rule 59E-7 introduces reporting 18 new elements, bringing the total to 64.

- Provider Medicare Number
- Medical/Health Record Number
- Patient Ethnicity
- Patient Race
- Patient Country Code
- Type of Service Code
- Source of Admission/Point of Origin
- Inpatient Admission Time
- Discharge Time
- Physical Therapy Charges
- Occupational Therapy Charges
- Speech/language Therapy Charges
- Emergency Department Date of Arrival
- Attending Practitioner National Provider Identification Number
- Operating or Performing Practitioner National Provider Identification Number
- Other Operating or Performing Practitioner National Provider Identification Number
- Nursery Level II Charges
- Emergency Department Date of Arrival

New Rule 59B-9 introduces reporting 17 new elements bringing the total to 49 data elements, not including header elements.

- Provider Medicare Number
- Medical/Health Record Number
- Patient Ethnicity
- Patient Race
- Patient Country Code
- Source of Admission/Point of Origin
- Evaluation and Management Codes (1)-(5)
- Other CPT Codes (1)-(30)
- Attending Practitioner Identification Number
- Operating or Performing Practitioner Identification Number
- Other Operating or Performing Practitioner Identification Number
- Trauma Response Revenue
- Gastro-Intestinal Services Revenue
- Lithotripsy Revenue
- Emergency Department Hour of Discharge
- Service Location
- Patient Status

In addition to the new rule data elements, other modification occurred to existing elements such as patient sex, patient race, payer code, and POA.

Public Release of Discharge Data

The Florida Center's Office of Data Collection & Quality Assurance (DCQA) collects all facility discharge data. Approximately 309 hospitals, 215 Emergency Departments, 550 freestanding ambulatory surgical centers and numerous lithotripsy centers and cardiac catheterization laboratories currently submit quarterly reports to AHCA.

A limited set of the discharge data is available to the public once 75% of the reporting facilities have certified the accuracy of their data. Reporting facilities must certify their patient data (the final step of the submission process) within 5 months after the end of the covered quarter.

Certification status for all facilities or by individual facility by data type/year/quarter is available at the Web link below. Data catalogs, price lists and data layout & file descriptions by facility type are available at the Florida Center Web address as well:

http://ahca.myflorida.com/schs/DataD/DataD.shtml

The Limited Data Set

The "Limited" in AHCA's Limited Data Set stems from the need to protect the confidentiality of persons whose data is included in the release. This is accomplished by masking some data elements before they are available to the public.

Inpatient Data Set:

AHCA releases approximately 35 detailed patient data elements. AHCA does not release the following data elements:

- Patient ID # (number assigned by hospital)
- Patient's Social Security Number
- Date of birth (converted to age)
- Admission date (reported as day of week of admission)
- Discharge date (reported as day of week of discharge)
- Principal procedure date (reported as number of days to procedures)

Ambulatory and Emergency Department Data Set:

AHCA releases approximately 63 outpatient data elements. AHCA does not release the following data elements:

- Patient ID # (number assigned by facility)
- Patient's Social Security Number
- Date of birth (converted to age)
- Begin Visit Date
- Ending Visit Date

Comprehensive Rehabilitation Data Set:

For years 1993 to 2009, AHCA releases approximately 14 detailed patient data elements based on the HCFA10 primary condition codes below:

01 *Stroke*
02 *Spinal Cord Morbidity*
03 *Congenital Deformity*
04 *Amputation*
05 *Major Multiple Trauma*
06 *Fracture of the Femur (Hip Fracture)*
07 *Brain Morbidity*
08 *Poly-Arthritis, Including Rheumatoid Arthritis*
09 *Neurological Disorders, Including Multiple Sclerosis, Motor*
10 *Burns*
11 *All Conditions*

AHCA does not release the following comprehensive rehabilitation data elements:

- Patient ID # (number assigned by hospital)
- Patient's Social Security Number
- Date of birth (converted to age)
- Admission date (reported as day of week of admission)
- Discharge date (reported as day of week of discharge)

Transmission Format:

The format used to transmit purchased data varies depending on the data type. The following datasets are generally available in the following formats.

Inpatient Data is available for purchase on CD/ROM. Hard copy aggregated reports are also available by individual or merged quarters. Reports can be generated by hospital, county, Local Health Council, region or statewide. Special ad-hoc reports are also available (i.e. specific ICD CM codes; reports for specific ages of patients, etc.).

Ambulatory and Emergency Department Data is available on CD.

Comprehensive Rehabilitation Data is available electronically and can be e-mailed. Special ad-hoc reports are also available (i.e. county; reports for specific ages of patients, etc.).

Available Quarters

- **Inpatient Data:** beginning with the first quarter of 1988.
- **Ambulatory Data:** beginning with the first quarter of 1997.
- **Emergency Department Data:** beginning with the first quarter of 2005.
- **Comprehensive Rehabilitation Data:** beginning with the third quarter of 1993.

Pricing

For information, current pricing and ordering, please visit the Florida Center Web site at:

Florida Health Finder/ Order Data

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

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.

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.

Ambulatory Exemptions

All ambulatory surgery centers (ASC) 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.**

In order to qualify for a quarterly exemption, Rule 59B-9 requires the entity's Executive Officer, administrator or authorized designee to submit a letter to the Agency certifying that the ambulatory center has had fewer than 200 patient visits for the reporting period.

The Agency must receive the exemption letter 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.

The exemption request should include the following information:

- Facility name and AHCA Facility ID
- Quarter/year
- Total number of visits for the quarter

Fax Exemption requests to 850-488-1261 ***Attn: Cindy Kucheman***
or mail to:

AHCA/Florida Center for Health Information and Transparency;
Attn: Cindy Kucheman
2727 Mahan Drive, MS #16
Tallahassee, Florida 32308

Extensions

An extension request is not required for submission after 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.

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

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.

A written resubmission request signed by the facility executive officer, administrator or authorized designee must be sent to the Administrator of the Agency's Office of Data Collection. The Agency will determine if resubmission is warranted and respond to the facility granting or denying the resubmission request.

Resubmission requests must be in writing.
The resubmission letter should include the following information:

- The name and AHCA number of the Facility
- The quarter/ year(s) to be resubmitted
- Data type: Inpatient or Ambulatory
- *A separate request must be submitted for each data type*
- Reason for the changes and corrections
- Specify the cause contributing to the inaccurate reporting
- The number of records affected
- The date when the corrected file will be resubmitted to the Agency

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 Versions in Section 3)***

Example:

An acceptable request may stem from a vendor change that occurred close to the reporting due date or incorrect mapping that results in missing records.

Remember: Resubmissions are costly. We recommend that facilities maintain an electronic copy of the clean, certified XML data file for at least twelve months. This will expedite and simplify the process should resubmission be required.

Establishing a Facility User ID

A reporting facility is required to establish an Internet submission account and ID number for each data submitter. The facility may obtain this ID by completing and submitting the "Facility User Account Agreement Form" available on the Reporting Resources link below at the Florida Center/Data Collection Web site address:

http://ahca.myflorida.com/SCHS/DataCollection/docs/FACILITYUSERAGREEMENTidssupport.pdf

Each data submitter receives a User ID and initial password. The User ID is the facility ACHA number plus an account digit. Two leading zero's must precede the User ID for login to the Data Submission system. Example: 001002991.

Use the Initial Password for the first login attempt. The system will prompt the user to create their own password.

Establishing/Updating a Facility Contact

In addition to submitting the "Facility User Account Agreement Form" above, the facility must establish a designated contact person by completing the "Contact Information Update Form" available on the Reporting Resources page at the Florida Center/Data Collection Web site address:

http://ahca.myflorida.com/SCHS/DataCollection/docs/ContactInformationUpdateForm.pdf

AHCA will email reports and correspondence to the designated facility contact person.

A facility should designate an alternate contact to prepare and/or submit data files to AHCA in the event the primary contact is unavailable. Alternate contacts should be reasonably knowledgeable of data submission to respond to AHCA staff as needed.

Facilities can change their contact information by completing and submitting the "Contact Information Update Form" to AHCA. ***The facility is responsible to notify AHCA whenever a contact change occurs.***

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 codify the record types within the data set.

All data set submissions use the following web address:

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

XML Schemas

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

The AS/ED data XML Schema is available at:

2017 http://ahca.myflorida.com/xmlschemas/AS10-2.xsd

No longer in use

2018 http://ahca.myflorida.com/xmlschemas/AS10-3.xsd

The Inpatient Data XML Schema available at

2017 http://ahca.myflorida.com/xmlschemas/PD10-3.xsd

No longer in use

2018 http://ahca.myflorida.com/xmlschemas/PD10-4.xsd

Data Web Site Submission Specifications

Data submission is available 24 hours a day, 7 days a week, using the Internet Data Submission System (IDSS). The IDSS is a secure online system that utilizes Secure Sockets Layer (SSL) 128-bit encryption to protect information sent between the user's browser and AHCA server.

A short video and step-by-step PowerPoint presentation on how to submit both inpatient and outpatient discharge data through the secure Web site is available on Training Resources page at Data Collection Web site address:

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

We recommend new contacts review this presentation prior to become familiar with the navigation of the various screens of the submission process.

AHCA Provides a XML TEST WEB SITE where facilities can validate that they have correctly mastered the XML file format. The Test site requires a new account password setup. Please call Cindy Kucheman at 850-412-3760 to receive a password or email Cindy.Kucheman@ahca.myflorida.com.

https://b.apps.ahca.myflorida.com/ahcauploadinpatient/logon.aspx?ReturnUrl=%2fahcauploadinpatient%2f

Data Versions

The AHCA Web server will reject a file unless formatted according to the correct schema version for the reported dates. The facility must select the correct Data Type schema matching the file format when submitting online data files. The following table identifies the correct data version to select upon submission.

Data Type	Version	Discharge Year	Implementation
Inpatient			
ICD-10	PD10-3 PD10-4	Q4 2015-2017 2018	Modified 01/23/2014 Modified 01/01/2018
Ambulatory			
ICD-10	AS10-2 AS10-3	Q4 2015-2017 2018	Modified 01/23/2014 Modified 01/01/2018

Data Assistance

Please contact Nancy Tamariz or Cindy Kucheman if you need help resolving 'Upload Unsuccessful' errors. We are more than happy to provide assistance with data upload errors, XML problems or other questions regarding data submission or data requirements.

Nancy Tamariz at 850-412-3741 or nancy.tamariz@ahca.myflorida.com
Cindy Kucheman at 850-412-3760 or cindy.kucheman@ahca.myflorida.com

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

Step 1: Select the appropriate Pro-code/ Facility Type:

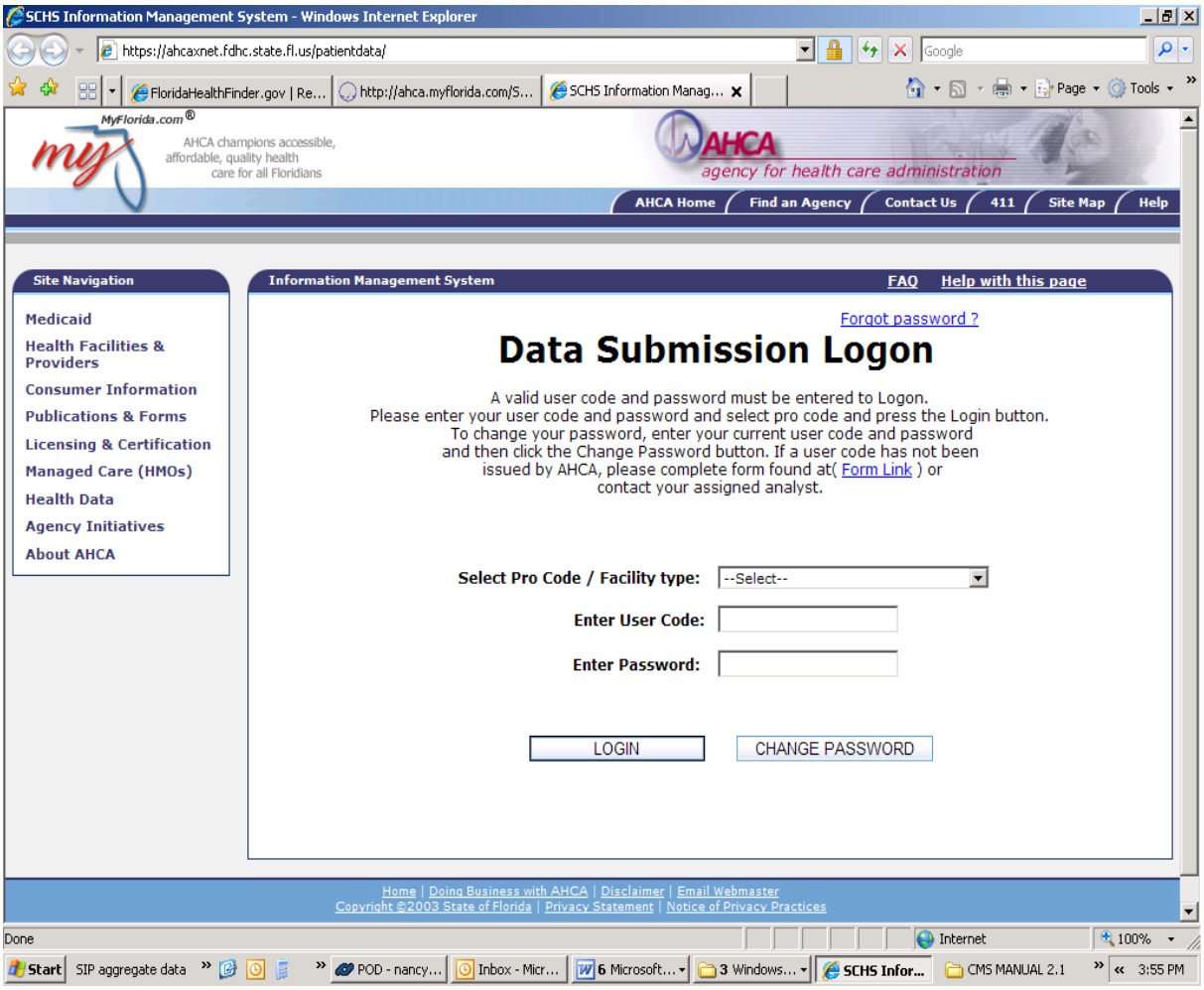
The Pro-code is automatically inserted as a user selects facility type from the drop down box. Pro-code designations are:

14 – Ambulatory Centers

23 – Hospitals

64 – Cardiac Catheterization

66 – Lithotripsy



Step 2: Enter User Code

The User Code is the 8-digit AHCA Number **+** the assigned user number 1-4. Up to 4 users may be assigned a User Code per facility.

For example, for AHCA number 100005, the first user would be assigned User Code 001000051 and the second 001000052 and so forth.

If your AHCA number is less than 8 digits, this number must be padded with leading zeros. Example AHCA # 115 --> 00000115.

Step 3: Enter the Password assigned to you by the Agency

Upon initial login, the system will automatically prompt the user to change the password.

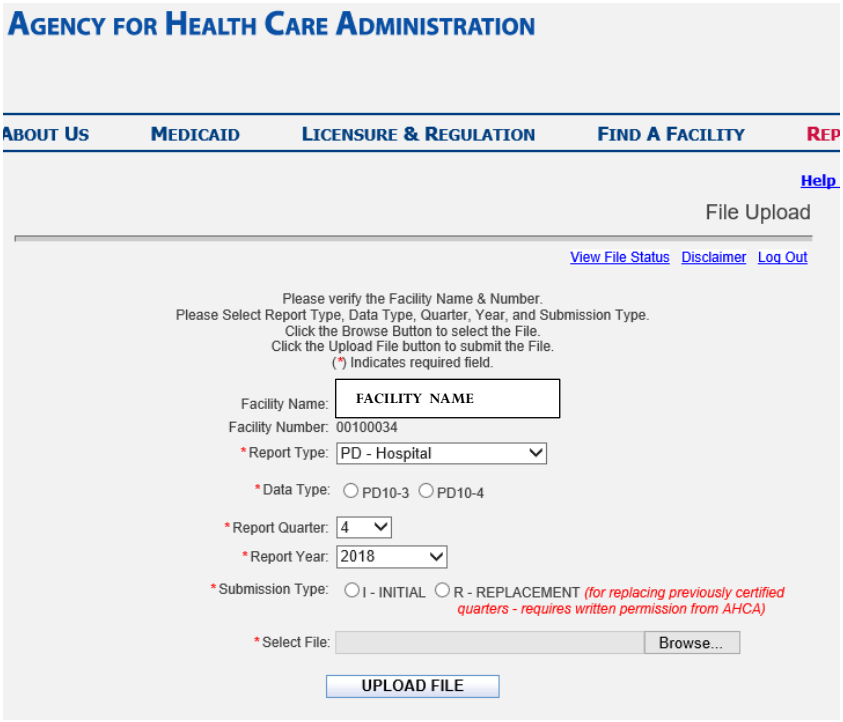
Step 4: Accept Disclaimer

You must accept the terms of this disclaimer and click "Continue". If the disclaimer is NOT accepted, the user's session will terminate and redirect to the login page.

Step 5: Upload facility XML File

- Verify Facility Name and Number
- Select the correct Report Type
- *Select the correct Data Type for the discharge year*
- Select Quarter and Year
- Select "I" for Initial submission. "R" is reserved for resubmission (replacement) of previously certified data only.
- Select Browse and locate your data file
- Select the file to upload
- Select Upload File

FILE UPLOAD SCREEN



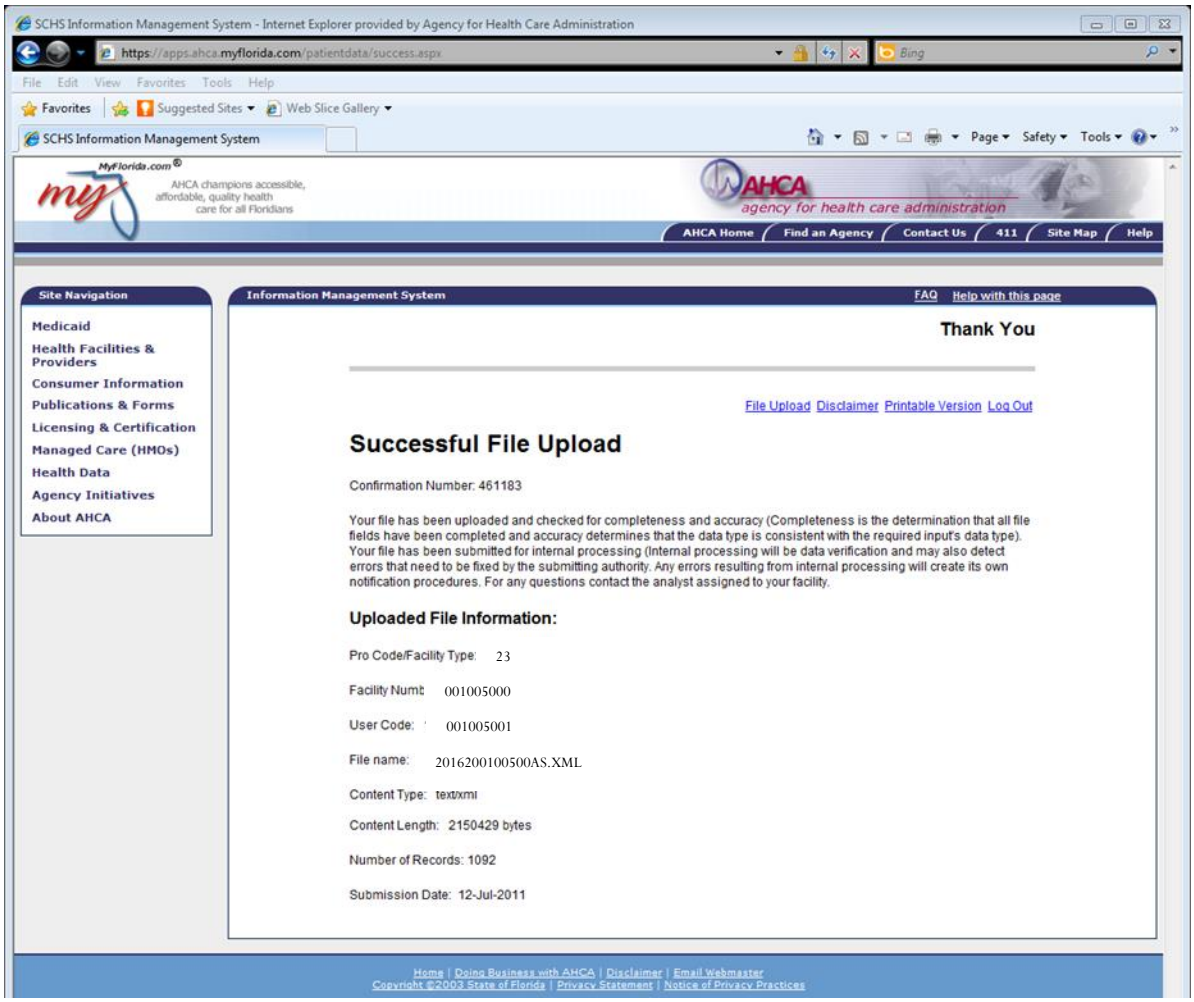
Step 6: Verify successful upload

A XML format checker validates the file format. If the format is correct, the user receives a 'Successful File Upload' message. If the format checker detects an XML format error, the user receives an 'Unsuccessful File Upload 'message. The facility must correct the XML error and upload the file again.

The format checker does not validate the accuracy or system edits.

Upon successful upload, an assigned analyst runs the data file to audit against multiple system edits.

SUCCESSFUL UPLOAD SCREEN



Step 7: You may log out from this screen by clicking "Log Out"

- You can get a printable version of the page by clicking "Printable Version."
- You may return to the Disclaimer page by clicking "Disclaimer."

If an Unsuccessful File Upload Submission screen is displayed, continue to step 8.

Step 8: Unsuccessful data submission

The user is directed to an error page containing a list of errors and a brief description of the file has XML formatting error.

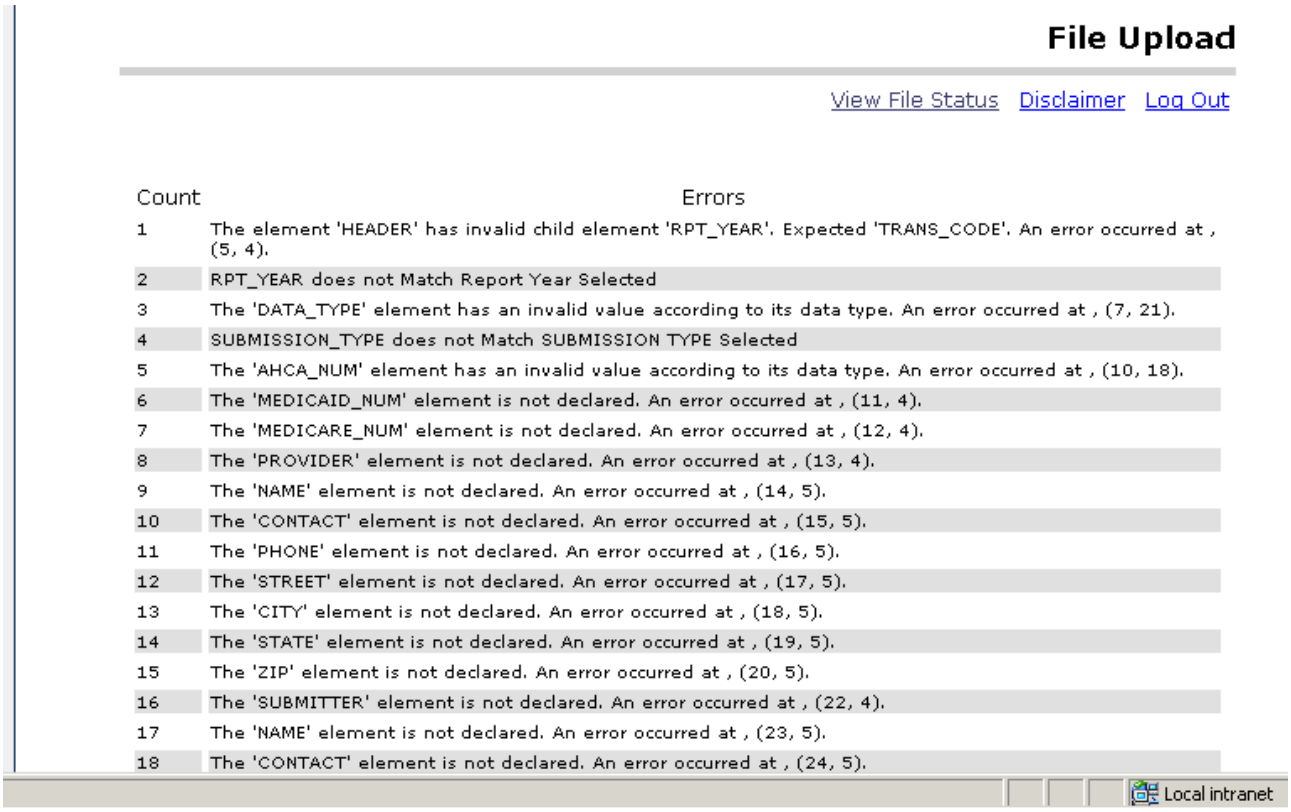
The XML formatting errors will be presented with a test description of the error followed by two numbers: e.g. (3,5). These numbers indicate the location of the error within the submitted XML file. The first number in the sequence is the LINE, (or row) of your XML file while the second number in the sequence is the POSITION (or column) within the file. The user can print this screen, but afterwards you must log out of the system. The facility must correct all of the errors listed before resubmitting the file.

XML format requires opening and closing tags for each data element, for example:
<RPT_YEAR>2019</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.

AHCA recommends file validation thru the Test Submission portal before submission to the production Submission portal.

UNSUCCESSFUL FILE UPLOAD SCREEN



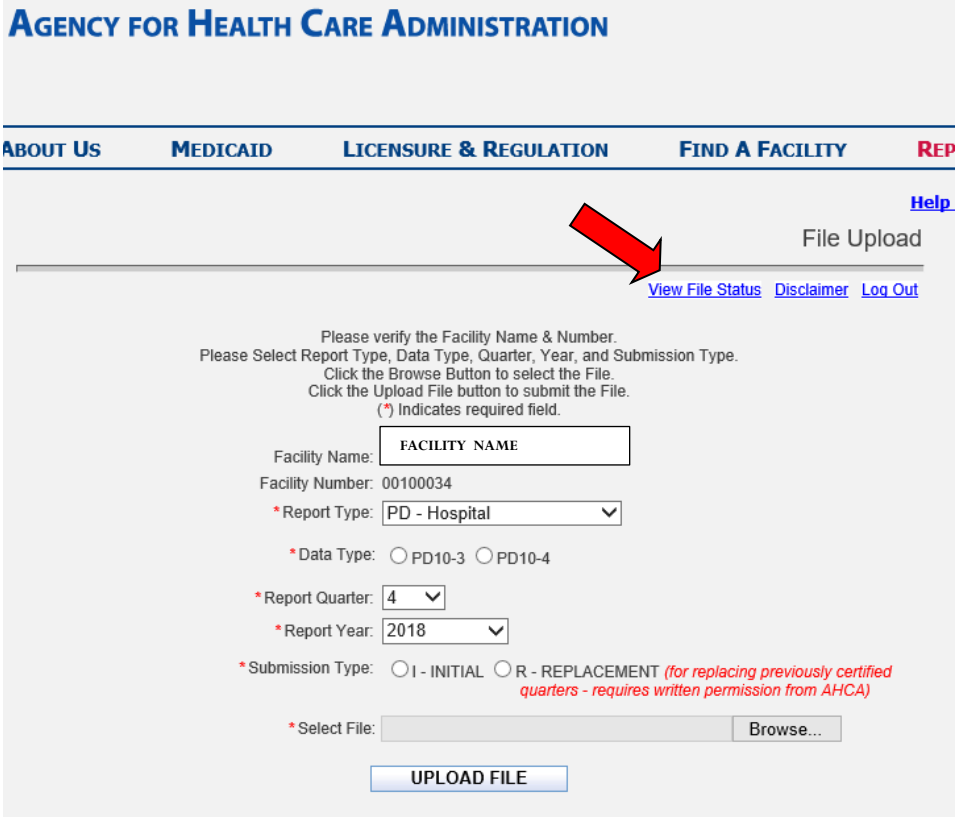
File Submission Status

Facility contacts are encouraged to check the progress of their quarterly file submission by viewing the file status. Frequent status checking will assure completion of the reporting requirement prior to the certification deadline.

CHECKING FILE STATUS

Step 1: To Check your file status

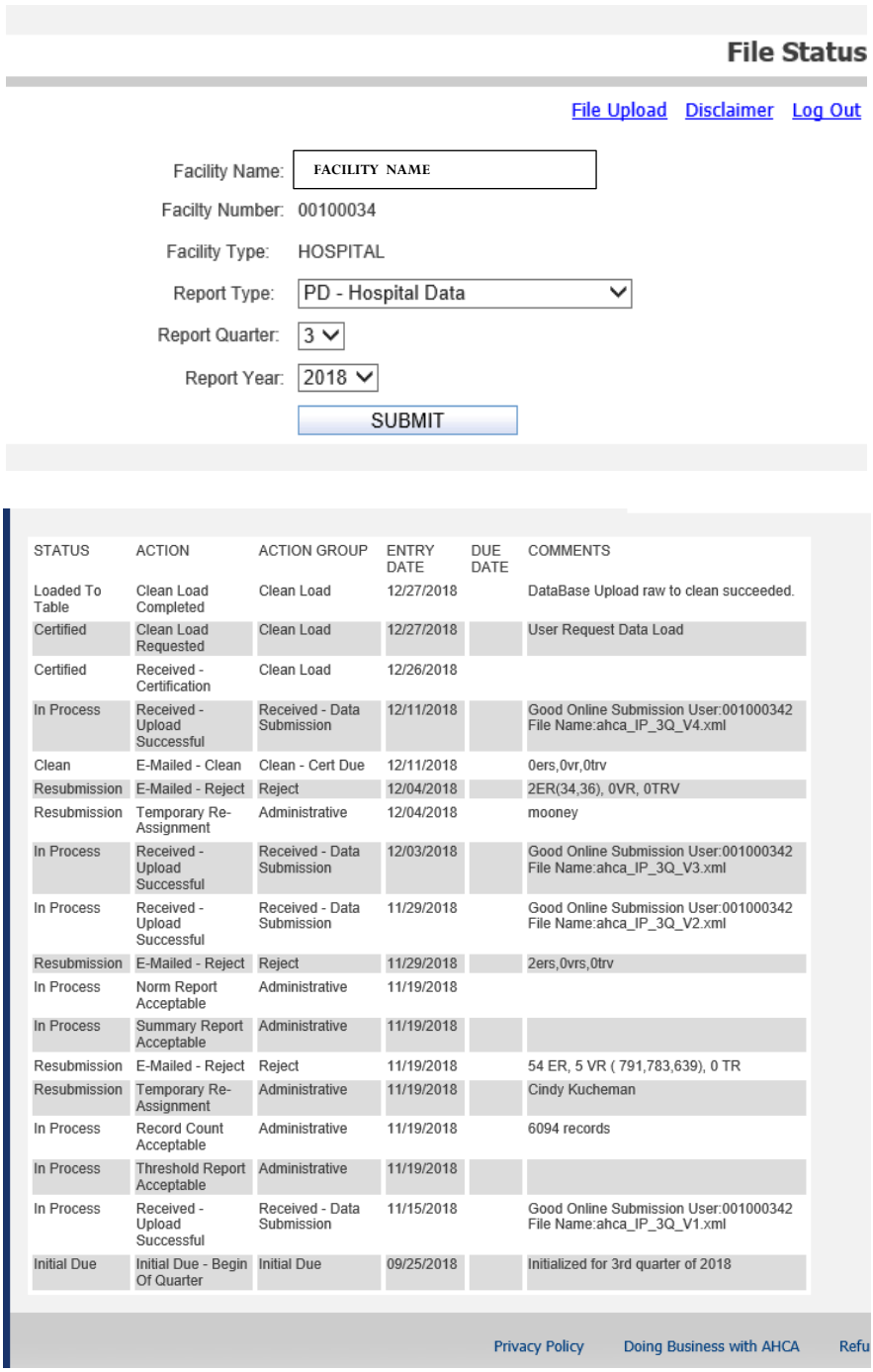
- Click View File Status from the File Upload Screen
- Verify Facility Name and Number
- Select the correct Report Type
- Select Quarter and Year
- Select Submit



Step 2: Review facility quarterly status

This screen will display the submission history of the facility.
To change quarter, reselect the quarter and click Submit.

FILE STATUS SCREEN



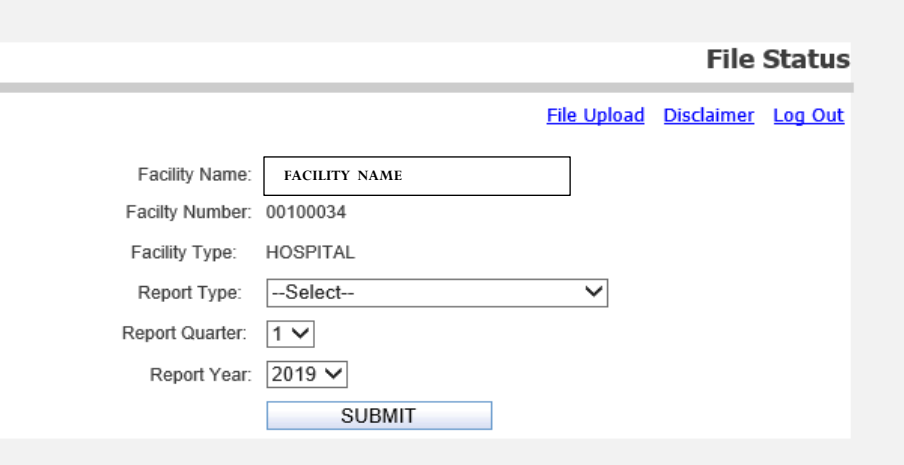
STATUS	ACTION	ACTION GROUP	ENTRY DATE	DUE DATE	COMMENTS
Loaded To Table	Clean Load Completed	Clean Load	12/27/2018		DataBase Upload raw to clean succeeded.
Certified	Clean Load Requested	Clean Load	12/27/2018		User Request Data Load
Certified	Received - Certification	Clean Load	12/26/2018		
In Process	Received - Upload Successful	Received - Data Submission	12/11/2018		Good Online Submission User:001000342 File Name:ahca_IP_3Q_V4.xml
Clean	E-Mailed - Clean	Clean - Cert Due	12/11/2018		0ers,0vr,0trv
Resubmission	E-Mailed - Reject	Reject	12/04/2018		2ER(34,36), 0VR, 0TRV
Resubmission	Temporary Re-Assignment	Administrative	12/04/2018		mooney
In Process	Received - Upload Successful	Received - Data Submission	12/03/2018		Good Online Submission User:001000342 File Name:ahca_IP_3Q_V3.xml
In Process	Received - Upload Successful	Received - Data Submission	11/29/2018		Good Online Submission User:001000342 File Name:ahca_IP_3Q_V2.xml
Resubmission	E-Mailed - Reject	Reject	11/29/2018		2ers,0vrs,0trv
In Process	Norm Report Acceptable	Administrative	11/19/2018		
In Process	Summary Report Acceptable	Administrative	11/19/2018		
Resubmission	E-Mailed - Reject	Reject	11/19/2018		54 ER, 5 VR (791,783,639), 0 TR
Resubmission	Temporary Re-Assignment	Administrative	11/19/2018		Cindy Kucheman
In Process	Record Count Acceptable	Administrative	11/19/2018		6094 records
In Process	Threshold Report Acceptable	Administrative	11/19/2018		
In Process	Received - Upload Successful	Received - Data Submission	11/15/2018		Good Online Submission User:001000342 File Name:ahca_IP_3Q_V1.xml
Initial Due	Initial Due - Begin Of Quarter	Initial Due	09/25/2018		Initialized for 3rd quarter of 2018

Step 3: Review facility quarterly status

This screen will display the submission tracking history of the facility. This is very useful to validate file completion and certification.

To change quarter, reselect the quarter and click Submit.

FILE STATUS QUERY SCREEN



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 PD10-4 and AS10-3:

PD10-4 (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/PD10-4.xsd">
  <HEADER>
```

AS10-3 (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/AS10-3.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.

Transaction Code

Element Name: Transaction Code

Definition: The type of reporting period

Parameters: 1 alpha character

Codes/Values: Q = calendar quarter report

Conditions: Required for all data reporting

Notes:

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Transaction Code is not valid	Must be a single alpha character (Q) only.	UPLOAD FAILURE

Report Year

Element Name: Report Year

Definition: The year of the data

Parameters: 4 numeric characters

Codes/Values: Format is YYYY

Conditions: Required for IP/CR/AS/ED reporting

Notes:

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Report Year is not a valid format	Report year must be numeric in the format YYYY	UPLOAD FAILURE

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 for IP/CR/AS/ED reporting

Notes: The report quarters are based on the calendar year

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	**HEADER**	Report Quarter not valid (1-4)	Must be single numeric using (1,2,3 or 4) only	**UPLOAD FAILURE**

Data Type

Element Name: Data Type

Definition: The type of data submitted

Parameters: 4 alpha-numeric characters

Codes/Values: Enter **PD10-4** for Inpatient Data beginning Q1 2018 data reporting
Enter **AS10-3** for AS/ED data beginning Q1 2018 data reporting

Conditions: Required for IP/CR/AS/ED reporting

Notes: **ICD-10 codes started Q4 2015**

Edit Applications:

INPATIENT

Audit	Location	Audit Message	Audit Description	Audit Severity
12	HEADER	Data Type is not PD10-4	Must be alpha/numeric using PD10-4 or PD10-3 if prior to Q1 2018.	Error

AMBULATORY/ED

Audit	Location	Audit Message	Audit Description	Audit Severity
256	HEADER	Data Type is not AS10-3	Must be alpha/numeric using AS10-3 or AS10-2 if prior to Q1 2018	Error

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 for IP/CR/AS/ED reporting

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.*

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Submission Type is not I or R	Must be a single alpha character (I or R)	UPLOAD FAILURE

Processing Date

Element Name: Processing Date

Definition: The creation date that the data file

Parameters: 8 numeric characters

Codes/Values: YYYY-MM-DD format

Conditions: Required for IP/CR/AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Processing Date is invalid	Must be numeric characters using a valid date and format (YYYY-MM-DD)	UPLOAD FAILURE

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: At least 8 and no more than 10 numeric characters

Codes/Values: N/A

Conditions: Required for IP/CR/AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	AHCA Facility Number is empty	Must be at least 8 but no more than 10 numeric characters using a valid hospital ID number assigned by AHCA.	UPLOAD FAILURE

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 for IP/CR/AS/ED reporting
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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Medicare Number is empty	Must contain 7 numeric characters	UPLOAD FAILURE

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 for IP/CR/AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Facility Name is Empty	The name of the facility that performed the inpatient services represented by the data. Up to a forty-character field.	UPLOAD FAILURE

Contact Person Name

Element Name: Contact Person Name

Definition: The name of the contact person for the hospital

Parameters: Up to 25 characters

Codes/Values: Format: Last Name, First Name

Conditions: Required for IP/CR/AS/ED reporting

Notes: *The facility must notify AHCA whenever a change in contact occurs.* See page 20.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Contact Name Format is invalid	Must be no more than 25 alpha characters. Last name, First name format.	UPLOAD FAILURE

Contact Person Telephone Number

Element Name: Contact Person Telephone Number

Definition: The area code business telephone number, and if applicable, extension for the contact person

Parameters: Up to 19 characters

Codes/Values: (AAA)XXX-XXXX-EEEEE (with extension)
(AAA)XXX-XXXX-00000 (no extension)

Conditions: Required for IP/CR/AS/ED reporting

Notes: AAA – area code
XXX-XXXX – seven (7) digit phone number
EEEEE - extension
00000 – zero fill for no extension

The facility must notify AHCA whenever a change in contact occurs.
See page 20.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Contact Phone Number format is invalid	Must contain at least 10 numeric characters in the following numeric format (AAA)XXX-XXXX-EEEEE. Zero fill if no extension.	UPLOAD FAILURE

Contact Person E-Mail Address

Element Name: Contact Person E-Mail Address

Definition: The email address of the contact person

Parameters: N/A

Codes/Values: N/A

Conditions: Required for IP/CR/AS/ED reporting

Notes: *The facility must notify AHCA whenever a change in contact occurs.* **See page 20.**

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Contact E-mail format is invalid	Must contain alpha/numeric characters. No character limitation or formatting mentioned.	UPLOAD FAILURE

Contact Person Street or P.O. Box Address

Element Name: Contact Person Street or P.O. Box Address

Definition: The street or post office box address of the contact person's mailing address

Parameters: Up to 40 characters

Codes/Values: N/A

Conditions: Required for IP/CR/AS/ED reporting

Notes: *The facility must notify AHCA whenever a change in contact occurs.* See page 20.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Contact Street Address is empty	Must contain no more than 40 alpha/numeric characters	UPLOAD FAILURE

Contact Person Mailing Address City

Element Name: Contact Person Mailing Address City

Definition: The city of the contact person's address

Parameters: Up to 25 characters

Codes/Values: N/A

Conditions: Required for IP/CR/AS/ED reporting

Notes: *The facility must notify AHCA whenever a change in contact occurs.* See page 20.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Contact City is empty	Must contain no more than 25 alpha characters	UPLOAD FAILURE

Contact Person Mailing Address State

Element Name: Contact Person Mailing Address State

Definition: The state of the contact person's address

Parameters: Up to 2 alpha characters

Codes/Values: Format: XX in upper case

Conditions: Required for IP/CR/AS/ED reporting

Notes: Use the U.S. Postal Service state abbreviation (i.e., FL)

For a list of appropriate state abbreviations, visit the Reporting Resources page available at the Florida Center/Data Collection Web site address:

http://ahca.myflorida.com/SCHS/division.shtml#DataC

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Contact State is invalid	Must contain 2 upper case alpha characters using valid state abbreviation in the format XX.	UPLOAD FAILURE

Contact Person Mailing Address Zip Code

Element Name: Contact Person Mailing Address Zip code

Definition: The zip code of the contact mailing address

Parameters: Up to 10 characters

Codes/Values: XXXXX (without extension)
XXXXX-XXXX (with extension)

Conditions: Required for IP/CR/AS/ED reporting

Notes: To verify U.S. Postal Zip Codes, you may visit the USPS Zip code lookup search at: http://zip4.usps.com/zip4/citytown.jsp

The zip code should be 5 digits and the extension should be 4 digits, if applicable.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	HEADER	Contact Zip Code format is invalid	Must contain at least 5 numeric characters, zip +4 allowed if applicable. Format XXXXX-XXXX.	UPLOAD FAILURE

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.
- ✓ 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: 8 to 10 numeric characters

Codes/Values: Must be a valid AHCA number

Conditions: Required for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	AHCA Facility ID is not valid	An eight to ten (8-10) digit number assigned by AHCA must be reported	UPLOAD FAILURE

Patient Control Number

Element Name: Patient Control Number

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 for IP/CR reporting

Notes: Duplicate patient control numbers (Record ids) cannot be duplicated

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

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
	SCHEMA	Patient Control Number is empty	Must contain up to 24 alphanumeric characters representing a code assigned by the facility as a unique identifier for each record.	**UPLOAD FAILURE**
26	**DEMOGRAPH**	Duplicate Record ID (Patient Control) numbers exist	The same Record ID (Patient Control Number) is reported more than once in the same file	Error

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 03

Codes/Values: N/A

Conditions: Required for IP/CR reporting

Notes:

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Medical Record ID Number is empty	Must contain up to 24 alphanumeric characters representing a code assigned by the facility as a unique identifier for each record.	UPLOAD FAILURE

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 below

Conditions: Required for IP/CR reporting

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.

Reference the Social Security Administration Web site for verification of assigned Social Security number prefixes: www.ssa.gov/employer/stateweb.htm

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 a SSN Patient is under 2 years of age and does not have a SSN	777777777

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
27	DEMOGRAPH	Social Security Number invalid	The Patient Social Security Number field contains a number that is not a valid number recognized by the Social Security Administration or the unknown Default Code.	Error
638	DEMOGRAPH	Same SSN, different race, sex, or date of birth	Two or more records have the same SSN with different races, sex, or date of birth.	Error

Patient Ethnicity

Element Name: Patient Ethnicity

Definition: Self-designated by the patient, patient's parent, or guardian

Parameters: 2 digit alpha-numeric code

Codes/Values:

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

Conditions: Required for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Patient Ethnicity is invalid	The Patient Ethnicity field contains an invalid value. Patient Ethnicity is a required field and must contain an alpha-numeric value (E1,E 2,or E 7)	UPLOAD FAILURE

Patient Race

Element Name: Patient Race

Definition: Self-designated by the patient, patient's parent, or guardian

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 for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Race not valid (Not 1-7)	The Patient Race field contains an invalid value. Patient Race is a required field and must contain a numeric value (1, 2, 3, 4, 5, 6, 7)	UPLOAD FAILURE

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 for IP/CR reporting

Notes: Unknown birthdates should use the default of 1880-01-01.

The reporting entity must verify age greater than 115 years

The date of birth is used to calculate patient age

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Month of birth is not zero filled	Patient date of birth is a 10 digit field in the format YYYY-MM-DD, where the MM represents the numbered months of the year from 01-12. For single digit months, enter the month with use of a zero fill. (01-09)	UPLOAD FAILURE
50	DEMOGRAPH	Admit Date=DOB, Admit Priority not = 4,	The admit date can only equal the date of birth if the patient is a newborn and the patient was transferred from another facility where they were an inpatient.	Error

Edit Applications (cont):

Audit	Location	Audit Message	Audit Description	Audit Severity
46	DEMOGRAPH	Date of birth is after admit date	A date of birth after the admit date is not permitted.	Error
37	FATAL	Date of Birth is Invalid	Must contain a value using 10 numeric characters in format YYYY-MM-DD. A birth date after the discharge date is not permitted.	Error
639	DEMOGRAPH	Patient age exceeds 115 years	An age greater than one hundred fifteen (115) years is not permitted unless verified by the reporting entity.	Verify
34	NEWBORN	Priority of Admission=4 and Age not 0 days	If the priority of admission=4 (newborn), the age must be less than 1 day.	Error
36	NEWBORN	Newborn Source or Type, Age>1 day	If the Newborn source is 10 and the priority of admission=4 (newborn), the age must be less than 1 day.	Error

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 for IP/CR reporting

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 is used to determine validity of dependent ICD codes, Diagnostic Related Group (DRG) classification process and in data analysis

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Patient Sex is invalid. Not (M,F, or U)	Patient Sex is invalid; this is a required field and must contain a single alpha character(M,F, or U)	UPLOAD FAILURE
785	DEMOGRAPH	Patient sex=U	Monitors use of unknown sex	Error

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 for IP/CR reporting
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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
30	DEMOGRAPH	Patient ZIP Code is invalid	The Patient's Zip Code is invalid; the code must be the five (5) digit US Postal Service zip code of the patient's permanent residence, with exceptions for Zip Code Defaults.	Error
749	DEMOGRAPH	Patient ZIP Code is a PO Box	The Patient's Zip Code is invalid; the code must be the five (5) digit US Postal Service zip code of the patient's permanent residence.	Count

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 FI 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 for IP/CR reporting.

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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
752	DEMOGRAPH	Patient Country Code is invalid	The Patient's Country is invalid; the code must be the 2-digit ISO code of the patient's permanent residence, with exceptions for Country code Defaults.	Error

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 for IP/CR hospitals

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; amputation; major multiple trauma; fracture of femur (hip fracture); brain Morbidity; polyarthritis, including rheumatoid arthritis; neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease; and burns. ***Rehab units such as Psychiatric Rehab and ventilator rehab are not classified as comprehensive rehab.***

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Type of Service Code is invalid	The Type of Service Code is invalid; the code must be either 1 or 2.	UPLOAD FAILURE
782	FATAL	CR Facility with Inpatient Type of Service = 1	Facility license is a comprehensive rehab hospital and type of service is not 2.	Error
786	FATAL	Acute care hospital with CR Type of Service	Only hospitals that have comprehensive rehab beds should report comprehensive rehab data with type of service '2'	Error
783	DEMOGRAPH	Overlapping DOS, but with different Types of Service	Type of Service 1 and 2 must have distinct dates of service.	Error

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 for IP/CR reporting

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. Use of Code 5 does not require revenue code 068X

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
31	DEMOGRAPH	Patient Priority of admission is invalid	Must contain a one digit code (1, 2, 3, 4, 5) representing the scheduling priority of admission.	Error
50	DEMOGRAPH	Admit Date=DOB, Priority of Admission Type not 4, Admit Source must be 04	The admit date can only equal the date of birth if the patient is a newborn and the patient was transferred from another facility where they were an inpatient.	Error
742	DEMOGRAPH	Trauma Priority of Admission at a Non-Trauma Facility	Priority type 5 and facility is not a Florida licensed trauma center.	Error
743	DEMOGRAPH	Trauma Charge at a Non-Trauma facility	Facility must be a Florida licensed trauma center if Rev code 068 charges are present.	Error
744	DEMOGRAPH	Trauma Charge without Trauma Priority of Admission	Trauma Charges and Priority type not "5".	Error

Threshold Applications:

Audit	Allowable %	Audit Message	Audit Description	Audit Severity
T- 2	52.0%	More Deliveries than Newborns	Compares the number of priority type 4 (newborn) to the number of OB procedures 72-75.	Verify

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
~~07~~	~~Emergency Room~~ ***Discontinued effective 1/1/2011***
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 for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
32	DEMOGRAPH	Patient source of admission is invalid	Must contain a two digit code 01-13; or alpha codes D, E or F.	Error
33	NEWBORN	Newborn Source of Admission without Newborn Priority	Use of newborn source of admission is only permissible with use of newborn priority of admission code.	Error
34	NEWBORN	Priority of Admission=4 and Age not 0 days	If the priority of admission=4 (newborn), then the age corresponds accordingly.	Error
35	NEWBORN	Newborn priority of admission without newborn source	Use of newborn priority of admission is only permissible with use of special source of admission codes 10-14.	Error
36	NEWBORN	Newborn source or priority, Age >1 day	Priority of admission is newborn and child's age is greater than 1 day.	Error

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 for IP/CR reporting

Notes: Admission Date must equal or precede the discharge date

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Admit Date is Invalid	Must contain a value using 10 numeric characters in the format YYYY-MM-DD. Admission date must equal or precede the discharge date.	UPLOAD FAILURE
SCHEMA	SCHEMA	Month of Admit is not zero filled	Admit date must contain 10 numeric characters in the format YYYY-MM-DD,	UPLOAD FAILURE
791	DEMOGRAPH	Admit Date more than 6 days after ED Date of Arrival	ED arrival date more than 6 days prior to the inpatient admit date.	Error

Edit Applications (cont)

Audit	Location	Audit Message	Audit Description	Audit Severity
47	DEMOGRAPH	Admit Date is after discharge date	Admit date must equal or precede the discharge date.	Error
783	DEMOGRAPH	Overlapping DOS with different types of service	Patient has the same SSN and DOB. Service type 1 and 2 DOS are mutually inclusive,	Verify

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 for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Inpatient Admit Time is blank, invalid, or 99	Must be a two digit numeric character using 00 through 23 and 99 representing the hour on a 24-hour clock during which inpatient admission occurred.	UPLOAD FAILURE

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 for IP/CR reporting

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

Discharge Date must equal or follow the admission date

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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Month of discharge is not zero filled	Discharge date must contain 10 numeric characters in the format YYYY-MM-DD,	UPLOAD FAILURE
SCHEMA	SCHEMA	Day of Discharge is not zero filled	Discharge date must contain 10 numeric characters in the format YYYY-MM-DD,	UPLOAD FAILURE
342	DISCHARGE	Discharge date=admit date (potential outpatient)	If the discharge date equals the admission date, the reporting entity must verify that these dates are correct and the visit accurately classified as an inpatient visit.	Verify
708	DISCHARGE	Discharge date is not within the Reporting Quarter	The discharge date must fall within the reporting period indicated in the header.	Error
499	DEMOGRAPH	Length of Stay >365	Length of stay is greater than 365 days according to admit date and discharge date	Verify
783	DEMOGRAPH	Overlapping DOS with different types of service	Patient has the same SSN, DOB, service type 1 and 2, and DOS are mutually inclusive,	Verify
43	FATAL	Discharge Date is invalid	Discharge date must contain 10 numeric characters in the format YYYY-MM-DD and fall within the reporting quarter	Error

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 for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	**SCHEMA**	Discharge Time is blank, invalid, or 99	Must be a two digit numeric character using 00 through 23 and 99 representing the hour on a 24-hour clock during which inpatient discharge occurred.	**UPLOAD FAILURE**
778	**DEMOGRAPH**	Discharge Time equal Admit Time	Discharge Time cannot be the same as the Admit Time. Excludes Discharge Status 07 and 20.	Error

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; 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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Discharge status is invalid	Must contain a two-digit code indicating the patient's disposition at discharge.	UPLOAD FAILURE

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 for IP/CR reporting

Notes: Report payer codes based on AHCA specifications

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

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, home owners or general business liability coverage, and/or commercial liability claims

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Payer is invalid	Payer Code is invalid, must contain a valid single uppercase alpha character (A-E ; H-O; Q)	UPLOAD FAILURE
793	DEMOGRAPH	Patient Age Over 19 and Payer=O (Kid-Care)	A patient over the age of 19 is being reported with Kid-Care as the principal payer	Error

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 time period 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 for IP/CR reporting

Notes: Include POA- Present on Admission Indicator

The reporting entity must verify inconsistency between the principal diagnosis code and patient sex and/or patient age.

A diagnosis code cannot repeat as a principal or other diagnosis for each hospitalization reported

The primary medical diagnosis or condition data will determine why the patient required hospital care. Patients with similar diagnosis are compared using the DRG assignment. The Agency reports morbidity/mortality rate measures to the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality based on this information.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	DX	Principal diagnosis is missing	Must contain a valid ICD-10-CM for the reporting period representing the diagnosis established to be chiefly responsible for occasioning the admission.	UPLOAD FAILURE
150	DX	Principal diagnosis code cannot be an "ECMORB" code	Report ECMORB codes in the external cause of Morbidity field only, not in the Principal diagnosis field.	Error
151	DX	Principal diagnosis conflicts with patients age	The age of the patient does not agree with an age specific ICD-10 code. The reporting entity must verify inconsistency between the principal diagnosis code and patient age.	Error
182	DX	Principal Diagnosis Code conflicts with patients sex	The sex of the patient does not agree with a sex specific ICD-10 code. The reporting entity must verify inconsistency between the principal diagnosis code and patient age.	Error
SCHEMA	DX	Principal diagnosis is unacceptable	Principal diagnosis code must contain a valid ICD-10-CM code acceptable for the reporting period.	UPLOAD FAILURE
246	DX	Principal diagnosis repeated in secondary codes	The record contains duplicate ICD diagnosis codes.	Error
343	DX	Principal diagnosis is invalid	Principal Diagnosis is a required field and must contain a valid ICD-10 code. Enter the code with a decimal point and upper case alpha characters.	Error
646	DX	Primary Diagnosis Ends in a Decimal	Report the Diagnosis Code with a decimal point included in the valid code. Do not use a decimal at the end of a valid code.	Error
738	DX	PDX Invalid as a discharge diagnosis (DRG 998)	The diagnosis code is not within the DRG grouping range- ungroupable.	Fatal
740	FATAL	DRG=999 (Invalid Principal Diagnosis) >= 10/01/2008	The diagnosis code is not within the DRG grouping range- ungroupable.	Fatal

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 a-q

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 time period reported

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

Conditions: Required for IP/CR reporting

Notes: **The XML schema format requires that the data file not include unused 'Other Diagnosis' XML tags. Including unused tags will result in the file failing the format checker.**

Remove unused XML tags if not reported

Include Present on Admission Indicator (POA) for each Other Diagnosis Code reported

The reporting entity must verify inconsistency between the principal diagnosis code and patient sex and/or patient age.

An Other Diagnosis code cannot repeat as a principal or other diagnosis for each hospitalization 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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
152-181	DX	Secondary diagnosis 01-30 conflicts with patients age	The age of the patient does not agree with an age specific ICD-10 code. The reporting entity must verify inconsistency between the secondary diagnosis code and patient age.	Verify
183-212	DX	Secondary diagnosis 01-30 conflicts with patients sex	The sex of the patient does not agree with a sex specific ICD-10 code. The reporting entity must verify inconsistency between the secondary diagnosis code and patient age.	Verify
247-275	DX	Secondary diagnosis 01-30 repeated in secondary codes	The same secondary diagnosis code is reported more than once in the same record.	Error
344-373	DX	Secondary diagnosis 01-30 is invalid	If reported, a Secondary Diagnosis must contain a valid ICD-10 code. Enter the code with a decimal point and upper case alpha characters.	Error
647-676	DX	Secondary Diagnosis 01-30 Ends in a Decimal	Report the Diagnosis Code with a decimal point included in the valid code. Do not use a decimal at the end of a valid code.	Error

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 IP reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
502	POA	POA for Principal DX not valid for the DX code	The Present on Admission indicator field is 1 and the Primary Diagnosis code is not exempt.	Error
503-532	POA	POA for SDX 01-30 not valid for the DX code	The Present on Admission indicator field is 1 and the Secondary Diagnosis code is not exempt.	Error
533	POA	POA for ECMORB code 1 is not valid for the ECMORB code	The Present on Admission indicator field is 1 and the ECMORB code is not exempt.	Error
534	POA	POA for ECMORB code 2 is not valid for the ECMORB code	The Present on Admission indicator field is 1 and the ECMORB code is not exempt.	Error
535	POA	POA for ECMORB code 3 is not valid for the ECMORB code	The Present on Admission indicator field is 1 and the ECMORB code is not exempt.	Error
SCHEMA	SCHEMA	POA for Principal DX is not valid. (PD10-1 on)	POA code is not Y, N, U, W or 1 or is blank.	UPLOAD FAILURE
SCHEMA	SCHEMA	POA for SDX is not valid.	POA code is not Y, N, U, W or 1 or is blank.	UPLOAD FAILURE
SCHEMA	SCHEMA	POA for ECMORB 1, 2, OR 3 is not a valid Code.	POA code is not Y, N, U, W or 1 or is blank.	UPLOAD FAILURE

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 tags if not reported

The XML schema format requires that the data file not include unused 'Principle Procedure Codes' XML tags. Including unused tags will result in the file failing the format checker

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

The reporting entity must verify inconsistency between the principal Procedure code and patient sex.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
85	PROCEDURE	Principal Procedure without valid procedure date	Must contain ten digit numerical characters in format YYYY-MM-DD. If the principal procedure is reported, a valid principal procedure date must be reported	Error
116	PROCEDURE	Principal Procedure date without Principal Procedure	If a procedure date is reported a corresponding valid Principal procedure code must be reported	Error
374	PROCEDURE	Principal Procedure code is invalid	Must contain a valid ICD-10-PCS procedure code for the reporting period	Error

Audit	Location	Audit Message	Audit Description	Audit Severity
405	PROCEDURE	Principal Procedure code conflicts with patients age	The age of the patient does not agree with an age specific ICD-10-PCS procedure code	Error
436	PROCEDURE	Principal Procedure code conflicts with patients sex	The sex of the patient does not agree with the gender specific ICD-10-PCS procedure code	Error
SCHEMA	PROCEDURE	Principal Procedure ends in a decimal	Procedure code cannot contains a decimal point.	UPLOAD FAILURE
280	PROCEDURE	Principal Procedure code more than 6 days before admission	The reported principal procedure date is too many days prior to the admission date.	Error
311	PROCEDURE	Principal Procedure code after discharge date	The reported principal procedure date must be before the discharge date.	Error

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	PROCEDURE	Principal Procedure without valid procedure date	Must contain ten digit numerical characters in format YYYY-MM-DD.	UPLOAD FAILURE
85	PROCEDURE	Principal Procedure date is invalid	Must contain ten digit numerical characters in format YYYY-MM-DD.	Error
116	PROCEDURE	Principal Procedure date without Principal Procedure	A procedure date must correspond if a Principal procedure code is reported.	Error

Edit Applications (cont):

Audit	Location	Audit Message	Audit Description	Audit Severity
280	PROCEDURE	Principal Procedure Date more than 6 days before admit date	The reported principal procedure date is too many days prior to the admission date.	Error
311	PROCEDURE	Principal Procedure Date after discharge date	The reported principal procedure date must be before the discharge date.	Error

Other Procedure Code (1-30)

Element Name: Other Procedure Code 1-30

Definition: The ICD-10-PCS code identifying 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: If a principal procedure is not reported, an Other Procedure Code must not be reported except when discharge status is 07

Notes: Remove unused XML tags if not reported

The XML schema format requires that the data file not include unused 'Other Procedure' XML tags. Including unused tags will result in the file failing the format checker

Inconsistency between the procedure code and patient sex OR patient age must be verified by the reporting entity

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
86-115	PROCEDURE	Secondary Procedure 01-30 date is invalid	Must contain ten digit numerical characters in format YYYY-MM-DD. If a secondary procedure is reported, a valid procedure date must be reported.	Error
117-146	PROCEDURE	Secondary Procedure 01-30 without Procedure date	Must contain ten digit numerical characters in format YYYY-MM-DD. If a secondary procedure is reported, a valid procedure date must be reported.	Error
281-310	PROCEDURE	Secondary Procedure 1-30 more than 6 days before Admission	The reported secondary procedure date is too many days prior to the admission date.	Error
375-404	PROCEDURE	Secondary Procedure 01-30 is invalid	Must contain a valid ICD-10-PCS procedure code for the reporting period	Error
437-466	PROCEDURE	Secondary Procedure 01-30 conflicts with patients sex	The sex of the patient does not agree with the gender specific ICD-10-PCS procedure code	Verify

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: **The XML schema format requires that the data file not include unused 'Other Procedure' XML tags. Including unused tags will result in the file failing the format checker**

Remove unused XML tags if not reported

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	PROCEDURE	Invalid procedure date	Must contain ten digit numerical characters in format YYYY-MM-DD	UPLOAD FAILURE
86-115	PROCEDURE	Secondary Procedure 01-30 date is invalid	Must contain ten digit numerical characters in format YYYY-MM-DD.	Error
117-146	PROCEDURE	Secondary Procedure 01-30 without Procedure date	Must contain ten digit numerical characters in format YYYY-MM-DD. If a secondary procedure is reported, a valid procedure date must be reported.	Error
281-310	PROCEDURE	Secondary Proc 01-30 Date more than 6 days before admit date	The reported secondary procedure date is too many days prior to the admission date.	Error
312-341	PROCEDURE	Secondary Proc 01-30 date after discharge date	The reported secondary procedure date must be before the discharge date.	Error

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 for IP/CR reporting if applicable

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

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	PRACTITIONER	Attending practitioner ID is empty	Attending practitioner license number is a required entry. For military physicians not licensed in Florida, use US999999999.	UPLOAD FAILURE
571	PRACTITIONER	Attending practitioner ID is invalid	Must contain the valid Florida practitioner license number of the attending practitioner responsible for the care of the patient at the time of service. A required entry.	Error

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 for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
761	PRACTITIONER	Attending practitioner NPI is empty	Attending practitioner NPI number is a required entry and may be the same as the other, operating or performing practitioner. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error
775	PRACTITIONER	Attending practitioner NPI is invalid	Attending practitioner NPI number is a required entry and must be 10 characters in length. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error

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: Required for IP/CR reporting if applicable

Notes: To verify practitioner license numbers, visit the DOH Florida Medical License Search:
https://appsmqa.doh.state.fl.us/irm00praes/praslist.asp

The operating medical doctor is the practitioner performing the principal procedure

The Operating or Performing Practitioner may be the same as the attending physician

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

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
572	PRACTITIONER	Performing practitioner ID without Principal Procedure	A record with a Performing or Operating practitioner must have a corresponding Principal ICD-10-CM procedure code	Error

Edit Applications cont

Audit	Location	Audit Message	Audit Description	Audit Severity
573	PRACTITIONER	Principal Procedure without Performing practitioner	A record with a Principal ICD-10-PCS procedure code must have a corresponding Performing or Operating practitioner	Error
574	PRACTITIONER	Performing Practitioner ID is invalid	Must contain the valid Florida license number of the practitioner who performed the principal procedure reported. No entry is permitted if a principal procedure is not reported.	Error

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 for IP/CR reporting if applicable

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
763	DEMOGRAPH	Operating or Performing practitioner ID without NPI number or NPI without a state Florida license	Performing state license w/o a Performing NPI *OR* NPI number w/o Performing state license. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error
776	PRACTITIONER	Operating or Performing practitioner NPI is invalid	Performing practitioner NPI number is a required entry and must be 10 characters in length.	Error
762	DEMOGRAPH	Principal Procedure without Performing Practitioner NPI	A Perfoming Practitioner NPI must be reported with a Principle Procedure	Error

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: Required for IP/CR reporting if applicable

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

The 'Other' Operating or Performing Practitioners and 'Operating' or Performing practitioners cannot be the same.

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
575	PRACTITIONER	Other practitioner ID is the same as Performing practitioner	The other operating or performing practitioner must differ from the operating or performing practitioner. The other operating or performing practitioner may be the attending practitioner. No entry is permitted consistent with the records of the reporting entity.	Error
576	PRACTITIONER	Other practitioner State license ID is invalid	Must contain the valid Florida license number of any other practitioner responsible for the patient's care. The other operating or performing practitioner may be the attending practitioner. No entry is permitted consistent with the records of the reporting entity.	Error

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 for IP/CR reporting if applicable

Notes: The 'Other' Operating or Performing Practitioners and 'Operating' or Performing practitioners cannot be the same.

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
764	DEMOGRAPH	Other practitioner ID without NPI number or NPI without a state Florida license	Other practitioner state license w/o Other practitioner NPI *OR* NPI number w/o Other practitioner state license. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error
777	PRACTITIONER	Other Operating or Performing practitioner NPI is invalid	Other Performing practitioner NPI number is a required entry and must be 10 characters in length. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error

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 for IP/CR reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
741	DEMOGRAPH	Total charges > 3 million	A record exceeds total charge of $3 million	Error
52	REV	Total Charges = 0 and priority type not 4	The reporting entity must verify Zero (0) charges. Newborn Priority type 4-excluded.	Error
SCHEMA	SCHEMA	Total Charges less than $0 or not numeric	Must contain a numeric value or Zero (0) dollars. Negative amounts are not permitted.	UPLOAD FAILURE
276	REV	Sum of sub charges <> total or charge data invalid	The sum of all charges reported must equal total charges, plus or minus thirteen dollars. Report in dollars numerically without dollar signs or commas, excluding cents.	Error
501	REV	Per Diem not between $200 and $200,000	Per Diem charges do not fall between $200 and $200,000	Error
746	REV	Record has no room charges	Charges for room, ICU, CCU, or Nursery must be included for Inpatient stay.	Error
277	REV	Comp Rehab Charges but Type of Service not 2	Charges for comp rehab can only be reported for type of service 2	Error
278	REV	Type of Service =2, comp rehab charges not reported	Type of Service 2 must report comp rehab charges	Error

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 for IP reporting if applicable

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Nursery Charges are not reported or invalid	No charge was reported. Report zero if there are no charges. This is a required entry and must be consistent with patient records. Report charges in whole numbers. Report zero (0) if there are no charges to report	UPLOAD FAILURE
746	REV	Record has no room charges	Charges for room, ICU, CCU, or Nursery must be included for each Inpatient record.	Error

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 for IP/CR reporting

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

The sum of all charges reported must equal total charges, plus or minus thirteen (13) dollars

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
741	DEMOGRAPH	Total charges greater than $ 3 million	A record exceeds total charge of $3 million	Error

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 below

Conditions: A required field for patients whose age is less than two (2) years of age *at admission*

Zero fill if the patient is two (2) years of age or older

Notes: This data allows for linking of multiple records for the same patient. This field can be used to "un-duplicate" counts for different types of medical conditions when a patient is hospitalized more than once. 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 a SSN Patient is under 2 years of age and does not have a SSN	777777777

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
635	INFANT	Infant Linkage Identifier is not valid	Must contain a nine digit numerical character indicating the SSN of the patient's mother if patient is less than two years of age. If the patient is age two or older, zero fill. Assign 777777777 for mother's SSN where efforts to obtain was unsuccessful; 333333333 if infant is in the custody of the State of Florida or adopted and mother's SSN is unavailable.	Error
636	INFANT	Infant Linkage Identifier ≠ Patient's SSN	Infant Linkage should equal mother's SSN if patient is less than two and zero fill if older than two.	Verify

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 for IP/CR reporting

Notes: The reporting entity must verify Inconsistency between the admitting diagnosis code and patient sex and/or age

This data element **does not require** a Present On Admission (POA) indicator

Follow official coding guidelines for ICD reporting

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
621	ADMIT	Admitting Diagnosis is missing	Admitting diagnosis is a required field and must contain a valid ICD-10-CM code for the reporting period.	Error
622	ADMIT	Admitting Diagnosis ends in a decimal	Admitting diagnosis is entered with use of a decimal that is included in the valid code, but must not end in a decimal.	Error

Edit Applications (cont):

Audit	Location	Audit Message	Audit Description	Audit Severity
623	ADMIT	Admitting Diagnosis conflicts with patients age	The reporting entity must verify inconsistency between the admitting diagnosis and the patient age.	Error
624	ADMIT	Admitting Diagnosis code conflicts with patients sex	The reporting entity must verify inconsistency between the admitting diagnosis and the patient sex.	Error
745	DX	Admitting Diagnosis is invalid	Admitting Diagnosis is a required field and must contain a valid ICD-10 code. The code is entered with use of decimal point and upper case alpha characters.	Error

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: Required for IP reporting

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

Assign and report the ECMORB code(s) on all hospital encounter treatments, Morbidity, poisoning, adverse effect or misadventure, for both cause and place of occurrence as appropriate

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
626	ECMORB	ECMORB code 1 is invalid or is not an ECMORB code	If not space filled, must be a valid ICD-10-CM cause of Morbidity code for the reporting period.	Error
627	ECMORB	ECMORB code 2 is invalid or is not an ECMORB code	If not space filled, must be a valid ICD-10-CM cause of Morbidity code for the reporting period.	Error
628	ECMORB	ECMORB code 3 is invalid or is not an ECMORB code	If not space filled, must be a valid ICD-10-CM cause of Morbidity code for the reporting period.	Error
629	ECMORB	ECMORB code 1 ends in a decimal	Report the ECMORB Diagnosis Code with a decimal point included in the valid code. Do not use a decimal at the end of a valid code.	Error
630	ECMORB	ECMORB code 2 ends in a decimal	Report the ECMORB Diagnosis Code with a decimal point included in the valid code. Do not use a decimal at the end of a valid code	Error
631	ECMORB	ECMORB code 3 ends in a decimal	Report the ECMORB Diagnosis Code with a decimal point included in the valid code. Do not use a decimal at the end of a valid code	Error
632	ECMORB	ECMORB code 1 is Repeated in ECMORB codes 2-3	The same ECMORB code is used more than once in the same record.	Error
633	ECMORB	ECMORB code 2 is Repeated in ECMORB code 3	The same ECMORB code is used more than once in the same record.	Error

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 for IP/CR reporting
Use 0000-00-00 for patients not admitted through the ED

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	ED Date of Arrival is missing or invalid	Must contain a value using 10 numeric characters in the format YYYY-MM-DD.	UPLOAD FAILURE
757	DEMOGRAPH	ED Date of Arrival without ED charges	ED charges must accompany ED admissions excluding Payer Types A,B, I	Error
759	DEMOGRAPH	ED Date of Arrival is after hospital Admit Date	ED arrival date must equal or precede the admit date.	Error
760	DEMOGRAPH	ED Date of Arrival without Hour or Hour without Date	ED arrival date must contain an Hour of Arrival. Hour of Arrival must contain an ED Date of Arrival	Error
791	DEMOGRAPH	Admit Date more than 6 days after ED Date of Arrival	ED arrival date more than 6 days before the admit date.	Error

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 for IP/CR reporting

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.***

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Ed Hour of Arrival is missing or invalid	Must be a two digit numeric character using 00 through 23 and 99 representing the hour on a 24-hour clock during which registration in the emergency department occurred.	UPLOAD FAILURE
758	DEMOGRAPH	ED Hour of Arrival without ED charges	ED charges must accompany ED Hour of Arrival excluding Payer Types A,B, I	Error
780	DEMOGRAPH	ED Hour of Arrival equal Inpatient Discharge Time	ED Hour of arrival date cannot be the same as the inpatient discharge time.	Error
760	DEMOGRAPH	ED Date of Arrival without Hour or Hour without Date	ED arrival date must contain an Hour of Arrival. Hour of Arrival must contain an ED Date of Arrival	Error

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
00 Not admitted from the ED

Conditions: Required for IP reporting

Notes: Effective for discharges after July 1, 2011 (Q3 2011).

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
787	DEMOGRAPH	Condition Code is P7 and ED Date of Arrival is missing	A valid ED Date of arrival must be present if Condition Code is P7	Error
788	DEMOGRAPH	Condition Code is 00 and ED Data elements are present	Flag if 00 and either ERCHGS, ED Date of Arrival, ED Hour of Arrival *are present* Exclude date 00/00/0000 and hour 99.	Error
SCHEMA	SCHEMA	Condition code is Blank	Condition code is Blank and the date is greater than 6/30/2011	UPLOAD FAILURE
SCHEMA	SCHEMA	Condition code is invalid	Must contain P7, 00 or blank if the patient was admitted in the ED	UPLOAD FAILURE

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 for IP/CR reporting

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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
645	TRAILER	Records reported submitted not number actually submitted	The total number of records in the file must equal the number of records entered in the Trailer record	Error

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.***
- ✓ 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 10021 and 69999, inclusive and between 92920 through 92998 and 93451 through 93533; **AND if** (*updated cardiac reporting range starting Q1 2013)*

- 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

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 reporting is not limited to the ambulatory reporting criteria.

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: 8 to 10 numeric characters

Codes/Values: Must be a valid AHCA number

Conditions: Required for AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Invalid AHCA ID	An eight to ten (8-10) digit number assigned by AHCA must be reported	UPLOAD FAILURE
SCHEMA	SCHEMA	AHCA ID is not same as Reported in Header	AHCA Facility ID number must be the same as the AHCA ID number reported in the Header Record, an eight to ten (8-10) digit number assigned by AHCA.	UPLOAD FAILURE

Element Name: Patient Control Number

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 03 or HCFA-1500 FL 26

Codes/Values: N/A

Conditions: Required for AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
25	DEMOGRAPH	Duplicate Record ID (Patient Control) numbers exist	The same Record ID (Patient Control Number) is reported more than once in the same file	Error

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 for AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Medical Record ID Number is empty	Must contain up to 24 alpha numeric characters representing a code assigned by the facility as a unique identifier for each record.	UPLOAD FAILURE

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 below

Conditions: Required for AS/ED reporting

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.

Reference the Social Security Administration Web site for verification of assigned Social Security number prefixes: www.ssa.gov/employer/stateweb.htm

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
28	DEMOGRAPH	Social Security Number invalid	The Patient Social Security Number field contains a number that is not a valid number recognized by the Social Security Administration and is not the unknown SSN Default Code.	Error
155	DEMOGRAPH	Same SSN, Different Race, Sex, or Date of Birth	Two or more records have the same SSN with different races, sex, or dates of birth	Error
178	DEMOGRAPH	Duplicate SSN & Date of Service	Service type = 1 and multiple records with the same SSN and Date of Service. Combine into one record for each visit.	Error

Patient Ethnicity

Element Name: Patient Ethnicity

Definition: Self-designated by the patient, patient's parent, or guardian

Parameters: 2 digit alpha-numeric code

Codes/Values:

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

Conditions: Required for AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Patient Ethnicity is invalid	The Patient Ethnicity field contains an invalid value. Patient Ethnicity is a required field and must contain an alpha-numeric value (E1,E2, or E 7)	UPLOAD FAILURE

Element Name: Patient Race

Definition: Self-designated by the patient, patient's parent, or guardian

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 for AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Race not valid (Not 1-7)	The Patient Race field contains an invalid value. Patient Race is a required field and must contain a numeric value (1, 2, 3, 4, 5, 6, or 7)	UPLOAD FAILURE

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 for AS/ED reporting

Notes: Unknown birthdates should use the default of 1880-01-01.

Age greater than 115 years must be verified by the reporting entity

This data element is used to calculate patient age

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
30	DEMOGRAPH	Birth Date is after Begin or End Date	The patient's date of birth is after the beginning date of service or ending date of service	Error
31	DEMOGRAPH	Birth Date is not a valid date	Patient Birth Date is invalid; this is a required field and must contain a value using 10 numeric characters in format YYYY-MM-DD. Type of service=2 can use 1880-01-01 when efforts to obtain the patients date of birth are unsuccessful	Error
155	DEMOGRAPH	Same SSN, Different Race, Sex, or Date of Birth	Two or more records have the same SSN with different races, sex, or dates of birth	Error
160	DEMOGRAPH	Patient age exceeds 115 years	An age > 115 years is not permitted unless verified by the reporting entity.	Verify

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 for AS/ED reporting

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.

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Patient Sex is not Valid (M,F, or U)	Patient Sex is invalid; this is a required field and must contain a single alpha character. Patient Sex=U must be verified by the reporting entity.	UPLOAD FAILURE
155	DEMOGRAPH	Same SSN, Different Race, Sex, or Date of Birth	Two or more records have the same SSN with different races, sex, or dates of birth	Error
261	DEMOGRAPH	Patient Sex is U-Unknown	Monitors use of unknown sex	Error

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 for AS/ED reporting
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 considered to be 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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
33	DEMOGRAPH	Invalid Patient ZIP Code	The Patient Zip Code is invalid, the code must be the five (5) digit US Postal Service zip code of the patients permanent residence, with exceptions:00009- Foreign residences , 00007- Homeless patients, and 00000 - If unavailable	Error
211	DEMOGRAPH	Patient ZIP Code is a PO Box	The Patient Zip Code is invalid, the code must be the five (5) digit US Postal Service zip code of the patients permanent residence.	Count

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 for AS/ED reporting

Notes:

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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
208	DEMOGRAPH	Patient Country Code is invalid	The Patient's Country is invalid; the code must be the 2 digit ISO code of the patient's permanent residence or default.	Error

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 for AS/ED reporting

Notes:

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Invalid Type of Service code	Type of Service code is invalid, must use single numeric character indicating type of service: 1-Ambulatory surgery or 2-Emergency department visit	UPLOAD FAILURE

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
07	Emergency Room *Discontinued effective 1/1/2011*
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 for AS/ED reporting
Type of service 1 – use default code '00'

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
204	DEMOGRAPH	Patient source of admission is invalid	Type of service = 2 and Source of Admit not equal to 01, 02, 04-06, 08, 09, or D-F	Error
205	DEMOGRAPH	Type of Service 1 and Source of Admission not 00	Type of Service 1 must zero fill the Source of Admission.	Error

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 for AS/ED reporting

Notes: Report payer codes based on AHCA specifications

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

Payer L – Self-Pay: Patients with no 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 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, home owners or general business liability coverage, and/or commercial liability claims

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Invalid Payer (AS/ED)	Payer Code is invalid, must contain a valid single uppercase alpha character (A-E and H-Q)	UPLOAD FAILURE
37	DEMOGRAPH	Invalid Use of Payer P in ED Data	Use of Payer=P (unknown) is used only if payer information is not available, and type of service is 2 and patient status is 07	Error
180	DEMOGRAPH	Invalid Use of Payer P (Pro Code 14)	Ambulatory Surgical Centers Payer P - Unknown	Error
262	DEMOGRAPH	Patient Age Over 20 and Payer=0 (Kid-Care)	A patient over the age of 20 is being reported with Kid-Care as the principal payer	Error

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/ED reporting

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

The reporting entity must verify inconsistency between the principal diagnosis code and patient sex and/or patient age.

A diagnosis code cannot be used more than once as a principal or other diagnosis for each hospitalization reported

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
38	DX	Primary Diagnosis is empty and Not ED Discharged AMA	Each record must contain a valid ICD-10 code 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 consistent with the records of the reporting entity.	Error
39	DX	Primary Diagnosis Ends in a Decimal	Diagnosis codes must be valid ICD-10code, entered with use of the decimal point that is contained in the code.	Error
49	DX	Primary Diagnosis is invalid	Principal Diagnosis is a required field and must contain a valid ICD-10 code.	Error
59	DX	Primary Diagnosis conflicts with Patient Sex	The sex of the patient does not agree with a sex specific ICD-10 Diagnosis Code.	Error
69	DX	Primary Diagnosis conflicts with Patient Age	The age of the patient does not agree with an age specific ICD-10 Diagnosis Code	Error
80	DX	Primary Diagnosis is repeated in Secondary Diagnosis Codes	The same ICD diagnosis code is reported more than once on the same record.	Error

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: Required for AS/ED reporting

Notes: **The XML schema format requires that the data file not include unused 'Other Diagnosis' XML tags. Including unused tags will result in the file failing the format checker.**

The reporting entity must verify inconsistency between the principal diagnosis code and patient sex and/or patient age.

An Other Diagnosis code cannot be used more than once as a principal or other diagnosis for each discharge record reported

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

Report external cause of Morbidity codes in the designated External Cause of Morbidity Code (ECMORB) fields

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
50 - 58	DX	Secondary Diagnosis 1 – 9 is Invalid	If reported, the Secondary Diagnosis 1 – 9 Code field must contain a valid ICD-10 code.	Error
60 - 68	DX	Secondary Diagnosis 1 -9 conflicts with Patient Sex	The sex of the patient does not agree with a sex specific ICD-10 Secondary Diagnosis 1 – 9 Code.	Verify
70 - 78	DX	Secondary Diagnosis 1 – 9 conflicts with Patient Age	The age of the patient does not agree with an age specific ICD-10 Secondary Diagnosis 1 – 9 Code	Verify
81 - 88	DX	SDX 1-8 is repeated in Secondary Diagnosis Codes 2-9	The same ICD diagnosis code is reported more than once on the same record.	Error

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 time period 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: **The XML schema format requires that the data file not include unused 'Evaluation/Management XML tags. Including unused tags will result in the file failing the format checker.** (*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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
191	PROCEDURE	At Least 1 E&M Code is not in the reportable range	Evaluation and Management code not in the reportable range	Error
257	PROCEDURE	Type of Service = 1 and E&M Code is present	Type of service 1 is not required to report an E/M code and should remove the E/M tag.	Error
258	PROCEDURE	E&M Code is 99999, not '07' discharge status or $0 charges	ED type of service "2" cannot use code default code 99999 unless the discharge status is 07 or ED charges are $0.	Error
174	DEMOGRAPH	Type of Service =2 and E&M code blank.	Type of Service 2 must report a valid E&M code or default code. E&M cannot be left blank.	Error

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 time period reported

Conditions: Required for AS/ED reporting
Type of Service 1- MUST contain revenue charges in designated revenue fields AND 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

The XML schema format requires that the data file not include unused 'Other CPT' XML tags. Including unused tags will result in the file failing the format checker.

Report the procedures performed in the Other CPT's 1-30 fields. At least one procedure must be in surgical in nature and within the reportable range for type of service 1.

The reporting entity must verify inconsistency between the principal diagnosis code and patient sex and/or patient age.

No more than 30 other CPT or HCPCS procedure codes may be reported; less than 30 entries or no entry is permitted

Do not report Evaluation & Management codes for emergency department visits or office visits in the Other CPT fields.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
91	PROCEDURE	Procedure codes are not in the reportable range for ASC	Must contain 1 CPT or HCPCS code in collectable range for Type of service 1. The reportable range for the edit are 10021-36399; 36426 through 69999; 92920 through 92998; and 93451 through 93533	Error
93 - 102	PROCEDURE	Secondary Procedure 1 -10 is Invalid	If reported, the Secondary Procedure 1 – 10 Code field must contain a valid CPT or HCPCS code.	Error
103 - 112	PROCEDURE	Secondary Procedure 1 – 10 Conflicts with Patient Sex	The sex of the patient does not agree with the sex specific Secondary CPT or HCPCS Procedure 1 – 10 code	Verify
190	PROCEDURE	At least 1 procedure code is in the E&M code range	Evaluation and Management codes cannot repeat in Other CPT fields	Error
200	PROCEDURE	Venipuncture and 80000-89399 as only procedures	Venipuncture codes (36415/36416) are non-reportable as primary and/or in conjunction with lab service codes 80000-83999.	Error
215-234	PROCEDURE	Secondary Procedure 11 -30 is Invalid	If reported, the Secondary Procedure 11 – 30 Code field must contain a valid CPT or HCPCS code.	Error
235-254	PROCEDURE	Secondary Procedure 11 – 30 Conflicts with Patient Sex	The sex of the patient does not agree with the sex specific Secondary CPT or HCPCS Procedure 11 – 30 code	Verify

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 for AS/ED reporting if applicable

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

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

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
150	PRACTITIONER	Invalid Attending Practitioner ID	Field must contain a valid practitioner ID in format ME12345, APRN1234567, OS1234 with no zero fill or leading zeros	Error
194	PRACTITIONER	Attending Practitioner ID without NPI number or NPI without a state Florida license	Attending Practitioner state license w/o NPI *OR* NPI number w/o Attending state license.	Error

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 for AS/ED reporting if applicable

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
194	PRACTITIONER	Attending Practitioner ID w/out NPI number or NPI w/out a state Florida license	Attending Practitioner state license w/o NPI *OR* NPI number w/o Attending state license. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error
197	PRACTITIONER	Attending practitioner NPI is invalid	Attending practitioner NPI number is a required entry and must be 10 characters in length. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error

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/ED reporting if applicable

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: http://ww2.doh.state.fl.us/irm00praes/praslist.asp

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
151	PRACTITIONER	Invalid Performing Practitioner number	Field must contain a valid practitioner ID in format ME12345, APRN1234567, OS1234 with no zero fill or leading zeros	Error
153	PRACTITIONER	Performing Practitioner without Principal Procedure	A record with a Performing Practitioner must have a corresponding Principal CPT or HCPCS procedure code	Error
195	PRACTITIONER	Performing Practitioner ID w/out NPI number or NPI w/out a Fla license	Performing Practitioner license number w/o NPI OR NPI number w/o Performing state ID.	Error

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/ED reporting if applicable

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
195	PRACTITIONER	Operating/Performing Practitioner ID w/out NPI number or NPI w/out a Florida license	Performing Practitioner state license w/o NPI *OR* NPI number w/o Performing state ID. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error
198	PRACTITIONER	Operating/Performing practitioner NPI is invalid	Operating/Performing practitioner NPI number is a required entry and must be 10 characters in length.	Error

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: Required for AS/ED reporting if applicable

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
152	PRACTITIONER	Invalid Other Practitioner ID	Field must contain a valid practitioner ID in format ME12345, APRN1234567, OS1234 with no zero fill or leading zeros	Error
196	PRACTITIONER	Other Performing Practitioner ID w/out NPI number or NPI w/out a Florida license	Other Performing Practitioner license number w/o NPI *OR* NPI number w/o Other Performing state ID. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error

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 (see notes)

Conditions: Required for AS/ED reporting if applicable

Notes: The other operating or performing practitioner must *NOT* be the same as the operating or performing practitioner

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
196	PRACTITIONER	Other Performing Practitioner ID w/out NPI number or NPI w/out a state Florida license	Other Performing Practitioner FL license w/o NPI *OR* NPI number w/o Other Performing FL ID. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error
199	PRACTITIONER	Other Performing practitioner NPI is invalid	Other Performing practitioner NPI number is a required entry and must be 10 characters in length. For military physicians, medical residents, unknown, or others not required to use NPI use 999999999.	Error

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 for AS/ED reporting

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

Report zero (0) if there are no charges. All revenue code fields must be populated with either a dollar charge or zero.

Unused revenue tags can NOT be removed

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Charge are not Numeric, less than $0, contain dollar signs or decimals	Must contain a numeric value or Zero (0) dollars. Report zero if there are no charges.	UPLOAD FAILURE
266	REV	Trauma Charge at a Non-Trauma Facility (ED)	Facility must be a Florida licensed trauma center if Rev code 068 charges are present.	Error

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
Zero-filled

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

Conditions: Required for AS/ED reporting

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

Report zero (0) if there are no charges. All revenue codes must be reported with either a dollar charge or zero

Unused revenue tags can NOT be removed

Freestanding Ambulatory Surgery Centers must verify records having a Total Charge>$250,000.

The hospital ambulatory services must verify records having a Total Charge>$300,000.

The hospital Emergency Department must verify records having a Total Charge>$300,000.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Charge are not Numeric, less than $0, contain dollar signs or decimals	Must contain a numeric value or Zero (0) dollars. Report zero if there are no charges.	UPLOAD FAILURE
125	REV	Total Charge not within $13 of Sum of Sub-Charges	The sum of all sub-charges reported must equal total charges, plus or minus 13 dollars.	Error
127	REV	E.D. Bill with Total Charge>$300,000	Total charges exceed $300,000 and must be verified by the reporting entity.	Error
158	REV	Total Charge=0 and Not ED Discharged AMA	The total charge reported is $0 and the patient discharge status was not coded as AMA (07). Zero charges must be verified by the reporting entity.	Error
263	REV	Outpatient Bill with Total Charge>$250,000	Freestanding ACS total charges exceed $250,000 and must be verified by the reporting entity.	Error
264	REV	Outpatient Bill with Total Charge>$300,000	Hospital AS total charges exceed $300,000 and must be verified by the reporting entity.	Error
265	REV	Outpatient Bill with Total Charge>$1,000,000	Total charges exceed $1,000,000 and must be verified by the reporting entity.	Error

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 for AS/ED reporting

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

A **"Visit"** is defined as a face to face encounter between a health care provider and a patient who is not formally admitted as an inpatient or who is not admitted to the same facility's acute care hospital setting immediately following the encounter

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.

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Patient Visit Begin Date is not valid	Must contain a value using 10 numeric characters in the format YYYY-MM-DD.	UPLOAD FAILURE
182	DEMOGRAPH	Sunday Visits (Freestanding ASC Pro Code 14)	Ambulatory Surgical Centers Weekend Visits	Verify
267	DEMOGRAPH	Begin date<> End Date in free standing ASC	Free-standing ASC cannot have a LOS greater than zero.	Error

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 for AS/ED reporting

Notes: Patient visit ending date must occur within the calendar quarter reported in the header record

Patient visit ending date must equal or follow the patient visit beginning date

The reporting entity must verify records where the end date of the patient's visit is more than 8 days after the beginning date

Repetitive Services -Includes visits for services that recur for an individual patient. Report these services monthly until the treatment is completed

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Visit End Date is Invalid	Must contain a value using 10 numeric characters in the format YYYY-MM-DD.	UPLOAD FAILURE
130	DEMOGRAPH	Patient Visit End Date is before Visit Begin Date	Visit end date must be equal to or after visit begin date	Error
SCHEMA	DEMOGRAPH	Patient Visit End Date is empty	Visit end date is a required field	UPLOAD FAILURE
132	DEMOGRAPH	Patient End date is not in the reporting period	Visit end date must occur within the reporting period as shown on the header record	Error
157	DEMOGRAPH	Patient End Date > 8 days	Patient End date is 8 or more days after the visit begin date	Verify
184	DEMOGRAPH	Visit end Date > 32 days	Patient end date is greater than 32 days from the begin date and type of service = 2 (ED)	Error

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 for AS/ED reporting

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Hour of Arrival is Invalid	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. Must be two numeric characters using 00 through 23	UPLOAD FAILURE
214	DEMOGRAPH	Hour of Arrival and ED Discharge Hour = 99	Both ED hour of Arrival and Discharge Time cannot = 99 Unknown	Error

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 for ED (type 2) reporting
AS (type 1) –use default code '99'

Notes: Use 99 where efforts to obtain the information have been unsuccessful
XML Element tag cannot be removed

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	**SCHEMA**	ED Hour of Discharge Time is missing or invalid	Must be a two digit numeric character using 00 through 23 and 99 representing the hour on a 24-hour clock during which Emergency Department discharge occurred.	**UPLOAD FAILURE**

Edit Applications: cont

Audit	Location	Audit Message	Audit Description	Audit Severity
207	DEMOGRAPH	ED Hour of Discharge Time is not 99 for ASC	ASC type of service 1 must use default code 99 for the ED hour of discharge.	Error

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 time period reported

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

Conditions: Required reporting for ED type of service-2; optional reporting for AS type of service-1.

Notes: Remove unused XML tags if not reported

Follow official coding guidelines for ICD reporting

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
135	DEMOGRAPH	Patient Reason for Visit Code in Invalid	If reported, must contain a valid ICD-10-CM code and entered with the decimal point and **upper case alpha characters**.	Error

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: Entry 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: Report for ED reporting type of service '2'

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

Do not report for Type of service 1 visits

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

Use the 7th character in ICD-10-CM code to report an initial encounter, subsequent encounter, or sequelae (late effect)

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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
90	ECMORB	ECMORB codes in Diagnosis or Reason for Visit Codes	Diagnosis code and Reason for Visit Code fields must contain a valid ICD-10code; ECMORB codes must be reported ONLY in ECMORB code field	Error
141	ECMORB	ECMORB code1 is not a valid ECMORB code	If not space filled, must be a valid ICD-10-CM cause of Morbidity code V.00-Y.99 for the reporting period.	Error
142	ECMORB	ECMORB code2 is not a valid ECMORB code	If not space filled, must be a valid ICD-10-CM cause of Morbidity code V.00-Y.99 for the reporting period.	Error
143	ECMORB	ECMORB code3 is not a valid ECMORB code	If not space filled, must be a valid ICD-10-CM cause of Morbidity code V.00-Y.99 for the reporting period. The code must be entered with use of a decimal point that and upper case alpha characters.	Error
144	ECMORB	ECMORB code 1 is Repeated in ECMORB codes 2-3	An external cause of Morbidity code cannot be used more than once for each visit reported.	Error
145	ECMORB	ECMORB code 2 is Repeated in ECMORB code 3	An external cause of Morbidity code cannot be used more than once for each visit reported.	Error

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 reporting if the facility license includes an "offsite" Emergency department.

*Facilities having only one off-site location will use "A".

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

Notes: Remove XML tag if type of service is 1 or for hospitals without an offsite ED location. **Including blank elements will result in the file being rejected at upload.**

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
202	DEMOGRAPH	Facility unlicensed for Service Location code	Facility not licensed for an off-site ED and service location code is A	Error
SCHEMA	SCHEMA	Invalid Service Location code	Service Location code is invalid indicating off-site ED location of service:	UPLOAD FAILURE
203	DEMOGRAPH	Type of service = 1, Service Location reported	Service Location is reserved for Off-Site ED's. ASC's do not provide ED services.	Error

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 for AS/ED reporting

Notes: **Home - 01** - Includes discharge to home; group home, foster care, and other residential care arrangements; 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

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
SCHEMA	SCHEMA	Patient status is invalid	Must contain a two digit code indicating the patient's disposition at discharge.	UPLOAD FAILURE
177	DEMOGRAPH	Ambulatory Surgery Death	An ambulatory visit with discharge status 20 must be verified.	Verify

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 for AS/ED reporting

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

During resubmission if a record is being deleted from the file, update the record count in the Trailer Record

Edit Applications:

Audit	Location	Audit Message	Audit Description	Audit Severity
149	TRAILER	Number of Records field in Trailer not the Number in DATA	The total number of records that are reported in the trailer record MUST match the total number of records in the data file, excluding the header and the trailer records.	Error

Understanding the Auditing Process and AHCA Reports

The Data Auditor is a software product employed by the Agency to process inpatient, emergency department and ambulatory surgery records received from hospitals and other providers. The Auditor receives data in a specified XML format, performs a number of administrative and clinical edits on the data and generates several error summaries and reports based on this information. Once the data is error free, the facility certifies the data. The certified data is uploaded to an Oracle database for storage and eventual use by the Agency. As part of this process, the inpatient data file is filtered through a DRG grouper based on the data year and exports a DRG variable to the data file for upload to the Oracle database.

A table containing the specific audits applied to each record is maintained on a server within the Agency. All data submitted for processing through the Auditor uses this central file to edit and identify errors. The centralization of this file and other validation tables makes it possible to update and maintain consistency for all record level audits.

The Auditor generates several report types to assist the facility in identifying errors in their own data. To minimize errors and subsequent submissions, the facility should review reports to assure their software is programmed correctly.

Reports are emailed to the facility in PDF format labeled as AR, FER, VR, TR, TRV, NR, SRA, or SRB for report type identification. Each facility has the option to select the files they wish to review. The individual report types are described in the following pages.

Audit Summary Report (AR)

The Audit Summary is an aggregate count of total records that failed each audit.

By reviewing the COUNTS section, one may quickly see the total number of records with errors.

The audit report lists the edit number and description and the number of records failing that specific audit.

Edits are applied individually to each record, so it is possible for a series of records to pass all audits and still be incorrect. For example, if a Discharge Status 20 (expired) is reported for every record, they would pass the audit, yet it is unlikely that every patient discharged had expired.

The report lists the aggregate total number of records submitted, quarters, and data type.

DISCHARGE DATA SUMMARY REPORT

Audit #	Audit	Cases
DATE		
260	! Audits are current as of 04/12/2013	1
COUNTS		
1	! Total Records Submitted - AS 10-3 Audits	1208
2	! Distinct End Dates (Q1-90-91, Q2-91, Q3-92, Q4-92)	61
7	! Records in Trailer File	1
8	! Ambulatory Records (Type of Service=1)	1208
211	! Patient ZIP Code is a PO Box	17
268	! Total Records with Errors	17
DEMOGRAPH		
33	Invalid Patient ZIP Code	1
177	Ambulatory Surgery Death	4
261	Patient Sex is U (Unknown)	1
DX		
38	Primary Diagnosis is empty and Not ED Discharged AMA	7
50	Secondary Diagnosis 1 is Invalid	1
51	Secondary Diagnosis 2 is Invalid	1
52	Secondary Diagnosis 3 is Invalid	1
PROCEDURE		
91	No Procedures are in the Collected Range for Amb Surg	2

The Facility Error report identifies each error contained in the data file as denoted in the aggregate AR report.

The Error Report lists the error associated with each record patient control identification number, audit number, audit description, and the total number of records that failed the audit.

Agency for Health Care Administration
Office of Data Collection
Ambulatory/ED Error Report

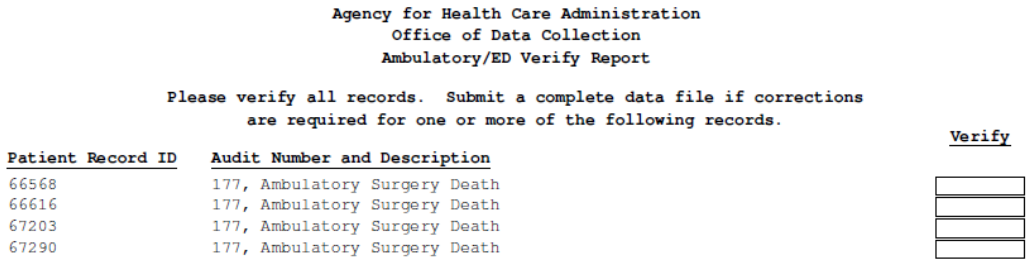
Patient Record ID	Audit Number and Description
66323	91, No Procedures are in the Collected Range for Amb Surg
66394	51, Secondary Diagnosis 2 is Invalid
66504	52, Secondary Diagnosis 3 is Invalid
66684	38, Primary Diagnosis is empty and Not ED Discharged AMA
66723	33, Invalid Patient ZIP Code
66857	38, Primary Diagnosis is empty and Not ED Discharged AMA
66966	38, Primary Diagnosis is empty and Not ED Discharged AMA
67057	38, Primary Diagnosis is empty and Not ED Discharged AMA
67057	261, Patient Sex is U (Unknown)
67144	50, Secondary Diagnosis 1 is Invalid
67271	91, No Procedures are in the Collected Range for Amb Surg
67277	38, Primary Diagnosis is empty and Not ED Discharged AMA
67279	38, Primary Diagnosis is empty and Not ED Discharged AMA
67309	38, Primary Diagnosis is empty and Not ED Discharged AMA

Verification Reports include two types: Edit verification and Threshold verification.

The Agency has the ability to "exclude" questionable audits. For example, if a record failed the audit or exceeded a threshold, but the facility provides a satisfactory written explanation, the edit may be excluded.

The verification report provides a brief summary of the audit or threshold failure to compare to their internal records. If the flagged record is correct, the facility must check the box, provide a written explanation, and sign the verification indicating that the record was reviewed and deemed correct.

If the facility discovers that the record is incorrect, the facility must correct the data file and resubmit the corrected data file to the Agency. The facility should also update their data system to reflect the correction.



Agency for Health Care Administration
Office of Data Collection
Ambulatory/ED Verify Report

Please verify all records. Submit a complete data file if corrections are required for one or more of the following records.

Patient Record ID	Audit Number and Description	Verify
66568	177, Ambulatory Surgery Death	☐
66616	177, Ambulatory Surgery Death	☐
67203	177, Ambulatory Surgery Death	☐
67290	177, Ambulatory Surgery Death	☐

The Norm report compares the present element data counts to the facility historical range.

The purpose of the norm report is to point out variations in facility data submitted over time. For example, if 15% of facility patients were Medicare last year, but the current data submission shows that 40% of their cases are Medicare, this could indicate a problem requiring further research.

The analyst will highlight the out of range elements that the facility must verify. The facility must sign the verification page and provide a written explanation.

If the facility discovers that the records are incorrect, the facility must correct the data file and resubmit the corrected data file to the Agency.

DISCHARGE DATA SUMMARY REPORT

	Actual Cases	Expected Range (Hospital Norm) Lower	Upper	Result
Type of Service				
1 - Ambulatory Surgery	547	511	631	
2 - Emergency Department	10,938	10,854	10,974	
Service Location				
A - Off Site Emergency Department	0	0	0	
Patient Race				
1 - American Indian or Alaska Native	2	0	10	
2 - Asian	31	29	65	
3 - Black or African American	8,468	8,246	8,491	
4 - Native Hawaiian / Oth Pac Island	0	0	6	
5 - White	2,851	2,852	3,094	---
6 - Other	112	64	112	
7 - Unknown	21	0	6	+++
Patient Ethnicity				
E1 - Hispanic or Latino	2,065	2,056	2,272	
E2 - Non-Hispanic or Latino	9,386	9,172	9,390	
E7 - Unknown	34	24	56	
Payer				
A or B (Medicare or Medicare Managed Care)	1,707	1,523	1,715	
C or D (Medicaid or Medicaid Managed Care)	4,073	4,261	4,530	---
E - Commercial Insurance	2,160	1,993	2,206	

This report is a quality tool that compares the current quarter's data to my facility's previous four quarterly submissions.
I acknowledge that I have reviewed this report for accuracy.

Contact Name (Print) _____ Contact Signature _____ Date _____

Contact Phone (Include Extension) _____

Comments:

How the Norm Report is calculated

Data is compiled from the previous 4 quarterly submissions and stored for each tested condition for each facility. The Norm report determines if a reported element is significantly different from historical reporting

While you can never be 100% certain that the differences are due to actual differences or to normal variation, you can approach 100% certainty. The amount of certainty is called a confidence interval. The Norm reports currently use a 99% confidence level.

The report ***uses the individual facility historical (Norm) data to determine the number of discharges to be expected in the current data submission***. An upper and lower confidence level is established based upon the percentage of cases seen in the norm and the number of discharges in the submission.

If the reported percentage falls outside the calculated range we can be confident that the variation is in fact due to actual differences in the data, not due to sampling.

The fact that an item is being reported in a manner which is significantly different from historical reporting does not mean it is wrong, it simply means it is different. In many cases, items that are significantly different from historical reporting may indicate issues.

Examples of these issues may be:

1. A hospital opens up a Women's health center but the percentage of patients who are women reported after the opening is not significantly different from those before the opening.

2. A hospital changes vendors for its billing and medical records services and its mix of commercial cases jumps, but there were no new commercial contracts signed.

   This may indicate an issue between the old vendor's definition of Commercial Vs the new vendor's definition. This does not necessarily indicate that the new vendor is wrong. The old vendor could have been wrong and the new vendor has corrected the issue

Summary Report

The summary report provides an overview of the aggregated data for each element submitted by the facility. The report gives the facility a high level view of many of the key data fields and a last chance 'quality' check from a high level prior to certification.

The summary reports may reflect data patterns or trends not obvious at the record level.

For example, no error will occur if all records identify the payer as Medicare. However, it is highly unlikely that all patients have the same payer. It would become immediately apparent that there was a system error upon review of the aggregate summaries.

The Data Summary Report lists each acceptable value, or range of values, for each key field in the file, as well as the number of occurrences, percent of total, total charges, average charge and average age. This report is an excellent summary of activity within the organization. This should be a "reality check" for the facility since patterns, or changes in patterns within each field are highly visible

DISCHARGE DATA SUMMARY REPORT

	Discharges	PCT	Charges	PCT	Avg Charge	Avg Age
Type of Service						
Ambulatory Surgery	1,208	100.00%	$13,301,386	100.00%	$11,011	64.9
On-Site E.D.	0	0.00%	$0	0.00%	$0	0.0
Off-Site E.D.	0	0.00%	$0	0.00%	$0	0.0
Total:	1,208	100.00%	$13,301,386	100.00%	$11,011	64.9
ZIP Code Type						
00000-Unknown	0	0.00%	$0	0.00%	$0	0.0
00007-Homeless	0	0.00%	$0	0.00%	$0	0.0
00009-Foreign	0	0.00%	$0	0.00%	$0	0.0
P.O. Box	17	1.40%	$176,784	1.32%	$10,399	64.0
Non P.O. Box	1,190	98.50%	$13,114,982	98.59%	$11,020	64.9
Total:	1,207	99.91%	$13,291,766	99.92%	$11,012	64.8
Patient Age						
<1	0	0.00%	$0	0.00%	$0	0.0
1-17	2	0.16%	$15,653	0.11%	$7,826	11.5
18-24	6	0.49%	$80,924	0.60%	$13,487	21.5
25-29	10	0.82%	$120,019	0.90%	$12,001	27.7
30-34	14	1.15%	$132,067	0.99%	$9,433	32.2
35-39	26	2.15%	$333,644	2.50%	$12,832	37.2
40-44	35	2.89%	$521,379	3.91%	$14,896	41.9
45-49	43	3.55%	$579,207	4.35%	$13,469	47.4
50-54	87	7.20%	$1,099,005	8.26%	$12,632	51.9
55-59	149	12.33%	$1,880,937	14.14%	$12,623	56.9
60-64	147	12.16%	$1,760,638	13.23%	$11,977	62.1
65-69	203	16.80%	$2,176,652	16.36%	$10,722	67.0
70-74	202	16.72%	$1,927,927	14.49%	$9,544	71.8
75-79	142	11.75%	$1,404,090	10.55%	$9,887	76.6
80-84	91	7.53%	$788,655	5.92%	$8,666	81.5
85-99	51	4.22%	$480,589	3.61%	$9,423	87.5
100-115	0	0.00%	$0	0.00%	$0	0.0
116-UP	0	0.00%	$0	0.00%	$0	0.0

Below are important elements to review before certification that are common reasons why a facility is required to resubmit.

ELEMENTS-INPATIENT	Discharges	PCT	WHAT TO REVIEW
Type of Service			
1-Inpatient	11,977	98.03%	Is the number of discharges in line with your average?
2-Comp Rehab	240	1.96%	If applicable, are CR beds reported?
ED Hr Arrival-Admit Hr			
Not an ED Admit	5,991	49.03%	
Same Hour	38	0.31%	
Different Hour	6,188	50.65%	
Condition Code			
Not reported	0	0.00%	
Not Treated in ED	5,991	49.03%	**Does this reflect # of direct admits?**
Treated in ED	6,226	50.96%	**Does this reflect # of ED admits?**
Admission Priority			
1-Emergency	6,145	50.29%	Does this agree with the ED Condition Code?
2-Urgent	1,942	15.89%	
3-Elective	2,141	17.52%	
4-Newborn	1,563	12.79%	Does this agree with the # newborns born at your facility?
5-Trauma	426	3.48%	Is the # of trauma admits correct? Are you a licensed Trauma Center?

ELEMENTS-INPATIENT	Discharges	PCT	WHAT TO REVIEW
Discharge Month and Year			
2017, July	4,157	34.02%	Are all months reported for the quarter?
2017, August	4,384	35.88%	What is explanation for higher or lower monthly/quarterly record counts?
2017, September	3,676	30.08%	
Total Gross Charges			**LOS** **Avg Charge**
$100,000-$499,999	2, 541	20.79%	
$500,000+	236	1.93%	46 $927,845
			Is the Avg Charge resonable?
Patient Sex			
M-Male	5,483	44.88%	
F-Female	6,724	55.11%	
U-Unknown	10	0.01%	Is the # of Unknown Sex correct?
Patient Race			
1-Am Indian / AK	14	0.11%	Do the Race #'s agree with the facility demographics?
2-Asian	176	1.44%	
3-Black/Af Americ	2,650	21.69%	
4-Hawaiian/Pac Is	9	0.07%	
5-White	7,166	58.65%	
6-Other	2,037	16.67%	
7-Unknown	165	1.35%	Is the # of unknown excessive?

In addition to the common elements above, these are exclusive to ASED data set

ELEMENTS-ASED	Discharges	PCT	WHAT TO REVIEW
Type of Service			
Ambulatory Surgery	2,484.00	8.44%	
On-Site E.D.	26,940	91.55%	
On-Site E.D.	0	0.00%	Does your facility have an OSED?
Off-Site E.D. A	2,000		Is each location reported?
Off-Site E.D. B	2,500		
Off-Site E.D. C	1,800		
EC Morb Code Count			
0 EC Morb Codes	24,474	83.17%	Are ECMORB codes reported in ED visits?
1 EC MORB Codes	1,953	6.63%	
2 EC MORB Codes	1,161	3.94%	
3 EC MORB Codes	1,836	6.23%	

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.

Correction Period: The time allowed for a hospital to make required corrections and resubmit their data.

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. For example, all records of newborn infants present in an inpatient data set would comprise the data universe for newborn auditing. Audits specific to data elements found only in newborn records will apply only to those records, and the allowable threshold of error is calculated upon the total number of records in that newborn data universe.

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 to contain incomplete data or to contain illogical data.

Extension: A formal written request from the facility to AHCA requesting an extension due to extenuating circumstances.

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.

Fatal Error: An error on any audit that requires 100% accuracy. A single fatal error will cause the entire data set in which it resides to be rejected.

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).

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 Letter: A letter of assessed fines sent to a facility CEO for Patient Data Reporting Delinquencies when a facility fails to certify on time or files false or incomplete reports.

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. Even if the organs are donated, the deceased patient should not be retained under inpatient status or readmitted with a principal diagnosis of V59.x (organ donor).

Plan of Correction: In the event that a hospital is unable to make required corrections to a data set, the hospital may submit a plan of correction.

The hospital must document why the errors cannot be corrected, what has been identified as the cause of those errors, and what steps the hospital is implementing to ensure the errors do not recur. If accepted, the Plan of Correction will serve in lieu of corrections for the reporting period in which the Plan is accepted.

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.

Report: A report is defined as the collection of all Hospital Discharge Data Records, or all Emergency Care Data Records, or all Ambulatory Surgery Data Records required to be submitted by a reporting facility for one reporting period.

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

Report Due Date: The report due date is either the **1st for IP or the 10th for AS/ED of the SECOND month after the end of each reporting period**; thus the due date for the January 1 through March 31 reports is no later than June 1/10 of the same year; the due date for the April 1 through June 30 reports is no later than September 1/10; the due date for the July 1 through September 30 reports is no later than December 1/10 ; and the due date for the October 1 through December 31 reports is no later than March 1/10 of the following year.

Resubmission: The submission of a corrected data set a subsequent time **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 reporting of a data report and accompanying required forms by a reporting hospital to the AHCA.

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 hospital during a Test Period, to be evaluated for the purpose of providing assistance to the hospital 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. The threshold report documents the percentage and record count of error allowed on a data set or individual data elements.

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.

Forms

Print forms from the Reporting Resource page at Florida Center/Data Collection Web site address:

http://ahca.myflorida.com/SCHS/DataCollection/2010-Resources.shtml

Internet Data Submission Registration Forms

- **Contact Form**
- **Facility User Account Agreement**

Contact Form

PATIENT DATA CONTACT PERSONNEL DOCUMENTATION FORM
AHCA ID #: _____ **DATE:** _____

PLEASE INDICATE THE CONTACT TYPE BELOW AND PROVIDE ANY NECESSARY CORRECTIONS ON THE LINE BELOW THE ITEM TO BE UPDATED. ONCE ALL UPDATES HAVE BEEN MADE, RETURN THIS FORM TO THE AGENCY AS SOON AS POSSIBLE. THANK YOU

☐ AMBULATORY SURGERY/EMERGENCY DEPARTMENT ☐ INPATIENT/COMP REHAB
☐ BOTH ☐ NO CORRECTIONS REQUIRED

FACILITY NAME: _____	CONTACT: _____
CEO: _____	CONTACT EMAIL: _____
CEO EMAIL: _____	CONTACT PHONE #: _____
CEO PHONE #: _____	CONTACT FAX #: _____
CEO FAX #: _____	SECONDARY CONTACT: PLEASE INCLUDE AN ALTERNATE CONTACT WHO WILL BE RESPONSIBILE FOR ASSISTING AHCA WITH DATA COLLECTION QUESTIONS.
FACILITY MAILING ADDRESS: _____ _____	CONTACT: _____
FACILTY WEB ADDRESS: _____	CONTACT EMAIL: _____
	CONTACT PHONE #: _____
	CONTACT FAX#: _____

FACILITY USER ACCOUNT AGREEMENT

Please print clearly

Section 1: Internet Data Submission (IDS) User Account Information *(all information is required)*

1. FACILITY NAME: _____

2. AHCA NUMBER: _____

3. NAME OF IDS USERS (FIRST, MIDDLE INITIAL, LAST):

A. USER 01: _____
B. USER 02: _____
C. USER 03: _____
D. USER 04: _____

4. FACILITY ADDRESS:	**5. USER E-MAIL ADDRESS:** A. USER 01: _____ B. USER 02: _____ C. USER 03: _____ D. USER 04: _____
6. BUSINESS PHONE: A. USER 01: _____ B. USER 02: _____ C. USER 03: _____ D. USER 04: _____	**7. BUSINESS FAX:**

I understand that as an IDS User, I can submit data and retrieve the status of the data on behalf of the above designated facility.

I understand that by signing this document I am authorizing the Agency to send users of this system emails from time to time as it deems necessary.

By signing this document I acknowledge reading, understanding, and agreeing to its contents.

I understand that as an appointed User Account Administrator on behalf of the facility, I have the responsibility to:
1. Create/add and delete user accounts for other IDS users within my facility. Creating a user account grants access for an individual to read, submit and correct my facility's confidential data. Deleting user accounts revokes this access.
2. Modify the demographic information for my facility's Primary, Secondary and Administrator Contacts. This will be the method that SCHS is notified of any changes in name, mailing address, phone number, and e-mail address for each contact. Modifying contact demographic information directly changes the information on the SCHS database.
3. Reset passwords for IDS users within my facility. In the event that a user misplaces or forgets their password, they will be directed to contact their User Account Administrator to have it reset. The User Account Administrator should authenticate the user prior to resetting the password and issuing a new password.
4. Unlock IDS user accounts. IDS will lock user accounts after three (3) unsuccessful log on attempts. When the account is locked, users will be required to contact their User Account Administrator to unlock their account.

By signing this document I acknowledge reading, understanding, and agreeing to its contents

8. USER SIGNATURES: **DATE:** _____

A. USER 01:

B. USER 02:

C. USER 03:

D. USER 04:

The **original** of this completed form, for each user at a reporting facility having IDS on-line access, shall be provided to SCHS at the time it is prepared and signed.

Section 2: For SCHS use only

Date Received:	Date Authenticated/Enrolled:	By:

Please Note: The Facility Administrator or Primary Contact at each facility must complete and sign the Third Party Authorization Agreement form approving a Designated Agent if a third party will be submitting this data to AHCA on behalf of the reporting entity.

An Ambulatory or Inpatient certification form is sent to the facility contact by the analyst when the facility is deemed clean and ready for certification.

CERTIFICATION OF AMBULATORY PATIENT DATA
To
STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION
Office of Data Collection and Quality Assurance
2727 Mahan Drive, Mail Stop 16
Tallahassee, Florida 32308-5403

(Name of Provider)	(AHCA Number)
(Street Address)	(Telephone Number)
(City and Zip Code)	(Fax Number)

I have examined the ambulatory patient data report and, to the best of my 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.

Report period of worksheets: _____ TO _____

NAME OF EXECUTIVE OFFICER: _____

OFFICIAL TITLE: _____

SIGNATURE: _____

DATE: _____

"Executive Officer" as defined in 59B-9.031(6)
chief executive officer, chief financial officer, chief operating officer, president, vice president in charge of a principal business unit, division or function

AHCA form 4200-0007, July 2017 59B-9.035(1) Florida Administrative Code

CERTIFICATION OF INPATIENT PATIENT DATA
To
STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION
Office of Data Collection and Quality Assurance
2727 Mahan Drive
Fort Knox, Building #3, Mail Stop 16
Tallahassee, Florida 32308-5403

(Name of Provider)	(AHCA Number)
(Street Address)	(Telephone Number)
(City and Zip Code)	(Fax Number)

I have examined the ambulatory patient data report and, to the best of my 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.

Report period of worksheets: _____ **TO** _____

NAME OF EXECUTIVE OFFICER: _____

OFFICIAL TITLE: _____

SIGNATURE: _____

DATE: _____

"Executive Officer" as defined in 59E-7.021(5)
chief executive officer, chief financial officer, chief operating officer, president, vice president in charge of a principal business unit, division or function

AHCA Form 4200-0002, July 2017 **59E-7.025(1), Florida Administrative Code**

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

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
RES/RES000	Resident	RES000
HSE	Unlicensed House Physician	HSE1234
TRN	Unlicensed Medical Doctor in Training	TRN1234
PA	Physician Assistant	PA1234567
Osteopath Physician		
OS	Osteopathic Physician	OS12345
UO	Unlicensed Osteopathic Registration	UO1234
Dentist		
DN	Dentist	DN1234
DTP	Dental Teaching Permit	DTP1234
TPUM	Dental Teaching Permit for Univ. of Miami	TPUM1234
TPNU	Dental Teaching Permit for Nova Univ.	TPNU1234
TPUF	Dental Teaching Permit for Univ. of FL	TPUF1234
DRP	Dental Residency Permit	DRP1234
Podiatrist		
PO	Podiatric Physician	PO12345
PR	Podiatric Resident Registration	PR123
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:

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

- 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 NPI numbers on the NPPES website
- 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 may be found at the Reporting Resources page at the Florida Center/Data Collection Web address:

http://ahca.myflorida.com/SCHS/DataCollection/2010-Resources.shtml

Inpatient

Data Specifications: (**PD10-4, Q1 2018**)

- Inpatient/ Comprehensive Rehab XML Schema PD10-4 http://ahca.myflorida.com/xmlschemas/PD10-4.xsd
- Inpatient/ Comprehensive Rehab XML Sample File PD10-4 http://ahca.myflorida.com/SCHS/DataCollection/docs/IPCRSampeFilePD104_041116.pdf

- Inpatient / Comprehensive Rehab Data Elements
- Inpatient Audit/ Threshold Dictionary PD10-4

Data Specifications: (**PD10-3, Q42015 - 2017**) ***NO LONGER USED***

- Inpatient/ Comprehensive Rehab XML Schema PD10-3 http://ahca.myflorida.com/xmlschemas/PD10-3.xsd
- Inpatient/ Comprehensive Rehab XML Sample File PD10-3 http://ahca.myflorida.com/SCHS/DataCollection/docs/IPCRSampeFilePD103_041116.pdf

Data Specifications: (**AS10-3, Q1 2018**)

- Ambulatory/ED XML Schema
  www.ahca.myflorida.com/xmlschemas/AS10-3.xsd
- Ambulatory/ED XML Sample File
- http://ahca.myflorida.com/SCHS/DataCollection/docs/ASEDSampleFileAS103.pdf

- Ambulatory/ED Patient Data Elements
- Ambulatory/ED Audit/Threshold dictionary

Data Specifications: (**AS10-2, Q42015 - 2017**) *NO LONGER USED*

- Ambulatory/ED XML Schema
  www.ahca.myflorida.com/xmlschemas/AS10-2.xsd
- Ambulatory/ED XML Sample File
- http://ahca.myflorida.com/SCHS/DataCollection/docs/ASEDSampleFileAS102.pdf